NHS
South Yorkshire
Integrated Care Board

Practice Delivery Agreement 2024-25

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PDA 2024-25
Main Principles

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- The aim of the PDA is to invest in the capacity needed to deliver a consistently high standard of General Practice across Barnsley
- Reviewed and Refreshed Annually
- 2024-25 has a strong focus on Barnsley Place Priorities and SY ICB Strategic Priorities
- Utilises Eclipse wherever possible however recognise will still require clinical system searches
- Targets and points reflect the level of work to be undertaken and impact towards Barnsley Place Priorities (particularly Respiratory and Frailty)

Financial Information

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- PDA 2024/25 has a total financial value sum of £3,209,635
- 47% is assigned to the Medicines Optimisation scheme and the remaining 53% to the other 6 schemes:

Respiratory	£ 499,044
Falls And Frailty	£ 166,348
Dementia Champions	£ 83,174
CVD	£ 609,943
Population Health Management	£ 221,798
Better and Fairer Access	£ 110,899
Medicines Optimisation	£1,518,429
TOTAL	**£3,209,635**

- Practices have been paid an upfront payment of 30% for schemes 1-6 (£507, 362). This is on condition Practices agree if do not sign the PDA 24/25 contract and agree to deliver, this 30% will be eligible for clawback
- A second 30% Payment due mid contract and remaining 40% paid on achievement at year end.

Respiratory
90 Points

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- **COPD1 – Case finding Undiagnosed COPD Patients – 25 Points**
  - Builds on the 23/24 Population Health Management Scheme.
  - Practices should review each patient in the cohort of 6> more SABA inhalers in last 12 months no diagnosis of COPD or Asthma
- **COPD2 – New Diagnosis Optimisation – 15 Points**
  - Practices should develop an internal system whereby any patient newly diagnosed with COPD receives a review within the first three months of diagnosis
- **COPD3 – Driving Improvements (Vaccinations and Smoking Cessation) - 25 Points**
  - Clinical System searches to be provided for three priority groups
    - COPD & Current smoker without any smoking cessation codes in last 12 month
    - COPD & no flu vaccination in last 12 month (exclude declined)
    - COPD & never received PPV vaccine
  - Practices should create an internal plan to drive up uptake in these groups.
  - Target to deliver a 20% reduction

Respiratory - Cont'd

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- **COPD4 – Reviewing High Risk Patients within Eclipse – 5 Points**
  - Practices to identify their High Risk and Very High Risk patients within Eclipse
  - Practices should then review this list to identify if an intervention can be offered which may prevent a secondary care admission
- **COPD5 – Early Follow Up Review Post Discharge – 15 Points**
  - Following a discharge of an admission for an AE of COPD, Practices are asked to review patient within one month to act on any requests from discharge summary
  - To specific target, but readmission rates for AE of COPD will be monitored to identify if early fu from primary care has impacted readmission rates
- **COPD6 – Clinical Education and Training – 5 Points**
  - Practices to send at least 1 GP and at least 1 Practice Nurse to the 20th November 2024 Respiratory BEST event

Falls and Frailty
30 Points

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- **FF01 – Ageing Well Assessments – 30 Points**
  - Continuation of indicator within Population Health Management Scheme in PDA 23/24 which 28/31 Practices achieved
  - Acknowledge feedback from PDA 23/24 this was a high workload indicator, therefore the points value has been increased from 10 points to 30 points
  - Practices should use Eclipse to identify people between the age of 60yrs and 69yrs who have a flag of social vulnerability and live within the 20% most deprived communities in Barnsley IMD1) and offer an Aging Well Assessment
  - Achievement monitored on the recording of review in Eclipse
  - Practices will be given a target in line with PDA 23/24 achievement / normalised weighted list size at January 2024.

Dementia Champions
15 Points

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- **DEM01 – Dementia Champion – 15 Points**
  - Continuation from previous PDA's
  - Each Practice to have a Dementia Champion who can undertake the Barnsley Dementia Champion Job Profile (updated for PDA 24/25)
  - Dementia Champion to attend 3 meetings throughout the year:
    - One meeting with professionals across the borough.
    - Attend 1 of 3 community events at neighbourhood level, to include attendance and input in online planning meeting with neighbourhood and Barnsley wide partners. Promote event in your neighbourhood and invite patients and carers.
    - One in person practice visit with ICB/BMBC colleagues to review if practice is dementia friendly, ensure dementia champions are accessing and sharing resources for patients and carers, and ensure all staff know who practice dementia champion(s) are.
  - Quarterly reconciliation of the dementia register with SWYPFT memory services

CVD
110 Points

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- **CVD01a – Atrial Fibrillation – 10 Points**
  - Manual pulse rhythm checks in high risk populations to detect any irregularities
  - Practices should undertake opportunistic pulse checks on all people that are high risk of developing atrial fibrillation:
  - Heart failure, cardiovascular disease, valve disease, hypertension, diabetes, excessive alcohol intake, >65 years of age, hyperthyroidism.
  - Also pulse rhythm and rate in people presenting with the following symptoms:
  - Breathlessness, palpitations, syncope or dizziness
- **CVD01b – Atrial Fibrillation – 15 Points**
  - Practices will receive payment for conducting assessments on patients newly diagnosed with atrial fibrillation. This involves performing diagnostics and follow-up care for individuals identified with an irregular pulse, while excluding those who are determined not to have atrial fibrillation.

CVD – Cont'd

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- **CVD02a – High Risk of CVD – 15 Points**
  - All patients at 'high risk' of CVD (See definition section) should be invited for an annual review to discuss their risk factors and intervention/support offered to enable them to lower their risk, including lipid/BP optimisation and referral to health trainer or other appropriate services to support with healthy lifestyle choices.
  - a) High risk of cardiovascular disease (QRISK ≥20%) without an annual review focusing on those in deprivation decile 1-2.
- **CVD02b – High Risk of CVD – 10 Points**
  - All patients at 'high risk' of CVD (See definition section) should be invited for an annual review to discuss their risk factors and intervention/support offered to enable them to lower their risk, including lipid/BP optimisation and referral to health trainer or other appropriate services to support with healthy lifestyle choices.
  - b) High risk of cardiovascular disease (QRISK 10-19.9%) NOT on statin focusing on those in deprivation decile 1-2.
- **CVD03 – Heart Failure – 30 Points**
  - CVD03a (20 Points) Practices should review all patients with heart failure due to LVSD who are not on an ACEI/ARB and BB (or contraindicated/declined), with a focus on deprivation deciles 1-2. Consideration should be given for additional medication/referral as per local/national guidance if patients remain symptomatic.
  - CVD03b (10 Points) - All patients with heart failure (regardless of cause) should have their functional capacity assessed and recorded using the New York Heart Association Score

CVD- Cont'd

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- **CVD04 – Secondary Prevention of CVD – Lipid Management – 20 Points**
  - Practices should use Eclipse to identify people who would benefit the most from a review of their lipids and medication and these should be optimised as per NICE guideline [NG238] Published: 14 December 2023
- **CVD05 – Hypertension Case Finding – Quality Checks – 10 Points**
  - Practices should review and follow-up patients identified on Eclipse as potentially having undiagnosed hypertension:
    - Hypertension not recorded with Systolic > 160mmHg at any time.
    - Hypertension not recorded with latest Systolic > 160 mmHg.
    - Hypertension not recorded with Systolic > 160mmHg at any time and latest >140mmHg.
  - Where there is a clear indication elevated blood pressure has been for and treatment started for hypertension practices should retrospectively add any 'missing' diagnoses.

- Most elements of CVD Scheme a continuation of previous PDA's

Population Health Management
40 Points

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- **PHM01 – Early Years – 5 Points**
  - Practices should deliver a very brief intervention at the time of pre-school immunisations that will involve asking three or four questions linked to child development, offering information, advice or signposting to support services as required.
- **PHM02 – Targeted communications and websites – 10 Points**
  - Practices should send communications, such as SMS text messages, to target groups to promote local universal services that may support them to improve their health or address the wider determinants of their health:
    - A communication to parents/guardians of young children to promote universal services for children and families, such as the Family Service Directory.
    - A communication to older residents at risk of falls or frailty relating to guidance on how to look after their health, including physical activity
    - A communication to patients with respiratory conditions with very high or high PRISM about the local warm homes offer (advice, boiler replacement and insulation.
    - A communication to working age people with chronic conditions relating to physical activity
  - Practices will also be asked to make sure that their websites have up-to-date information around local services for young families and older people, a link to the Barnsley webpages “what’s your move’, ‘more money in your pocket’, employment support and housing.

PHM – Cont'd

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- **PHM03 – Early Diagnosis and Treatment of Chronic Disease – 25 Points**
- Eclipse software will identify the following cohorts of patients.
    - Repeated raised HbA1c >48 and no coded diagnosis of diabetes within past 12 months
    - HbA1c below 53 on a hypoglycaemic agent/insulin
    - Type 1 diabetics not requesting monthly insulin prescriptions regularly (high risk of DKA, poor control)
    - Type 2 diabetics not requesting diabetes medication regularly (risk of HONK, poor control, increased risk complications)
    - Type 2 Diabetics with HbA1c above 100 (candidates for insulin/stepping up oral therapy/onward ref. to DSN)
    - Coded for gestational diabetes without a code of Type 1 or 2 Diabetes Mellitus who have not had Hba1c in the last 12 months
    - screening diabetic patients through review of LFTs for non-alcoholic FATTY liver disease
- Practices should validate lists within the Eclipse software (or practice system) and remove any patients unsuitable for review.
- Practices should then contact all remaining patients, for example by SMS text message, to offer a review in practice to confirm diagnosis, commence treatment as required or offer information and advice.

Better and Fairer Access 20 Points

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- **BFA01 – Socially Vulnerable – 5 Points**
  - Practices should use Eclipse to identify people between the age of 20yrs and 59yrs who have a flag of social vulnerability, mental health and more than two A&E attendances in the last year.
  - A member of the practice team to contact people in the cohort and offer/promote a personalised care intervention (Social Prescribing or Health and Wellbeing Coach).
  - Practices will record the outcome in Eclipse and the core clinical system, so it is included in the patient record.
- **BFA02 – Veteran Friendly Accredited – 5 Points**
  - Practices sign up on the website and read the accreditation pack and:
    - Share the key information from the accreditation pack with colleagues
    - Ask patients registering with the surgery if they have ever served in the British Armed Forces and record their answer in their patient record.
    - Stay up-to-date with best practice via the quarterly Veteran Friendly Accreditation newsletter, which provides easy access to the latest information and learning
- **BFA03 – Safer Surgery Scheme – 10 Points**
  - Practices are asked to sign up to be a member of Safe Surgeries. This requires practices to:
    - Declare that they are a ‘Safe Surgery’ for everyone.
    - Ensuring that lack of ID or proof of address, immigration status or language are not barriers to patient registration.
    - Confirm the contact person for Safe Surgeries.
    - Sign up at least one other member of the practice team to receive Safe Surgeries communications.
    - Members of the practice team to participate in Safe Surgeries training

Medicines Optimisation

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- This scheme builds on previous years' schemes and the purpose of this scheme is to encourage the high quality, safe and cost-effective use of medicines across the patient pathway.
- Practices are asked to deliver all work by February 2025.
- There are interdependencies with other 2024/25 PDA schemes, but no duplication occurs.
- Work will be undertaken in the following areas:

Blood Glucose & Ketone Monitoring and CGM Sensors

Respiratory

Controlled Drugs

Items which should no longer be routinely prescribed in primary care.

Antibiotic Prescribing and Antimicrobial Stewardship (AMS)

Direct Oral Anticoagulants (DOACs)

Antidepressant Prescribing Audit Improving Valproate Safety

Carbocisteine Review

Emollient Review

Overactive bladder Reviews
Review of Prescribing Data: Unspecified Drugs

Appliance and Wound Care Reviews and Ordering Processes

Targeted medication reviews

Scriptswitch

Eclipse Live: RADAR Reviews & High-Cost Drug Report

Population Health Management Reviews / Eclipse Live PROTECT programme

Practice meetings to discuss medicines optimisation issues

QIPP changes

Potential Generic Savings

Unlicensed Specials

Dose Optimisation and Reverse Dose Optimisation Review Nutrition
Amber / Amber G prescribing audit(s)

Additional high priority Medicines Optimisation workstreams (including SYICB wide Medicines Optimisation workstreams)