NHS
Hammersmith and Fulham
Clinical Commissioning Group

2018/19
Enhanced Primary Care Services
Quarterly Performance Report

Primary Care Commissioning Committee

20 November 2018

Contents

Glossary

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CCMI	This refers to patients who have complex common mental health problems as defined in the Mental Health service specification
Flex Report	means the initial activity report produced at the end of the Month by the Commissioner to allow Providers to review and correct data quality issues;
Freeze Report	means the report that is a produced after a set period of time allowable for correction of identified data quality issues. After the activity is frozen it cannot be further amended;
Practice-based services	This refers to services (i.e. Phlebotomy) that all practices are expected to provide for their registered patients ensuring 100% service take up across all practices
Network-level services	This refers services that are provided by a number of practices on behalf of their networks via interpractice referrals, and in accordance with any specified competency requirements.
Primary Care Network	means a group of GP Practices that are geographically located closely to each other and who have agreed to work together to deliver services and outcomes for the benefit of their registered patient population
Quarter (Q)	means each three (3) month period commencing on 1 April, 1 July, 1 October and 1 January as the case may be and "Quarterly" shall be interpreted accordingly;
SMI	This refers to patients who have serious mental illness as defined in the Mental Health service specification

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Section 1:
Out of Hospital Services

This section provides a summary of Q1 (18/19) performance for out of hospital services. Q2 (18/19) flex data has also been included in sections of this report to provide an indicative year to date position.

1.1 Service Coverage

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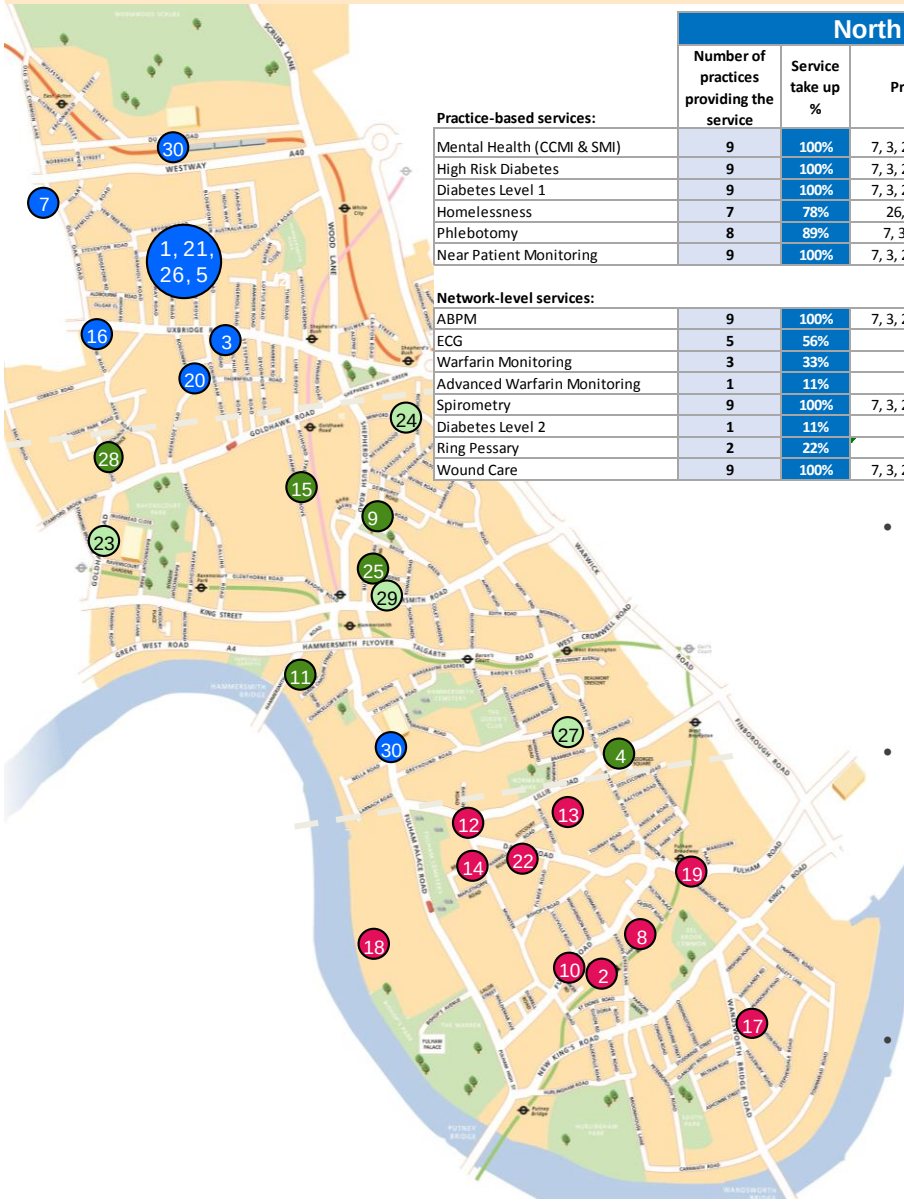
A key focus of the Enhanced Primary Care (EPC) Contract is to ensure that services are delivered by practices and networks in an equitable and efficient way achieving 100% population coverage for the population of Hammersmith and Fulham. The below table provides a summary of practices that have signed up to deliver services within each network.



Practice-based services:	North			Central			South		
	Number of practices providing the service	Service take up %	Practice reference:	Number of practices providing the service	Service take up %	Practice reference:	Number of practices providing the service	Service take up %	Practice reference:
Mental Health (CCMI & SMI)	9	100%	7, 3, 26, 21, 16, 1, 5, 30, 20	10	100%	24, 29, 27, 23, 28, 15, 11, 25, 9, 4	9	90%	14, 18, 13, 22, 8, 19, 17, 10, 2
High Risk Diabetes	9	100%	7, 3, 26, 21, 16, 1, 5, 30, 20	10	100%	24, 29, 27, 23, 28, 15, 11, 25, 9, 4	9	90%	14, 18, 13, 22, 8, 19, 17, 10, 3
Diabetes Level 1	9	100%	7, 3, 26, 21, 16, 1, 5, 30, 20	10	100%	24, 29, 27, 23, 28, 15, 11, 25, 9, 4	9	90%	14, 18, 13, 22, 8, 19, 17, 10, 4
Homelessness	7	78%	26, 21, 16, 1, 5, 30, 20	9	90%	24, 29, 27, 23, 28, 15, 11, 25, 4	9	90%	14, 18, 13, 22, 8, 19, 17, 10, 5
Phlebotomy	8	89%	7, 3, 26, 21, 16, 1, 5, 30	10	100%	24, 29, 27, 23, 28, 15, 11, 25, 9, 4	9	90%	14, 18, 13, 22, 8, 19, 17, 10, 7
Near Patient Monitoring	9	100%	7, 3, 26, 21, 16, 1, 5, 30, 20	10	100%	24, 29, 27, 23, 28, 15, 11, 25, 9, 4	9	90%	14, 18, 13, 22, 8, 19, 17, 10, 8
Network-level services:									
ABPM	9	100%	7, 3, 26, 21, 16, 1, 5, 30, 20	10	100%	24, 29, 27, 23, 28, 15, 11, 25, 9, 4	7	70%	14,13, 8, 19, 17, 10, 2
ECG	5	56%	26, 1, 5, 30, 20	6	60%	24, 29, 27, 11, 25, 9	6	60%	14, 13, 8, 19, 17, 2
Warfarin Monitoring	3	33%	5, 30, 20	10	100%	24, 29, 27, 23, 28, 15, 11, 25, 9, 4	6	60%	14, 13, 8, 19, 17, 2
Advanced Warfarin Monitoring	1	11%	5	6	60%	24, 29, 27, 23, 15, 11, 4	3	30%	14, 13, 10
Spirometry	9	100%	7, 3, 26, 21, 16, 1, 5, 30, 20	10	100%	24, 29, 27, 23, 28, 15, 11, 25, 9, 4	7	70%	14, 13, 8, 19, 17, 10, 2
Diabetes Level 2	1	11%	5	7	70%	24, 29, 27, 23, 15, 11, 4	3	30%	14, 13, 17
Ring Pessary	2	22%	5, 30	2	20%	11,15	3	30%	19, 17, 10
Wound Care	9	100%	7, 3, 26, 21, 16, 1, 5, 30, 20	10	100%	24, 29, 27, 23, 28, 15, 11, 25, 9, 4	7	70%	14, 13, 8, 19, 17, 10, 2

- The Southern Network has 90% take up of practice-based services due to the suspension of services at one practice as a result of on-going CQC investigation.
- Three practices have signed up to deliver warfarin monitoring services in the Northern Network. Currently the service is only operation at the Parkview Practice (5); the remaining two practices are working towards mobilisation.
- Practices who do not currently offer the full portfolio of practice-based services are expected to refer patients to neighbouring practices pending mobilisation.

E-Code	No.	Practice Name	Oct 18 Weighted List Size
E85005	7	Westway Surgery (Dr Dasgupta & Partner)	3,398
E85077	3	Shepherd's Bush Medical Centre	3,420
E85624	26	Dr Uppal & Partners, Parkview	7,234
E85659	21	Dr Kukar, Parkview	1,732
E85748	16	The Medical Centre (Dr Kukar)	5,527
Y02906	1	Canberra Old Oak Surgery	5,735
E85048	5	Parkview Practice	6,672
Y02589	30	Hammersmith & Fulham Centres for Healt	7,550
E85042	20	The New Surgery	5,265
E85055	24	The Bush Doctors	11,628
E85020	29	Brook Green Medical Centre	13,720
E85003	27	North End Medical Centre	17,048
E85636	23	Park Medical Centre	9,539
E85032	28	Ashchurch Surgery	5,001
E85016	15	Richford Gate Medical Practice	10,722
E85033	11	Hammersmith Bridge Surgery	10,168
E85074	25	Brook Green Surgery	4,356
E85125	9	Sterndale Surgery	4,175
E85008	4	82 Lillie Road Surgery	8,000
E85029	14	Dr Jefferies, 292 Munster Road	11,668
E85038	18	Palace Surgery	4,447
E85124	13	GP at Hand	34,259
E85649	12	Fulham Cross Medical Centre	2,745
E85672	22	Salisbury Surgery	1,171
E85025	8	Cassidy Road Medical Centre	5,883
E85118	19	Fulham Medical Centre	6,344
E85128	17	Sands End Health Clinic	11,408
E85685	10	Lillyville Surgery	7,769
E85719	2	Ashville Surgery	10,021
			236,604

1.2 Activity Performance

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The below graph provides a summary of Q1 (18/19) activity performance for services excluding Diabetes (High Risk and Level 1) and Mental Health services as these are reported separately on pages 9 & 10.

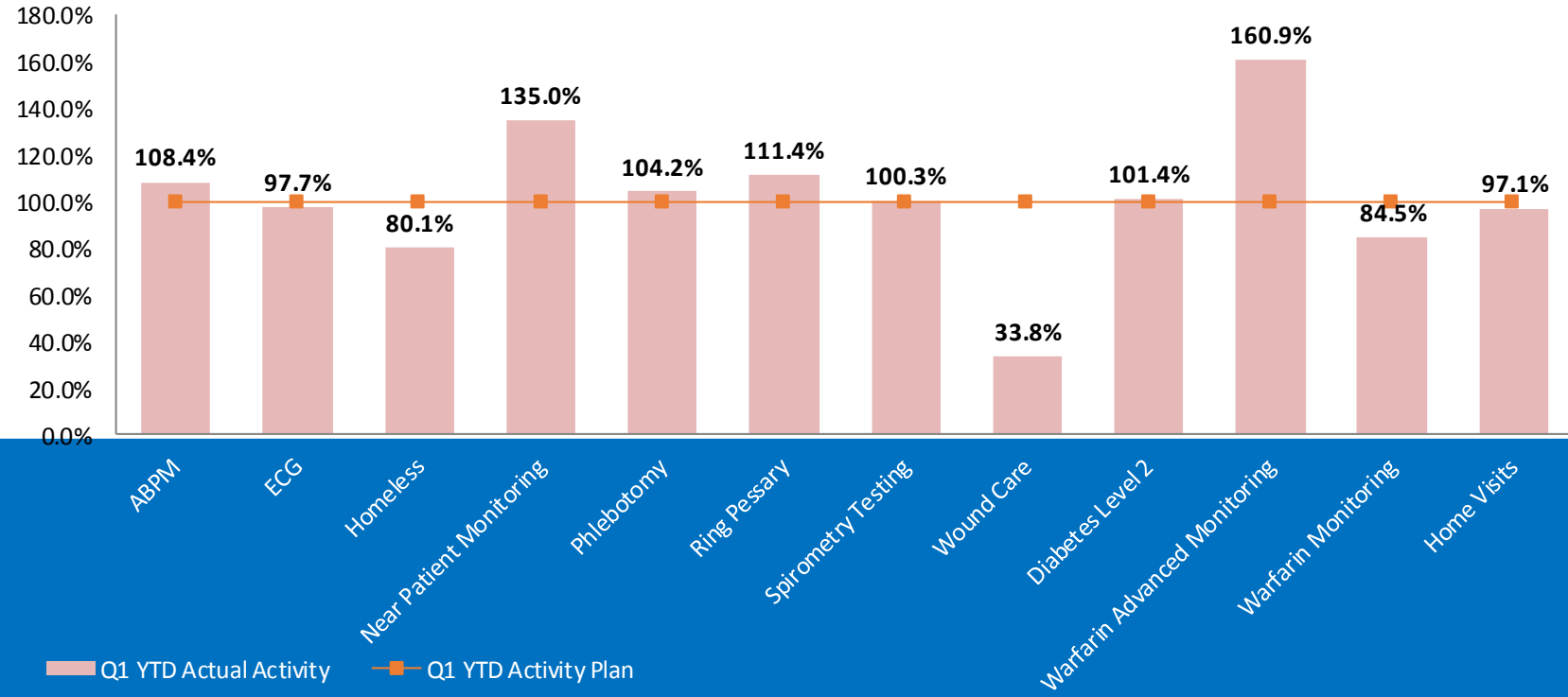
Significant over performance in **Warfarin Advanced Monitoring** is the result of practices incorrectly coding Warfarin Monitoring patients under this service; this is an issue across CWHHE practices which has not been helped by the new clinical template design. Further modification of the template has been requested.

Increased coding of **Near patient Monitoring** activity following practice clinical audits in Q4 (17/18) is attributed to over performance for the service.

Wound care activity is increasing following underperformance in Q1; non completion of clinical templates has been cited as an issue not only for wound care but other services. A data quality improvement plan will be developed with the GP Federation to help improve the quality of data entry across practices.

Quarterly Activity Summary (Q1 Freeze & Q2 Flex):

Service	Q1 Activity 18/19 Freeze	Q2 Activity 18/19 YTD Flex	% increase/ decrease
ABPM	108.4%	99.6%	⇩ -8.8%
ECG	97.7%	98.3%	⇨ 0.6%
Homeless	80.1%	69.2%	⇩ -10.8%
Near Patient Monitoring	135.0%	115.0%	⇩ -20.0%
Phlebotomy	104.2%	104.1%	⇨ -0.1%
Ring Pessary	111.4%	126.6%	⇧ 15.2%
Spirometry Testing	100.3%	94.4%	⇨ -5.8%
Wound Care	33.8%	56.7%	⇧ 22.9%
Diabetes Level 2	101.4%	84.9%	⇩ -16.5%
Warfarin Advanced Monitoring	160.9%	143.2%	⇩ -17.8%
Warfarin Monitoring	84.5%	82.3%	⇨ -2.2%
Home Visits	97.1%	98.9%	⇨ 1.8%



1.3 Network Activity Performance

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The below table provides a summary of Q1 (18/19) performance for services at a network-level. Performance for Mental Health and Diabetes High Risk and Level 2 services are reported separately on pages 9 &10.

Table 1

Service	North			Central			Southern			Total		
	Q1 Plan Activity	Q1 Actual Activity	% performance against plan (activity)	Q1 Plan Activity	Q1 Actual Activity	% performance against plan (activity)	Q1 Plan Activity	Q1 Actual Activity	% performance against plan (activity)	Q1 Plan Activity	Q1 Actual Activity	% performance against plan (activity)
ABPM	77	74	96%	322	368	114%	173	179	103%	573	621	108%
Diabetes Level 2	11	4	35%	22	34	155%	9	5	55%	42	43	101%
ECG	202	250	124%	835	800	96%	397	350	88%	1,433	1,400	98%
Home Visits	0	-	0%	358	426	119%	375	286	76%	733	712	97%
Homeless	186	111	60%	194	159	82%	137	144	105%	517	414	80%
Near Patient Monitoring	35	62	176%	194	230	119%	102	154	152%	330	446	135%
Phlebotomy	2,299	2,074	90%	9,938	10,537	106%	5,260	5,620	107%	17,496	18,231	104%
Ring Pessary	2	5	250%	15	14	95%	3	3	100%	20	22	111%
Spirometry Testing	190	239	126%	312	318	102%	332	279	84%	834	836	100%
Warfarin Advanced Monitoring	4	6	150%	27	52	194%	16	10	65%	42	68	161%
Warfarin Monitoring	18	16	91%	570	462	81%	259	237	91%	846	715	84%
Wound Care	506	178	35%	1,550	553	36%	839	248	30%	2,895	979	34%
April 2018 list size (weighted)			46,122			92,815			84,720			223,656

Table 2

Practice-based services	Number of practices not providing service	% performance against YTD Plan/Number of practices				
		0- 25%	26- 50%	51 - 75%	76- 100%	100% >
ABPM	3	5	1	0	6	14
Homeless	1	16	0	4	3	5
Near Patient Monitoring	1	6	2	0	4	16
Phlebotomy	1	1	1	1	9	16

Network-based services	Number of practices not providing services and referring out	% performance against YTD Plan/Number of practices				
		0- 25%	26- 50%	51 - 75%	76- 100%	100% >
Wound Care	3	10	13	2	0	1
Ring Pessary	21	3	0	2	1	2
Spirometry Testing	3	3	3	3	5	12
Diabetes Level 2	18	2	4	0	1	4
ECG	12	2	0	1	5	9
Warfarin Advanced Monitoring	19	5	2	1	0	2
Warfarin Monitoring	10	1	0	4	10	4

- Activity plans for all services are based on the 17/18 outturn position
- The Northern Network significantly underperformed against their Q1 activity plan for Diabetes Level 2
- Wound care activity was low across all primary care networks in Q1, although activity is increasing based on the Q2 flex position (see page 6)
- Despite an overall performance of 80% demonstrated in Table 1; the majority of practices in Q1 achieved 0-25% delivery against the Q1 activity plan for the Homeless service as shown in Table 2.

1.4 Interpractice Referrals

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The below table summarises the % of activity delivered for practice and network-based services based on Q1 (18/19) freeze data.
Practice-based services: This refers to services (i.e. Phlebotomy) that all practices are expected to provide for their registered patients ensuring 100% service take up across all practices
Network-level services: This refers services that are provided by a number of practices on behalf of their networks via interpractice referrals, and in accordance with any specified competency requirements.

The majority of activity is delivered by practices providing services to their own registered patients

In Q1, there were 59 instances were practices did not deliver any activity or refer out to other practices

The CCG and GP Federation will monitor GP referrals for community and acute services to identify any missed opportunity to deliver activity within primary care

	Own-practice activity (%)	Inter-practice referral activity (%)	Number of practices who did not deliver any activity or refer out in Q1 (18/19)
Practice-based services:			
ABPM	96%	4%	4
Near Patient Monitoring	99%	1%	6
Phlebotomy	99%	1%	0
Homeless	96%	4%	15
Network-based services:			
Wound Care	100%	0%	0
Ring Pessary	95%	5%	19
Spirometry	99%	1%	0
Diabetes Level 2	100%	0%	19
ECG	80%	20%	1
Warfarin Advanced Monitoring	80%	20%	14
Warfarin Monitoring	69%	31%	0

1.5 Diabetes Performance

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The below table provides a summary of Q2 (18/19) performance against the diabetes treatment targets for each primary care network.

CCG	Network	List size	Diabetes register	% Diabetes prevalence	Uncoded diabetes (HbA1c ≥48 or gluc ≥11)	% 9 key care processes in 15m	% HbA1c in 15m	% BP in last 15m	% Cholesterol in 15m	% BMI in 15m	% ACR in 15m	% eGFR in 15m	% Foot risk in 15m	% Retinal screening in 15m	% Smoking status in 15m	% HbA1c, BP, Lipids to target (Chol 4)	% HbA1c, BP, Lipids to target (Chol 5)	% HbA1c ≤ 53 in newly diagnosed	% HbA1c ≤ 58	% BP ≤ 140/80	% Chol ≤ 4	% Chol ≤ 5	% patients on Atorvastatin 20mg+	% Care planning in 15m	% Hypoglycaemia monitoring	% Structured education in newly diagnosed	Non-diabetic hyperglycaemia register	% NDH prevalence	NDH: diabetes ratio	% NDH annual review	% Offered referral to NDPP or info hub
H&F	Central	100494	3872	3.9	313	57.3	93.6	94.1	91.6	86.1	74.4	93.0	81.8	80.8	88.0	22.6	33.8	73.1	62.3	62.0	45.6	71.8	55.6	73.9	89.9	71.8	3553	3.5	0.92	43.7	45.8
	North	50351	2515	5.0	292	48.6	90.1	91.6	87.8	79.7	69.9	89.0	79.3	78.3	84.4	16.8	28.4	62.7	55.7	60.8	38.3	66.5	48.2	69.2	89.6	55.7	1727	3.4	0.69	55.4	67.7
	South	102950	2566	2.5	303	51.3	90.8	92.6	89.4	82.3	71.5	90.1	78.2	75.0	88.0	19.6	31.6	66.7	60.0	58.9	40.5	68.6	44.7	72.8	87.1	62.5	2418	2.3	0.94	42.5	43.8
H&F Total		253795	8953	3.5	908	53.2	91.8	93.0	89.9	83.2	72.3	91.1	80.1	78.4	87.0	20.1	31.6	68.0	59.8	60.8	42.1	69.4	50.4	72.2	88.9	64.1	7698	3.0	0.86	45.9	50.1
Grand Total		253795	8953	3.5	908	53.2	91.8	93.0	89.9	83.2	72.3	91.1	80.1	78.4	87.0	20.1	31.6	68.0	59.8	60.8	42.1	69.4	50.4	72.2	88.9	64.1	7698	3.0	0.86	45.9	50.1

Performance against the diabetes treatment targets has been poor across all H&F primary care networks despite the work undertaken by the HF local team via weekly practice visits and virtual clinics. The Central Network has achieved better than the North and South in relation to the percentage of patients within the network receiving the three treatment targets – HbA1c, BP and Lipids (Chol 4)

The CCG Primary Care Team, GP Federation and Diabetes Transformation Team are due to meet on the 21 November to discuss key areas for improvement and to identify further remedial actions, which will focus on:

- Increasing the use of diabetes clinical templates across practices
- Increasing the number of patients referred for structured education
- Targeting underachieving practices ensuring full engagement with the primary care support team
- Sharing best practice and establishing a peer-led monitoring approach within and across Networks

1.6 Mental Health (CCMI & SMI)

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The below table provides a summary of Q1 (18/19) activity performance for mental health by primary care network. This data includes activity relating to patients with complex common mental health problems (CCMI) and serious mental illness (SMI).

	Annual Plan		Q1 Plan		Q1 Actual		Q1 Variance	
Network	**Annual Review**	**Follow-up**	**Annual Review**	**Follow-up**	**Annual Review**	**Follow-up**	**Annual Review**	**Follow-up**
North	352	704	88	176	9	0	10%	0%
Central	1192	2384	298	596	116	55	39%	9%
South	763	1525	191	382	131	22	69%	6%
H&F	**2,307**	**4,613**	**577**	**1,154**	**256**	**77**	**44%**	

- It is important to note that:
  - Mental Health is a year of care service. In 2018/19, GP practices are expected to deliver a number of key care processes to **2307** CCMI and SMI patients over a 12 month period as part of annual review and follow-up appointments
  - Follow-up appointments are not payable unless an Annual Review has also been carried out in the same financial year. The above follow-up activity relates to patients who have had an annual review and follow-up appointment during Q1.
  - Q1 was a transition period for Networks; practices were still working under the old CCMI and SMI service specifications in Q1 (18/19) and preparing to mobilise the combined mental health specification from Q2(18/19)
  - Primary care networks achieved 44% against their Q1 plan for annual reviews.
  - The number of follow up appointments undertaken in Q1 (18/19) was significantly below plan (7%), particularly in the Northern Network.
  - A Mental Health Dashboard is being developed which will provide a more detailed summary of network performance against the mental health key care processes including SMI population coverage. This will be available to the Committee as part of the Q2 performance report.

1.7 Financial Performance

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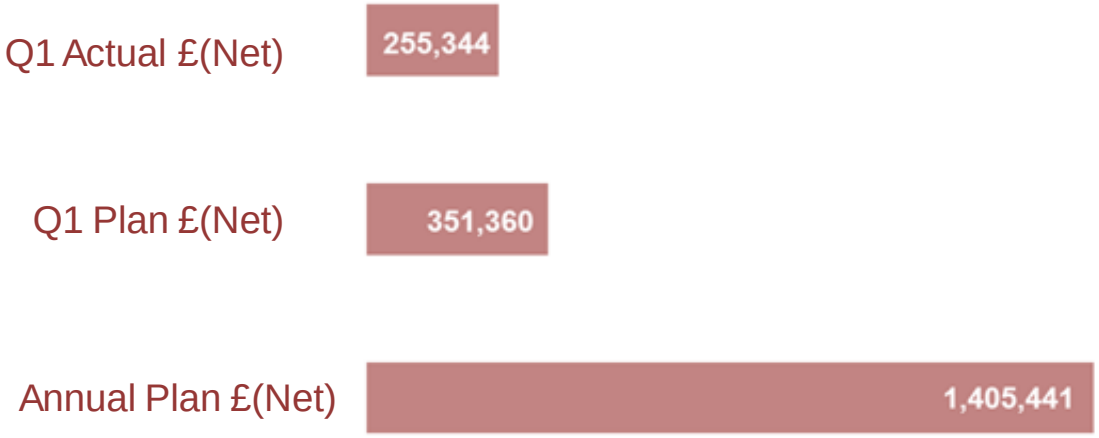
The below data provides a summary of Q1 financial performance against plan (%) for all services excluding Diabetes High Risk and Level 1 as these services are subject to an end year reconciliation.



Network	Annual Plan £(Net)	Q1 YTD Plan £(Net)	Q1 Actual £(Net)	Q1 Variance £(Net)	% YTD Performance
North	194,452	48,613	32,215	- 16,399	86%
Central	763,020	190,755	142,555	- 48,200	96%
South	447,968	111,992	80,574	- 31,418	100%
Total	1,405,441	351,360	255,344	- 96,017	73%

H&F networks performed at 73% against their Q1 financial plan for services excluding Diabetes High Risk and Level 1)

1.8 Financial Performance

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The below graph shows financial performance against plan (%) for services based on the Q1 (18/19) freeze position excluding Diabetes High Risk and Level 1 (as these services are subject to an end year reconciliation).

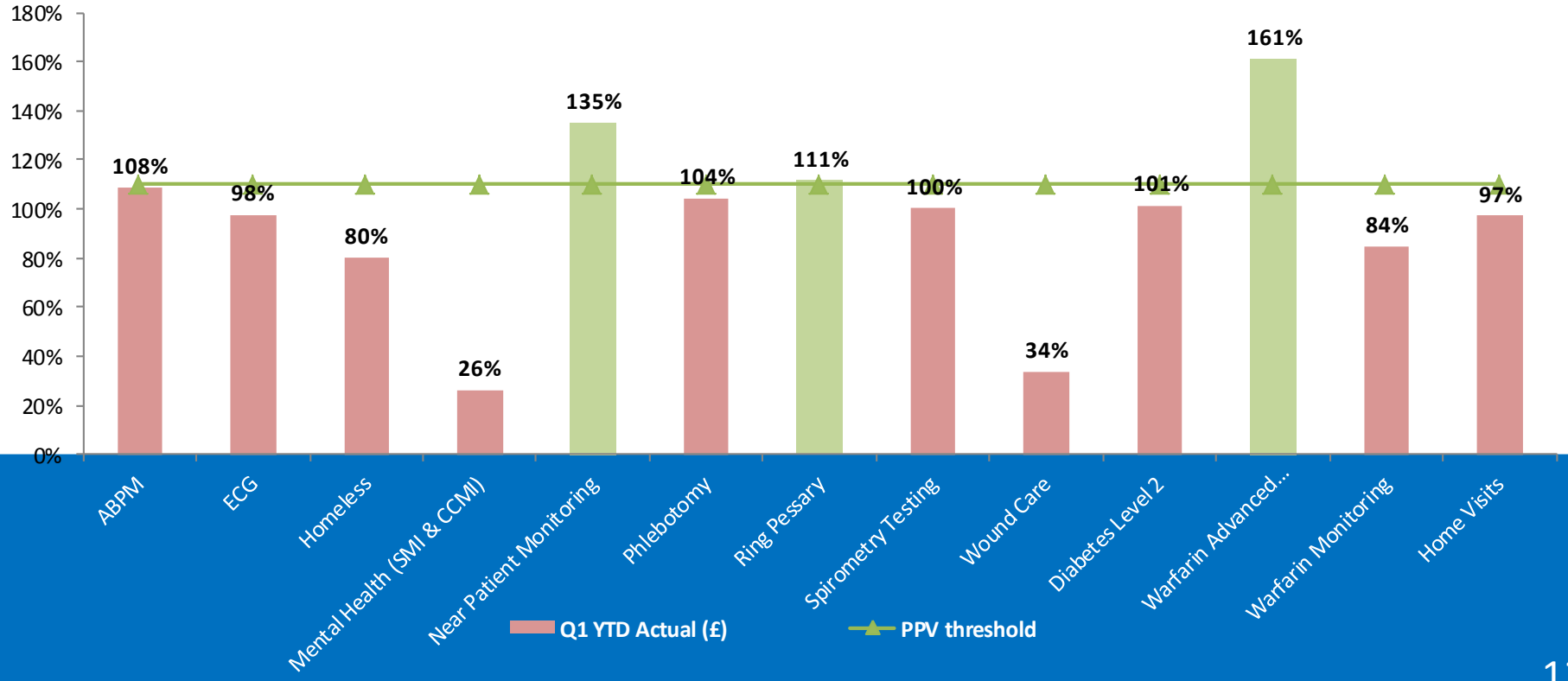
All service budgets are set on 17/18 outturn. Services that underperformed last financial year are likely to over perform in 18/19 as activity ramps up – this is the case for **ring pessary**

All Q1 activity was delivered within budget, however it is worth noting that:

- Practices collectively exceeded the Post Payment Verification (PPV) threshold (110%) for Warfarin Advanced Monitoring, Near Patient Monitoring and Ring Pessary.
- Three practices exceeded their individual out of hospital services (OOHS) budget above 10%

Quarterly Activity Summary (Q1 Freeze & Q2 Flex):

Service	Q1 18/19 YTD (£) Freeze	Q2 8/19 YTD (£) Flex	% increase/ decrease
ABPM	108.4%	99.6%	-8.8%
ECG	97.7%	98.3%	0.6%
Homeless	80.1%	69.2%	-10.8%
Mental Health (SMI & CCMI)	26.4%	27.7%	1.3%
Near Patient Monitoring	135.0%	115.0%	-20.0%
Phlebotomy	104.2%	104.1%	-0.1%
Ring Pessary	111.4%	126.6%	15.2%
Spirometry Testing	100.3%	94.4%	-5.8%
Wound Care	33.8%	56.7%	22.9%
Diabetes Level 2	101.4%	84.9%	-16.5%
Warfarin Advanced Monitoring	160.9%	143.2%	-17.8%
Warfarin Monitoring	84.5%	82.3%	-2.2%
Home Visits	97.1%	98.9%	1.8%



1.8 Clinical Audits

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Under the EPC Contract, the GP Federation and practices are required to deliver an annual clinical audit programme to monitor the quality and clinical effectiveness of contracted activity. The clinical audit programme will consist of 4 audits per annum across for agreed service lines. To date, the GP Federation has completed two audits for warfarin monitoring and spirometry services. A summary of key audit findings and actions are provided below.

Service	Audit aims and objectives	Participants	Key audit findings	Key actions/update	Month the audit was undertaken
Spirometry	To provide assurance of the safety and quality of the services being provided, and to identify areas for improvement and development. The audit also aimed to establish the number of staff who are on the ARTP register and identify any further training needs. *Objectives:* • To ensure that practices have the equipment required to perform safe and accurate spirometry, and that this is adequately maintained. • To ensure that practices have a clinical protocol in place for performing spirometry. • To ensure that spirometry is performed for recognised diagnostic and monitoring indications. • To ensure that adequate data is collected to allow accurate interpretation of a spirometry result. • To ensure that practice staff performing and interpreting spirometry have received appropriate training and certification.	21 of the 23 practices providing a spirometry service took part of the audit.	• Every practice has a spirometer which meets the ISO standard 267823. • All practices except one performed 100% of spirometry tests for a recognised clinical indication. • Only one practice always performed post-bronchodilator spirometry (as per national guidance) when monitoring asthma and COPD patients, with the rest mostly performing baseline spirometry only. • Most practices always performed baseline spirometry (as per national guidance) for these patients undergoing diagnostic spirometry. • Three practices have spirometers which have not received an annual preventative maintenance check in the last 12 months. • Gaps in training needs have been identified; Most practices do not have any staff who are ARTP registered, and none have a full complement of registered staff.	• The remaining two practices have now completed and submitted their audit returns and their results are similar to those of other practices. • The GP Federation has developed an action plan to address the specific areas of improvements identified through the audit. This is being reviewed with the GP Federation as part of monthly contract meetings. • Training needs identified through the audit are being reviewed by the CCG as part of wider considerations regarding reduced CEPN funding	October 18

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Service	Audit aims and objectives	Participants	Key audit findings	Key actions/update	Month the audit was undertaken
Warfarin Monitoring	To provide assurance of the safety and quality of the services being provided in relation to 'Warfarin monitoring' Out of Hospital services. *Objectives:* • To ensure that patients taking warfarin are achieving adequate and safe levels of anticoagulation. • To ensure that patients taking warfarin are not suffering significant adverse events as a result of anticoagulation. • To ensure the warfarin monitoring service provides safe and ongoing follow up of patients taking warfarin. • To ensure patients have the information they need to manage their anticoagulation between warfarin monitoring appointments. • To ensure each practice is compliant with recommended internal and external quality control processes. • To ensure those practices performing advanced warfarin monitoring are doing so in accordance with recognised loading protocols.	All 16 practices providing a warfarin monitoring service across 18 sites took part in the audit.	• 16 sites have an overall time in therapeutic range within two standard deviations of the national mean, i.e. – above 65%, which is the generally accepted national standard. The two remaining sites are close to this threshold, within 2% of the generally accepted standard. • All practices have a process in place for following up patients who do not attend their warfarin monitoring appointment. In all but one practice, every patient has a Yellow Book with written dosing instructions. • Most practices (94%) are performing internal quality control to acceptable level, on the basis that fortnightly quality control checks were considered an acceptable exception. • All practices providing an Advanced warfarin monitoring demonstrated a safe warfarin initiation service.	Following the audit: • Practices with a TTR below 65% reviewed all patients with a personal TTR below 65%. • Practices not using a Yellow Book for all patients established an alternative method of communicating dosing instructions. • All practices are now performing at least fortnightly internal quality control	August 18

1.11 National and NWL Quality Indicators

NHS Hammersmith and Fulham Clinical Commissioning Group

The below Quality Dashboard was introduced for GP Federations to track and report nationally mandated and NWL core quality indicators required of the NHS Standard Contract.

- GP practice non-engagement remains a challenge for the H&F GP Federation; although 52% practices submitted returns for the quality dashboard in June and the compliant rate has dropped during Q2 (2018/19). The GP Federation is now undertaking quarterly practice visits and compliance against the below quality dashboard is a standing agenda item at both practice-level and network meetings. Non-engaging practices will be given until the 15/12/18 to submit all relevant information. Practices who fail to provide the information within the agreed timescale will be issued a contract performance notice which may result in a financial penalty.
- The below complaints were raised over the past 6 months:
  - A patient complained about a mental health appointment that they had received with a nurse. The patient felt that the questions asked by the nurse did not relate to her illness and that the nurse did not understand her illness. The practice has written to the patient to explain that the questions asked were required as part of her review appointment and that the nurse will receive further training.
  - A complaint was raised following a warfarin home visit in which a health care support worker (HCSW) disposed of a needle in the patient's own rubbish bin. The practice has taken measures to ensure that the HCSW always has a sharps bin when attending home visit appointments. This is an isolated incident as this has not occurred with other home visits
  - The remaining complaints raised in September were in relation to GP appointment waiting time not specific to out of hospital service appointments.

								Q1			Q2		
Indicator	**Description**	**Category**	**Reporting Source**	**Frequency of Report**	**Threshold**	**Numerator**	**Denominator**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**
					Number of practices who have completed the dashboard (Indicators 1-5.1):			**20**	**9**	**15**	**13**	**10**	**12**
					Total Number of Practices:			**29**	**29**	**29**	**29**	**29**	**29**
					Compliance rate			**69%**	**31%**	**52%**	**45%**	**34%**	**41%**
CORE QUALITY REQUIREMENTS													
Children's Safeguarding	All staff have received appropriate Children's safeguarding training, at the appropriate level (see below) within the last 3 years	Core Quality Requirements	MIR	Quarterly	≥ 90%	Total number of staff who are up to date with safeguarding children training.	Number of Staff who require safeguarding children training (including those who are trained)	93.6%			95.4%		
Adult's Safeguarding	All staff have received appropriate Adult's safeguarding training within the last 3 years	Core Quality Requirements	MIR	Quarterly	≥ 90%	Number of staff who are up to date with safeguarding adult training.	Number of Staff who require safeguarding adult training (including those who are trained)	90.0%			95.4%		
PREVENT Training	All staff have received PREVENT training in the last 3 years	Core Quality Requirements	MIR	Quarterly	≥ 70%	Number of staff who are up to date with Prevent training requirements (in line with NHSE guidance)	Total number of staff	85.4%			95.3%		
Central Alerting System	Full compliance with Central Alerting System	Core Quality Requirements	MIR	Monthly	100%	Number of applicable CAS alerts responded to	Number of applicable CAS alerts	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Central Alerting System	Full compliance with Central Alerting System	Core Quality Requirements	MIR	Monthly	0%	Number of alerts where assurance is overdue	Number of applicable CAS alerts	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Complaints	Number of Complaints received	Core Quality Requirements	MIR	Monthly	≥ 1	Number of complaints received	-	2	0	0	0	0	2
Complaint acknowledgment	Complaints shall be acknowledged within 3 working days	Core Quality Requirements	MIR	Monthly	100%	Number of complaints acknowledged in 3 working days	Number of complaints received	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Complaint Response	Complaints shall be responded to within agreed timeframes, as per local policy	Core Quality Requirements	MIR	Monthly	≥ 95%	Number of complaints responded to within agreed timeframe	Total number of complaints, excluding complex complaints	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

1.8 National and NWL Quality Indicators

The medication error report in April 2018 relates to a patient on methotrexate who received care under the near patient monitoring service (NPM). The patient requested repeat medication but was overdue for blood tests. The practice tried to call the patient but was unsuccessful, so the practice sent a text message requesting the patient have blood taken so that the methotrexate could be issued. The patient did not respond to the practice's contact attempts so therefore the medication was withheld pending blood test. Meanwhile, the chemist dispensed the medication in the dosset box without the methotrexate.

The patient did not realise that the methotrexate was not included in the dosset box until the next month when the practice had made a further request for bloods. There was no harm to the patient, and to avoid future medication errors the practice has asked the patient and pharmacist to look out for methotrexate and added a note to the prescription for the pharmacy to check if the methotrexate has not been issued. This is the only patient that is seen by the practice under this NPM who receives their medication via dosset box.

The GP Federation has a standing clinical governance agenda item at the monthly network meetings to promote shared learning and best practice.

SERIOUS INCIDENTS/NEVER EVENTS/DUTY OF CANDOUR													
Serious Incidents	Number of Serious Incidents Reported		STEIS	Monthly	≥ 1	Number of Serious Incidents reported.	-	0	0	0	0	0	0
Serious Incidents Reporting	Timely Reporting of Serious Incidents	Core Quality Requirements	STEIS	Monthly	≥ 95%	Number of Serious Incidents reported within 2 operational days of the date that the practice became aware of the incident.	Number of Serious incidents that occurred	N/A	N/A	N/A	N/A	N/A	N/A
Medication Errors	Number of Medication Errors Reported			Monthly				1	0	0	0	0	0
Never Event	Number of Never Events Reported			Monthly	≥ 1	Number of Never Events reported.	-	0	0	0	0	0	0
Never Event Reporting	The occurrence of a Never Event as defined in the Never Events Policy Framework graded as Serious Incidents	Never Events		Monthly	100%	Number of Never Events graded as SIs	Number of Never Events	N/A	N/A	N/A	N/A	N/A	N/A
Duty of Candour	Breaches in respect of the Duty of Candour	Duty of Candour		Monthly	< 1	Number of breaches of the Duty of Candour	-	0	0	0	0	0	0

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Section 2: Population Health Management

This section provides a summary of Q2 (18/19) performance against the key outcome measures for population health management

2.1 Population Health Outcomes

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The table below provides an outline of the outcomes to be delivered through the population health management specification, with a summary of the rationale and the metrics that will be used to monitor outcome delivery.

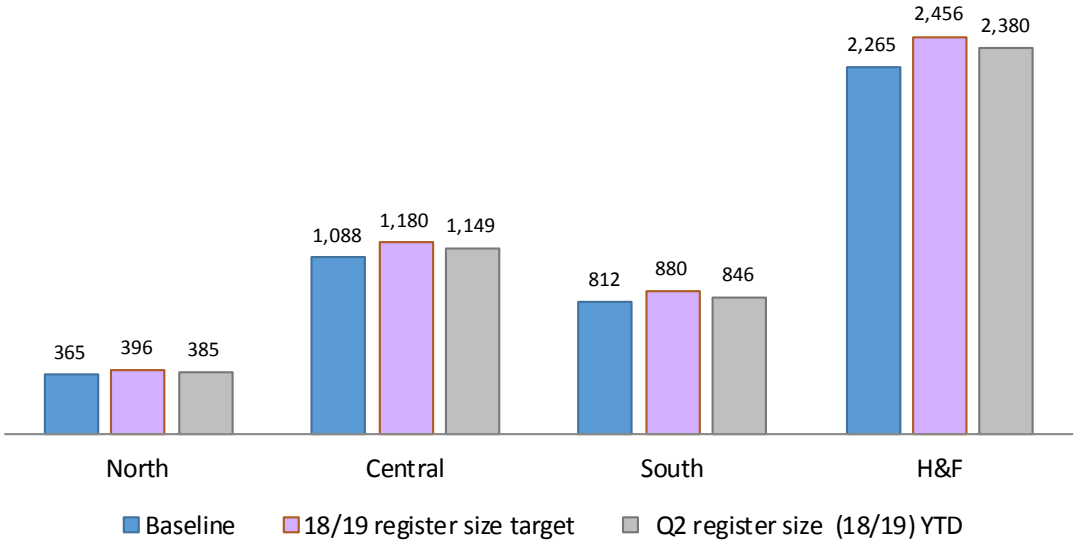
Outcome *What are we trying to achieve?*	**Summary of Rationale** *Why are we focussing on this area?*	**Ref**	**Key Outcomes Measure** *How will we measure success?*
Improved identification of people with Atrial Fibrillation (AF) and Hypertension to help prevent the risk of stroke	512 strokes per year could be avoided in NW London by detecting and diagnosing AF and providing effective anti-coagulation to prevent AF related stroke. 198,691 people have hypertension which is diagnosed and controlled – this is around 40% of the estimated total number of people with hypertension in NW London. The population model suggests that AF and Hypertension both have higher undiagnosed rates in Hammersmith and Fulham compared nationally.	**A1**	% increase in AF diagnosis
		H1	% increase in Hypertension diagnosis
Improved quality of care for people with COPD through early identification, accurate diagnosis and through a proactive approach to disease management	The diagnosed prevalence of COPD in H&F is 1.06% and the estimated prevalence is 1.7%. Whilst the population models suggest there may be better levels of diagnosis than nationally, there could still be over 1,500 additional patients with undiagnosed COPD in the borough. 9 out of 10 COPD cases are caused by smoking; H&F has the fourth highest smoking prevalence in London.	**C1**	% increase in accurate COPD diagnosis
	H&F has very high rates of non-elective admissions for acute COPD exacerbations. The rates were the highest in NW London in 16/17 when expressed as a proportion of those on GP COPD registers. Although numbers have dropped in 17/18, the rate of COPD admissions in H&F still remains high when compared to elsewhere.	**C2**	% reduction in emergency admissions for COPD exacerbations
Improved quality and experience of care for people with frailty	WSIC identifies that the top 10% most frail patients account for half of whole system costs. H&F is an outlier amongst its peers for NEL rates for those aged 60+, including readmissions. This is across a range of diagnoses. The population projections estimate that the number of 85+years old in H&F will grow by 45% in the next decade (GLA), creating further pressure on the local health and care system.	**F1**	% reduction in number of bed days for admissions related to frailty

2.2 Atrial Fibrillation Diagnosis (A1)

NHS Hammersmith and Fulham Clinical Commissioning Group

What are we trying to achieve? An improvement in the detection of undiagnosed Atrial Fibrillation to help prevent stroke through earlier intervention. Based on Public Health England data, H&F has 1,446 patients with undiagnosed AF in the population. Our aim is to increase the register size by 8.4% in 18/19. This equates to a recorded prevalence of 1.01% (191 additional cases) from 0.93%.

Key Outcome Measure: % increase in AF diagnosis (A1)



Baseline		2018/19 target increase		8.4%
	QOF register (numbers)	Additional patients on list to meet this increase	New QOF register size	New QOF actual prevalence after improvement (%)
North	365	31	396	0.80%
Central	1,088	92	1,180	1.19%
South	812	68	880	0.92%
H&F	2,265	191	2,456	1.01%

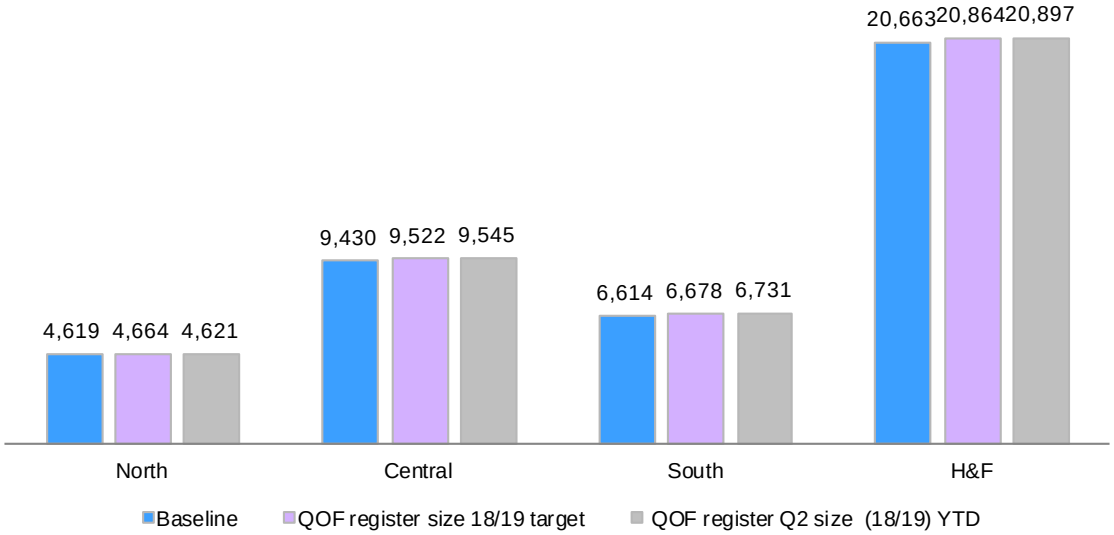
- All networks are making very good progress towards achieving their year end target
- The Central Network is closest to achieving its target at 97%.
- At a practice level the Southern Network has two practices that have exceeded their target, in relation to their QOF register size while the Central & Northern Networks has one practice that has exceeded the target;
- Variation in outcomes across practices will be monitored at monthly network meetings supported by network clinical leads

2.3 Hypertension Diagnosis (H1)

NHS Hammersmith and Fulham Clinical Commissioning Group

What are we trying to achieve? An improvement in detection of hypertension closer to the expected population prevalence. Based on Public Health England data, H&F has 10,544 patients with undiagnosed hypertension in the population. Our aim is to increase the register size by 1% in 2018/19. This equates to a prevalence of 10% (201 additional cases) from 9.9%. The target is based on progress that has been made in other CCG areas with a similar baseline and/or demographics such as Ealing, Bradford and Telford and Wrekin CCGs.

Key Outcome Measure: % increase in Hypertension diagnosis (H1)



Baseline		2018/19 target increase		1.0%
	QOF register (numbers) **	Additional patients on list to meet this increase	New QOF register size	New QOF actual prevalence after improvement (%)
North	4,619	45	4,664	11.3%
Central	9,430	92	9,522	11.3%
South	6,614	64	6,678	8.0%
H&F	20,663	201	20,864	10.0%

Overall the CCG have met its target for new QOF register size as of Q2; this is largely due to the Central and Southern network who have already exceeded their target. The Northern network is on track to achieve its year end target; four practices within the Network have contributed significantly to the network target.

2.4 COPD Diagnosis (C1)

Hammersmith and Fulham Clinical Commissioning Group

What are we trying to achieve?: An improvement in the accurate detection of COPD closer to the expected population prevalence. Based on Public Health England data, H&F has 1,542 patients with undiagnosed COPD in the population. Our aim is to increase the register size by 4.6% in 18/19. This equates to a recorded prevalence of 1.10% (124 additional cases).

Key Outcome Measure: % increase in accurate COPD diagnosis (C1)

	Baseline			2018/19 target increase	4.6%	
	QOF register (numbers)	QOF recorded prevalence (%)	Expected population prevalence (%)	Additional patients on list to meet this increase	New QOF register size	New QOF recorded prevalence after improvement
North	449	0.90%	1.4%	21	470	0.94%
Central	1,272	1.27%	1.8%	59	1,331	1.33%
South	951	0.91%	1.7%	44	995	0.96%
H&F	**2,672**	1.05%	1.7%	**124**	**2,796**	**1.10%**

Data collection from H&F virtual review clinics has identified cases of inaccurate respiratory diagnoses. Primary care networks were asked to undertake a review of cases on their COPD QOF registers during Q2 (2018/18) to ensure the accuracy of diagnoses.

This enables practices to focus clinical resources on the right patients, giving Networks the best chance to impact on COPD related emergency admissions (C2). Achievement against C1 will be monitored against the Q2 baseline as shown in the above table.

2.5 COPD Management (C2)

NHS Hammersmith and Fulham Clinical Commissioning Group

What are we trying to achieve?:
Improved and more intensive management of patients with COPD with focus on self-management and patient activation to prevent and limit the severity of exacerbations.

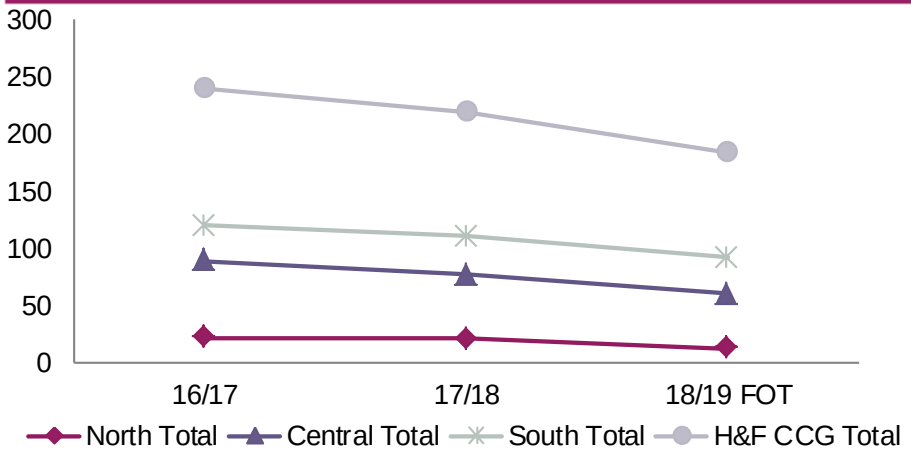
Our aim is to reduce the number of emergency admissions for COPD exacerbation by 20 events with an estimated gross cost reduction of £51k by 2018/19; and a cumulative gross cost reduction of £119k by 2019/20.

Key Outcome Measure: % reduction in emergency admissions for COPD exacerbations (C2)

2018/19 target change		-18.4%
New annual admissions	**Annual reduction in admissions against 17/18 baseline**	**Annual reduction in cost admissions**
17	-4	-£10,045
45	-10	-£26,307
25	-6	-£14,828
87	-20	-£51,180

Number of COPD exacerbations (Yearly Comparison)

Network	16/17	17/18	M1-6 18/19	18/19 FOT	Difference
North	22	21	6	12	-9
Central	67	56	24	48	-8
South	31	33	16	32	-1
H&F	120	110	46	92	-18



	COPD exacerbation rate per 1,000 COPD patients	
Network	17/18	18/19 FOT
North	49.1	28.0
Central	44.9	38.5
South	35.1	34.0
H&F	42.1	35.2

A reduction in the number of COPD exacerbations by 18 events is forecasted for 18/19, based on the Month 6 position

The Northern Network who had the highest rate of COPD exacerbation rate per 1000 COPD patients in 17/18 (see Table 2) are on track to achieve their target.