Indicator 3b Collaboration with primary care clinicians

Indicator 3b	
Indicator name	Collaboration with primary care clinicians.
Indicator weighting (% of CQUIN scheme available)	20% of 0.25% (0.05%)
Description of indicator	90% of patients to have either an up to date CPA (care programme approach), care plan or a comprehensive discharge summary shared with their GP. A local audit of communications should be completed.
Numerator	The number of patients in the audit sample for whom the mental health provider has provided to the GP* an up-to-date copy of the patient's care plan/CPA review letter or a discharge summary which sets out details of all of the following: i. NHS number ii. All primary and secondary mental and physical health diagnoses iii. Medications prescribed and recommendations (including duration and/or review, ongoing monitoring requirements, advice on starting, discontinuing or changing medication). iv. Ongoing monitoring and/or treatment needs for cardio-metabolic risk factors identified, as per the Lester Tool. v. Care plan or discharge plan *To take place within the following time periods: • Within 48 hours for patients discharged as inpatients • Within 2 weeks for patients on CPA
Denominator	Patients within the defined audit sample who are subject to the CPA, and who have been under the care of the mental health provider for at least 12 months at the time of the defined audit period.
Rationale for inclusion	With over 490,000 people with SMI registered with a GP, it is important to ensure a stronger emphasis on collaboration and communication between primary and secondary care. This is necessary given that in the longer term and certainly following discharge from secondary care, people with SMI should be supported to manage their health within primary care. Appropriate sharing and exchanging of information between practitioners about diagnosed physical and mental health conditions is essential for safe

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	practice. The rationale for this CQUIN is to ensure essential information needed for safe and effective care of patients who are also seen by secondary care mental health services is communicated to primary care professionals. Building on the developments made across England to improve communications between primary and secondary care, the CQUIN addresses further alignment and collaboration. To do this, responsibilities for conducting physical health checks and the on-going management of physical healthcare should be clearly identified and formalised locally. Electronic systems and infrastructure should continue to evolve to support the transfer of accurate and up to date patient records, making information accessible. By the end of 2016, NHS England plans to publish national best practice to support secondary and primary care in achieving the above.
Data source	Internal audit undertaken by mental health providers.
Frequency of data collection	Annual audit
Organisation responsible for data collection	Mental health provider
Frequency of reporting to commissioner	Results of local audit required to be reported to local commissioners in Quarter 4 of both 2017/18 and 2018/19.
Baseline period/date	Not applicable
Baseline value	Not applicable
Final indicator period/date (on which payment is based)	Quarter 3 of both 2017/18 and 2018/19.
Final indicator value (payment threshold)	90.0%
Final indicator reporting date	30 March 2018 and 29 March 2019
Are there rules for any agreed in-year milestones that result in payment?	Yes – see below
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Yes – see below
EXIT Route	To be determined locally

Milestones for indicator 3b

2017/18

Date/period milestone relates to 2017/18	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Quarter 2 17/18	Identify and develop clear plans for aligning and cross checking SMI QOF and CPA registers.	October 2017	20% of indicator weighting for part 3b
Quarter 3 17/18	Establish a clear shared care protocol between secondary care provider and primary care regarding physical health checks for people with SMI and the appropriate follow up. This should include information on: • Communication channels locally • Resources contributed to this agenda • Roles and responsibilities, including frequency of follow up annual physical health checks • Sharing and exchanging information regarding physical health of people with SMI, via electronic patient records across secondary and primary interfaces Audit to be undertaken by provider.	December 2017	50% of indicator weighting for part 3b
Quarter 4 17/18	Results of local audit required to be reported to local commissioners. (See sliding scale below for payment details) Action plan in place for 18/19 based on audit findings.	April 2018	30% of indicator weighting for part 3b

2018/19

Date/period milestone relates to 2018/19	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Quarter 1 18/19	Complete alignment of SMI QOF and CPA registers and have system in place for routine reconciliation going forward	July 2018	20% of indicator weighting for part 3b
Quarter 2 18/19	Review progress made in implementing shared care protocol between secondary care provider and primary care regarding physical health checks for people with SMI and the appropriate follow up checks. Agree joint action plan to address outstanding issues.	October 2018	50% of indicator weighting for part 3b
Quarter 3 18/19	Evidence status of interoperability of data and IT systems between secondary and primary care, to facilitate flow of information on physical health issues for people with SMI. Agree joint action plan to address outstanding issues. Audit to be undertaken by provider.	December 2018	10% of indicator weighting for part 3b
Quarter 4 18/19	Results of local audit required to be reported to local commissioners. (See sliding scale below for payment details).	April 2019	20% of indicator weighting for part 3b

Rules for partial achievement of indicator 3b

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value
49.9% or less	No payment
50.0% to 69.9%	25% payment
70.0% to 79.9%	50% payment
80.0% to 89.9%	75% payment
90.0% or above	100% payment

Supporting guidance and references for CQUIN 3a and 3b implementation

- **ICD 10 codes:**

For the purposes of the CQUIN, patients who have a diagnosis of psychosis, including schizophrenia and bipolar affective disorder with the relevant ICD-10 diagnostic codes will be included in the national audit: F10.5, F11.5, F12.5, F13.5, F14.5, F15.5, F16.5, F19.5, F20-29, F30.2, F31.2, F31.5, F32.3 and F33.3.

- **Lester tool:**

http://www.rcpsych.ac.uk/pdf/RCP_11049_Positive%20Cardiometabolic%20Health%20chart-%20website.pdf

- **NICE resources to support implementation:**
    - NICE guidelines make recommendations about the promotion of physical health in people with psychosis and schizophrenia, and a range of other guidelines are available to improve aspects of physical health including smoking cessation, obesity, glucose regulation, blood lipids, and lifestyle factors.
    - Implementation products (such as baseline assessment tools, NICE pathways, online learning modules, and local practice examples) can be found on the "tools and resources" tab of the guideline; for example https://www.nice.org.uk/guidance/cg178/resources which includes access to the Lester Positive Cardio metabolic Health Resource, endorsed by NICE.