GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales

Primary Care Quality

Quality and Productivity – Risk Profiling 2013

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Purpose and Summary of Document:

Strategy for Health Care in Wales, 'Together for Health' and 'Setting the Direction', highlight health professionals in primary and community care have a vital role to play in supporting the health and wellbeing of people in Wales, wherever they live and whatever their circumstances.

This guide is to support general medical practices to meet the requirements of the Quality and Outcomes Framework, Quality and Productivity Indicators: Risk Profiling 2013. It provides guidance on the role of GP teams, the role of Health Boards and suggestions on ways to meet the Quality Productivity (QP) requirements. The guide provides templates (in Word documents) that practices can adapt and use if they wish to do so.

Work Plan reference: Promote and support primary health care as a provider of public health interventions

1 QOF Quality and Productivity: Risk Profiling

1.1 Background

"Together for Health" and "Setting the Direction" aim to develop and deliver improved primary care and community based services, particularly for those who are frail, vulnerable and who have complex care needs.

Key principles include:

- Develop patients' ability to self-manage their health
- Emphasis on prevention, early diagnosis and high quality services
- Alignment of health and social care
- Developing services that are integrated and organised around the needs of the individual
- Work flexibly around the needs of the individual - using patient feedback as a key driver of continuous service improvement
- Strong clinical leadership

1.2 Delivery

More rapid progress is required to improve the focus on personalised care and to manage the rising demand in all sectors. The Welsh Government's "Delivering Local Integrated Care Plan" describes the Health Boards' roles in facilitating work across organisational and professional borders, strengthening the locality networks already established.

1.3 The Role of the GP team

GP practice teams understand the need for co-ordination of care and the challenge of managing the increasing numbers of patients with multiple co-morbidities. Practice teams can clearly articulate the needs of their patients to the Health Boards which should respond to ensure that appropriate support is made available to maximise the delivery of care in the community.

The Quality and Productivity indicators in QOF encourage GP practice teams to identify their most vulnerable patients and to reflect on their needs in formal team meetings.

A significant outcome of this planning would be for the team meetings to identify gaps in the available services to meet local needs. The team should include the GPs, practice nurses, community nurses and, ideally, social workers. However, it should be noted that for multi-disciplinary team meetings that include agencies other than health (e.g. social workers) it would be necessary to either obtain the consent of each patient discussed, or to restrict the discussions to anonymised case presentations. (Please refer to Annex 1 for a suggested template of minutes of QP multi-disciplinary team meeting).

The QP indicators specify the need to report the gaps in the development of support systems to meet local needs to the Health Board.

GP teams have already worked in a similar way to develop the management of unscheduled care pressures in previous QP work on A&E attendances.

1.4 The role of the Health Board

Health boards will receive annual reports from practices to inform how increased workload in primary and community services may be supported by the development of appropriate support systems to meet local needs. Boards should recognise the importance of demonstrating an active response to network proposals and the risk of disengagement if proposals that support the strategic agenda are not progressed. (Please refer to Annex 2 for a suggested template for an annual report).

2 QP requirement that practices should produce a list of 5% of patients in the practice who are predicted to be at significant risk of unscheduled care admission or community based alternatives.

There is no right or wrong way to produce this list.

Options a practice might consider may include:

- Using personal knowledge of patients to start the list
- Adding to the list opportunistically
- Team discussions
- Discussions with social workers
- Frequent house visit requests
- Frequent users of A&E
- Frailty registers
- Polypharmacy
- Using Read codes to identify:
  - Frequent hospital admissions
  - Patients with multiple co-morbidities
  - COPD patients with very low FEV1
  - Falls

There are also a number of risk stratification tools which could be used. (Please refer to the Annex 4 for a summary of what's available). It is known that such predictive tools may be more accurate than clinicians alone at identifying at-risk patient groups. At this time there is no preferred tool for Wales. However, the method chosen to create the list is not of over-riding importance.

The principal objective of the Quality and Productivity indicators in QOF is to encourage team meetings that focus on a collaborative approach to management planning of at-risk patients. The outcome of this process will be to provide more integrated and appropriate care to relevant individuals and to provide Health Boards with information that helps plan and develop the support and resources required to enhance the care of such patients in the community.

3 QP requirement that the practice identifies a minimum of 10% (with a maximum of 0.5% of the practice list) of those patients from the list produced in indicator QP15 who would most benefit from review and ensures there is

an active management plan in place for each patient. The active management plan must include an appropriate review date. The frequency of each patient's review should be determined in light of their clinical and care needs. The practice will be responsible for ensuring that an appropriate system is in place for monitoring and review of the patients identified.

It is recognised that management plans may already be in place for the most vulnerable of patients, but also that there will be opportunities to improve. The time spent in drafting management plans and attending team meetings can be achievable and effective as the benefits of collaboration may outweigh the loss of some surgery appointments as a result of practitioners being involved in this activity. Team meetings can agree how care can best be provided, prioritising interventions and considering opportunities for joint consultations and shared appointments. (Please refer to Annex 3 for a suggested template management plan for individual patients for use in these meetings).

Practices may wish to consider the use of certain READ codes such as :

- **MDT conference** **3874.**
- **MDT review** **6AE..**
- **Has self management plan** **8CMY.**
- **Agreement of care plan** **8CS..**

There is evidence to suggest that community based, comprehensive, patient centred care improves patient satisfaction, self-reported health and mental health whilst reducing long-term institutional care.

4 QP requires that practices reports annually to the Health Board on system changes that may benefit patients.

Practices will have at least four meetings during the year to review the needs of the patients identified as being at-risk. These meetings will identify opportunities for more effective systems of care and related changes in patient management. A suggested template for recording these meetings to provide evidence to Health Boards is attached as Annex 1 and 2.

It is recommended that these meetings are structured with the opportunity for all in the multi disciplinary group to contribute and lead to appropriate actions.

Locality networks could use this opportunity to provide the Health Board with a clear agenda of actions that will improve the delivery of effective patient-centred care. Locality networks should consider the prioritisation of actions to ensure the greatest impact and benefit for patients in the locality.

Health Boards must demonstrate how such proposals are being considered and managed.

Annex 1

Minutes of QP Multidisciplinary Team Meeting (Template)

1. <u>Date of meeting</u>
2. <u>Attendance list – including professional status</u>
3. <u>Apologies for absence</u>
4. <u>Anonymised list of patients identified and reviewed</u> *This could be in the form of GP software registration numbers for these patients. There is no need for a detailed recording of the discussion of each patient in these minutes. This information should be used to update each patient's management plan.*
5. **<u>Themes discussed</u> –** *it would be useful if the focus here was on identifying:* - ***<u>Issues raised from patient/carer feedback</u>*** - ***<u>Opportunities for more effective systems of care</u>*** - ***<u>Identifying service provision gaps</u>*** *This information could be easily collated into an annual report. Entries in the section "Identified service provision gaps" in the individual patient management plan templates should help contribute to completion of this section.*
6. <u>Date of next meeting</u>

Please note*: the above template is a suggestion on the areas that practices may wish to consider at QP Multi-disciplinary team meetings.*

Annex 2

Annual Report to Health Board on QP Risk profiling (template)

1. <u>Anonymised list of patients identified and reviewed</u>
- *This could be in the form of GP software registration numbers for these patients. The number of patients in this list should be 0.5 % of the practice list size (or 10% of the list identified for indicator QP15)*
2. <u>Collation of themes identified in multi-disciplinary discussions of these patients</u>
- *This is the main purpose of the annual report and is the practice's opportunity to communicate to the Health Board on:* o ***Patient/carer feedback*** o ***Opportunities for more effective systems of care*** o ***Service provision gaps*** - *Entries in the section "Identified service provision gaps" in the individual patient management plan templates should help contribute to completion of this section.*

Please note*: the above template is a suggestion on the areas that practices may wish to consider including within their QP Risk Profiling Annual Report that they send to the Health Board.*

Annex 3

Patient Active Management Plan (template)

(Practice Header)

Patient Active Management Plan	
PATIENT INFORMATION	
Patient name:	Title: Date of birth: / /
Address: Post code:	
Contact details:	
Lead GP:	
Lead practice nurse:	
Lead community nurse:	
Social worker:	
Date of assessment: / /	Date of review(s):
Patient consent to share information: • with other healthcare professionals involved in the patient's care e.g. OOH: YES / NO • with the multi-disciplinary team: YES / NO	
CARER / RESPONSIBLE ADULT INFORMATION	
Name:	Title:
Address: Post code:	
Contact details:	Relationship:
Additional emergency contact (if different from above): Name: Contact details:	Relationship:
PATIENT ASSESSMENT	
Medical needs:	
Medication review:	
Psychological needs – including mental capacity:	
Social needs:	

KEY MESSAGES	
Agreed patient goals:	
Patient/Carer feedback:	
Identified service provision gaps:	
OTHER RELEVANT INFORMATION	
Preferred place of care (if appropriate):	
Cardiopulmonary resuscitation discussed: YES / NO	If yes, please specify outcome:
Other healthcare professionals involved in patient's care (please provide name and contact details if available):	

***Please note**: the above template is a suggestion on the areas that practices may wish to consider to be included within a patient self management plan.*

Annex 4

Risk Prediction Resources

Health services research
Development of a predictive model to identify inpatients at risk of re-admission within 30 days of discharge (PARR-30)

John Billings[1], Ian Blunt[2], Adam Steventon[2], Theo Georghiou[2], Geraint Lewis[3], Martin Bardsley[2]
http://bmjopen.bmj.com/content/2/4/e001667.full

Kings Fund
Combined predictive model: Final Report 2006
http://www.kingsfund.org.uk/sites/files/kf/field/field_document/PARR-combined-predictive-model-final-report-dec06.pdf

Kings Fund
Predicting and reducing readmission to hospital
http://www.kingsfund.org.uk/projects/predicting-and-reducing-re-admission-hospital

Nuffield Trust
Choosing a predictive risk model: a guide for commissioners in England
http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/choosing_predictive_risk_model_guide_for_commissioners_nov11.pdf

NHS Midlands and East
Risk Stratification – a key driver of the Long Term Conditions delivery agenda
http://www.google.co.uk/url?sa=t&rct=j&q=kings%20fund%20combined%20predictive%20risk%20model&source=web&cd=4&ved=0CEEQFjAD&url=http%3A%2F%2Fwww.excellence.eastmidlands.nhs.uk%2FEasysiteWeb%2Fgetresource.axd%3FAssetID%3D47735%26type%3Dfull%26servicetype%3DAttachment&ei=kG9tUaXlCoy1ParKgaAB&usg=AFQjCNGO1-HGOpv4ZL5DLOWevkTJ6k7FjQ&bvm=bv.45175338,d.ZWU