Briefing: Somerset Practice Quality Scheme; a framework for innovation

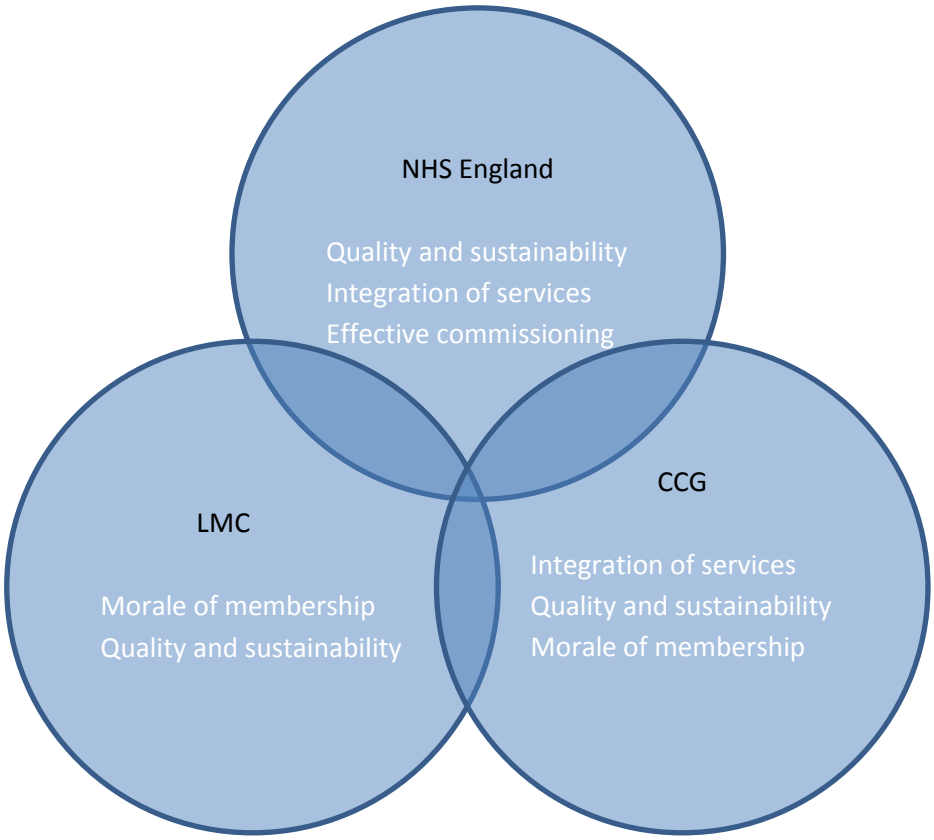
1 Purpose

1.1 To explain the context and contents of the local GP quality scheme pilot in Somerset. The pilot is an alternative approach to the Quality and Outcomes Framework element of the General Medical Services contract, as is known as the Somerset Practice Quality Scheme (SPQS).

2 Context

2.1 NHS England BNSSSG Area Team engaged with the clinical community in Somerset as part of the Improving General Practice call to action in autumn 2013. The view of GPs, the Clinical Commissioning Group and the Local Medical Committee was that the clinical skills of GPs were not being used to best effect in helping patients with the most complex needs. Recent research shows that the Quality and Outcomes Framework medicalises consultations and does not meet patients own objectives in managing their health (1). While it is recognised that QOF is more clinically relevant in 2014/15, it does not incentivise integrated multi-disciplinary working and does not align local priorities and incentives across the whole system. The purpose of the pilot is to test new discretionary approach to QOF which will allow freedom for clinicians to innovate while continuing to provide assurance of high quality care.

2.2 The key concerns of the three organisations involved in this pilot are shown below.



2.3 This pilot has arisen from the shared aims of all three organisations.

2.4 Somerset is at the leading edge of demographic change; between 2010 and 2035, the Somerset over- 75 population will double from 55,000 to 108,000. General practice provision in Somerset, while facing the challenges above, is also experiencing serious workforce and morale issues.

2.5 To deal with these demands and challenges, GPs in Somerset wish to work in a much more integrated way with other parts of the health and care system. This desire has been supported by the CCG, and this proposal is firmly rooted in the strategic priorities of the CCG. A system-wide transformation involving acute, community and social care providers is planned. Somerset already has a well-developed integration pilot centred on Yeovil District Hospital NHS Foundation Trust. The acute, community and mental health providers are all Foundation Trusts. In 2014/15 several new large-scale integration projects, based on patient flows to and from acute hospitals will be developed. Our intention is that no vulnerable patients feel left alone, but instead benefit from compassionate, proactive help to enable them to lead a good life.

3 Project objectives

3.1 The local solution to the challenges set out above is to allow GPs to innovate new ways of integrated working with other providers and pilot new ways of working together across practice groups by reducing the bureaucracy and target-chasing associated with QOF while continuing to provide assurance of clinical quality. This approach promotes clinical decision-making in partnership with patients. An initial one-year pilot is now underway, with further years possible if the scheme proves successful. The pilot was designed by a steering group which included patient representatives, and the Somerset Patient Participation Group Chairs Network was also involved. Other key stakeholders including Somerset Health and Wellbeing Board were briefed on the plans.

4 Practice delivery

4.1 The Somerset Practice Quality Scheme incentivises practices to work collaboratively with the CCG in two workstreams; integration and sustainability. These are described blow.

5 Workstream A: Integration.

5.1 Practices will meet together at locality level with other NHS and social care providers to discuss priorities for service integration, based on local clinical knowledge.

5.2 These discussions will lead to a shared local plan, identifying areas where new ways of working can be piloted.

5.3 These plans will be shared with the CCG which will facilitate alignment of local plans with the wider transformation plans, including the Better Care Fund and Five Year Strategy.

5.4 Practices will work together with other NHS and social care providers to pilot elements of that plan.

Although this sounds simple, it is extremely ambitious. The move we want to make is described below:

Our position now	Our position by the end of Year 1
▪ Practices work in isolation from other providers ▪ Relationships are often poor between agencies ▪ Patients need to see many agencies ▪ Providers do not have shared records ▪ Where integrated teams exist, GPs refer to them ▪ QOF dictates how often patients are reviewed ▪ Practice work is structured around QOF because it forms a large proportion of income	▪ Practices and other providers will have agreed shared plans ▪ The number of contacts patients have in order to meet their needs will be reduced ▪ Providers will all have access to shared records ▪ GPs will be part of integrated multi-disciplinary teams ▪ Patients and clinicians decide priorities together. ▪ The small incremental gains from suspending QOF reporting are used by practices to concentrate on the work that provides most value

If we do nothing, we will remain as we are. Instead, we want to make a real change in the way professionals work together.

6. **Workstream B: Sustainability**

6.1 Practices will work collaboratively to discuss and assess their sustainability, using resources provided by the CCG and Area Team and supported by the LMC.

6.2 Practices will work together at locality level to discuss the opportunities and threats of joint business developments and new models, ranging from sharing staffing all the way to lead provider networks and accountable care organisations.

6.3 Practices will develop proposals for shared working that improve sustainability and quality. These proposals will be shared with the LMC, Area Team and CCG.

6.4 Practices will pilot new ways of working within the financial year. The CCG and Area Team will support pilots with advice and potentially funding through a local collaboration fund.

6.5 Again, these are changes that may sounds simple, but in fact require space and support in order to happen. The move is described below:

Our position now	Our position by the end of Year 1
▪ Practices do not discuss their sustainability with each other ▪ GPs have few opportunities to meet and discuss the future with their peers ▪ There is little or no sharing of staff across practices ▪ Practices are unable to recruit new partners ▪ The GP workforce is ageing and increasingly seeking retirement ▪ The practice nurse workforce is ageing and increasingly seeking retirement ▪ A focus on QOF work leaves little space to rethink and redesign general practice ▪ Morale is low	▪ Practices will be building closer relationships with their neighbours ▪ GPs will have a clear view of threats and opportunities to their business model ▪ Practices will be supported to pilot new ways of working, on a continuum from shared nurse staffing, locality provision of urgent care, mergers, provider networks, alliance contracts and accountable care organisations. ▪ New developments such as integrated training opportunities will make Somerset an attractive option for GPs and nurses. ▪ Practices will have opportunities to think about how they wish to develop in future ▪ Morale will be improved

6.6 The capacity created by removing the link between QOF indicators and practice funding is limited, as much of the clinical work will continue. However the incremental gains from will allow practices to engage with the development of integrated, sustainable services. Since QOF represents a significant proportion of practice funding which is already committed as part of the existing business model, it is not possible to regard the full amount of QOF funding as available for new investment.

6.7 Payment for practices will be based on the funds available for QOF. Funding will be based on 2012/13 QOF achievement funding, corrected for the number of points available in 2014/15 and adjusted for prevalence and list size. No changes to the core GP contract or the associated capitation funding are proposed.

7 Benefits to national stakeholders

The Somerset pilot is expected to deliver the following benefits:

- A nationally supported local pilot to better understand the challenges and opportunities in relation to the role of general practice in more integrated care models. This could inform the national approach to primary care commissioning, in particular the extent to which a single national operating model can support local innovation.

- The pilot would also allow the benefits of co-commissioning between the CCG and Area Team to be delivered early on without formal joint commissioning

arrangements and pooled budgets. This would inform the development of formal joint commissioning structures later in 2014/15.

- Somerset is part of the NHS England Early Adopter Peer network, a group of CCGs delivering transformational service models across the six characteristics set out in the planning guidance. One of these is 'wider primary care, delivered at scale'. The Somerset Practice Quality Scheme proposal will therefore provide early learning across CCGs to accelerate the pace of change.

- The pilot will also inform the national GP contract negotiations, especially in understanding how a national contract framework can be influenced by innovative GPs at a local level.

8 Risks and mitigating actions

8.1 The key risk identified is that quality of general practice in Somerset declines or is perceived to decline. However there are strong safeguards built into the Somerset pilot:

- Somerset GPs have confirmed their intention to carry on providing high quality clinical care, irrespective of financial incentivisation. The clinical aspects of QOF are not being abandoned, but GPs will take a discretionary approach to QOF indicators, based on individual discussion with patients about their needs and aspirations. Recent research suggests that removal of incentivised indicators does not lead to rapid change in clinical behaviour (2).

- Practices will remain opted in to the GPES system so that Somerset continues to produce benchmarking data and contributes to national audits and other secondary data uses.

- The Area Team has a clear duty to performance manage the contracts it holds, and the CCG is a clinically-led organisation which takes responsibility for the clinical practice of its members. The Somerset proposal strengthens the quality measurement arrangement because the whole range of evaluation criteria will be assessed across the pilot year, rather than QOF performance being examined at a single point in the year.

- The pilot uses the flexibilities within the existing contract framework rather than introducing novel contract mechanisms such as alliance contracts. The Somerset scheme is offered to practices as a local enhanced service held by the Area Team, with payment for practices based on the funding they would have otherwise received through QOF.

9 Evaluation

9.1 The pilot will be robustly evaluated by the South West Academic Health Science Network.

9.2 Although the pilot focuses on organisational and developmental aspects of general practice, the evaluation measures also provide extensive measurement of clinical quality. The set of outcome measures chosen fully align with those selected for the Better Care Fund measures and the outcome measures selected by the Symphony integrated care pilot in South Somerset.

9.3 The indicators also include a number of areas which are indicative of the level of health inequalities in the local health economy, to ensure that we are reaching vulnerable and hard to reach groups. NICE Quality Standards have also been use to inform the selection of measures.

9.4 The measures selected reflect the aim of promoting integration, trust and collective effort across the Somerset health system. The current draft indicators and methods of measurement are described in the table overleaf. Please note these are subject ot final discussion and agreement.

SPQS Evaluation Measures		
Group 1: Patient Care Measures		
Measure	**Source**	**Notes**
Self-reported ability to manage own health	Patient Activation Measure questionnaires	Ideally needs to be a before and after measure. Links with CCG LTC programme and the national development programme for proactive care. Has huge potential to link patient and population outcome measures.
Patient experience	National GP Patient Survey	July 2014 data collection will be available in Jan 2015. Jan 2015 data collection will be available in July 2015. Out of step with SPQS programme so suggest this is treated only as a secondary data source.
Patient experience	Patient feedback using Healthwatch social media tool	Details to be confirmed by SWAHSN
Patient experience	Friends and Family Test Free Text	Not due to start until Dec so may not be viable data source
Patient experience of involvement in, and choices over, their care	Symphony patient questionnaire	
Patients ability to participate in work or other meaningful activities of their choosing and have links to their local community	Symphony patient questionnaire	
Quality of life for patients	Symphony patient questionnaire	
People have one key person who takes ownership for co-ordinating their care and are trusted	Symphony patient questionnaire	
People report that their care feels seamless and well co-ordinated	Symphony patient questionnaire	

Group 1: Patient Care Measures (continued)		
Measure	**Source**	**Notes**
Patient experience	Focus groups of patients	A better data source for patients with long-term conditions than the GP patient survey as only one question in the survey relates directly to long-term conditions
Small selection of indicators that provide an 'at a glance' measure of quality. These were selected not to prioritise some indicators over others, but to provide a feasible group of data that represents a good proxy measure of quality. The rationale for the selection is that irrespective of financial incentivisation, any practice providing good care will have high performance on the following indicators. Note that all indicators will be examined for final achievement as detailed in the line below. • Diabetes core processes (DM2-4, DM6-9, DM 12 and DM14) • COPD reviews (COPD3) • Care plans for patients with severe mental illness (MH2) • Quad med post MI (CHD6) • Smoking status recorded for patients with CHD, PAD, stroke/TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses (SMOK2)	CQRS via GPES	Visible through the year and included in the SPQS specification. Not suitable to compare with non-SPQS practices until QOF year-end because of the impact of point-chasing. Year-end data available June 2015. Note the further points on comparability below.

Group 1: Patient Care Measures (continued)		
QOF - all indicators	CQRS via GPES	Visible throughout the year. Provides one data source to inform discussion of quality. Not suitable to compare with non-SPQS practices until QOF year-end because of the impact of point-chasing. Year-end data available June 2015. There are quite complex methodological issues involved in measuring whether or not there has been a drop in QOF activity. Given the previous high scores of Somerset practices (98.8% in 2012/13), it is proposed to treat only reductions of 10% or more as significant. Of course this would relate to the reduction of number of points from 1000 to 559 for 2014/15. In addition, there is a danger of false positives arising from changes that relate to random chance. A confidence interval of 90% is proposed, and a control group established with a group of practices with similar characteristics in the South West of England.
Emergency admissions for ambulatory care sensitive admissions	CCG Outcome Indicator/ NHS Outcome Framework 3a	Aligns to Better Care Fund and Symphony measures as a system-wide indicator, although unlikely to show results from which inferences can be made within the timescale available.
No negative impact on health inequalities	Measure under discussion- advice sought from Public Health colleagues. A review of the literature has been undertaken. Possible measures include: 1. Relative PAM scores in time series from patients with low health activation	

	2. Access to primary care for patients in economically deprived areas 3. Gap between expected and actual prevalence on practice registers for common long-term conditions 4. Concordance with RCGP Health Inequalities Standing Group consensus statements	
Group 2: Organisational Measures		
Measure	**Source**	**Notes**
Extent to which integration and sustainability are promoted by the pilot	Analysis of quarterly progress reports and micro-evaluations of local SPQS pilot projects	Particular emphasis will be placed on improvements in organisational relationships. The theories of change methodology will be used to see what inferences can be drawn about the impact on patient care.
Extent to which integration is furthered by the pilot	Assessment of progress using the taxonomy of integration developed by SWAHSN	Links with SWAHSN evaluation of other integration pilots in the South West
Improvements in morale and motivation of GPs, nurses and other practice staff	Sibbald et al selected as measure for GP morale- this could also be used/ adapted for other groups	The Manchester University DH GP morale survey is partly based on Sibbald et al and the methodology may be directly transferrable. Choice of tool and methods of data gathering to be decided as soon as possible
Personal experience of the pilot	Focus groups/ individual interviews	The satisfaction, optimism and engagement of clinicians and others engaged in the pilot will be assessed

10 Conclusion

10.1 The message to the Area Team during the Call to Action engagement process was clear; general practice in Somerset cannot go on as it has been. Change is required, and the CCG, Area Team and LMC want to preserve the current high quality and build on it further to deliver shared ambition for integrated care. Somerset GPs have been highly engaged in describing what that future will look like, and what part they will be able to play.

10.2 The Somerset Practice Quality Scheme pilot will inform the national development of high quality, integrated, sustainable general practice now and for future generations.

10.3 For further information please contact:

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References

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2. Kontopantelis et al (2014) Withdrawing performance indicators: retrospective analysis of general practice performance under UK Quality and Outcomes Framework, British Medical Journal, 348:g330 doi: 10.136/bmj.g330 (published 27 January 2014)