Leeds Health & Care Partnership

NHS West Yorkshire Integrated Care Board

General Practice Outcomes Programme (GPOP) 2024/25

As a Leeds Health and Care Partnership, different members contribute in different ways to the delivery of system-wide goals linking both the triple aim of the NHS and the ambition in the Health and Wellbeing Strategy. The NHS triple aim is described as:

- Improving health and wellbeing including effects in relation to health inequalities.
- Improving quality of services including the effects of inequalities in relation to the benefits people can gain from these services.
- Ensuring sustainable use of resources.

General Practice plays a key role in delivering the NHS aims and the goals of the Healthy Leeds Plan in the context of Core20PLUS5, as well as providing the 'front door' to the NHS responding to both demand and managing risk that impacts across the whole system. We recognise this contribution and want to focus specifically on increasing continuity of care as a proven approach that improves outcomes, satisfaction for people using and working within general practice and reduces the need for unplanned care.

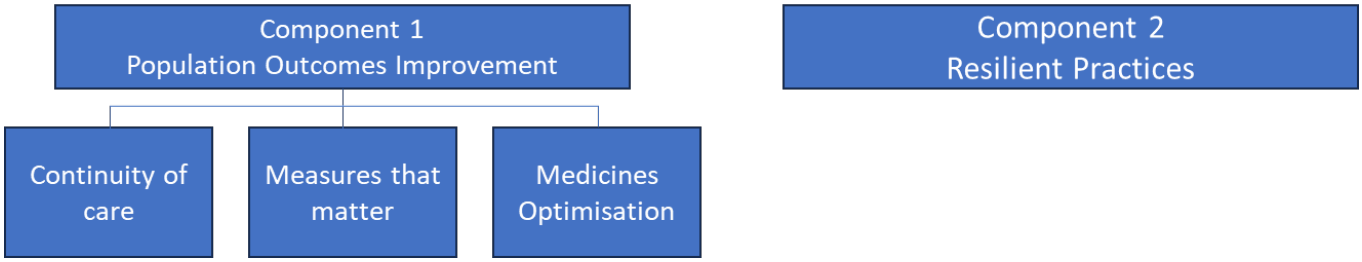
The Healthy Leeds Plan (HLP) outlines the health and care contribution towards delivering the Health and Wellbeing Strategy and sets out our high-level ambitions to improving health outcomes for the people of Leeds. It includes two system goals that partners have agreed to work toward:

1. reducing preventable unplanned utilisation across health settings and
2. increasing early identification and intervention (of both, risk factors and actual physical and mental illness).

Core20PLUS5 provides further strategic emphasis for the overall scheme, which is an NHS England approach to inform action to reduce healthcare inequalities at both national and system level. The approach defines a target population – the 'Core20PLUS5' – and identifies '5' focus clinical areas requiring accelerated improvement.

The scheme will support general practice in understanding and responding to the total registered population, working in an integrated way across the Primary Care Networks and within and through local communities and neighbourhoods (LCPs).

The scheme, which brings together 3 local enhanced services contains two elements and is based on guidance and evidence to support health inclusion (Click Here), **Population Outcomes Improvement** and **Resilient Practices**, with a clear number of deliverables that enables the measurement of 'things that matter' to underpin the continued additional local investment into general practice.



Component One: Section One
Continuity of Care

We would like to test this assumption in Leeds which theoretically asserts that currently a small number of people are accessing your services, using significant appointments on a reactive basis, with less focus continuity of care. This is looking at the repeated use which is unplanned and in response to patient demand – rather than proactive and trying to understand why these people continue to feel that their needs are not being met.

In this section we are asking Practices to:

- Utilise the RCGP continuity of care toolkit Continuity of care: About the toolkit | RCGP Learning PowerPoint Presentation (rcgp.org.uk)
- Identify and understand your practice population, including those who are high users of General Practice and those who do not attend (E.G. young adults) who should potentially be attending for vaccinations, screenings and long term condition reviews but do not access this care. (Data, Searches and guidance to be sent in May)

An example of how Practices could approach this work is outlined below:

Step One	*The ICB (Integrated Care Board) will provide you with high level data and clinical searches on who is attending the practice frequently with broad indications of cost incurred in practice.* *Discussions in practice about patients whose use is expected and managed who should be removed from the analysis*
Step Two	*Review the data as a practice.* *Identify any themes or trends, understand who is attending and who is not?*
Step Three	*Consider the following appraisal or PDSA cycle (see slide 7 and 19 from RCGP Continuity of care Toolkit presentation) to review this*
Step Four	*Complete a short report about how this has been implemented in practice*

Component One: Section Two
Measures that matter
In this section practices are asked to complete the following measures that matter:

1. **Learning Disability Annual Health Check and Completion of Health Action plan**
- Achieve 85% as a City- (Achieved 85.4% in 23/24)
  AND
- All practices within the PCN to commit to improve variation.

2. **Serious Mental Illness Annual Health Checks**
- 2a. Achieve 75% (6 components) as a City- (Achieved 83.6% in 23/24)
- 2b. Achieve 65% (9 components) as City- (Achieved 70% in 23/24)
  AND
- All practices within the PCN to commit to improve variation

3. **Hypertension - Achieved treated to BP age target**
- Achieve 77% as City- (Achieved 76.8% in 23/24)
  AND
- All practices within the PCN to commit to improve variation.

4. **Severe Frailty or Rockwood >=7 - Had CCSP review or PCP (after/on 01/04/24)**
- Achieve 50% of Severe frailty cohort* as a practice.

5. **Severe Frailty or Rockwood >=7 - Completed a ReSPECT form or on the GSF**
- Achieve 50% of Severe frailty cohort* as a practice

Component One: Section Three
Medicines Optimisation

In this section practices are asked to complete the following parts in relation to medicines optimisation:

Part 1- Community Pharmacy Integration, Medicines Waste, OTC & Selfcare Promotion

Bi-annual practice meeting with PCN Community Pharmacy Lead and/or Local Community Pharmacists

Include discussion on and joint approach/targets for:

- Increasing uptake of Pharmacy First services
- Reducing Medicines Waste – Greener Practices
- Minor ailments scheme and OTC/Selfcare promotion
- Managing out of stocks that require alternative prescriptions

Part 2- Reducing harm from problematic polypharmacy & overprescribing

Practice Specific Focus Cohorts for consideration – aligned to Healthy Leeds Plan:

The focus of this aspect is to support practices to identify cohorts of patients at most risk from overprescribing and problematic polypharmacy who would benefit from an SMR. The priority cohort(s) will be selected according to practice data. Supporting the use of appropriate templates, coding and demonstrating improvement in a cohort specific target.

Practice level data will be provided for the cohorts outlined below:

- Deprescribing SMR for those on EOL register (reduction in EOL average number of meds)
- Overtreatment in severe frail with diabetes (reduction in severe frail with diabetes with HBa1c <59mmol/mol)
- Asthma - Overuse of SABA – as per CHIRP reports. (reduction in patients with >6 SABA in 12months)
- STOMP – West & Seacroft PCNs ONLY. Pilot from May (increase in patients with LD with SMR/STOMP review readcode and “indication for each drug checked”)

Part 3- Collaboration on wider medicines optimisation

- Bi-annual practice meeting with ICB Medicines Optimisation representative to discuss the practice level medicines optimisation prescribing dashboard and practice prescribing budget.
- Nominated Practice GP Prescribing Lead (may be in addition to Practice Pharmacist Prescribing Lead) and Attendance at quarterly Prescribing Leads Meetings.
- Prescribing data demonstrates improvement/achievement of agreed 3 practice-specific areas for decreasing or stopping the use of medicines which are neither clinically, or cost-effective in line with National guidelines.
- Practice Prescribing Budget cost growth comes under England average cost growth for 24/25 including a reduction in prescribing for OTC medicine

Component Two: Resilient Practice

The focus of this component will be to improve the health and wellbeing of practice populations by providing sustainable access to services through an equitable funding approach which aims to address variation and embed a culture of continuous quality improvement.
All practices will be eligible to participate in this element providing the following services are available:*

- The practice is open 8am – 6.30pm Monday to Friday
- Participate in Opel reporting
- All Practices to complete the Doctors of the World Safe Surgeries toolkit and implement relevant actions *or* if already a part of safer surgeries the practice must choose one other initiative to support registered populations accessing general practice and reducing health inequalities.
- Each practice to have a carers champion (support from ICB to be confirmed) and the identification of Carers, signposting to Carers Leeds
- Self-assessment of how accessible your services are to people in inclusion health groups *(Template to be confirmed and sent out separately)*
- ECG and interpretation when clinically required in primary care to support an adult patient's management plan
- Access to a phlebotomy service (patients age 12+) encompassing all blood sampling for investigations, monitoring and follow up for the management of patients in primary care (secondary care requested bloods are covered via a separate agreement or via the CDC (Community Diagnostic Centre)/Chapel Allerton Hospital/Wharfedale Hospital).
- For 24/25, Spirometry will continue to be included within this specification whilst a formal review is undertaken of the provision in general practice.

NB. Practices should not be sending patients to hospital for routine phlebotomy and This is separate to Amber Shared Care LES payment for ECGs and Bloods needed for the safe monitoring of Amber drugs)

*Practices can determine how best these services are provided, through working collaboratively with other practices or as part of the PCN but any subcontracting arrangements (including the 6-6:30pm) should be agreed with the commissioner. Any issues with delivery should be flagged to the commissioner and/or via Opel reporting.

Additional information:

* Currently we expect practices to use a mix of eFI, Rockwood score and clinical acumen to include people in the 'severe frailty cohort' for proactive care. - We are open to discussions with practices or PCNs who feel that they are able to come up with a better process of cohort identification, particularly in identifying people with frailty and at risk of admission.

All appendixes are included in the initial email sent out on 24/04/2024:

Appendix 1- Payment Schedule

Appendix 2- Sign up form

Appendix 3- 24/25 EOY form