NHS London

An Introduction to a Pan London Approach to Improve Quality, Access and Patient Experience in G… l Practice

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Technical Guidance

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NHS London

Introduction to the Technical Guidance

The Pan London General Practice Outcome Standards and Technical Guidance should be read in conjunction with 'An Introduction to a Pan London Approach to Improve Quality, Access and Patient Experience in General Practice'. This sets out the approach to developing the standards and how the suite of measures should be used to improve quality and their limitations. Developing the outcome standards and agreeing an approach to quality improvement has been led by clinicians in collaboration with the Londonwide LMCs, NHS London and Commissioners.

The Technical Guidance provides the definition for each standard, the data source, evidence base and productivity opportunity. The outcome standards will be published from 1 April 2011 and will be updated at quarterly intervals for those standards data is available for. Year one will provide baseline data for practices, PCTs and emerging Consortia. This will provide a reflective tool for quality improvement purposes, raise awareness amongst GPs about performance and create an impetus for development and improvement.

The outcome standards draw on existing data sources to avoid creating any additional burden on practitioners to report new data. This has limited the outcome standards to areas that are currently measurable. As a result, there are limitations to the data that is available across a number of indicators, which is outlined throughout this document.

Reviewing a practices position should take into account trends over time and correlations between associated indicators. Grouping indicators in this way means the practice and commissioners can assess performance across a number of related measures. This will provide a more robust assessment of whether there are areas of care that require improvement. A practice's performance should be contextualised using data from other practices in similar locations and/or with similar populations.

Following the above process, if a practice appears to be consistently an outlier this should act as a stimulus for commissioners and the practice to explore further what the issues are and address effectively. This is an ongoing process that will influence practices to adapt by learning from what has worked in other areas and by encouraging GPs to strive for the best results compared to their peers.

When GP practices are grouped into local Consortia this will provide information for professionally led improvement and challenge. In future years this will become a tool for practitioners and commissioners to support primary medical service providers to improve against agreed targets and goals.

General Practice Outcome Standards

Outcome Domain	Number	Standard	Definition
Preventing People from Dying Prematurely – Cancer	1	One year cancer survival rates for breast cancer and lung cancer.	**Appropriate as an indicator of Consortia performance.** Reported one year relative cancer survival rates for breast cancer and lung cancer.
Preventing People from Dying Prematurely – Cancer	2	Cancer prevalence.	**Appropriate as an indicator of Consortia performance.** Reported versus expected prevalence for cancer.
Preventing People from Dying Prematurely – Cancer	3	Cervical screening.	**Appropriate as an indicator of general practice performance.** The percentage of patients aged from 25 to 64 whose notes record that a cervical smear has been performed in the last five years.
Preventing People from Dying Prematurely – Prevention	4	GP recorded smoking (Whole population).	**Appropriate as an indicator of general practice performance.** The percentage of patients per GP practice whose smoking status is recorded in the previous 15 months.
Preventing People from Dying Prematurely – Long Term Conditions	5	GP recorded smoking (Long-term conditions).	**Appropriate as an indicator of general practice performance.** The percentage of patients with selected long term conditions (LTCs), whose notes contain a record that smoking cessation advice or referral to a specialist service, where available, has been offered within the previous 15 months.
Preventing People from Dying Prematurely – Stroke and TIA	6	Atrial fibrillation prevalence.	**Appropriate as an indicator of Consortia performance.** Reported versus expected prevalence atrial fibrillation.

Preventing People from Dying Prematurely – Communicable Diseases	7	Immunisation uptake.	**Appropriate as an indicator of general practice performance.** The percentage of children who complete immunisation by the recommended age. To include rates of children who have been immunised at age 1 (DTaP/IPV/Hib) and age 2 (PCV Booster, Hib/MenC and a completed course of MMR).
Preventing People from Dying Prematurely – Communicable Diseases	8	Influenza immunisation uptake.	**Appropriate as an indicator of both general practice and Consortia performance.** The percentage of at risk patients aged over 65 who have a record of influenza immunisation in the preceding September to March period.
Enhancing Quality of life for people with long term conditions – Respiratory Disease	9	Chronic obstructive pulmonary disease (COPD) prevalence.	**Appropriate as an indicator of general practice performance.** Reported versus expected prevalence for Chronic Obstructive Pulmonary disease.
Enhancing Quality of life for people with long term conditions – Respiratory Disease	10	Asthma prevalence.	**Appropriate as an indicator of Consortia performance.** Reported versus expected prevalence for asthma.
Enhancing Quality of life for people with long term conditions – Heart Disease	11	Diabetes prevalence.	**Appropriate as an indicator of Consortia performance.** Reported versus expected prevalence for diabetes for people aged 17 and over.
Enhancing Quality of life for people with long term conditions – Heart Disease	12	Coronary heart disease prevalence (CHD). Work ongoing to develop triangulation with prescribing data.	**Appropriate as an indicator of general practice performance.** Reported versus expected prevalence for Coronary heart disease.

Enhancing Quality of life for people with long term conditions – Mental Health	13	Dementia prevalence.	**Appropriate as an indicator of Consortia performance.** Reported versus expected prevalence for dementia.
Enhancing Quality of life for people with long term conditions – Prescribing Management	14	Monitoring safe, rational and cost effective prescribing in general practice.	**Appropriate as an indicator of general practice performance.** Increase safety of prescribed non-steroidal anti-inflammatory drugs by reducing use of diclofenac and cox-2 inhibitors.
Helping People to Recover from Episodes of Illness or Following Injury – Unscheduled Care	15	Emergency hospital admission rates for specific chronic conditions usually managed in primary care.	**Appropriate as an indicator of Consortia performance alongside reporting general practice level data.** Rate of emergency hospital admissions for selected LTCs as a proportion of total number of patients per GP practice with selected LTCs. NHS Comparators LTCs to be included: Angina, Asthma, Congestive heart failure, COPD, Diabetes complications, Hypertension, Iron deficiency anaemia, Nutritional deficiencies.
Helping People to Recover from Episodes of Illness or Following Injury – Unscheduled Care	16	A&E attendances.	**Appropriate as an indicator of Consortia performance alongside reporting general practice level data.** The rate of A&E attendances per 1000 patients on GP register.
Ensuring People Have a Positive Experience of care – Quality of care	17	After consultation how well did you understand / feel better able to cope?	**Appropriate as an indicator of general practice performance.** Percentage of patients who answered 'yes', 'yes definitely' or 'yes, to some extent' to selected questions in the GP survey, as a proportion of total patients who responded to those questions.
Ensuring People Have a Positive Experience of care – Quality of care	18	Satisfaction with overall care received at surgery.	**Appropriate as an indicator of general practice performance.** Percentage of patients who reported being satisfied with overall care received at the surgery.

Ensuring People Have a Positive Experience of care – Quality of care	19	Patients changing practice without changing address.	**Appropriate as an indicator of general practice performance.** Percentage of patients who changed GP practice without changing address. (Needs to be tested and query established)
Ensuring People Have a Positive Experience of care – Continuity of Care	20	Ability to see a specific GP or Practice Nurse if wanted.	**Appropriate as an indicator of general practice performance.** Percentage of patients who are satisfied with the frequency of seeing a preferred doctor at the surgery.
Ensuring People Have a Positive Experience of care – Access to primary care	21	Advanced appointments. Satisfaction with opening hours. Ease of getting through on the phone.	**Appropriate as an indicator of general practice performance.** Access to Primary Care.
Treating and Caring for People in a Safe Environment and Protecting them from Avoidable Harm – SUI, Incident and complaint monitoring	22	Significant event reporting (One and three year targets).	**Appropriate as an indicator of Consortia performance.** All practices should complete a minimum of 3 reviews in the preceding year and twelve in the preceding 3 years, regardless of practice list size.

Preventing People from Dying Prematurely – Cancer

Standard

1. One year cancer survival rates for breast cancer and lung cancer.

Definition

Appropriate as an indicator of Consortia performance.

Reported relative one year cancer survival rates for breast and lung cancer.

Numerator: The number of patients diagnosed with breast or lung cancer in a year who are still alive one year after diagnosis.

Denominator: The total number of patients diagnosed with breast or lung cancer in a year.

The objective aims to deliver continuing improvements in the one year survival rate of patients diagnosed with cancer in London.

Organisations in the top quartile ranking within London are examples of good practice.

Monitoring, intervention and support would be required for those organisations within the bottom quartile ranking in London. Monitoring and support would be beneficial for those organisations within the mid quartiles within London.

Data Limitations: This data has not been standardised to control for other variables which could impact on survival rates, for example age or gender. When reviewing this data caution is required. Results for individual practices may be due to differences in the population. This data should be reviewed alongside other indicators and compared to practices in a similar context to get a holistic view of quality. Predicated survival rates will be reported when the data is available nationally.

Data Source

Published data via National Cancer Intelligence Network (NCIN).

Relevant data may also be published via practice profiles included with cancer commissioning toolkit (NCIN).

Latest cancer stats
S:\Performance\Knowledge & Intelligence\Cancer-PCT-2010-data.xls

Rationale

The All Party Parliamentary Report on Cancer (2009) reports that delays in diagnosing cancer are a major reason why one year cancer survival rates in England are worse than in other countries in Europe. Early diagnosis by general practice is essential if we are to bring cancer survival rates up to the level of the best of Europe. It has been estimated that, across the

NHS, earlier diagnosis could save 5,000 to 10,000 lives a year[1].

Of the 290,000 cases of cancer diagnosed in the UK each year, most will come via symptomatic presentation to primary care. Within an average year, a GP can expect to see one case of each of the four common cancers: breast, lung, colorectal and prostate[2].
The reasons for late diagnosis appear to be a combination of factors: patients coming forward later, cancer diagnoses being missed in primary care, and GPs having limited access to diagnostic tests[3].

From April 2011 GPs in England are to get speedier access to diagnostic tests in order to help diagnose less clear-cut cases of cancer. The new scheme will initially be targeted at lung, colorectal and ovarian cancers although it is intended to extend the scheme to all cancers within five years. Once implemented, patients will have key tests within two weeks of seeing the GP – reducing to one week in due course[4].

One year cancer survival rates for Breast Cancer, Lung Cancer and Colorectal Cancer are to be included in the National NHS Outcomes Framework from April 2011 as an indicator of earlier diagnosis for cancer patients.

QIPP Opportunity

Early diagnosis of cancer will allow less aggressive treatment programmes for patients improving quality of life and survival rates and contribute to a reduction in in-patient stays. This represents an opportunity saving of £13.3m.

Reduction in IP bed days and IP expenditures for cancer treatment are included as QIPP opportunities under the Right care work stream[5]. 2009/10 PCT data show a mid quartile range in emergency bed days per 1000 population between 28 and 37 with 18 London PCTs in "worst" quartile, if these had only the expected emergency bed days there would have been 36,500 fewer. Costed as excess bed days for HRG PA43B (other neoplasms w/o cc LOS 1+ days).

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[1] 06.01.2011; MacMillan, All Party Parliamentary Group on Cancer; Report of the All Party Parliamentary Group on Cancer's Inquiry into Inequalities in Cancer; http://www.macmillan.org.uk/Documents/GetInvolved/Campaigns/APPG/BritainAgainstCancer2009/CancerInequalitiesReport.pdf))

[2] 06.01.2011; Cancer Research UK; Cancer Insight, Promoting early diagnosis; http://info.cancerresearchuk.org/prod_consump/groups/cr_common/@nre/@hea/documents/generalcontent/017933.pdf

[3] 06.01.2011; MacMillan, All Party Parliamentary Group on Cancer; Report of the All Party Parliamentary Group on Cancer's Inquiry into Inequalities in Cancer; http://www.macmillan.org.uk/Documents/GetInvolved/Campaigns/APPG/BritainAgainstCancer2009/CancerInequalitiesReport.pdf))

[4] 06.01.11; Cancer Research UK; Improving cancer outcomes: An analysis of the implementation of the UK's cancer strategies 2006–2010; http://info.cancerresearchuk.org/prod_consump/groups/cr_common/@nre/@pol/documents/generalcontent/cr_048863.pdf

[5] 06.01.11; Department of Health; QIPP, National Workstreams; http://www.dh.gov.uk/en/Healthcare/Qualityandproductivity/DH_112316

Preventing People from Dying Prematurely – Cancer

Standard

2. Cancer Prevalence.

Definition

Appropriate as an indicator of Consortia performance.

Reported versus expected prevalence for cancer.

Numerator: Number of patients recorded by consortium practices as having condition as reported in QOF data.

Denominator: Expected number of patients by consortium practices on the disease register. Expected Prevalence of cancer calculated using age / sex specific rates from the Doncaster model applied to GP practice list size data.

The objective aims to deliver continuing improvements in the management and identification of coronary heart disease in London.

Organisations in the top quartile ranking within London are examples of good practice.

Monitoring, intervention and support would be required for those organisations within the bottom quartile ranking in London. Monitoring and support would be beneficial for those organisations within the mid quartiles within London.

Organisations will be ranked according to the absolute variance between actual and expected, were 1:1 is normal.

Note: Please refer to Guidance Notes for interpretation on Pg 61.

Data Limitations: Included as a crude benchmark only. Model used underestimates prevalence with national reported rate exceeding expected rate by 68%. When reviewing this data caution is required.

Data Source

NHS Information centre analysis published via NHS Comparators.

Source for national prevalence rates: Forman D, Stockton D, Moller H et al. Cancer prevalence in the UK: results from the EUROPREVAL study. Annals of Oncology 2003: 14: 648-654.

Rationale

Today there are just over two million people in the UK living with or beyond cancer diagnosed at any time and this is rising by more than 3% a year. Prevalence figures are influenced by both incidence and survival. Thus, the most prevalent types of cancer are those with a relatively high incidence rate and a good prognosis. In the UK the most

prevalent cancer in males is prostate cancer and in females it is breast cancer[6].

The latest analysis shows that at the end of 2006, there were over 200,000 prevalent cancer patients in the UK who were alive one year after their diagnosis. In total, there were 1.13 million cancer survivors in the UK who were up to 10 years from diagnosis at the end of 2006[7].

According to analysis on NHS comparators (2008/9), London primary care has identified a smaller proportion (155%) of patients with cancer (when compared to the modelled estimate) than the NHS as a whole (168%). There is considerable variation at practice level with some having identified at least 250% of the estimate and others less than 50% of the estimate.

The expected rates only take account of the age / sex distribution of the practice population and not other factors which may be relevant (e.g. relative deprivation, ethnic breakdown etc). Individual practices/GPs will vary in their ability to recognise the early symptoms of cancer and or/screening of patients for condition. Failure to identify these less severe cases will impact on 1 year survival rates, as cancer will be further advanced when finally diagnosed.

QIPP Opportunity

Improved case detection and management in primary care will help patients negotiate the specialist system and provide support to patients and their families. It is a necessity for enhanced recovery programmes and has the potential to reduce in-patient bed days which represents an opportunity of £6.5m.

Reduction in IP bed days and IP expenditures for cancer treatment are included as QIPP opportunities under the national Right Care workstream. 2009/10 PCT data show a mid quartile range in emergency admissions per 1000 population between 2.6 and 3.3 with 16 London PCTs in "worst" quartile, if these had only the expected admissions there would have been 3,800 fewer of these. Costed using national tariffs this represents an opportunity of £6.5m.

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[6] Dec 2010; Cancer Research UK; Prevalence (numbers of cancer survivors) – UK; http://info.cancerresearchuk.org/cancerstats/incidence/prevalence/

[7] 06.01.2011; Cancer Research UK; http://info.cancerresearchuk.org/cancerstats/incidence/prevalence/

Preventing People from Dying Prematurely – Cancer

Standard

3. Cervical Screening.

Definition

Appropriate as an indicator of general practice performance.

The percentage of patients aged from 25 to 64 whose notes record that a cervical smear has been performed in the last five years.

Numerator 1

The number of women aged 25-64 who have received cervical screening in the last 5 years.

Denominator 1

The number of women aged 25-64 eligible for screening (on 31st March 2010).

ACCOUNTABILTY

The objective aims to deliver continuing improvement in cervical screening rates in London.

Organisations in the top quartile ranking within London are examples of good practice, however, nationally expected performance has previously been set at 70% (25-49yrs) and 75% (50-64yrs).

All practices should aim to achieve a minimum of 70% performance across the full age range 25-64 years.

Data Source

Quarterly collection from PCTs required. Going forward this information will need to be collected from GP Consortia on a monthly basis.

Frequency: Quarterly.

Rationale

In Europe, cervical cancer is the second most common cause of death by cancer in young women, aged 15-44 years, after breast cancer. This is one of the few cancers that is preventable because pre-cancerous cell changes can be picked up before they have a chance to develop into cancer[8].

Cervical screening is provided in the practice, usually by the practice nurses and the practices have a flag on their system to alert them to when someone on their list is due a cervical smear or if they have failed to attend an appointment.

[8] 06.01.11; Cancer Research UK; http://www.cancerhelp.org.uk/type/cervical-cancer/about/cervical-cancer-screening;

2009/10 QOF data showed that London was the least well performing SHA on Cytology (additional service) with 80.7% of women in the relevant age group having a cervical smear in the last 5 years (as recorded in their notes and reported through QOF, NHS average 83.7%).

Variation ranges from between 85.8% to 76.3% for PCTs and from over 95% to fewer than 50% for GP practices.

QIPP Opportunity

Early detection of cervical abnormalities means that less invasive interventions can take place in out-patient settings, often at a precancerous stage, and the long term adverse impact on (often younger) women's lives is reduced. There were 804 new cases of cervical cancer in London during the period 2004-2006 with 263 deaths during 2006-2008. The potential to reduce in-patient bed days represents an opportunity of £1.1m across London.

Reduction in IP bed days and IP expenditures for cancer treatment are included as QIPP opportunities under the Right care workstream. 2009/10 PCT data show a mid quartile range in gynaecology cancer admissions per 1000 population between 0.5 and 1.3 with 5 London PCTs in "worst" quartile, if these had only the expected admissions there would have been 666 fewer. Costed as HRG PA43B (other neoplasms w/o cc LOS 1+ days) this represents an opportunity of £1.1m across London.

Preventing People from Dying Prematurely - Prevention

Standard

4. GP Recorded Smoking (Whole Population).

DH ceased quarterly data collection which may impact on our ability to secure the data.

Definition

Appropriate as an indicator of general practice performance.

The percentage of patients per GP practice whose smoking status is recorded in the previous 27 months.

Numerator: The number of patients per GP practice whose smoking status is recorded in the previous 27 months.

Denominator: The total number of patients on the practice list as reported on through QOF.

ACCOUNTABILTY

The objective aims to deliver continuing improvement in data quality for GP recorded smoking.

Organisations in the top quartile ranking within London are examples of good practice.

GP practices should aim to ensure the smoking status of a minimum of 85% of patients is recorded.

Data Source

QOF

Frequency: Annual

Rationale

Smoking is the single greatest cause of preventable illness and premature death in the UK. The effects on health from smoking have been known for many years and are well documented with 80% of the deaths from lung cancer being related to smoking. There has been a steady decline in the number of people who smoke in England over the last three decades. For smokers who give up, the chances of developing serious conditions or diseases are greatly reduced. This indicator is crucial to securing improvements in public health[9].

Stopping smoking reduces the risk of many of the conditions associated with smoking.

[9] 06.01.2011; Department of Health; http://www.dh.gov.uk/en/Publichealth/Healthimprovement/Tobacco/index.htm

However, lag times differ among conditions between smoking and development of disease. Although for some conditions the risk falls off quickly after quitting toward the level of a never smoker, for others there remains an elevated risk for many decades. Individual risk often depends on previous duration and intensity of smoking and varies between those with and without pre-existing evidence of disease. This means that it is important to promote smoking cessation as early as possible among young smokers who have the greatest chance of avoiding adverse smoking-related events. As these populations are usually in good health and have limited contact with the medical community, all opportunities need to be taken. Although the largest potential benefits are in young smokers, there are benefits from quitting even among elderly smokers and people with considerable co morbidities. These groups should also be encouraged to quit[10].

General Practitioners (GPs) are the major source of referral of smokers to the NHS stop smoking service, and we know that advice to stop smoking form a GP increases the chances of success, most likely by prompting quit attempts. Also most smokers expect their GP to raise and discuss the issue of smoking with them[11].

GPs should support the reduction of smoking, including identification and recording of smokers followed by the provision of stop smoking advice and services. Practices should focus on at risk groups, including those with co-morbidity and groups with higher prevalence rates[12].

Resources:
Smoking guidelines
http://www.nice.org.uk/guidance/index.jsp?action=byID&o=11375
http://www.nice.org.uk/guidance/index.jsp?action=byID&o=11925
http://www.nice.org.uk/PHI001

QIPP Opportunity

Smoking was a factor in over 26,000 London deaths during 2005-7 (LHO) and in over £133m of hospital admissions in 2008/9 (LHO). Smoking is a contributory factor in many conditions such as COPD which can be severely disabling and have major impacts on quality of life.

Having an accurate and up to date record of smoking status is a basic tool for primary care management and reduction of smoking. Recently discontinued GP recorded smoking prevalence data show that 3 London PCTs have never passed the quality threshold (70% of patient records having a recorded smoking status) and a further 8 failed at least 3 times in the latest 4 published quarters.

[10] 06.01.2011; NHS London; www.london.nhs.uk/.../PCT%20Performance%20Guide%20-%20Smoking. doc
[11] 06.01.2011; UK National Smoking Cessation Conference; http://www.uknscc.org/2006_uknscc/speakers/hayden_mcrobbie_2.html
[12] September 2008; GP Recorded Smoking, Data Collection Guidance; http://www.ic.nhs.uk/webfiles/Services/Omnibus%20Guidance/Collection%20Guidance/HotPr/GP%20Recorded%20Smoking/GP%20recorded%20Smoking%20Guidance%20v2.pdf

Preventing People from Dying Prematurely – Long-Term Conditions

Standard

5. GP Recorded Smoking (for Long-Term Conditions).

DH ceased quarterly data collection which may impact on our ability to secure the data.

Definition

Appropriate as an indicator of general practice performance.

The percentage of patients with selected long term conditions (LTCs), whose notes contain a record that smoking cessation advice or referral to a specialist service, where available, has been offered within the previous 15 months.

Numerator: The number of patients per GP practice with any or any combination of the following conditions: coronary heart disease, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who smoke whose notes contain a record that smoking cessation advice or referral to a specialist service, where available, has been offered within the previous 15 months.

Denominator: The number of patients per GP practice with any of the following conditions: coronary heart disease, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record positive smoking status in the previous 15 months.

ACCOUNTABILTY

The objective aims to deliver continuing reductions in smoking prevalence in people with long term conditions

Organisations in the top quartile ranking within London are examples of good practice.

GP practices should aim to offer 95% of patients with LTC's smoking cessation advice or referral to a specialist service, where available, within the previous 15 months.

Data Source

QOF

Frequency: Annual.

Rationale

People with long-term conditions such as asthma, diabetes, COPD and cardiovascular disease, seriously aggravate their conditions by smoking and cessation support is a crucial

ingredient in effective self-management of these conditions[13].

Smoking cessation interventions are a cost-effective way of reducing ill health. Quitting at any age provides both immediate and long-term health benefits. If those with co-morbidities continue to smoke, their risks of further health problems are worsened. In particular those with identified:

- CHD. Smoking is known to be associated with an increased risk of coronary heart disease.
- Stroke/TIA. Although there are few randomised clinical trials of the effects of risk factor modification in secondary prevention inferences can be drawn from the findings of primary prevention trials (that smoking cessation is beneficial).
- Hypertension. The British Hypertension Society recommends that smoking history should be taken for all patients with hypertension. Smoking is known to be associated with an increased risk of coronary heart disease and stroke.
- Diabetes. Smoking is an established risk factor for cardiovascular and other diseases.
- COPD. Smoking cessation is the single most effective – and cost-effective – intervention to reduce the risk of developing COPD and stop its progression. NICE quotes smoking cessation as the most effective way of preventing and slowing down the progression of COPD14.
- Asthma. Starting smoking as a teenager increases the risk of persisting asthma. New grade A evidence suggests that smoking reduces the benefits of inhaled steroids.
- Chronic Kidney Disease. There is good evidence from observational studies that people with CKD are at increased cardiovascular risk.
- Schizophrenia, bipolar affective disorder or other psychoses. People with serious mental illness are far more likely to smoke than the general population (Premature death and smoking related diseases respiratory, are also more common among people with serious mental illness who smoke than in the general population of smokers.

Having an accurate and up to date record of smoking status is a basic tool for primary care management and reduction of smoking. This is particularly important for those patients already included on relevant disease registers. 2009/10 QOF data show that at PCT level the percentage of the relevant disease registers either without smoking status or known to be smokers but without record of recent advice has a mid-quartile range between 5.5% and 6.5% with 10 London PCTs in the worst quartile. There were 88,000 patients in this category across London. These patients are not evenly distributed across GP practices, many practices have few patients in this category but others have over 250 (percentage range from under 0.5% to over 15%).

QIPP Opportunity

Smoking was a factor in over 26,000 London deaths during 2005-7 (LHO) and 11 PCTs had a standardised death rate for smoking attributable causes which was significantly

[13] October 2010; ash; Liberating the NHS: Commissioning for patients Response to Consultation; http://www.ash.org.uk/files/documents/ASH_759.pdf

[14] August 2007; Audit Scotland; Managing long-term conditions; http://www.audit-scotland.gov.uk/docs/health/2007/nr_070816_managing_long_term.pdf

higher than the English average. Smoking is a contributory factor in many conditions such as COPD which can be severely disabling and have major impacts on quality of life.

Smoking-attributable hospital admissions may have accounted for £133m across London in 2008/9 (LHO, includes MFF). The same study showed spend at PCT level varied from £26k to £49k per 1,000 (responsible population aged over 35).

Preventing People from Dying Prematurely – Stroke and TIA

Standard

6. Atrial Fibrillation Prevalence.

Definition

Appropriate as an indicator of Consortia performance.

Reported versus expected prevalence for atrial fibrillation.

Numerator 1: Number of patients recorded by consortium practices with a diagnosis of Atrial Fibrillation

Denominator1: Expected Number of patients suffering from Atrial Fibrillation by consortium practices on the disease register.

ACCOUNTABILTY

The objective aims to deliver continuing improvements in the management and identification of atrial fibrillation in London.

Organisations in the top quartile ranking within London are examples of good practice.

Monitoring, intervention and support would be required for those organisations within the bottom quartile ranking in London. Monitoring and support would be beneficial for those organisations within the mid quartiles within London.

Organisations will be ranked according to the absolute variance between actual and expected, where 1:1 is normal.

Note: Please refer to Guidance Notes for interpretation on Pg 61.

Data Limitations - The indicator is a measure of Consortia performance. Practice level data will also be provided to help Consortia understand if this is a population or practice issue. Where a practice is an outlier compared to other practices in a similar setting and context this could provide evidence that the practice could improve on their case finding work to identify at risk patients on their list.

Data Source

NHS Information centre analysis published via NHS Comparators.

Expected Prevalence of atrial fibrillation calculated using national age / sex specific rates from the don caster model applied to GP practice list size data.

Frequency: Annual.

Rationale

Atrial fibrillation (AF) is the most common sustained dysrhythmia, affecting at least 600,000 (1.2%) people in England alone. It is also a major cause of stroke. Uniquely, it is an eminently preventable cause of stroke with a simple highly effective treatment[15].

Atrial fibrillation is currently under recognised and under treated[16]. It is clear that improving identification of people with atrial fibrillation and inducing better intervention could prevent many thousands of strokes each year. The annual risk of stroke is five to six times greater in AF patients than in people with normal heart rhythm and is therefore a major risk factor for stroke[17].

GPs have a role in identifying and referring patients suitable for cardioversion, including urgent referral of appropriate newly diagnosed patients. Early cardio version is more likely to be successful initially, and sinus rhythm more likely to be maintained, in recent-onset AF[18].

Although initial assessment and treatment may be carried out in secondary care, GPs have an important role in managing AF[19]. Cases of AF are often detected, particularly in the elderly, during a general practice visit for an unrelated problem[20].

The age specific prevalence of atrial fibrillation is rising, presumably due to improved survival of people with coronary heart disease (the commonest underlying cause of AF). One percent of a typical practice population will be in AF; 5 per cent of over 65s, and 9 per cent of over 75s. Atrial fibrillation is associated with a five fold increase in risk of stroke[21].

QIPP Opportunity

Atrial fibrillation is a major risk factor for stroke and is also associated with a substantial mortality, and with morbidity and hospitalisation from heart failure, thromboembolism and impaired cognitive function. A good quality practice register is an important tool for primary care however 26 London PCTs appear in the quartile which has identified fewest cases (when compared to expected). The majority of these PCTs also appear among those with most hospital admissions and hospital expenditure for AF when compared to both register size and expected numbers. Improvement to the NHS average would realise an opportunity of £2.2m.

[15] Oct 2009; NHS Improvement; Heart and Stroke Improvement, Atrial fibrillation in primary care: making an impact on stroke prevention National priority project final summaries

[16] 24.01.11; NHS Improvement – Stroke, Supporting the development of stroke care networks, Stroke Prevention in Primary Care: Managing Atrial Fibrillation, Stroke Improvement Programme National Project 2009-10; http://www.improvement.nhs.uk/stroke/NationalProjects/StrokePreventioninPrimaryCareAF/tabid/76/Default.aspx

[17] Oct 2009; NHS Improvement; Heart and Stroke Improvement, Atrial fibrillation in primary care: making an impact on stroke prevention National priority project final summaries

[18] 24.01.2011; NHS National Prescribing Centre, Primary care management of atrial fibrillation; http://www.npc.co.uk/ebt/merec/cardio/atrial/resources/merec_bulletin_vol12_no5.pdf

[19] 24.01.2011; NHS National Prescribing Centre, Primary care management of atrial fibrillation; http://www.npc.co.uk/ebt/merec/cardio/atrial/resources/merec_bulletin_vol12_no5.pdf

[20] 2006; The National Collaborating Centre for Chronic Conditions, ATRIAL FIBRILLATION - National clinical guideline for management in primary and secondary care; http://www.nice.org.uk/nicemedia/live/10982/30055/30055.pdf

[21] 2008; British Medical Association, Quality and outcomes framework guidance - atrial fibrillation; http://www.bma.org.uk/employmentandcontracts/independent_contractors/quality_outcomes_framework/qof06.jsp?page=22

There is considerable variation at GP practice level with 79 practices identifying less than a third of their expected numbers (570 against an expected 2,200). Furthermore 7,600 AF patients registered with practices which did not obtain all the available QOF points. In 2009/10; 700 of these were registered with practices obtaining less than 75% of QOF points.

Preventing People from Dying Prematurely – Communicable Diseases

Standard

7. Immunisation Uptake.

Definition

Appropriate as an indicator of general practice performance.

The percentage of children who complete immunisation by the recommended age.

Immunisation rates for routine childhood vaccinations at age 1 (DTaP/IPV/Hib) and 2 years (PVC Booster, Hib/MenC and a completed course of MMR).

Numerator 1 : Number of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenzae type b (Hib) (i.e. three doses of DTaP/IPV/Hib).

Denominator 1: The number of children aged 1.

Indicator 1: The indicator is the numerator divided by the denominator, expressed as a percentage.

Numerator 2: Number of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster).

Denominator 2: The number of children aged 2.

Indicator 2: The indicator is the numerator divided by the denominator, expressed as a percentage.

Numerator 3: Number of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster).

Denominator 3: The number of children aged 2.

Indicator 3: The indicator is the numerator divided by the denominator, expressed as a percentage.

Numerator 4: Number of children aged 2 who have completed immunisation for measles, mumps and rubella (one dose of MMR).

Denominator 4: The number of children aged 2.

Indicator 4: The indicator is the numerator divided by the denominator, expressed as a percentage.

Note : The four indicators will be displayed individually, but viewed together will give a broad sense of how a practice is performing against childhood immunisations.

ACCOUNTABILTY

The objective aims to deliver continuing improvement in childhood immunisation rates in London.

Organisations in the top quartile ranking within London are examples of good practice.

Monitoring, intervention and support would be required for those organisations within the bottom quartile ranking in London or those that fall significantly short of World Health Organisation (WHO) recommend levels of immunisation.

Monitoring and support would be beneficial for those organisations within the mid quartiles within London.

World Health Organisation recommends a rate of 95% for all routine childhood vaccinations.

Data Source

HPA Cover returns.
http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/VaccineCoverageAndCOVER/

Frequency: Quarterly / Monthly.

Rationale

This indicator highlights an area of national and international concern to end the transmission of preventable life-threatening infectious diseases. Vaccines prevent infectious disease and can dramatically reduce disease and complications in early childhood, as well as mortality rates. Pre-school immunisation for the under 5 year olds in England enables the control of diseases such as diphtheria, tetanus, polio, pertussis, measles, rubella, Haemophilus influenza type b (Hib), pneumococcal infection and meningitis C[22].

Current World Health Organisation (WHO) immunisation recommendations states that at least 95% of children should receive three primary doses of diphtheria, tetanus, polio and pertussis in the first year of life and a first dose of measles, mumps and rubella containing vaccine by 2 years of age. London is not currently meeting these public health targets, which are in place to end the transmission of these vaccine-preventable life-threatening infectious diseases and is a public health priority for all trusts. Vaccine coverage is variable across London with some areas continuing to have particularly low coverage[23].

Immunisation is the single most cost-effective medical intervention for maintaining the Public Health of the population[24].

[22] 2009/10; Care Quality Commission; Child Immunisation Rates; http://www.cqc.org.uk/periodicreview/nationalcommitmentsandpriorities2009/10/primarycaretrusts/nationalpriorities/childhoodimmunisationrates.cfm
[23] December 2010; World Health Organisation; Benefits of Immunisation; http://www.who.int/immunization_delivery/benefits_of_immunization/en/index.html
[24] September 2010; Oxfordshire PCT; Community Health Oxfordshire; http://www.oxfordshirepct.nhs.uk/about-us/documents/109ClinicalImmunisationPolicySeptember2010.pdf

QIPP Opportunity

Hospitalisation for these conditions especially that of a child, is extremely worrying for the patient and their relatives, there is also the possibility of long term adverse sequelae. The availability of vaccination means that emergency admissions for these conditions are largely avoidable and there is a potential £1.1m opportunity across London.

2009/10 data show that at PCT level emergency admissions (per 1000 standardised population) for vaccine preventable conditions other than influenza have a mid-quartile range between 0.03 and 0.08 with 17 London PCTs in the worst quartile.

The programme budget data for 2009/10 suggests that there is a £1.1m opportunity across London (compared to expected spend NHS Comparators). There is considerable variation at GP practice level with admissions per 1,000 varying from 0 to over 1 and the size of the opportunity varying from £0 to £20,000 per practice (when compared to expected spend NHS Comparators).

Preventing People from Dying Prematurely – Communicable Diseases

Standard

8. Influenza Immunisation Uptake.

Definition

Appropriate as an indicator of both general practice and Consortia performance.

The percentage of at risk patients aged over 65 who have a record of influenza immunisation in the preceding September to March period.

Numerator : The number of patients aged over 65 per GP practice who have had influenza immunisation in the preceding 1 September to 31 January.

Denominator: The number of patients aged over 65 per GP practice.

ACCOUNTABILTY

The objective aims to deliver continuing improvement in influenza immunisation uptake in London.

Organisations in the top quartile ranking within London are examples of good practice.

Monitoring, intervention and support would be required for those organisations within the bottom quartile ranking in London or those that fall significantly short of the latest national reported rate of immunisation.

Monitoring and support would be beneficial for those organisations within the mid quartiles within London.

Notwithstanding the above practices and Consortia should aim to deliver performance greater than 75%.

In 2009-10 the national reported rate of immunisation was 72.4%.

Data Source

Annual collection from PCTs required initially. Going forward this information will be collected from GP Consortia.

Frequency: Annual.

Rationale

Adults with certain pre-conditions are recommended by the Joint Committee on Vaccination and Immunisation and the Department of Health (DH) to get the adult influenza immunisation to protect against illness.

When pre- conditions exist, such as diabetes, vaccinations can prevent against illnesses that can be very serious. GP's have a responsibility to provide flu vaccinations to those 'at-risk' with the following underlying conditions:

- a serious heart or chest complaint, including asthma
- serious kidney disease
- diabetes
- lowered immunity due to disease or treatment such as steroid medication or cancer treatment
- if you have ever had a stroke[25]

QIPP Opportunity

Hospitalisation for these conditions, especially where there are co-morbidities such as asthma, is extremely worrying for the patient and their relatives, There are many deaths each year from the effects of seasonal 'flu. The availability of vaccination means that emergency admissions for these conditions are avoidable representing a £5.1m opportunity across the London.

2009/10 data show that at PCT level emergency admissions (per 1000 standardised population) for vaccine preventable conditions influenza & pneumonia have a mid-quartile range between 1.75 and 2.59 with 7 London PCTs in the worst quartile. The programme budget data for 2009/10 suggests that there is a £5.1m opportunity across the London PCTs (compared to expected spend NHS Comparators).

There is considerable variation at GP practice level with admissions per 1,000 varying from 0 to over 5 and the size of the opportunity varying from £0 to more than £75,000 per practice (when compared to expected spend NHS Comparators).

[25] 07/01/2011; NHS Choices; Flu and the flu vaccine; http://www.nhs.uk/Livewell/winterhealth/Pages/Fluandthefluvaccine.aspx

Enhancing Quality of life for people with long term conditions – Respiratory Disease

Standard

9. Chronic Obstructive Pulmonary Disease (COPD) prevalence.

Definition

Appropriate as an indicator of general practice performance.

Reported versus expected prevalence for Chronic Obstructive Pulmonary Disease.

Numerator: Number of patients recorded by consortium practices as having COPD as reported in QOF data.

Denominator: Expected Number of patients by consortium practices on the disease register.

ACCOUNTABILTY

The objective aims to deliver continuing improvements in the management and identification of Chronic Obstructive Pulmonary Disease in London.

Organisations in the top quartile ranking within London are examples of good practice.

Monitoring, intervention and support would be required for those organisations within the bottom quartile ranking in London. Monitoring and support would be beneficial for those organisations within the mid quartiles within London.

Organisations will be ranked according to the absolute variance between actual and expected, were 1:1 is normal.

Note: Please refer to Guidance Notes on interpretation at Pg 61.

Data Source

NHS Information centre analysis published via NHS Comparators.

Expected prevalence data are derived using expected prevalence rates provided by ERPHO which take account of age, sex, ethnicity, smoking status and deprivation score at practice level.

Frequency: Annual.

Rationale

Almost one million people in the UK have been diagnosed with COPD, but it is estimated that true prevalence figures may be more than three times that figure (British Lung Foundation, 2009). COPD accounts for 23,500 deaths in the UK (ONS, 1999), 12% of all

acute medical admissions and 15% of all hospital bed days (Pearson, 1994). The cost to the UK economy is estimated at £492 millions per annum (Britton, 2003) of which 40% is expended on hospital care[26].

The burden of chronic obstructive pulmonary disease (COPD) is enormous and is increasing, but early, accurate diagnosis in a primary care setting can have a crucial impact on managing the condition. New NICE guidelines and the GMS Contract, with incentives, give GPs and practice nurses the opportunity to diagnose COPD patients and manage them in a structured fashion[27].

Clinicians in primary care have the skills to assess patients' symptoms and the adequacy of their control, monitor the progression of their disease, identify the development of complications and the need for referral to secondary care or other specialists[28].

The majority of patients with COPD are managed by general practitioners and members of the primary healthcare team with onward referral to secondary care when required[29]. The expected rates take account of age, sex, ethnicity, smoking status and deprivation score at practice level). Individual practices/GPs will vary in their ability to recognise the early symptoms of COPD and or/screening of patients for condition. Failure to identify cases early in the progression of the disease will impact on sensitivity to treatment, increase secondary care requirements and reduce quality of life.

According to analysis on NHS comparators (2008/9), London primary care has identified a smaller proportion (37%) of patients with COPD (when compared to the modelled estimate) than the NHS as a whole (56%). There is considerable variation at practice level with some having identified at least 20% more than the estimate and other less than 10% of the estimate.

QIPP Opportunity

Failure to identify cases early in the progression of the disease will impact on sensitivity to treatment, increase secondary care requirements and reduce quality of life. Some variation can be accounted for by local population characteristics, but much is due to the different ways that services are organised and delivered locally. An accurate and up to date practice register is a key tool in ensuring the good management in primary care which will reduce emergency admissions. From avoidable emergency admissions this presents a potential £0.9m opportunity across London.

The Right Care workstream identifies an opportunity to reduce emergency bed days, the numbers of which are determined by both admission rate and length of stay 2009/10 data. PCT level emergency admissions (per 1000 standardised population) for COPD have a mid-quartile range between 1.43 and 2.60 with 6 London PCTs in the worst quartile. The programme budget data for 2009/10 suggests that there is a £0.9m opportunity across the

[26] 06.01.2011; Royal College of Physicians; http://www.rcplondon.ac.uk/Pages/index.aspx
[27] Mar 2010; A Sharma; COPD in Primary Care
[28] 06.01.2011; NICE, National Clinical Guideline Centre, Chronic obstructive pulmonary disease: Management of chronic obstructive pulmonary disease in adults in primary and secondary care ; http://www.nice.org.uk/nicemedia/live/13029/49425/49425.pdf
[29] 06.01.2011; NHS; The Information Centre; Clinical and Health Outcomes Knowledge Base; http://www.nchod.nhs.uk/NCHOD/compendium.nsf/361d5bea85d84b7c802573a30020fcd5/ec72122664a5889d652572a500267a38!OpenDocument

London PCTs and a potential saving of 2,900 bed days (compared to expected spend NHS Comparators).

There is considerable variation at GP practice level with emergency admissions per 1,000 varying from 0 to over 10 and the size of the opportunity varying from £0 to more than £50,000 per practice, with some practices able to save more than 250 bed days (when compared to expected spend NHS Comparators).

Enhancing Quality of life for people with long term conditions – Respiratory Disease

Standard

10. Asthma prevalence.

Definition

Appropriate as an indicator of Consortia performance.

Reported versus expected prevalence for asthma.

Numerator: Number of patients recorded by consortium practices as having Asthma as reported in QOF data.

Denominator: Expected Number of patients by consortium practices on the disease register.

ACCOUNTABILTY

The objective aims to deliver continuing improvements in the management and identification of Asthma in London.

Organisations in the top quartile ranking within London are examples of good practice.

Monitoring, intervention and support would be required for those organisations within the bottom quartile ranking in London. Monitoring and support would be beneficial for those organisations within the mid quartiles within London.

Organisations will be ranked according to the absolute variance between actual and expected, were 1:1 is normal.

Note: Please refer to Guidance Notes on interpretation at Pg 61.

Data Limitations - The indicator is a measure of Consortia performance. Practice level data will also be provided to help Consortia understand if this is a population or practice issue. Where a practice is an outlier compared to other practices in a similar setting and context this could provide evidence that the practice could improve on their case finding work to identify at risk patients on their list.

Data Source

NHS Information centre analysis published via NHS Comparators.

Expected Prevalence of asthma calculated using national age / sex specific rates from the Doncaster model applied to GP practice list size data by age and sex.

Frequency: Annual basis - most recent is 2008/9.

Rationale

5.4m people in the UK are currently receiving treatment for asthma. An estimated 75% of hospital admissions for asthma are avoidable and as many as 90% of the deaths from asthma are preventable. There were over 79,794 emergency hospital admissions for asthma in the UK in 2008-09[30].

According to analysis on NHS comparators (2008/9), London primary care has identified a smaller proportion (53%) of patients with asthma (when compared to the modelled estimate) than the NHS as a whole (64%). There is considerable variation at practice level with some having identified slightly more than the estimate and other less than 25% of the estimate.

Asthma is a common condition which responds well to appropriate management and which is principally managed in primary care. The expected rates only take account of the age / sex distribution of the practice population and not other factors which may be relevant (eg relative deprivation, ethnic breakdown etc). Asthma is a variable condition and the asthma register should be constructed annually by searching for patients with a history of asthma who have been prescribed asthma-related drugs in the last 12 months.

QIPP Opportunity

Much of the variation in emergency admission to secondary care is due to a range of factors in the provision of a primary care, and to patients' understanding of their condition (and thus the ability to self manage). An accurate and up to date practice register is a key tool in ensuring good management in primary care which will reduce emergency admissions and presents a potential £2m opportunity saving across London.

The Right Care workstream identifies an opportunity to reduce emergency admissions, which indicate a loss of control of a person's asthma. 2009/10 data show that at PCT level emergency admissions (per 1000 standardised population) for asthma have a mid-quartile range between 0.88 and 1.34 with 6 London PCTs in the worst quartile. The programme budget data for 2009/10 suggests that there is only a small opportunity across London (compared to expected spend NHS Comparators) but variation between practices means that between GP practices with more than 1.34 admissions per 1000 there is an opportunity of over £2m.

There is considerable variation at GP practice level with emergency admissions per 1,000 varying from 0 to over 3 and the size of the opportunity varying from £0 to more than £15,000 per practice (when compared to expected spend NHS Comparators).

[30] 06.01.2011; Asthma UK; What is Asthma; http://www.asthma.org.uk/all_about_asthma/asthma_basics/

Enhancing Quality of life for people with long term conditions – Heart Disease

Standard

11. Diabetes prevalence.

Definition

Appropriate as an indicator of Consortia performance.

Reported versus expected prevalence of diabetes for people aged 17 and over.

Numerator: Number of patients aged 17 and over recorded by consortium practices as having diabetes as reported in QOF data.

Denominator: Expected number of patients by consortium practices on the disease register.

ACCOUNTABILTY

The objective aims to deliver continuing improvements in the management and identification of diabetes in London.

Organisations in the top quartile ranking within London are examples of good practice.

Monitoring, intervention and support would be required for those organisations within the bottom quartile ranking in London. Monitoring and support would be beneficial for those organisations within the mid quartiles within London.

Organisations will be ranked according to the absolute variance between actual and expected, were 1:1 is normal.

Note: Please refer to Guidance Notes on interpretation at Pg 61.

Data Limitation: Included as crude benchmark only. Does not take into account ethnicity and deprivation which are major determinants of diabetes.

The indicator is a measure of Consortia performance. Practice level data will also be provided to help Consortia understand if this is a population or practice issue. Where a practice is an outlier compared to other practices in a similar setting and context this could provide evidence that the practice could improve on their case finding work to identify at risk patients on their list.

Data Source

NHS Information centre analysis published via NHS Comparators.

Rates supplied by YHPHO from Forouhi N, Merrick D, Goyder E et al. Diabetes prevalence in England, 2001 - estimates from an epidemiological model. Diabetic Med 2005; 23: 189.

Frequency: Annual basis - most recent is 2008/9.

Rationale

Diabetes mellitus is one of the common endocrine diseases affecting all age groups. Effective control and monitoring can reduce mortality and morbidity[31]. In 2008, Yorkshire and Humber Public Health Observatory (YHPHO) estimated that more than 2.4 million people in England had diabetes (either diagnosed or undiagnosed). The YHPO forecasts that by 2025 the number will have risen to more than 3.6 million (about 6.5 per cent of the population). Type 2 diabetes mellitus accounts for approximately 90% of the population of patients with diabetes mellitus.

Diabetics are twice as likely to be admitted to hospital as non-Diabetics and people aged between 20 and 79 years who have diabetes are twice as likely to die as people without the condition. It is clear from best practice guidance that general practice plays a pivotal and significant contribution to the effective management of diabetes and should encompass awareness of risk factors and symptoms, prompt and appropriate referral, and holistic assessment[32].

Primary care has a pivotal role in ensuring that all people with diabetes mellitus receive effective diabetes care. This is recognised by the inclusion of clinical indicators for diabetes in the Quality and Outcomes Framework (QOF). Many patients with diabetes are now managed solely or mainly in primary care[33].

According to QOF analysis published via NHS comparators (2008/9), London primary care has identified a larger proportion (104%) of adult patients with diabetes (when compared to the modelled estimate) than the NHS as a whole (88%). There is considerable variation at practice level with some having identified more than 250% of the estimate and others less than 35% of the estimate.

Much of the management and monitoring of diabetic patients, particularly patients with Type 2 diabetes is undertaken by the general practitioner and members of the primary care team. The expected rates only take account of the age / sex and ethnic group composition of the practice population and not other factors which may be relevant (eg relative deprivation). In addition to the undiagnosed patients with diabetes there are other patients treated for diabetes when they do not in fact have the disease. Practices are therefore encouraged to adopt a systematic approach to confirm the diagnosis of diabetes.

QIPP Opportunity

In 2008/09 the National Diabetes Audit showed that only 50.8% of people with Type 2 diabetes, and 32.2% of those with Type 1 diabetes, had received all nine key care processes. An accurate and up to date practice register is a key tool in ensuring that patients have received their care processes and good management in primary care will reduce

[31] 06.01.2011; NHS; The Information Centre; Clinical and Health Outcomes Knowledge Base; http://www.nchod.nhs.uk/NCHOD/compendium.nsf/b57e6aaba3908b8d802573a30020fcda/e0f2d930d8cefc4a652572a50026ea14!OpenDocument

[32] June 2009; Prescribing for Diabetes in England - An Update: 2002-2008; www.yhpho.org.uk/resource/view.aspx?RID=9711

[33] June 2009; NICE; Quality and Outcomes Framework Indicator Development Programme; http://www.nice.org.uk/media/F40/4C/QOFAdvisoryCommitteeBriefingPaperDiabetes.pdf

emergency admissions which presents a potential £5.9m opportunity across London.

2009/10 QOF data show that at PCT level the inter quartile range for diabetes management points secured is between 97.5% and 93.3%. 15 London PCTs were in the worst quartile. 5,145 London diabetics were registered with practices that secured less than 2/3 (66%) of the available points.

2009/10 data show that at PCT level emergency admissions (per 1000 standardised population) for diabetes have a mid-quartile range between 0.72 and 1.14 with 16 London PCTs in the worst quartile. The programme budget data for 2009/10 suggests that there is an opportunity across London of £5.9m (compared to expected spend NHS Comparators). There is considerable variation at GP practice level with emergency admissions per 1,000 varying from 0 to over 4 and the size of the opportunity varying from £0 to more than £40,000 per practice (when compared to expected spend NHS Comparators).

Preventing People from Dying Prematurely – Heart Disease

Standard

12. Coronary Heart Disease (CHD) Prevalence.

Work to triangulate prevalence with prescribing data to be explored.

Definition

Appropriate as an indicator of general practice performance.

Reported versus expected prevalence for Coronary Heart Disease.

Numerator: Number of patients recorded by consortium practices as having Coronary Heart Disease as reported in QOF data.

Denominator: Expected number of patients by consortium practices on the disease register.

ACCOUNTABILTY

The objective aims to deliver continuing improvements in the management and identification of diabetes in London.

Organisations in the top quartile ranking within London are examples of good practice.

Monitoring, intervention and support would be required for those organisations within the bottom quartile ranking in London. Monitoring and support would be beneficial for those organisations within the mid quartiles within London.

Organisations will be ranked according to the absolute variance between actual and expected, where 1:1 is normal.

Note: Please refer to Guidance Notes on interpretation at Pg 61.

Data Source

NHS Information centre analysis published via NHS Comparators.

Expected prevalence data are derived using expected prevalence rates provided by ERPHO which take account of age, sex, ethnicity, smoking status and deprivation score at practice level.

E-pact prescribing data.

Frequency: Annual.

Rationale

Coronary heart disease is the single most common cause of premature death in the UK. The research evidence relating to the management of CHD is well established and if implemented can reduce the risk of death from CHD and improve the quality of life for patients. This standard focuses on the management of patients with established CHD consistent with clinical priorities in the four nations. (QOF Guidance, 2009).

Despite the general decline in deaths, the number of people living with CHD (prevalence) is increasing, partly as a result of the aging population. In 2007/08 local GP practices identified 7,000 adults with CHD, giving a crude prevalence of 4.3%, compared to the expected prevalence of 4.7% when standardised for age, gender and deprivation[34].

Data from the 2006 Health Survey for England suggest the prevalence of CHD in England was 6.5% in men and 4.0% in women. Prevalence rates increase with age, with more than 1 in 3 men and around 1 in 4 women aged 75 and over living with CHD. Within England the prevalence ranged from 2.3% in London to 4.9% in the North East of England.

The CHD NSF and now the new GMS contract state that general practitioners and primary care teams should develop a register of CHD patients, through which they can review medication, offer advice on diet and lifestyle, and maintain the necessary contact with patients most at risk of suffering renewed heart problems[35].

There will be an annual equity audit at practice (or cluster) level of CHD management encompassing measures of need, primary care management and secondary/tertiary management and thus reflecting the entire pathway. The model used is expected to be similar to that already used in other areas outside London (e.g. Rotherham) and variables/measures will be standardised (e.g. using Z scores or ranges) to enable sensible comparison between practices/clusters. It is anticipated that opportunities for improvement in CHD management will be identified.

QIPP Opportunity

Improved management and prevention in primary care, including better use of resources, is fundamental to reducing inequalities in CHD management and outcomes. For instance there is an opportunity with prescribing behaviours. There is a greater than 25% difference in the percentage of pravastatin/simvastatin per all statins prescribed among PCTs. Within London the range is from 69% to 83% (quarter ending June 2010. There is an almost six fold variation in the Ezetimibe cost per 1000 lipid-lowering STAR (09)-PUs items across the country with London PCTs occupying both extremes. This variation in prescribing practice for both pravastatin/simvastatin and Ezetimibe is greater than can be explained by differences in the population.

[34] 06.01.11; NHS Blackburn with Darwen; Health of the Population; Coronary Heart Disease; http://www.publichealth.bwdpct.nhs.uk/mortality-and-its-causes/circulatory-disease/chd/

[35] 2004; Department of Health, The National Service Framework for Coronary Heart Disease, Winning the War on Heart Disease, Progress report 2004; http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4077158.pdf

Enhancing Quality of life for people with long term conditions – Mental Health

Standard

13. Dementia Prevalence.

Definition

Appropriate as an indicator of Consortia performance.

Reported versus expected prevalence for dementia.

Numerator: Number of patients recorded by consortium practices as having dementia as reported in QOF data.

Denominator: Expected number of patients by consortium practices on the disease register.

ACCOUNTABILTY

The objective aims to deliver continuing improvements in the management and identification of dementia in London.

Organisations in the top quartile ranking within London are examples of good practice.

Monitoring, intervention and support would be required for those organisations within the bottom quartile ranking in London. Monitoring and support would be beneficial for those organisations within the mid quartiles within London.

Organisations will be ranked according to the absolute variance between actual and expected, were 1:1 is normal.

Note: Please refer to Guidance Notes on interpretation at Pg 61.

Data Limitations - The indicator is a measure of Consortia performance. Practice level data will also be provided to help Consortia understand if this is a population or practice issue. Where a practice is an outlier compared to other practices in a similar setting and context this could provide evidence that the practice could improve on their case finding work to identify at risk patients on their list.

Data Source

QOF data published through NHS Comparators with additional analysis.

Frequency: Annual Data.

Rationale

Dementia is a common condition. In England alone, there are currently 570,000 people living with dementia and a survey carried out in 2007 suggests that there are 54,000 people

in London with Dementia. That number is expected to double over the next 30 years. It is commonly reported that first contact and diagnosis often occur late in the illness and/or in crisis, when opportunities to maximise quality of life and prevent harm have passed (National Audit Office (NAO) 2007a).

The NAO analysed data on expected and recorded prevalence. This showed only five people per 1,000 aged 65-69 had been diagnosed compared to the estimated actual prevalence of 13 per 1,000. In peopled aged over 80, only 60 per 1,000 were diagnosed compared to the estimated actual prevalence of 122 per 1,000.

According to the NAO (2007a) GPs have 'ultimate' responsibility for each patient with dementia, regardless of whether they are living in their own residence or a care home. The GP often carries out a co-ordinating and monitoring role, and acts as a gateway to services that provide the necessary and appropriate intervention and support. Focus-group data shows that individuals can make a number of visits to the general practice before the GP recognises symptoms and makes a referral to a specialist or memory clinic (NAO 2007b)[36].

Early diagnosis gives patients the chance to have a say in their own care, and it gives families time to come to grips with the disease[37]. Research suggests that early diagnosis and intervention is important in increasing the quality of life and life expectancy of people with dementia, and that general practice plays a pivotal role in this[38]. GPs are uniquely able to facilitate effective treatment and support and are usually the "first port of call" for users seeking explanations for cognitive or behavioural changes (Weiner, 1997). The importance of GP engagement with early diagnosis has been highlighted as a key element of developing a comprehensive and high quality dementia care system in the UK (Iliffe et al., 2002). Those GPs committed to early diagnosis considered it to facilitate preventive intervention including the opportunity to offer treatment at a stage when it can be most effective. It also allows future needs to be considered in partnership with older people and their carers and appropriate plans to be made (Reisberg, Burns, & Brodaty, 1997; Wilkinson & Milne, 2003).

QIPP Opportunity

The majority of the dementia burden falls on families or carers, but early diagnosis and management from primary care can provide important support for patients and their families. It is important that reviews include the support needs of carers.

It is estimated that prevalence of dementia in London PCTs ranges between 5% and 8% of population aged at least 65 (0.4% – 1.2% of the total population). Prescriptions of dementia drugs range from 1 to 8 per patient (community care statistics 2005-6 published 2009 NHS Information Centre).

2009/10 QOF data show that at PCT level the inter quartile range for patients reviewed in the past 15 months was between 81.4.7% and 77.9%. Only 3 London PCTs were in the worst quartile but 4,800 London dementia patients had not been reviewed in the past 15 months and 2,500 of these were at practices where less than 2/3 had benefitted from such a review.

[36] June 2010; The King's Fund; Managing people with Long-Term Conditions
[37] November 2010; Dr. O Hammer; Identifying dementia early can cut the cost of care and reduce the financial burden of the disease in NHS; http://www.bmj.com/content/341/bmj.c6793.short/reply
[38] 07.01.2011; The King's Fund; Managing People with Long-Term Conditions

16 London GP practices were unable to produce a register of patients with dementia and 38 London GP practices failed to gain any points for recently reviewing the care of patients with dementia.

Enhancing Quality of life for people with long term conditions – Prescribing Management

Standard

14. Monitoring safe, rational and cost effective prescribing in general practice.

Definition

Appropriate as an indicator of general practice performance.

Increase safety of prescribed non-steroidal anti-inflammatory drugs by reducing use of diclofenac and cox-2 inhibitors.

Numerator: Total number of Diclofenac and Cox-2 inhibitor items prescribed.

Denominator: Total NSAID items prescribed.

The indicator will displayed be per 1000 patients on practice list.

Data Source

http://www.epact.ppa.nhs.uk/systems/sys_main_epact.htm

Frequency: Monthly.

Rationale

Involving patients in prescribing decisions and supporting them in taking their medicines is a key part of improving patient safety, health outcomes and satisfaction with care. Medication review is increasingly recognised as a cornerstone of medicines management[39].

There are long standing and well recognised safety concerns with all Non-steroidal anti-inflammatory drugs (NSAID) regarding gastrointestinal and renal adverse effects, and increased thromboembolic risks with many NSAIDs, including coxibs and some traditional NSAIDs.

There are significant and widening differences between localities in the proportion of NSAIDs which are ibuprofen and naproxen, and diclofenac still accounts for approximately 37% of all NSAID prescriptions in primary care in England[40].

Cox II selective inhibitors are prescribed predominantly within the primary care sector[41]. In 2004, 20.6 million items were prescribed in primary care and dispensed in the community for

[39] 06.01.11; British Medical Journal; Quality and outcomes framework guidance: Medicines management; http://www.bma.org.uk/employmentandcontracts/independent_contractors/quality_outcomes_framework/qof06.jsp?page=31

[40] 06.01.11; National Prescribing Centre, Key therapeutic topics 2010/11 - Medicines management options for local implementation: July 2010

non-steroidal anti-inflammatory drugs (NSAIDs) (BNF paragraph 10.1.1) at a net ingredient cost of £254 million. Of this, cox-II selective inhibitors accounted for 31% of items and 63% of cost[42].

Since 2000, there have been concerns that coxibs might be associated with an increased risk of serious cardiovascular thrombotic events such as myocardial infarction or stroke. The safety of coxibs and NSAIDs has been kept under continual review by CHM. New evidence for the NSAID diclofenac suggests that it has a cardiovascular risk similar to that of at least one coxib—etoricoxib. The prescribing of NSAIDs and coxibs should be based on careful consideration of a patient's condition and risk factors for treatment, particularly with regard to the known effects of NSAIDs and coxibs on the gastrointestinal and cardiovascular systems[43].

Because of the risk of adverse CV effects, coxibs would appear to have a very limited role in clinical practice. They are inappropriate to prescribe to patients who require aspirin for CV prevention because any GI benefits are diminished[44].

Bearing in mind that there does not seem to be a safe period over which there is no increased risk of CV events, and taking into account the high prescribing volume of diclofenac (approximately 2 million items per quarter in primary care in England) and the increased thrombotic risk being similar to that of coxibs (3 per 1000 patients per year), the prescribing of diclofenac could be associated with up to 2000 extra or premature CV events in England each year, compared with no treatment[45].

The widespread use of diclofenac in the UK indicates an immediate need for reconsideration of its use ahead of low-dose ibuprofen or naproxen (with a PPI if appropriate), in people at risk of CV disease who require an NSAID. Current advice from the CHM is that patients should not switch between NSAIDs without careful consideration of the overall safety profile of the products and the patients' individual risk factors and preferences[46].

Where NSAIDs are required, prescribing should be based on the safety profiles of individual NSAIDs and on individual patient risk factors[47].

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[41] 28.01.11; NICE implementation uptake report: cox II selective inhibitors, May 2009; http://www.nice.org.uk/usingguidance/measuringtheuseofguidance/niceimplementationuptakecommissionedreports/nice_implementation_uptake__commissioned_reports.jsp?domedia=1&mid=63F8D9EC-19B9-E0B5-D4B10471C5F45EFA

[42] 28.01.11; NICE implementation uptake report: cox II selective inhibitors, May 2009; http://www.nice.org.uk/usingguidance/measuringtheuseofguidance/niceimplementationuptakecommissionedreports/nice_implementation_uptake__commissioned_reports.jsp?domedia=1&mid=63F8D9EC-19B9-E0B5-D4B10471C5F45EFA

[43] 28.01.11; Medicines and Healthcare products Regulatory Agency; Safety of Selective and non-selective NSAIDs, Oct 2006; http://www.mhra.gov.uk/home/groups/pl-p/documents/websiteresources/con2025036.pdf

[44] 28.01.11; National Prescribing Centre; Data focused commentary: NSAIDs and musculoskeletal disease, 2006; http://www.npci.org.uk/therapeutics/pain/musculo/resources/dfc_musculo_pain.pdf

[45] 28.01.11; National Prescribing Centre; Data focused commentary: NSAIDs and musculoskeletal disease, 2006; http://www.npci.org.uk/therapeutics/pain/musculo/resources/dfc_musculo_pain.pdf

[46] 28.01.11; National Prescribing Centre; Cardiovascular and gastrointestinal safety of NSAIDs, Nov 2007; http://www.npc.co.uk/ebt/merec/cardio/cdrisk/merec_extra_no30.htm

[47] 28.01.11; National Prescribing Centre; Cardiovascular and gastrointestinal safety of NSAIDs, Nov 2007; http://www.npc.co.uk/ebt/merec/cardio/cdrisk/merec_extra_no30.htm

QIPP Opportunity

The objective of this indicator is to increase safety of prescribed non-steroidal anti-inflammatory drugs by reducing use of diclofenac and cox-2 inhibitors because of the associated increase in cardiovascular risk.

Prescribing data for the quarter ending March 2010 show that the mid-quartile range for diclofenac costs (NIC) was £49.33 to £75.61 per 1000 oral NSAIDs Star-Pus. 9 London PCTs in the most expensive quartile and 7 in the least expensive quartile. The mid-quartile range for Cox-2 inhibitors costs (NIC) was £45.10 to £79.68 per 1000 oral NSAIDs Star-Pus. 1 London PCT in the most expensive quartile and 18in the least expensive quartile.

Helping People to Recover from Episodes of Illness or Following Injury – Unscheduled Care

Standard

15. Emergency hospital admission rates for specific chronic conditions usually managed in primary care.

Definition

Appropriate as an indicator of Consortia performance alongside reporting general practice level data.

Rate of emergency hospital admissions for selected LTCs as a proportion of total number of patients per GP practice with selected LTCs.

NHS Comparators LTCs to be included: Angina, Asthma, Congestive Heart Failure, COPD, Diabetes complications, Hypertension, Iron deficiency anaemia, Nutritional deficiencies[48].

Numerator: Number of emergency hospital admissions per GP practice for those patients with selected LTCs.

Denominator: Total number of patients per GP practice with selected LTCs as reported on disease register.

NB The indicator is a measure of Consortia performance. Practice level data will also be provided to help Consortia understand if this is a population or practice issue. Where a practice is an outlier compared to other practices in a similar setting and context this could provide evidence that the practice could improve in this area. If emergency admissions are high across all practices then this could provide evidence that it is a commissioning issue.

ACCOUNTABILTY

The objective aims to deliver a reduction in the number of emergency admissions for specific LTCs usually managed in primary care in London.

Work will be undertaken to establish a baseline for London. All GP practices should aim to achieve this as a benchmark level. However, practices will also receive a quartile London ranking.

Organisations in the top quartile ranking within London are examples of good practice.

Monitoring, intervention and support would be required for those organisations within the bottom quartile ranking in London. Monitoring and support would be beneficial for those

[48] Dec 2010; Department of Health; NHS Outcomes Framework 2011/12 Technical details of indicators; http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_122954.pdf

organisations within the mid quartiles within London.

Data Source

SUS.

Frequency: Monthly.

Rationale

These conditions have been identified as ones where community care can avoid the need for hospitalisation. The purpose of the comparator is to help monitor potentially avoidable emergency hospital admissions for certain acute illnesses that are amenable to management in a primary care setting.

Progress in preventing conditions from becoming serious will be measured using the indicator 'emergency admissions for acute conditions that should not usually require hospital admission'. This indicator looks at conditions that should usually be managed without the patient having to be admitted to hospital. Where an individual has been admitted for one of these conditions, it may indicate that they have deteriorated more than should have been allowed by the adequate provision of healthcare in primary care or as an outpatient in hospital.

While some emergency admissions for these conditions might be unavoidable, and others may indicate inappropriate hospitalisation, a certain proportion will be linked to avoidable deterioration and this indicator is believed to be a suitable proxy measure for looking at this outcome[49].

In primary care, higher continuity of care with a GP is associated with lower risk of admission[50]. Many chronic conditions can – and should – be managed within the primary care setting[51].

QIPP Opportunity

Shortcomings in the quality of primary care management for these conditions can be reflected in increased emergency admissions or in longer stays than should be necessary because a condition has become more sever or because appropriate assistance is not available to support an earlier discharge. Excess bed days represent a potential pan London opportunity of £600k.

2009/10 SUS data on excess non elective bed days (i.e. incurred after trim point) published through NHS Comparators show that at PCT level:

[49] 06.01.11; Department of Health; The NHS Outcomes Framework 2011/12; http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_123138.pdf

[50] S Purdy; August 2010; Avoiding Hospital Admissions ; The King's Fund

[51] 06.01.11; Department of Health; Chronic disease management and self-care; http://www.cardiacrehabilitation.org.uk/a2z/Clinical%20Guidelines/England/National%20Service%20Framework%20Chronic%20Disease%20Management.pdf

- *for diabetes spells between 4% and 10% (inter-quartile range) of tariff expenditure was incurred on excess bed days, 6 London PCTs were in the worst quartile. Excess bed days created a pan London opportunity of £600k.*
- *for cardiac disorders spells between 7% and 10% (inter-quartile range) of tariff expenditure was incurred on excess bed days, 9 London PCTs were in the worst quartile. Excess bed days created a pan London opportunity of £7.9m.*

Helping People to Recover from Episodes of Illness or Following Injury – Unscheduled Care

Standard

16. A&E attendances.

Definition

Appropriate as an indicator of Consortia performance alongside reporting general practice level data.

The rate of A&E attendances per 1000 patients on GP register.

Numerator: Total number of Type 1 A&E attendances per GP practice.

(Analysis will be undertaken to assess the benefits of reporting this indicator by minor/major grouped HRGs).

Denominator: Total number of patients on practice register.

The indicator will be the numerator divided by the denominator multiplied by 1000.

NB The indicator is a measure of Consortia performance. Practice level data will also be provided to help Consortia understand if this is a population or practice issue. Where a practice is an outlier compared to other practices in a similar setting and context this could provide evidence that the practice could improve in this area. If A&E attendances are high across all practices then this could provide evidence that it is a commissioning issue.

ACCOUNTABILTY

The objective aims to deliver a reduction in the number of type 1 A&E attendances, particularly those patients discharged to their GP or discharged without follow up.

Work will be undertaken to establish a baseline for London. All GP practices should aim to achieve this as a benchmark level. However, practices will also receive a quartile London ranking.

Organisations in the top quartile ranking within London are examples of good practice.

Monitoring, intervention and support would be required for those organisations within the bottom quartile ranking in London. Monitoring and support would be beneficial for those organisations within the mid quartiles within London.

Data Source

SUS.

Frequency: Monthly.

Rationale

Good practice states it is better for patients to be treated closer to home in a more local setting. Currently confusion over GP's out of hours and access services plus many other issues is leading to a greater number of inappropriate A&E attendances. This has contributed to record A&E attendance figures in the last year, which has a massive impact on the NHS budget[52].

Dissatisfied with the availability of GP services out of working hours, Londoners are instead using A&E departments for urgent care. Londoners are dissatisfied with the availability of GP services outside normal working hours – it is the only aspect of services provided by GPs with which there is net dissatisfaction. As a result, Londoners are using A&E departments for urgent care instead. London has by far the highest rates of both A&E attendances and A&E admissions in the country. Many people are attending A&E who could be better cared for elsewhere. The provision of care for people with minor illness and injury in A&E departments is not ideal – patients may be seen by junior doctors rather than GPs (although the latter are better skilled and experienced in dealing with minor illness and injury and with people with long-term conditions)[53].

In NHS Bolton a dashboard was developed for GP practices to monitor their own patients' recent attendances at A&E and out-of-hours services. In 2009-10 the PCT achieved a 3.23% reduction in A&E attendances[54]. They found the urgent care dashboard was an excellent tool to help manage case loads and increase the delivery of effective healthcare[55].

By having a better offering in the community use of A&E can be reduced and up to 50% of patients could potentially be treated in primary care. This can be achieved by better care management of long-term conditions by using integrated teams of clinicians spanning primary care, secondary care and other service providers to reduce repeat attendances. In addition a clear need has been identified to provide a genuine primary care offering to those self referred patients currently bypassing primary care and presenting at A&E. In London this has been assessed to equate to some 1.75m attendances or 50% of the total attendances at A&E per year[56].

QIPP Opportunity

Good primary care access, including out of hours, will reduce the number of divertible A&E attendances and contribute towards improved management of chronic conditions.

2009/10 A&E attendance data published through NHS Comparators show that at PCT level the inter quartile range for minor tariff attendances was between 15.4 and 98.3 per 1,000 (standardised population), 13 London PCTs were in the worst quartile. There is a pan-

[52] Professor Lord A Darzi; July 2007; NHS London; Healthcare for London: A Framework for Action
[53] Professor Lord A Darzi; July 2007; NHS London; Healthcare for London: A Framework for Action
[54] 2010; NHS North West, Urgent Care Clinical Pathway Group; http://www.innovatenow.org.uk/documents/UrgentCare.pdf
[55] 06.01.2011; Connecting for Health, NHS Bolton staff dash to clinical improvement; http://www.connectingforhealth.nhs.uk/systemsandservices/clindash/publications/bolton.pdf
[56] Healthcare for London, CSL, Quick Reference Guide; http://www.healthcareforlondon.nhs.uk/assets/Publications/Quick-reference-guide/01-QuickreferenceguideHealthcareforLondon.pdf)

London opportunity of £8.4m from those minor tariff attendances resulting in either discharge without follow-up or discharge to GP (compared to expected rates).

The picture was more varied among GP practices with minor tariff attendances ranging from 2.8 to over 200 per 1,000 on the list. Practice opportunity sizes range from £0 to over £25,000 (discharged to GP) and £0 to over £45,000 (discharged without follow-up).

Ensuring People Have a Positive Experience of care – Quality of care

Standard

17. After consultation how well did you understand / feel better able to cope?

Definition

Appropriate as an indicator of general practice performance.

Percentage of patient who answered 'yes', 'yes definitely' or 'yes, to some extent' to selected questions in the GP survey, as a proportion of total patients who responded to those questions.

Numerator 1: Having answered 'yes' to the question 'Have you had discussions in the past 12 months with a doctor or nurse about how best to deal with your health problem?' those patient who also answered 'yes' to 'In these discussions, did the doctor or nurse take notice of your views about how to deal with your health problem?

Denominator 1: The number of patients responding to the question in the GP Patient Survey excluding those who answered 'don't know' or 'not applicable'.

Indicator 1: Indicator 1 is numerator 1 divided by denominator 1, expressed as a percentage.

Numerator 2: Having answered 'yes' to the question 'Have you had discussions in the past 12 months with a doctor or nurse about how best to deal with your health problem?' those patient who also answered 'yes' to 'In these discussions, did the doctor or nurse give you information about the things you might do to deal with your health problem?

Denominator 2: The number of patients responding to the question in the GP Patient Survey excluding those who answered 'don't know' or 'not applicable'.

Indicator 2: Indicator 2 is numerator 2 divided by denominator 3, expressed as a percentage.

Numerator 3: Having answered 'yes' to the question 'Have you had discussions in the past 12 months with a doctor or nurse about how best to deal with your health problem?' those patient who also answered 'yes' to 'In these discussions, did you and the doctor or nurse agree about how best to manage your health problem?

Denominator 3: The number of patients responding to the question in the GP Patient Survey excluding those who answered 'don't know' or 'not applicable'.

Indicator 3: Indicator 3 is numerator 3 divided by denominator 3, expressed as a percentage.

Numerator 4: Having answered 'yes' to the question 'Have you had discussions in the past 12 months with a doctor or nurse about how best to deal with your health problem?' those patient who also answered 'yes' to 'In these discussions, did the doctor or nurse give you a

written document about the discussions you had about managing your health problem?

Denominator 4: The number of patients responding to the question in the GP Patient Survey excluding those who answered 'don't know' or 'not applicable'.

Indicator 4: Indicator 4 is numerator 4 divided by denominator 4, expressed as a percentage.

Numerator 5: Having answered 'yes' to the question 'Have you had discussions in the past 12 months with a doctor or nurse about how best to deal with your health problem?' those patient who also answered 'yes' to 'In these discussions, did you want a written plan summarising your discussion with the doctor or nurse?

Denominator 5: The number of patients responding to the question in the GP Patient Survey excluding those who answered 'don't know' or 'not applicable'.

Indicator 5: Indicator 5 is numerator 5 divided by denominator 5, expressed as a percentage.

Numerator 6: Having answered 'yes' to the question 'Have you had discussions in the past 12 months with a doctor or nurse about how best to deal with your health problem?' those patient who also answered 'yes' to 'In these discussions, did the doctor or nurse ever tell you that you had something called a 'care plan?

Denominator 6: The number of patients responding to the question in the GP Patient Survey excluding those who answered 'don't know' or 'not applicable'.

Indicator 6: Indicator 6 is numerator 6 divided by denominator 6, expressed as a percentage.

Numerator 7: The number of patients who answered 'yes, definitely' or 'yes, to some extent' to the question Do you think that having these discussions with your doctor or nurse has helped improve how you manage your health problem?

Denominator 7: The number of patients responding to the question in the GP Patient Survey excluding those who answered 'don't know/can't remember'.

Indicator 7: Indicator 7 is numerator 7 divided by denominator 7, expressed as a percentage.

The results of each indicator will be displayed individually, but viewed together will give a broad sense of how a practice is performing with regard to patients understanding and feeling better able to cope after a consultation.

NB This will be used as an initial measure of patient experience using historical data to show trends over time. This will be amended to align with any contractual agreements on measuring patient experience.

ACCOUNTABILTY

The objective aims to deliver improved patient experience in primary care, specifically helping the patient to feel better informed and able to cope following consultation.

Organisations in the top quartile ranking within London are examples of good practice.

Monitoring, intervention and support would be required for those organisations within the bottom quartile ranking in London. Monitoring and support would be beneficial for those organisations within the mid quartiles within London.

Data Source

GP Patient Survey.

Frequency: Bi-annually.

Rationale

Engaging patients and carers in discussions about care and ensuring that decisions about treatment are shared between health care staff and patients can improve the management of the condition, improve patients' experience of care and link commissioning decisions and improvement initiatives to the needs of service users.

There is good evidence that patients who are well-informed about their condition and their options for care and treatment are more likely to follow the agreed treatment plan (Marinker 1997). There is additional evidence that good communication between doctors and their patients enhances patient outcomes (Stewart 1995). Information is a pre-requisite to expressing preferences and exercising choice in relation to treatment.

A good consultation should achieve a number of objectives, including perhaps an enhanced doctor-patient relationship. The skills to improve consultation outcomes can be learned and developed through consultation analysis. Such improvements can simultaneously recognise and improve the important relationship between doctors and patients[57].

QIPP Opportunity

London respondents are less likely to be satisfied with the care received than the NHS (85% compared with 90%). London PCTs ranged from 80% to 88%.

[57] 06.01.11; Patient UK; Consultation Analysis; http://www.patient.co.uk/doctor/Consultation-Analysis.htm

Ensuring People Have a Positive Experience of care – Quality of care

Standard

18. Satisfaction with overall care received at surgery.

Definition

Appropriate as an indicator of general practice performance.

Percentage of patients who reported being satisfied with overall care received at the surgery.

Numerator 1: The number of respondents who answered 'very satisfied or 'fairly satisfied' to the question, 'In general, how satisfied are you with the care you get at your GP surgery or health centre?'

Denominator 1: The number of patients responding to the question in the GP Patient Survey.

Indicator 1: Indicator 1 is numerator 1 divided by denominator 1, expressed as a percentage.

Numerator 2: The number of respondents who answered 'yes, would definitely recommend' or 'Yes, might recommend' to the question, Would you recommend your GP surgery or health centre to someone who has just moved to your local area?'

Denominator 2: The number of patients responding to the question in the GP Patient Survey.

Indicator 2: Indicator 2 is numerator 2 divided by denominator 2, expressed as a percentage.

The results of both indicators will be displayed individually, but viewed together will give a broad sense of how a practice is performing with regard to satisfaction with overall care received at surgery.

NB This will be used as an initial measure of patient experience using historical data to show trends over time. This will be amended to align with any contractual agreements on measuring patient experience.

ACCOUNTABILTY

The objective aims to deliver improved patient experience in primary care across the full range of services provided.

Organisations in the top quartile ranking within London are examples of good practice.

Monitoring, intervention and support would be required for those organisations within the bottom quartile ranking in London. Monitoring and support would be beneficial for those organisations within the mid quartiles within London.

Data Source

GP Patient Survey.

Frequency: Bi-annually.

Rationale

Patient satisfaction is an important outcome of health care services and can affect compliance with medical advice, service utilisation, and the clinician-patient relationship[58].

Measures of patient experience offer a more direct route to assessing the patients' perception of both continuity and the quality of the GP-patient relationship[59].

A number of analyses demonstrate that [these] improved health outcomes are also associated with increased patient satisfaction and, critically, with reduced aggregate health care spending[60].

Satisfaction with a doctor consultation has been shown to be crucial to a patient's recovery or a good long-term prognosis, affecting everything from the clinical outcome, to compliance/co-operation with the treatment, depression and anxiety, and complaints and malpractice litigation[61].

QIPP Opportunity

Because between 80%-90% of all medical encounters take place in primary care, research is essential to form the effective delivery of care.

They (GPs and NHS services) can both improve the quality of care for patients and avoid unnecessary costs elsewhere in the system.

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[58] 2007; M Howard; J Goertzen; B Hutchison; J Kaczorowski; K Morris; Patient Satisfaction with Care for Urgent Health Problems: A Survey of Family Practice Patients; http://www.annfammed.org/cgi/reprint/5/5/419.pdf

[59] 06.01.11; Continuity of care and the patient experience, The King's Fund; http://www.kingsfund.org.uk/current_projects/gp_inquiry/dimensions_of_care/continuity_of_care.html

[60] 06.01.11; Listening to the Capital's GPs, Londonwide LMCs; http://www.lmc.org.uk/uploads/files/news/2008/ctc%20responses/generic_response_final26.02.08.pdf

[61] 06.01.10; Clinical Discovery; A measure of patient Satisfaction; http://www.clinicaldiscovery.com/readArticle.aspx?articleId=141; April 2010

Ensuring People Have a Positive Experience of care – Quality of care

Standard

19. Patients changing practice without changing address.

UNDER DEVELOPMENT – Needs to be established whether we are able to track patients who change practice without changing address. There may also be information governance issues around this data.

Definition

Appropriate as an indicator of general practice performance.

Percentage of patients who changed GP practice without changing address.

Numerator: The number of patient who change practice without changing address.

Denominator: Total number of patients on practice list as reported through QOF.

NB This is a developmental measure that provides a proxy for patient satisfaction with their practice. The removal of practice boundaries from April 2011 could result in flux in the system. If there is high patient turnover, until this stabilises, patients changing practice without changing address could be a result of the introduction of choice. If a practice has a continuing decline in patients registered with them, without those patients changing address and a similar pattern is not evident in other practices in a similar context and setting, this could provide evidence the practice needs to improve in this area.

An additional supporting indicator will be used in conjunction with the above main indicator to assess overall practice list migration.

Supporting Numerator: Total number of patient on practice list in quarter.

Supporting Denominator: Total number of patient on practice list in the same quarter in the previous financial year.

The indicator will be displayed as a percentage shift.

Data Source

Difficult to track as patient identifiable information required.

Frequency:

Rationale

This is a new measure that has been developed to provide an indication of overall patient satisfaction with their practice. The Government's White paper intends to make choice a reality by removing practice boundaries and providing people with the ability to register with any practice from April 2012. If there is a higher proportion of patients than expected changing

practice without changing address this provides a signal that the practice may not be providing a service that meets the needs of its patients. This is a development measure in the 1st year to provide a baseline as proxy for quality in the longer term.

This indicator is a developmental measure and will show how well patients are able to exercise choice across London.

QIPP Opportunity

London respondents less likely to definitely recommend surgery than the NHS (53% compared with 61%). London PCTs ranged from 44% to 61%.

Ensuring People Have a Positive Experience of care – Continuity of Care

Standard

20. Ability to see a specific GP or Practice Nurse if wanted.

Definition

Appropriate as an indicator of general practice performance.

Percentage of patients who are satisfied with the frequency of seeing a preferred doctor at the surgery.

Numerator 1: The number of respondents who answered 'always or almost always' or 'a lot of the time' to the question, How often do you see the doctor you prefer to see?'

Denominator 1: The number of patients responding to the question in the GP Patient Survey excluding those patients that responded 'Not tried at this GP surgery or health centre'.

NB This will be used as an initial measure of patient experience using historical data to show trends over time. This will be amended to align with any contractual agreements on measuring patient experience.

ACCOUNTABILTY

The objective aims to deliver improved patient experience in primary care and improved levels of care though continuity.

Organisations in the top quartile ranking within London are examples of good practice.

Monitoring, intervention and support would be required for those organisations within the bottom quartile ranking in London. Monitoring and support would be beneficial for those organisations within the mid quartiles within London.

Data Source

GP Patient Survey.

Frequency: Bi-annually.

Rationale

Relationship continuity is generally highly valued by patients and staff, and there is convincing evidence of its association with better health outcomes. The advantages and benefits of relationship continuity have been shown to include: increased satisfaction for patients and staff, for example patients show how they value their chosen clinician by their willingness to wait longer; and increased security and trust within the doctor- patient relationship. This increases willingness to accept medical advice and adherence to long term

preventive regimes such as statin medication.

Continuity of care appears as a central feature of most definitions of general practice and primary care. Relationship continuity is inextricably woven into the traditions and core values of general practice. Guidance from the RCGP on good medical practice emphasises the importance of a continuing GP- patient relationship, and elaborates on the GP's contribution to an effective partnership with patients, based on openness, trust and good communication.

Continuity of care – in the sense of a patient repeatedly consulting the same doctor and forming a therapeutic relationship – has been described as an essential feature of general practice in England. Generally, relationship continuity is highly valued by patients and clinicians, and the balance of evidence suggests that it leads to more satisfied patients and staff, reduced costs and better health outcomes.

Continuity of care becomes increasingly important for patients as they age, develop multiple morbidities and complex problems, or become socially or psychologically vulnerable.

The balance of evidence is that relationship continuity leads to increased satisfaction among patients and staff, reduced costs and better health outcomes, although there are some risk s and disadvantages that need to be understood and mitigated[62].

QIPP Opportunity

London respondents slightly less likely to have a preferred GP than the NHS (58% compared with 61%). London PCTs ranged from 51% ham to 64%.

London respondents slightly less likely to usually see their preferred GP than the NHS (66% compared with 71%). London PCTs ranged from 57% to 70%.

Reduced costs: prescriptions, tests, A&E attendance, and hospital admissions. A recent Dutch study found that newly registered patients used more health care resources during their first year with a practice than in subsequent years (Kings Fund).

[62] 06.01.11; Continuity of care and the patient experience, The King's Fund; http://www.kingsfund.org.uk/current_projects/gp_inquiry/dimensions_of_care/continuity_of_care.html

Ensuring People Have a Positive Experience of care – Access to primary care

Standard

21. Advanced appointments. Satisfaction with opening hours. Ease of getting through on the phone.

Definition

Appropriate as an indicator of general practice performance.

Access to Primary Care.

Numerator 1: The number of patients responding to the question in the GP Patient Survey who state that they were able to get an appointment with a doctor more than 2 full weekdays in advance.

Denominator 1: The number of patients responding to the question in the GP Patient Survey on booking an appointment more than two full weekdays in advance, excluding those who selected "Can't remember".

Indicator 1: Indicator 1 is numerator 1 divided by denominator 1, expressed as a percentage.

Numerator 2: The number of patients responding to the question in the GP Patient Survey who state that they were "very satisfied" or "fairly satisfied" with their GP practice opening hours.

Denominator 2 : The number of patients responding to the question in the GP Patient Survey on satisfaction with GP practice opening hours, excluding those who responded "I'm not sure when my GP surgery or health centre is open".

Indicator 2: Indicator 2 is numerator 2 divided by denominator 2, expressed as a percentage.

Numerator 3 : The number of patients responding 'very easy' or 'fairly easy' to the question in the GP Patient Survey 'In the past 6 months, how easy have you found the following? Getting Through on the telephone.

Denominator 3 : The number of patients responding to the question in the GP Patient Survey on 'In the past 6 months, how easy have you found the following? Getting Through on the telephone, excluding those who selected "Haven't tried", or "Don't Know".

Indicator 3: Indicator 3 is numerator 3 divided by denominator 3, expressed as a percentage.

The results of the three indicators will be displayed individually, but viewed together will give a broad sense of how a practice is performing with regard to access to primary care.

NB This will be used as an initial measure of patient experience using historical data to show trends over time. This will be amended to align with any contractual agreements on measuring patient experience.

Data Source

GP Patient Survey.

Frequency: Quarterly (Rolling year data).

Rationale

Ensuring good access to GP services has always been a key concern for the NHS in England. Much has been written about access to health care in general, and to primary care services in particular. Policy on access to primary care (and GPs in particular) has developed over time from concern about 'under-doctored areas' to include more sophisticated action on speed of access through, for example, targets on maximum waiting time for appointment.

Patients place a high priority on having good access to GPs. A number of issues relate to access and availability. These include being able to get through on the telephone, having an appointment system that meets the needs of your patients, providing appointments with particular doctors in order to provide continuity of care and having a system that identifies urgent problems.

In general, healthcare professionals share with colleagues an overall responsibility to ensure that all patients have access to medical care, and professionals should work with their Primary Care Organisation to ensure adequate arrangements are in place[63].

QIPP Opportunity

London respondents who had tried to see a GP fairly quickly were less likely to have been successful than those elsewhere (76% success compared to 80% success). London PCTs ranged from 71% (the lowest reported success rate among English PCTs) to 85%.

London respondents less likely to have found it easy to contact their practice on the phone than NHS (62% compared with 65%). London PCTs ranged from 54% to 71%.

London respondents less likely to be satisfied with practice opening hours than NHS average (76% compared with 79%). London PCTs ranged from 73% to 81%.

[63] July 2008; The Royal College of General Practitioners; Good Medical Practice for General Practitioners

Treating and Caring for People in a Safe Environment and protecting them from Avoidable Harm – SUI, Incident and complaint monitoring

Standard

22. Significant Event Reporting (One and Three year targets).

Definition

Appropriate as an indicator of Consortia performance.

The practice has undertaken a minimum of 3 significant event reviews in the past year and twelve in the past 3 years, which could include:

- any death occurring in the practice premises
- new cancer diagnoses
- deaths where terminal care has taken place at home
- any suicides
- admissions under the Mental Health Act
- child protection cases
- medication errors.

A significant event occurring when a patient may have been subjected to harm, had the circumstance/outcome been different (near miss).

This indicator is not suitable for numerator / denominator analysis. All practices should complete a minimum of 3 reviews in the preceding year and twelve in the preceding 3 years, regardless of practice list size.

The results of both parts of the indicator will be displayed as:

- Achieved the required number of significant event reviews in previous 1 year / 3 years

or

- Failed to achieve the required number of significant event reviews in previous 1 year / 3 years.

Data Source

QOF.

Frequency: Annual.

Rationale

Significant event review is a recognised methodology for reflecting on important events within a practice and is an accepted process as evidence for GMC revalidation. It is

important that the practice view complaints as a potential source for learning and for change and development[64].

Significant event analysis is not new, although its terminology may have changed. It was first known as critical event monitoring. It provides structure to an activity which anyway happens informally between health care professionals. It is the discussion of cases and events and the learning obtained through reflection and is an extension of audit activity. Discussion of specific events can provoke emotions that can be harnessed to achieve change. For it to be effective, it needs to be practised in a culture that avoids allocating blame and involves all disciplines within the practice[65].

Reports should include a summary of each complaint or suggestion and an identification of any learning points which came out of the review. It may be useful to agree at the time of each review how the learning points or areas for change will be communicated to the team; it is likely that not all team members will be involved in every review meeting for various reasons. It may also be useful to identify an individual responsible for implementing the change and monitoring its progress[66].

QIPP Opportunity

2009/10 QOF data show that London practices collected 93.8% of available points for conducting annual reviews of patient complaints (NHS average 96.8%); 90.7% of available points for undertaking significant event review in past 3 years(NHS average 94.9%) and 93.2% of available points for conducting significant event reviews in past year (NHS average 96.6%).

Practices in 6 PCTs collected all the available points for conducting annual complaints reviews but some practices collected only 66% of available points and London had 7 of the 10 lowest scoring PCTs. 93 Practices failed to collect any points for conducting annual complaints reviews.

Similar picture on significant event reviews with London PCTs supplying 6 of lowest scoring 10 PCTs on reviews in oats year (range 100% to 61.7%). 103 Practices failed to collect any points for conducting significant event reviews in the past year.

[64] 31.01.11; NHS Employers; Quality and Outcomes Framework guidance for GMS contract 2008/09, Delivering investment in general practice, Apr 2008; http://www.nhsemployers.org/SiteCollectionDocuments/QUALITY_OUT_COMPLETE_CD_110209.pdf

[65] 31.01.11; NHS Employers; Quality and Outcomes Framework guidance for GMS contract 2008/09, Delivering investment in general practice, Apr 2008; http://www.nhsemployers.org/SiteCollectionDocuments/QUALITY_OUT_COMPLETE_CD_110209.pdf

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Guidance Notes – Interpretation guidance for reported versus expected prevalence data

Interpretation Low

Lower than expected underlying risk - The underlying risk of the practice population is lower than that expected by the calculation of the expected QOF rates.

Note at practice level QOF expected rates for diabetes, asthma, atrial fibrillation and dementia only take account of the age / sex distribution of the practice population not other factors (e.g. relative deprivation, ethnic breakdown etc).

COPD and CHD expected data takes account of age, sex, ethnicity, smoking status and deprivation score at practice level.

Ineffective case finding - Practice may be poor at recognition of symptoms and or/screening of patients for condition. Failure to identify less severe cases could possibly mean a higher proportion of severe cases in overall disease register than average.

Effective prevention of incidence - Effective identification of at risk patients coupled with advice/intervention to reduce risk of development of condition.

Coding Issues - Lack of correspondence between codes used for extracting data for QMAS and codes used for defining prevalence for epidemiological purposes. QOF registers are constructed to underpin indicators on quality of care. QMAS only uses Read codes that are common to all three versions (version 2, version 3 and CVT).

Interpretation High

Higher than expected underlying risk - The underlying risk of the practice population is higher than that expected by the calculation of the expected QOF rates.

Note at practice level QOF expected rates for diabetes, asthma, atrial fibrillation and dementia only take account of the age / sex distribution of the practice population not other factors (e.g. relative deprivation, ethnic breakdown etc).

COPD and CHD expected data takes account of age, sex, ethnicity, smoking status and deprivation score at practice level.

Effective case finding - Good recognition of symptoms and or/screening of patients for condition. Identification of less severe cases could possibly mean a higher proportion of less severe cases in overall disease register than average.

Ineffective prevention of incidence. E.g. Failure to identify at risk patients and/or failure to give advice/intervention to reduce risk.

Coding Issues - Lack of correspondence between codes used for extracting data for QMAS and codes used for defining prevalence for epidemiological purposes. QOF registers are constructed to underpin indicators on quality of care. QMAS only uses Read codes that are common to all three versions (version 2, version 3 and CVT).