PQCS Primary Care Standards 2020/21

Primary Care System Capacity and Demand (£0.75)	As a system we want to understand the following aspects of General Practice Access to support system resilience during Covid-19 and the upcoming winter period: i. What mode of patient contact is available (e.g. Online/telephone/video consultations) ii. What capacity is available for each practice? iii. What is the impact on any staff absence on the services and capacity? a) Practices will need to consent to share this data for the purpose of system wide COVID-19 planning and support to the system development partners to undertake the necessary work to configure the practice systems in order to create views within Apex and Insight Enterprise versions to show practice, PCN, Federation and CCG/System wide view of amalgamated activity, capacity and workforce absence. b) To do this we are asking practices to: i. Give individual practice consent to share this information ii. Validate the appointment book data for individual practice with a member of the Apex team iii. Review validated data as a PCN to further explore usage / functionality to support PCN workforce plans iv. Agree workforce plans and submit a baseline assessment using the provided template no later than 31st July 2020 (previously issued to GP Providers winter 2019/20). <u>Use of Information</u> GP providers are informed that no 'standards' are set within this area and information will not be used for contract performance management purposes. Information will be used to inform system resilience planning during the Covid-19 pandemic and during winter 2020/21.
Supporting Shielded Patients (£0.75)	a) Practices to make contact with all patients on shielded list and cover the following areas: i. Discuss what shielding means, ii. Describe any changes to their ongoing care and treatment, including home visiting wherever this is clinically needed iii. Confirmed named contact arrangements for support iv. Confirm they have an arrangement in place for receiving their medications and v. Check that they are aware of the Government support offer.

<table>
<tr><td></td><td>Practices to code these discussions (as previously issued) with:

 
<table>
<tr><th>Code</th><th>Concept ID</th><th>Description ID</th></tr>
<tr><td>Advice given about 2019 novel coronavirus infection</td><td>1240721000000105</td><td>2809161000000110</td></tr>
<tr><td>Educated about 2019 novel coronavirus infection</td><td>1240711000000104</td><td>2809171000000115</td></tr>
</table>

c) Practices to submit numbers of patients on shielded list - take figures from updated EMIS searches (can compare numbers coded with contact versus total numbers)

d) Practices to refer suitable shielded patients to Social Prescriber to offer non-medical support and coded with:

871691000000100 - Social prescribing offered (finding)
871711000000103 - Social prescribing declined (situation)
871731000000106 - Referral to social prescribing service (procedure)

Note: The above arrangements will be subject to ongoing refinement as national guidance for Shielded Patients is updated.</td></tr>
<tr><td>MDT Care for Care Home and other patients with complex needs. (£0.75)</td><td>(a) Undertake no less than monthly MDT meetings to enhance care to care home and other complex patient’s. The MDT can either be within the GP practice and/or at a Primary Care Network. It is expected that Complex Geriatric Assessment (CGA) is at the heart of MDT process using the provided EMIS clinical template <u>for all</u> Care Home patients.</td></tr>
<tr><td>Prescribing (£0.75)</td><td>(a) Improve Antibiotic Prescribing

1) Audit, choice of either a. Adherence to Pan Mersey Formulary, b. Adherence to Pan Mersey formulary focusing on specific infections such as skin and soft tissue infections or other GP own choice.
2) E-learning on AMR and Covid-19 (approx. 1 hr).

(b) Improved Uptake of Electronic Prescription Service (EPS4)

How EPS Phase 4 works?

Previously, it was only possible to issue an EPS prescription where the patient nominated a pharmacy or another dispenser. EPS had been most advantageous for patients who received regular medication and who tended to get their prescriptions dispensed at the same pharmacy most of the time.</td></tr>
</table>

Under Phase 4 of EPS, prescriptions would be sent via EPS by default, whether a patient has an EPS nomination in place or not. However, where certain criteria are met, a paper prescription would still be used, for example:

when a patient explicitly asks their GP for a paper prescription; or
when the medicine being prescribed is not listed in the NHS list of medicines (dm+d).

To adopt EPS4 practices do not need to contact all patients individually as it is possible for practices to adopt EPS4 automatically. It is recommended however that it is advisable that checks should be made first.

In support of this target MLCSU Technicians have been making these checks to ensure that practices are ready to initiate.

The requirement for PCQS is for THE GP Practice to have adopted EPS4 by March 2021.

(c) Electronic Repeat Dispensing (ERD)

Continued delivery of the electronic Repeat Dispensing Scheme;

a. Continued review of the appropriateness of patients as part of routine clinical reviews.

b. Offer electronic repeat dispensing to patients as part of usual contact. Document discussion

c. Practices need to read code each reviewed patient using the appropriate read code:

Repeat dispensing term	SNOMED code
On repeat dispensing system	414938004
Repeat dispensing at designated Pharmacy	415291006
Patient consent given for repeat dispensing information transfer	416224003
Repeat dispensing service offered	880351000000104
Repeat dispensing service declined	783871000000107
Withdrawn from repeat dispensing system	198371000000101

d. This will be monitored by the CCG Business intelligence team on a quarterly basis. No action from the practice will be required although an indicative

	Wirral target is set of approximately 3% of the total population,
Total Funding	£3 per patient per annum split equally across the 4 delivery areas (Inc Quarter 1 monies for 2020/21)

1. IMPLICATIONS

1.1 Although the £3 monies (Circa £1,000,000) are within the Primary Care budget the expenditure is discretionary other than retained PMS Premium monies allocated to the budget. CCGs are mandated to reinvest PMS Premium retained monies back into primary care.

1.2 As with previous years a 60% aspirational payment would be for signing up to the scheme. A 40% reward payment would be made at year end subject to completion of the required actions. It is proposed that 100% clawback of aspirational monies is made if actions aren't fully completed.

1.3 An appeals process via the Primary Care Committee is available to GP providers.

1.4 Standards maybe subject to change if new guidance is released e.g. For Shielded Patients. These would be negotiated with GP providers prior to amendments being enacted.

1.5 Ongoing monitoring of the PCQS will be undertaken by the CCG's Primary Care Team.

2. CONCLUSION

4.1 The PCQS aims to support the General Practice's systems response to Covid-19 whilst also maintaining delivery of other key initiatives established in 2019/20.

3. APPENDICES

Letter.	Title of Appendix
A.	Actions for provision of NHS Care to People Shielding at Home

Appendix A Actions for provision of NHS Care to People Shielding at Home

Whilst people are continuing to shield at home, they may be less likely to seek and access the NHS care they need, because of the advice to stay at home.
The NHS has already significantly changed how it operates to address that risk. In the light of that initial experience, an advisory group has informed this guidance. It provides a list of 9 actions that the NHS should continue to take or implement now, if not already in place.

Systems (STPs/ICSs) have the overall lead responsibility for ensuring that these actions are fully in place in their geography. These actions apply to all providers of NHS care.
Although focused on people shielding at home, most of the actions have a wider relevance for the proactive provision of coordinated and convenient NHS care for patients with significant ongoing needs.

The NHS should:
1. **Put in place a lead, named care coordinator/team.** Every patient shielding at home should have a lead, named care coordinator or single point of contact to help support patient-led follow up or provide regular check ins, where these are required. For most patients this will be someone from their GP practice. In some cases where the main ongoing care is with a specialist, it may be a secondary care or community health team. For children and young people, it may be paediatricians at secondary or tertiary hospitals or Advanced Nurse Specialists in all environments. In some cases, it may be appropriate to identify a (clinical or non-clinical, e.g. social prescribing link worker) care coordinator who can coordinate activities between different healthcare teams, for example pharmacies, mental or community health services.

2. **Proactively contact** those in the 'shielding' cohort to ensure they know how to access care if they need it and have an appropriate personalised care plan for when this needs to happen. Mental health, learning disability and autism teams should ensure that patients under their care who are known to be shielding are proactively contacted and supported through this time; for example, with helplines / websites staffed by trust teams.

3. **Review and adjust personalised care plans.** Given the diverse health, care and wellbeing needs of shielding patients, personalised care plans should be adjusted on the basis of individual circumstance, preference and an assessment of clinical risk. A particular focus should be placed on tackling health inequalities. Care plans should focus on meeting the mental, physical and wider social needs of patients. In balancing risks, priority should be given to care which supports quality of life, autonomy, dignity and daily functioning. The plan, or as a minimum a discussion on key decisions for care and treatment, should:

a. be developed through shared decision-making with the individual, and with parents, carers and community teams if appropriate (e.g. learning disability liaison nurses)
b. take account of an individual's clinical condition(s), preferences and circumstances, including access to, and confidence in, using digital tools / technology
c. include the named care co-ordinator or single point of contact where needed
d. balance wellbeing, treatment needs and social vulnerabilities with risks of exposure
e. cover all aspects of the individual's needs (physical, mental health and wellbeing)
f. include arrangements for medicines delivery at home, as required of community pharmacy
g. ensure that patients have direct access to the appropriate clinical team via e-mail, telephone or in any other way that facilitates communication between the patient and their contact point
h. incorporate any reasonable adjustments they need1
i. be owned by the individual who should where possible, have a (digital) copy of their plan / record of decisions taken

1 In line with current policies and procedures, care should be adjusted to reflect and adequately respond to an individual's disability, ability to comprehend and converse; ensuring everyone can access the same safe care
2 Patients identified as being clinically extremely vulnerable are recorded as such in their summary care record, and this is also visible in the "additional information" section of the SCR which is shared across the system unless the patient has dissented from this

4. **Support self-management** to help patients to have the knowledge, skills, confidence and support they need to manage their own health and wellbeing effectively in the context of their everyday life during this pandemic. This includes information to parent / carers and age specific information. More information on self-management support is available here.

5. **Provide NHS care at home, wherever possible**; virtually or online by preference. This includes GP and hospital outpatient appointments, e.g. using tools such as AttendAnywhere. Particular focus should be paid to supporting those who may have the greatest challenges in accessing care remotely, to reduce health inequalities. Where remote service delivery is not possible, it should be via safe (i.e. infection controlled) general practice or community health service home visiting where clinically necessary. Systems should expand and resource all relevant home-based services, such as a home-visiting phlebotomy service.

6. Wherever care at home is not possible, **provide safe NHS care in infection-controlled clinical settings**, in line with latest infection prevention and control guidance. For, example for invasive treatments, diagnostic tests or procedures. In such cases, identify a safe location and ensure the patient has safe 'door-to-door' transport (see requirements for patient transport). All NHS providers can access the Summary Care Record Application (SCRa) which has a specific flag for every patient currently recorded as being shielded. Advance warning should be given when a clinically extremely vulnerable patient is to attend an NHS site and can make additional adjustments, wherever possible, to further reduce exposure. This can be confirmed via pre-appointment checks or the Summary Care Record application[2]. Ambulances should also let emergency departments know where they are conveying a patient who is clinically extremely vulnerable. Any paperwork or information about their care plans should accompany the individual and be given to the hospital team. Clinically extremely vulnerable patients have been asked to prepare a single hospital bag for these situations.

7. **Provide regular checks and treatment.** Ensure patients continue to access regular checks, screening and treatment[3] where needed, both for both physical health and mental wellbeing. In specialties such as audiology, dentistry and eye care careful consideration should be given to the benefits of intervention against the potential risks, if remote checks are not possible. These regular checks and treatments should form part of an individual's care plan or health 'passport'. Everyone in the clinically extremely vulnerable group should be given access to the seasonal flu vaccine.

8. **Ensure rapid access urgent and emergency care**. In the event of a rapid deterioration, and in alignment with the patient's wishes, patients needing urgent or emergency treatment should be conveyed to hospital as quickly as possible. Before attending hospital, they should call 111 or 999, so that the ambulance service and hospital can make necessary arrangements to deliver safe care.

9. **Make every contact count**, to deliver more than one check or treatment when visiting someone's home and coordinating activity across primary, community, mental health and hospital care, i.e. taking a multi-disciplinary approach to care. This is particularly important to ensure regular mental health and safeguarding checks, which may involve upskilling some staff, or clinicians working in innovative ways across disciplines. It is as true for urban as rural areas.