Quality Assurance and Improvement Framework

Supplementary Guidance for the GMS Contract Wales

2020/21

Background

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

The detail set out in this guidance has been amended from the 2019/20 guidance, to take account of changes in working practice necessitated by the Covid-19 pandemic. All amendments have been agreed between Welsh Government, GPC Wales and NHS Wales. This guidance is supplementary to the original Quality Assurance and Improvement Framework, Guidance for the GMS Contract 2019/20 and focuses on the changes that have been agreed for 2020/21.

Summary of changes

Value of QAIF Points	The current QAIF point value will be retained at £179 per point for the QAIF year 1 October 2020 to 30 September 2021.
New QI project to be introduced to replace to existing requirement to undertake QI training	The introduction of a new QI project related to Covid learning with a focus on planning for urgent care across clusters under the new ways of working. This has strong links to work already being undertaken at cluster level and provides a focus for learning to be adopted at practice level. This will replace the existing requirement to undertake QI training.
Removal of inactive AF indicators and disease register indicators	In recognition of the ongoing maintenance of disease registers and the 90% practice coverage of the AF QI Project, the inactive AF indicators and disease register indicators will be removed from QAIF, with disease registers becoming a core function, with the associated funding of £4.125m transferred into GSum. The maintenance of accurate disease registers becomes a core contractual activity, this reflects the expectation of good record keeping as a professional standard.

Quality Improvement 2020/21

Quality Improvement is based on a basket" of quality improvement projects which are to be delivered at cluster level. The basket of projects available for 2020-21 will be:

  a. Patient Safety Programme - Reducing medicines related harm through a multi-faceted intervention for the cluster population.
  b. Reducing stroke risk through improved management of Atrial Fibrillation in for the cluster population.

c. Ceilings of care / Advanced Care planning.
d. Urinary tract infection to multi-disciplinary Antimicrobial Stewardship 2019/20
e. Covid Learning – Focus on planning for urgent care across Clusters under the new ways of working.

The Covid Learning QI project replaces the mandatory requirement from 2019/20 to undertake quality improvement training. Practices participating in QAIF are required to undertake the Patient Safety Programme and Covid Learning QI projects as mandatory plus one project from options b, c or d. Practices can continue with the optional QI project they started in 2019/20 and complete during 2020/21.

Summary of QAIF Points for 2020/21

Quality Assurance domain

Clinical sub domain - active indicators	48
- inactive indicators	77
Cluster network sub domain	200

Quality Improvement domain

Patient safety project	65
QI project 1 (carried over from 2019/20)	60
QI project Covid-19 Learning (replaces QI training)	60

Total points for QA and QI   510

QI Project Covid -19 Learning

Introduction

In some areas of Wales, there has been a very high incidence of patients with proven or suspected COVID-19 which has placed a great burden on primary care teams at times, either through delivery of direct patient care or through direct experience of illness in their teams themselves. GMS practices and their primary care teams have consequently transformed the way they have worked in response to this COVID-19 pandemic. They have adopted new modes of consultation at a scale and pace unseen elsewhere in the NHS in Wales. Clinicians and administration staff have adopted infection control precautions and worked differently within practices and with neighbouring practices and community services in the cluster.

It is recognised that there may be future waves of acute COVID-19 cases. There will also be an impact on patients without COVID-19 but who will need access to primary care services delivered in a different way for acute problems or existing long term conditions. There is also likely to be a lasting legacy of patients with physical and mental complications of COVID-19 who will call on primary care for support.

This QI project aims to address these multiple issues over the time span of the contract.

Practices to implement standardised recording of clinical contacts as a means of reliably measuring clinical activity. The data will be used to better plan services related to acute conditions and long term care, delivered by all clinicians.

Outcome measures
- Percentage of practices producing cleansing reports showing improvements in data quality (indicating accuracy of encounter)

Process measures
- Percentage of practices showing a long term trend to increased validated activity as proportion of all recorded activity

Requirements of the QI project

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

Practice level

Practices will accurately record every encounter between a clinician using a standard template to a standard supported by medical defence organisations and NHS Indemnity, applying standard definitions:
- Date of encounter
- Time of start of Encounter
- Site of encounter (main surgery, branch surgery name, remote, outpatient etc)

- Mode of encounter (tel, video, digital online, in surgery, home visit, clinic visit, etc)
- Name of clinician
- Clinician job title or role

These will be recorded in a way that is easily reportable externally (and auditable within the practice). Practices may choose to use other words for recording the site or service or role to suit its own processes but must map these to the standard definitions. E.g. a practice may choose to record a mode of encounter as 'diabetic clinic' where the patient is seen on the practice premises, but this would count as an 'in surgery' mode of encounter.

'Administration' will not be used to record a clinical encounter, and so will be used as a control measure.

All clinical members of the practice team will be included in reports, including clinicians employed by the LHB.

Where an administrative member of staff directs a patient to a clinician (e.g. "*You have an acute eye problem so please attend a high street optician*) under an agree practice protocol or directive of a clinician, then this too should be recorded using the standard definitions and included in the reports.

I. Practices will report frequencies and percentages of the above standard definitions at intervals (to be agreed) using reporting mechanisms inbuilt in GP system software. Data will be reported by each category, e.g. job title or role type, but not by the name of individuals

II. Practices will share their activity reports with cluster leads for discussion at clusters and for sharing with LHBs for planning

III. Practices will undertake regular (quarterly) data cleansing exercises to ensure data is being recorded consistently by all clinicians. These reports will be shared with the cluster leads

IV. Practices will ensure any clinical contacts (regardless of whether in person in the surgery or at home, telephone, video or online digital) for conditions relating to respiratory symptoms are recorded using Read/SNOMED CT codes contained within a national template. The template will be based on the Community COVID-19 pathway and will include codes for
   a. Reasons for the consultation (e.g. febrile illness)
   b. Symptoms (e.g. cough, breathlessness)
   c. Clinical observations (e.g. oxygen saturation, BP, pulse)
   d. Disposal of patients (e.g. admission to hospital)
   e. Working diagnosis (e.g. suspected COVID-19)

V. The practice will agree for anonymised data relating to this template to be extracted by NWIS from their computer systems for sharing with clusters and LHBs in order to plan and deliver services more effectively.

VI. The practice will need to work with Locum Doctors to ensure that they are knowledgeable of the process.

Cluster level

Cluster leads will be responsible for collating the data from practices, aggregate reports will be produced demonstrating activity by standard definitions across the

cluster, this will allow for comparison with other clusters across Wales. These reports are to be discussed with cluster members and decisions/action points to be recorded in the meeting minutes.

The data will be used to support planning of cluster initiatives and business cases, it will also be used alongside any data from cluster initiatives (e.g. cluster hubs) for planning services.

Health Board level

Using the existing data sources, the Local Health Board will calculate a figure to signify the total primary care activity in a practice or cluster, compromising the relevant practices activity, out of hours activity, NHS111 activity and relevant ED activity.

LHBs will support their informatics teams to prioritise the development of analysis techniques for reporting on the activity data and publish the data in a form that can easily used by cluster leads in discussions with their cluster members.
LHBs will need to ensure that all community staff are supported to record in a lifelong record in GMS practices where agreed, in the same consistent way. LHBs will work with Locum Doctors to ensure they are aware of this need to record data in the standard way, regardless of the practice that they are working in. There will be a standard template for practices to complete, rolled out by the individual LHBs.

LHBs will use the activity and clinical data in planning services and rebalancing resources across the health and care system, as part of the IMTP process.

Measurement of the implementation of the project

The outcomes we expect from the project are:-

- Cluster and LHB IMTPs will reflect any need to rebalance resources across the system
- Cluster clinical Hubs (including COVID-19 themed hubs and overflow hubs) will be supported and resourced where activity data suggest they will be of benefit
- Practices and Clusters will become aware if their patients contact ED and GPOOH services at rates which suggest they are outliers, and will reflect, discuss and plan potential measures to address any causes of any inappropriate component of said ED/OOH attendance.