NHS
Bolton
Clinical Commissioning Group

**NHS BOLTON CLINICAL COMMISSIONING GROUP**
**Public Board Meeting**

**AGENDA ITEM NO: …………7…………………..**

**Date of Meeting: ……….Friday 17 June 2022……………………….**

| | | |
|---|---|---|
| **TITLE OF REPORT:** | Bolton Quality Contract 2022/23 | |
| **AUTHOR:** | Lesley Hardman – Head of Primary Care Development | |
| **PRESENTED BY:** | Alan Stephenson/Stephen Liversedge | |
| **PURPOSE OF PAPER:**<br>**(Linking to Strategic Objectives)** | To update the Board on the BQC 2022 – 2023 and the agreed finance | |
| **LINKS TO CORPORATE OBJECTIVES (tick relevant boxes):** | **Deliver the outcomes in the Bolton Joint Health and Care Plan.** | |
| | **Ensure compliance with the NHS statutory duties and NHS Constitution.** | |
| | **Deliver financial balance.** | |
| | **Regulatory Requirement.** | |
| | **Standing Item.** | |
| **RECOMMENDATION TO THE BOARD:**<br>**(Please be clear if decision required, or for noting)** | To approve PCCC recommendations for the BQC 2022/23 | |
| **COMMITTEES/GROUPS PREVIOUSLY CONSULTED:** | PCCC<br>Informal LMC<br>Clinical Leads<br>CCG Executive | |
| **REVIEW OF CONFLICTS OF INTEREST:** | Considered during PCCC and conflicted members not involved in decision making | |
| **VIEW OF THE PATIENTS, CARERS OR THE PUBLIC, AND THE EXTENT OF THEIR INVOLVEMENT:** | Considered as part of PCCC, where Healthwatch and Councillors present | |
| **OUTCOME OF EQUALITY IMPACT ASSESSMENT (EIA) AND ANY ASSOCIATED RISKS:** | Included as part of the review of the BQC | |

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# Bolton Quality Contract 2022 - 2023

# The standards and options for payment – as recommended by the PCCC

**Public Board – 17 June 2022**

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# General principles for the setting of the 2022 – 2023 BQC

- **Acknowledge the effects of the pandemic on general practice**
- **Endeavour to achieve pre-pandemic targets**
- **Setting KPIs**
    - Re-instate pre-pandemic targets, where possible
- **Consult with member practices and the LMC**
- **Seek agreement from the PCCC**

# The standards 2022 - 2023

1. Access to General Practice
2. Ageing Well
3. Carers
4. Defined Patient Groups
5. Health Improvement
6. Long Term Conditions – Best Care
7. Practice Engagement (new name for membership engagement)
8. Prescribing

The same arenas as 2019 – 2020
No changes to the number of Standards.

# Standard 1.
# Access

# KPIs for 2022 - 2023

| Standards | | Target |
|---|---|---|
| **Access** | • **Deliver access to general practice** | 80 contacts per 1,000 pop |
| | • **Deliver Face to Face contacts** | 25 contacts per 1000 pop |
| | • **Undertake 2 Access Audits – only one will count towards the KPI** | |

# The Practice will be expected to…

- Provide 10 bookable sessions (am/pm). Out of Hours (OOHs) cover should not be utilised on Wednesday afternoons. Federated arrangements are acceptable to provide cover between practices
- Offer access to both male and female clinicians (not all 10 sessions). Federated arrangements are acceptable to provide cover between practices
- Remain open between 8.00am - 6.30pm Monday to Friday
- Deliver a minimum of 80 contacts per 1000 population per week
- Deliver a minimum of 25 face to face contacts per 1000 population per week
- Empty slots will not count towards the minimum of 80 contacts per 1000 population per week target
- Contacts may be provided by a GP (including a trainee GP), Advanced Nurse Practitioner (ANP) or other First Contact Practitioner (MSK Practitioner, MH Practitioner, Pharmacist, Paramedic, Physician Associate), and may be face to face, by telephone, video, online or home visit
- Offer pre-bookable appointments one month in advance
- Have a process for unplanned or urgent appointments (extras determined by a clinician)
- Offer telephone consultations
- Ensure children under 12 are assessed by a clinician the same day
- Accept deflections from A&E, North West Ambulance Service (NWAS), Community Services and OOH provider
- Improve on patient survey measures
- Undertake two access audits using the specified template. Work with a member of the Primary Care Development & Health Improvement Team to cross check the audits, and agree the outcomes

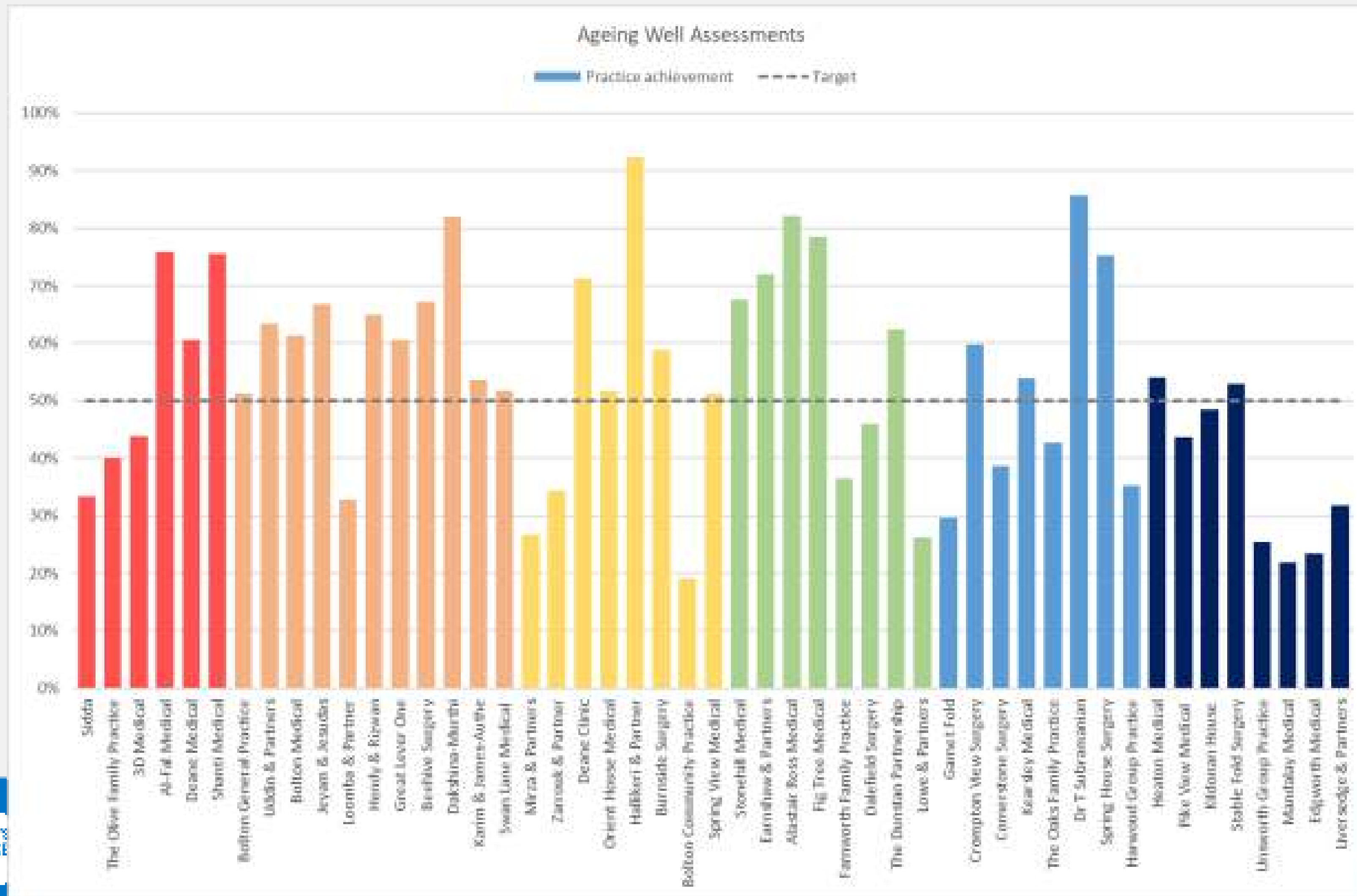
# Standard 2.
# Ageing Well

# KPIs for 2022 - 2023

| Standards | | Target |
|---|---|---|
| **Ageing Well** | • **Ageing Well Assessments** | 50% |

# Ageing Well – Ageing well assessments (Target 50%)

- **29 practices currently on target (March 2022 data)**
- **Bolton wide: 48%**



# The Practice will be expected to…

- Provide an Ageing Well assessment for eligible patients aged 65 to 74 years every 3 years and discuss the importance of ageing well, and reducing the risk of frailty in later years
- Whenever possible assessments should be face to face but, if this is clinically inappropriate, telephone assessment should be undertaken and a plan made for any necessary care
- Use the Ageing Well template developed by the Primary Care Directorate to record all assessments
- Use the practice system codes provided by the Primary Care Development & Health Improvement Team
- Have a system in place to follow up DNAs
- Allow access to the practice system for the Data Quality Team and the Primary Care Development & Health Improvement Team
- Submit data quarterly

# The Practice will be expected to…

**‘Proactive prevention’ - reducing the risk of frailty in later life**

## 65 – 74 years - *Ageing Well* Health Assessment

1. Dementia screening
2. Falls risk
3. FRAX
4. Flu Vaccs
5. Malnutrition and hydration
6. Pulse checking
7. Social isolation
8. Medication compliance

# Standard 3.
# Carers

# KPIs for 2022 - 2023

| Standards | | Targets |
|---|---|---|
| Carers | • Register | 2% |
| | • Annual Health Check | 80% |

# The Practice will be expected to…

- Have a named Carers Champion
- Allow the Carers Champion to attend the dedicated training forum
- Maintain and update a Carers Register
- Offer all carers a health check at a time to suit them and their caring responsibilities
- Provide a comprehensive annual health check for all patients on the Carers Register
- Whenever possible health checks should be face to face. If this is clinically inappropriate, telephone assessment should be undertaken and a plan made for any necessary care
- Use the dedicated carers template to record all health checks
- Allow access to the practice system for the Data Quality Team
- Submit data quarterly
- Ensure that all staff, including receptionists, are ‘carer aware’, and have a basic understanding of support available
- Ensure that patients are given the correct information to self-refer to Bolton Carers
- Display information in the waiting room, to help carers identify themselves, and to highlight available support and information

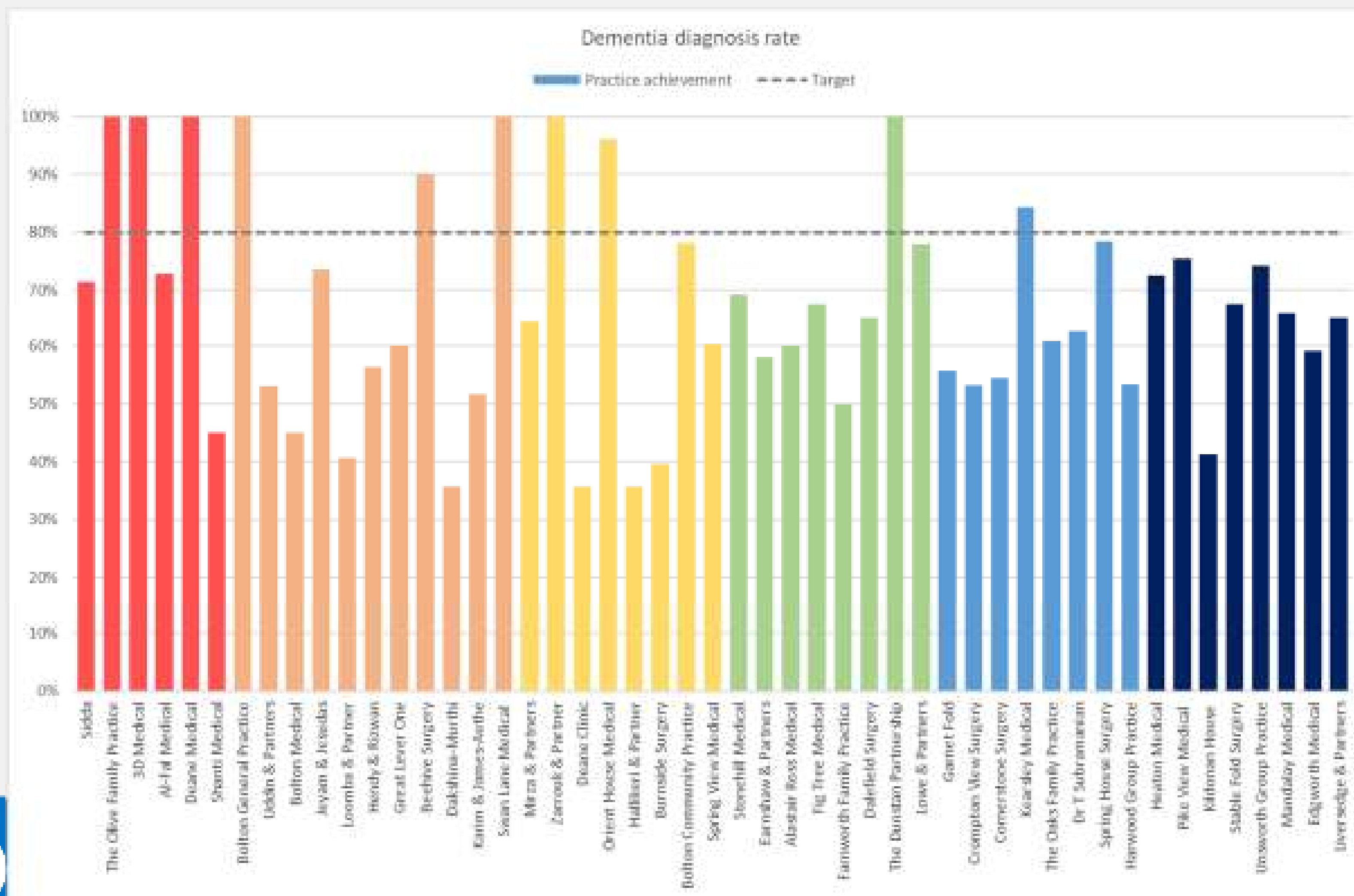
# Standard 4.
# Defined Patient Groups

# KPIs for 2022 - 2023

| Standards | | Targets |
|---|---|---|
| **Defined Patient Groups** | • **Dementia - expected prevalence** | 80% |
| | • **Dementia - annual review** | 80% |
| | • **Military Veteran**<br>Add the status to the patient care record | |

# Defined Patient Groups – Expected dementia prevalence (Target 80%)

- **10 practices currently on target (March 2022 data)**
- **Bolton wide: 73%**



# The Practice will be expected to…

**a. Dementia**

- Undertake opportunistic screening
- Use a screening tool specified by the practice. The 6 Item Cognitive Impairment Test (6CIT), or the Montreal Cognitive Assessment Test (MOCA), are recommended, as per the Bolton Dementia Pathway
- Provide a comprehensive annual review for all patients on the dementia register
- Whenever possible reviews should be face to face, but if this is clinically inappropriate, telephone assessment should be undertaken and a plan made for any necessary care and future reviews
- Use the dementia template to record all reviews
- Use the practice system codes provided by the Primary Care Development & Health Improvement Team
- Clearly document in any referral letter if the patient is on the dementia register
- Allow access to the practice system for the Data Quality Team
- Submit data quarterly

**b. Military Veterans**

- Have a named Military Veteran Lead (needs to be registered healthcare professional)
- Record Armed Forces Veterans & Reservists on the practice system
- Document clearly in any referral letter if the patient is on the Military Veterans register
- Comply with the requirements of the Armed Forces Covenant
- Submit data quarterly
- Apply to become a Military Veteran Friendly GP Accredited Practice

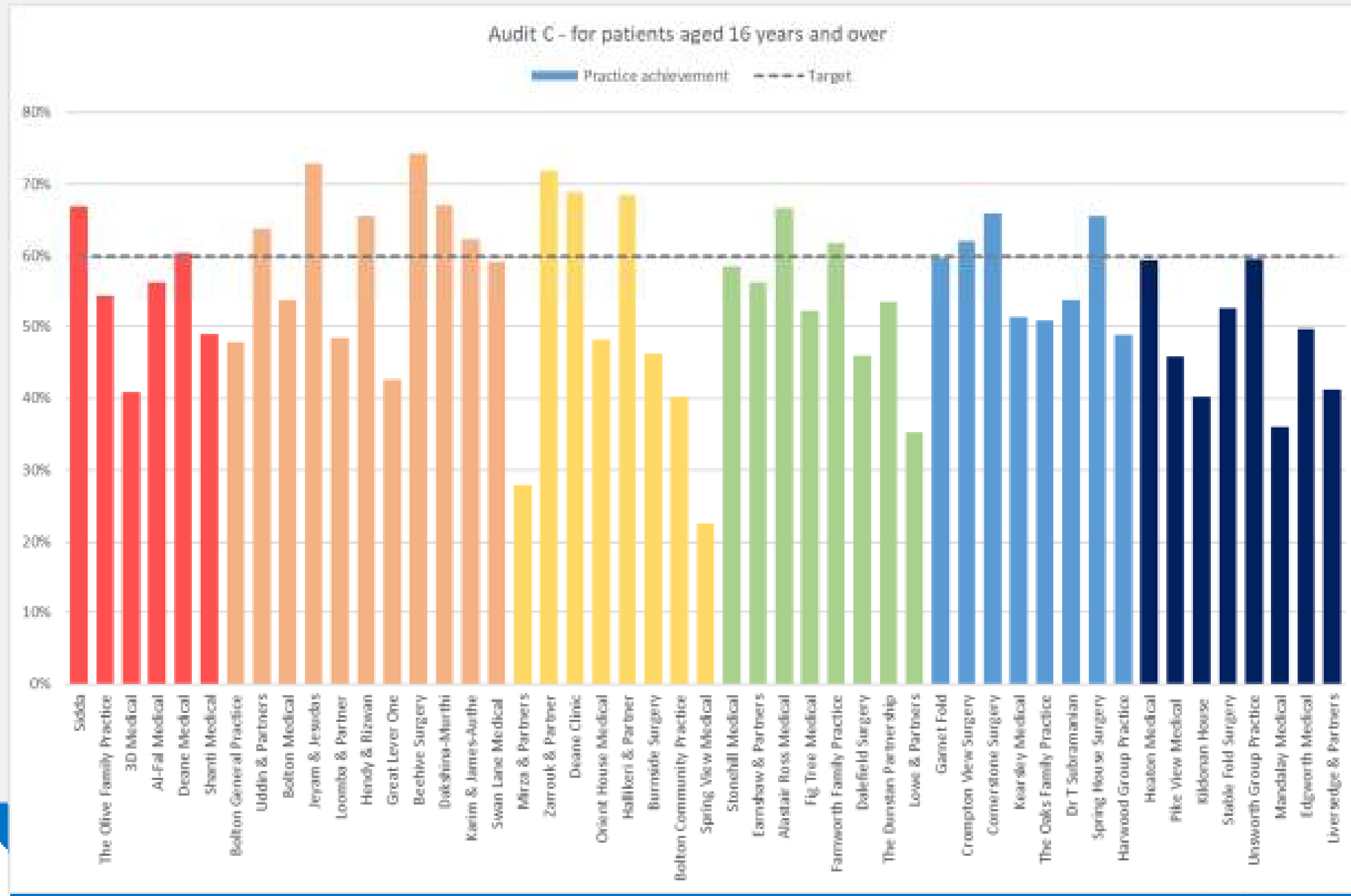
# Standard 5.
# Health Improvement

# KPIs for 2022 - 2023

| Standards | | Targets |
|---|---|---|
| **Health Improvement** | • **AUDIT C** | 60% |
| | • **Record BMI** | 67% |
| | • **NHS Health Checks** | 68% |
| | • **High Risk CVD** | 68% |
| | • **Screening Diabetes** | 86% |
| | • **Record smoking status** | 85% |

# Health Improvement – Audit C (Target 60%)

- **16 practices currently on target (March 2022 data)**
- **Bolton wide: 52%**

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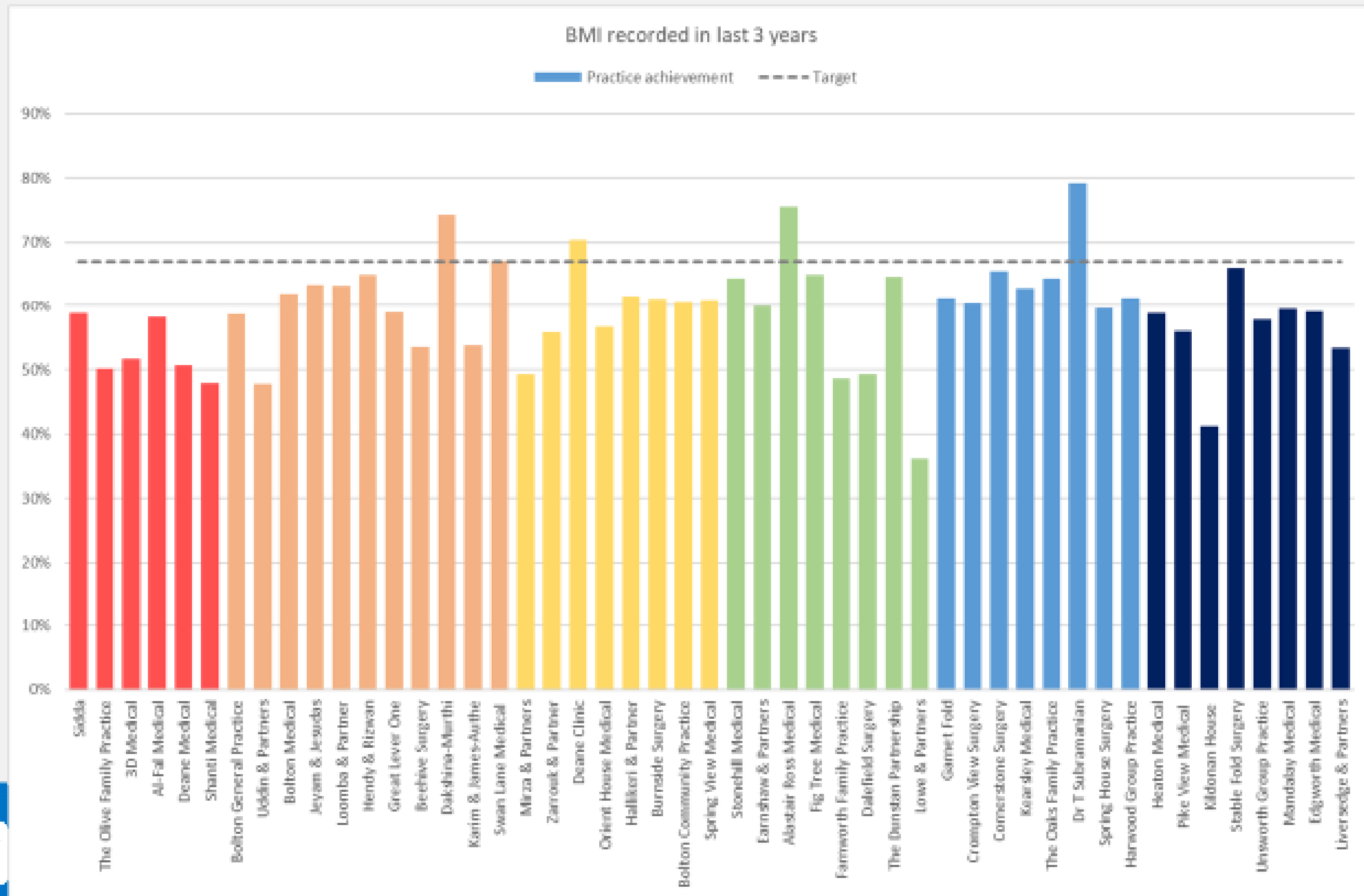
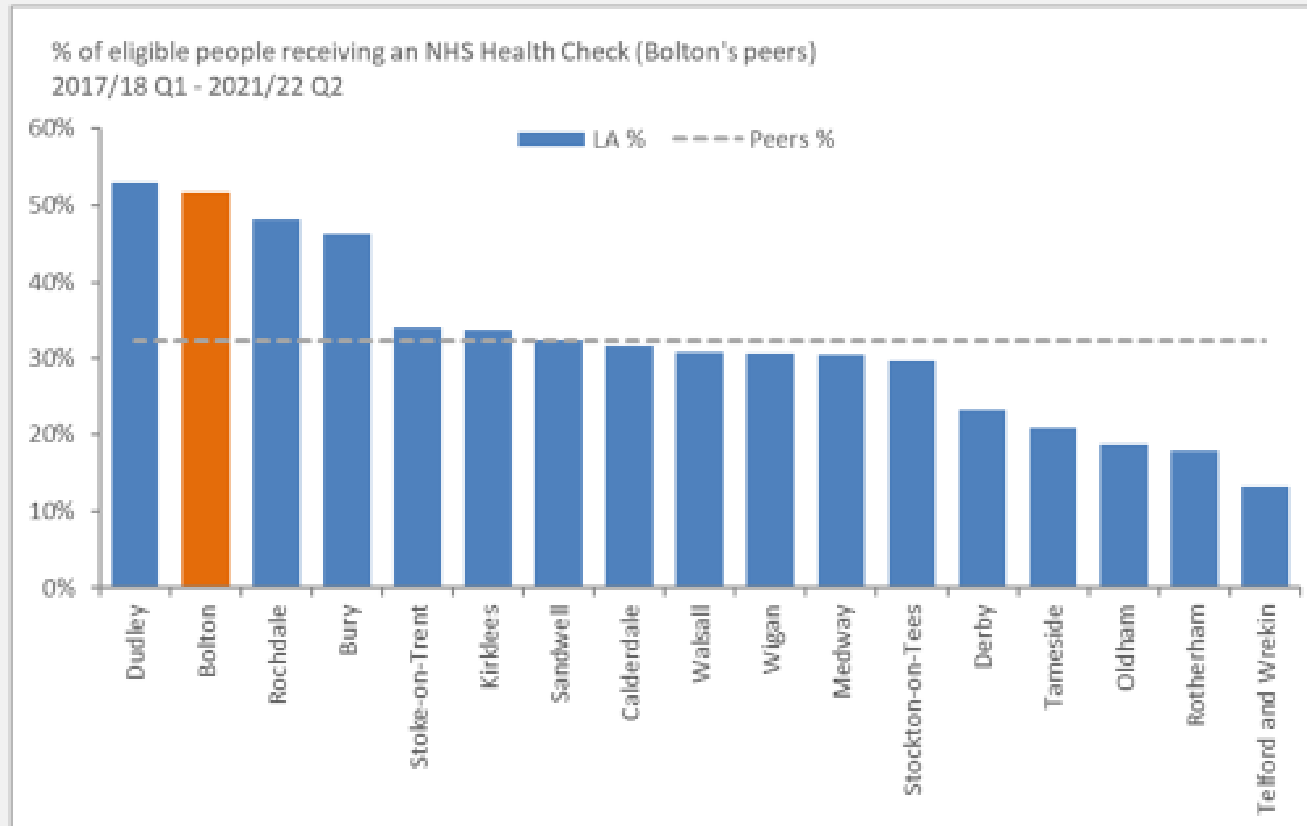
# Health Improvement – BMI recorded (Target 67%)

- **5 practices currently on target (March 2022 data)**
- **Bolton wide: 59%**



# NHS Health Checks – how are we doing?




| | Bolton | Rochdale | Bury | Manchester | Wigan | Trafford | Stockport | Salford | Tameside | Oldham |
|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 Q1 - 2021/22 Q2 | 51.6% | 48.2% | 46.3% | 33.7% | 30.6% | 30.2% | 25.6% | 23.3% | 20.8% | 18.6% |

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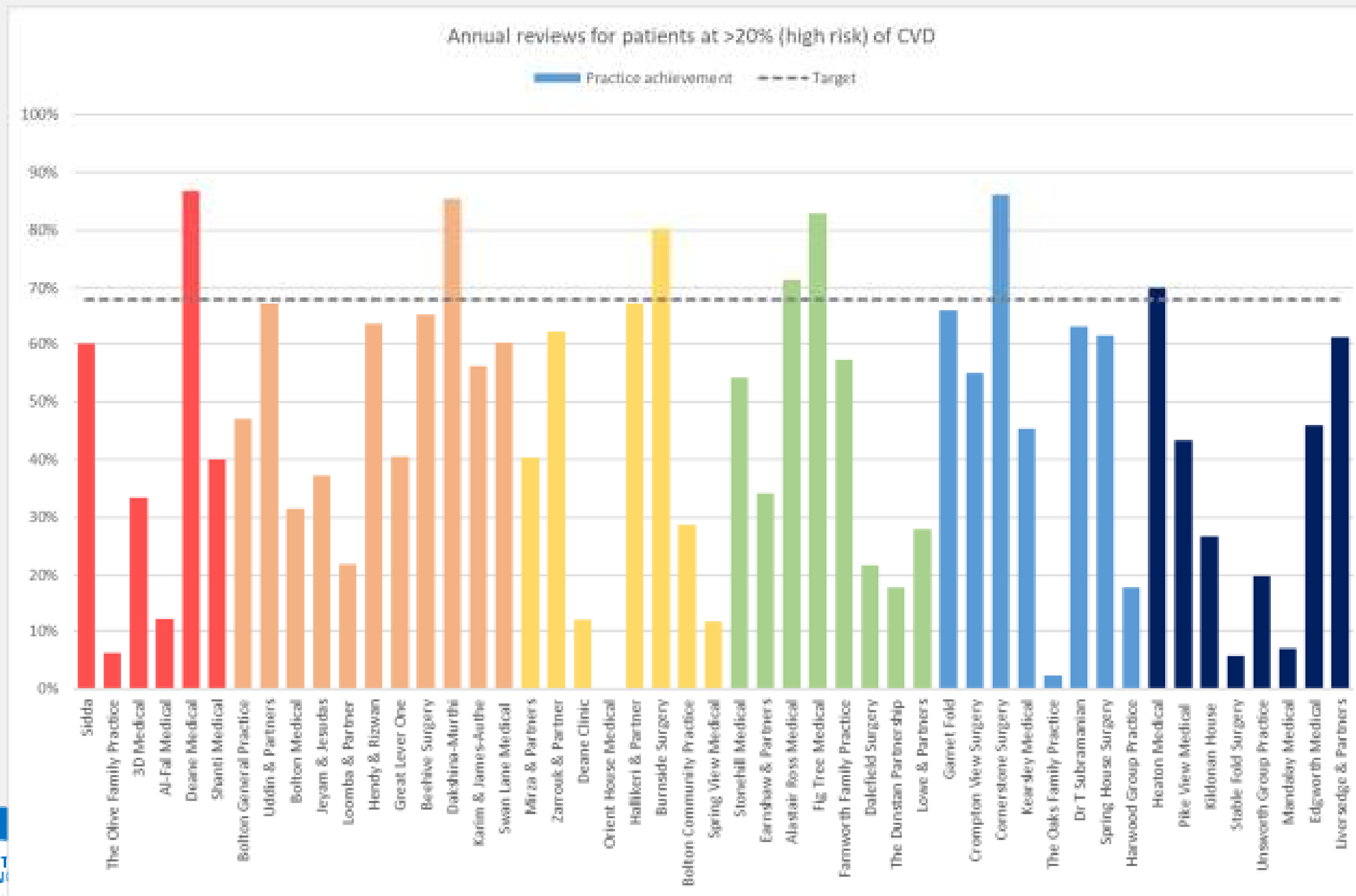
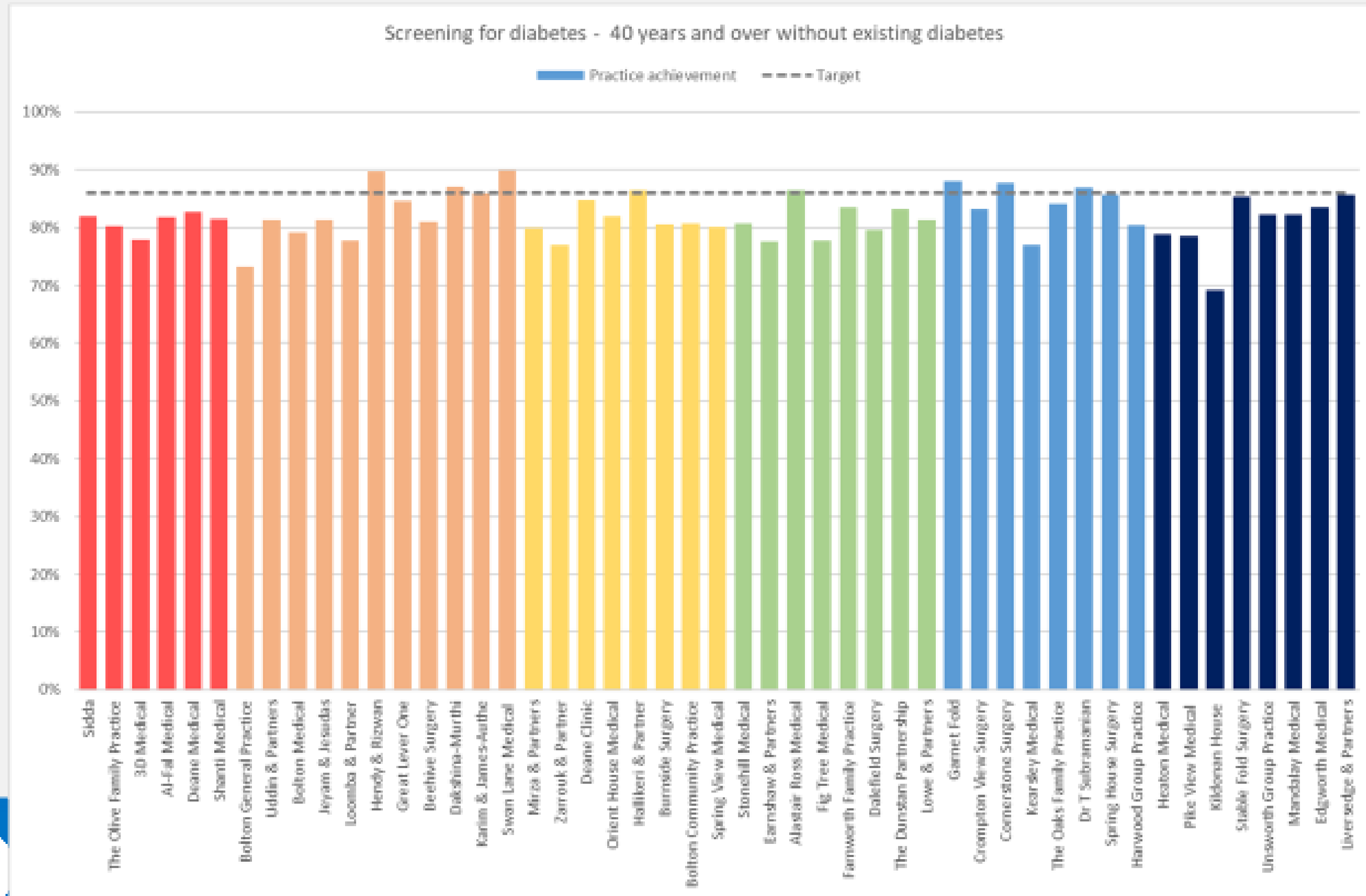
# Health Improvement – High risk CVD (Target 68%)

- **7 practices currently on target (March 2022 data)**
- **Bolton wide: 38%**



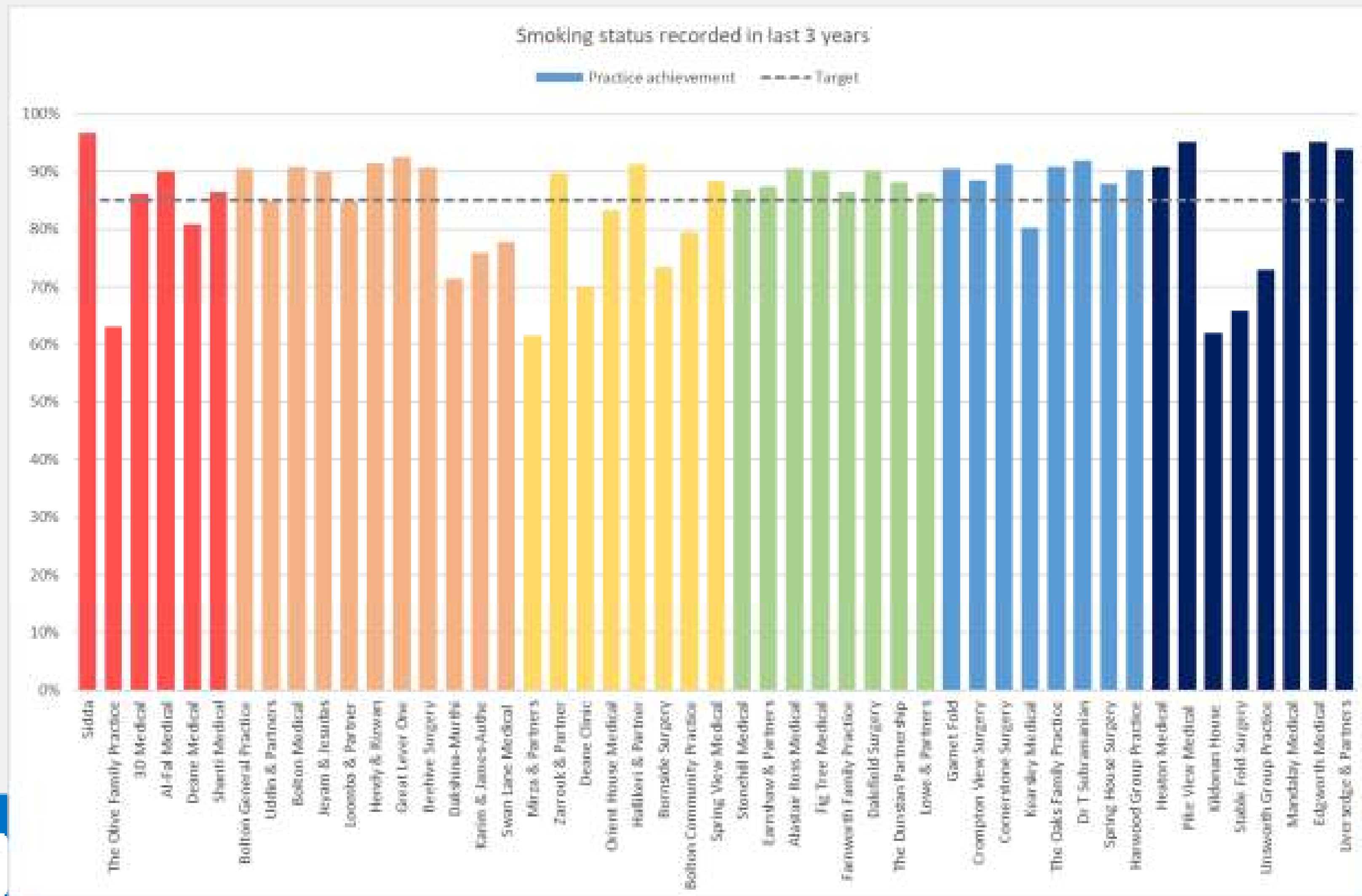
# Health Improvement – Screening for diabetes (Target 86%)

- 9 practices currently on target (March 2022 data)
- Bolton wide: 81%



# Health Improvement – Smoking status recorded (Target 85%)

- **33 practices currently on target (March 2022 data)**
- **Bolton wide: 84%**



# Prevalence of diabetes in Greater Manchester

**Greater Manchester Diabetes Register Size - Actual vs Projected**

Legend: Diabetes register size; Projection based on 2012/13

Y axis: 0, 50,000, 100,000, 150,000, 200,000, 250,000

| Year | Diabetes register size | Projection based on 2012/13 |
|---|---|---|
| 2008/09 | 118,348 | |
| 2009/10 | 125,479 | |
| 2010/11 | 131,106 | |
| 2011/12 | 137,082 | |
| 2012/13 | 143,629 | |
| 2013/14 | 149,734 | 149,778 |
| 2014/15 | 156,553 | 155,995 |
| 2015/16 | 163,637 | 162,211 |
| 2016/17 | 167,967 | 168,428 |
| 2017/18 | 173,257 | 174,644 |
| 2018/19 | 178,825 | 180,861 |
| 2019/20 | 183,376 | 187,077 |
| 2020/21 | 183,805 | 193,294 |

# Prevalence of diabetes in Bolton

**Diabetes Register Size - Actual vs Projected**

Legend: Actual, Projected

| Year | Actual | Projected |
|---|---|---|
| 2008/09 | | |
| 2009/10 | | |
| 2010/11 | | |
| 2011/12 | | |
| 2012/13 | | |
| 2013/14 | 17,894 | 18,508 |
| 2014/15 | 18,571 | 19,431 |
| 2015/16 | 18,943 | 20,353 |
| 2016/17 | 19,238 | 21,276 |
| 2017/18 | 19,665 | 22,198 |
| 2018/19 | 20,340 | 23,121 |
| 2019/20 | 21,255 | 24,044 |
| 2020/21 | 21,224 | 24,966 |
| 2021/22* | 21,778 | 25,889 |

Y axis: 0, 5,000, 10,000, 15,000, 20,000, 25,000, 30,000

*2021/22 from December 2021 Best Care registers, previous years from QOF registers

# The Practice will be expected to…

- **Undertake Alcohol AUDIT Cs every 2 years**
  - With patients aged 16 years and over
- **Record BMI every 3 years**
  - Record the BMI of every patient aged 16 years and over every 3 years
- **Offer a Bolton NHS Health Check every 5 years**
  - To all eligible patients aged 40 – 74 years of age
- **Highly recommend CVD High Risk Annual Reviews**
  - To all eligible patients - over 40 years with a risk score of ≥ 20%
- **Offer Diabetes/At Risk of Diabetes Screening**
  - To all patients aged over 40 years of age every 5 years (Practices with a high Asian population should offer a diabetes screen to patients aged 30 years and over)
- **Record Smoking Status every 3 years**
  - Record the smoking status of every patient aged 16 years and over every 3 years
- **Refer At risk of Diabetes patients**
  - All eligible patients should be offered a lifestyle intervention with either the GP, PN, Health Trainer, or the National Diabetes Prevention Programme (NDPP) for lifestyle modification

**Further delivery detail can be found in the book.**
**Same as previous years**

# Standard 6.
# Long Term Conditions
# BEST CARE

# KPIs for 2022 - 2023

| Standards | | Targets |
| --- | --- | --- |
| **Long Term Conditions – BEST CARE** | • **AF** | 500 |
| | • **Asthma (5-11 years)** | 400 |
| | • **Asthma (12 years +)** | 400 |
| | • **CKD** | 400 |
| | • **COPD** | 480 |
| | • **Diabetes** | 710 |
| | • **HF with LVD** | 450 |

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# The Practice will be expected to…

- Provide a comprehensive annual review and other reviews as necessary for patients on the registers
- Whenever possible reviews should be face to face. If this is clinically inappropriate, telephone reviews should be conducted and a plan made for care and future reviews. Any indicators reviewed by telephone should be coded using the BQC templates
- Use the Best Care templates developed by the Primary Care Development & Health Improvement Team to record all reviews
- Use the practice system codes provided by the Primary Care Development & Health Improvement Team
- Improve the care of people on the Best Care registers
- Identify a Practice Best Care Lead for:
  - AF
  - Asthma - Adults
  - Asthma - Children
  - CKD
  - COPD
  - Diabetes
  - HF (with LVSD)
- Allow access to the practice system for the Data Quality Team and Primary Care Development & Health Improvement Team
- Submit data to Bolton CCG quarterly

# Standard 7.
# Practice Engagement

## formerly Membership Engagement

# Mandatory Requirements for 2022 - 2023

1. Bolton Care Record
2. Cancer
3. Clinical Audits
4. Emergency Planning
5. End of Life
6. GP & PM Events and Meetings
7. Incident Reporting
8. Monitoring and Reporting
9. Patient Participation
10. Phlebotomy (including shared care monitoring)
11. Safeguarding
12. System Working
13. Transfer of Care
14. Workforce

# The Practice will be expected to…

1. **Bolton Care Record**

- Use the Bolton Care Record where appropriate

2. **Cancer**

- Have a named Cancer Lead
- Provide all patients, who are affected under the 2ww suspected cancer pathway, written information about the pathway and importance of attending the appointment
- Practice cancer lead to undertake one education online e-learning module from Manchester Cancer Primary Care Education website GATEWAY C

3. **Clinical Audit**

- Undertake one clinical audit – to be specified by the Primary Care
- Directorate

# The Practice will be expected to…

**4. Emergency Planning**

- Review the Business Continuity Plan (BCP), and revise as necessary. Submit a copy of the BCP by the end of September annually
- The BCP should include a process for emergency prescribing
- In the event of an emergency provide support to local rest centres, if and when required
- Develop and implement a process for patients to receive a prophylactic treatment (including vaccination) during local outbreaks of infectious diseases

**5. End of Life**

- Have a named EOL Lead
- Hold monthly (as a minimum) Palliative Care/Gold Standards Framework (GSF) meetings
- Undertake one audit to help identify potential non-cancer EOL patients, using prognosis indicator guides to improve detection of non-cancer EOL patients
- Organise for EOL Lead to undertake communication and advanced care planning training
- Share care plans electronically with other health and social care professionals involved in the care of the patient

# The Practice will be expected to…

**6. GP & Practice Manager Meetings and Events**

- **Clinical Leads** – Facilitate a GP to attend at least 10 out of 12 monthly Clinical Lead meetings. The GP must feedback to the wider practice team
- **Prescribing Event** – Facilitate the GP Prescribing Lead, or the named GP Deputy, to attend the annual prescribing event
- **PM Forum** – Facilitate the Practice Manager, or a named Deputy Practice Manager to attend 5 out of 6 bi-monthly forum meetings

**7. Incident Reporting**

- Have a named Safety Lead
- Organise for the Safety Lead to attend the annual Quality & Safety Event, then disseminate safety information within the practice
- Submit clinical incidents to the Primary Care Directorate. Incidents should be documented by GPs, ANPs, NPs, PNs, Pharmacists and other primary care clinicians including the new primary care workforce e.g. Clinical Pharmacists, MSK Practitioners and Mental Health Practitioners

# The Practice will be expected to…

**8. Monitoring and Reporting**

- Submit data to the Primary Care Directorate on a quarterly basis, to timescales organised by the Primary Care Development & Health Improvement Team

**9. Patient Participation**

- Encourage patients to take part in Friends and Family Test (FFT)
- Have a named PPG Lead
- Organise one Patient Participation Groups (PPGs) within 12 months. The format can be either face to face or via email
- Improve on patient survey measures

# The Practice will be expected to…

**10. Phlebotomy**

- Practices will be expected to provide in-house phlebotomy services to all patients 12 years and older. This will include:
- Provision and assessment of all blood monitoring that the practice has agreed to under a shared care agreement (SCA) or for drugs/interventions that are designated AMBER by the GMMMG and require statutory monitoring. Shared care must be agreed and accepted between parties involved in patient care
- Ensure clinicians maintain clinical competence by accessing the up to date monitoring requirements for any SCA/AMBER agreements signed and all patients are reviewed in line with these monitoring requirements
- If requested, provide the Primary Care Development and Health Improvement Team with a signed declaration to verify that the Practice has a written protocol for the provision of a phlebotomy service, in line with CQC requirements for premises, infection control and needle stick injuries.
- A further declaration may be requested to ensure all staff delivering this service are adequately trained, competent to deliver, have Hepatitis B protection, and have phlebotomy included as a duty within their job description, and the Practice have suitable indemnity
- The Practice should keep records and practice system codes appropriately for Post Payment Verification visits (PPV)

# The Practice will be expected to…

## 11. Safeguarding

- Have a named Safeguarding Lead
- Facilitate the Safeguarding Lead (ideally a clinician) to attend the Safeguarding Event.
- Have a named Mental Capacity Act Lead
- Provide access to safeguarding training relating to children, vulnerable adults, Looked After Children (LAC), PREVENT, Liberty Protection Safeguards (previously Deprivation of Liberty Safeguards), and Mental Capacity Act awareness for all staff at a level appropriate to their role including obtaining assurance re: training for staff employed in new clinic roles aligned to the practice e.g. Mental Health Practitioners, MSK Practitioners
- Participate in safeguarding practice audits, supported by the Safeguarding Team
- Engage in follow up assurance visits, from the safeguarding team, if any outstanding issues or concerns remain from the visit in 2022 or highlighted from other inspections
- e.g. CQC
- Produce reports as requested by Children's Social Care Child Protection Unit for initial and review Child Protection Conferences and for conferences related to adult protection
- Ensure that all looked after children have a clear flag on their records, and ensure that all children leaving care are asked if they want their records to be flagged as a care leaver
- Contribute to information sharing via the IRIS advocate educators for MARAC (multi agency risk assessment conference) for those individuals who are victims of high risk domestic abuse
- Contribute to information sharing processes and participate in statutory adult and child safeguarding reviews e.g. child safeguarding practice reviews, serious adult review, child death reviews, local learning reviews and domestic homicide reviews
- Provide assurance of improved outcomes based on implementation of recommendations from safeguarding practice reviews, safeguarding adult reviews, domestic homicide reviews

# The Practice will be expected to…

**12. System Working**

- Provide briefings to all practice staff on new ways of working e.g. integrated care systems
- Allow all practice staff to be familiar with, and fully engage in PCN working
- Allow all practice staff to be familiar with, and fully engage in wider neighbourhood working

**13. Transfer of Care**

- Accept transfer of care at the appropriate point, to ensure the best possible patient experience, in the most appropriate clinical setting
- Ensure the recommendations of the CSB and the GM Medicines Group are followed
- Cascade information about transfer of care to the wider practice team

**14. Workforce Audit**

- Undertake an annual workforce audit of the practice workforce
- Send the workforce audit to the Primary Care Development and Health Improvement Team

| MANDATORY STANDARD | | KPIs |
|---|---|---|
| **7.**<br><br>**Practice Engagement** | • Bolton Care Record (BCR) | Confirm use of the BCR – by declaration |
| | • Cancer | Submit certificate of e-learning for 1 GP |
| | • Clinical Audit | Submit 1 clinical audit |
| | • Emergency Planning | Submit 1 Business Continuity Plan |
| | • End of Life | Submit 1 non-cancer audit |
| | • GP & PM Meetings & Events | GP to attend 10/12 CLs & PM to attend 5/6 PM Forums, GP to attend Prescribing Event |
| | • Incident Reporting | Submit 1 incident per WTE clinician, Attend Q&S Event, Safety Champion |
| | • Monitoring & Reporting | Submit quarterly data, and provide access to practice system for DQF |
| | • Patient Participation | One PPG within 12 month period |
| | • Phlebotomy (& shared care) | Confirm in-house phlebotomy service – aged 12 years+ - by declaration |
| | • Safeguarding | Submit GP SGAA audit by December, Safeguarding Lead, Attend Safeguarding event |
| | • System Working | Confirm PCN and neighbourhood working – by declaration |
| | • Transfer of Care | Confirm acceptance of CSB recommendations – by declaration |
| | • Workforce Audit | Submit 1 electronic workforce audit |

# Standard 8. Prescribing

# KPIs for 2022 - 2023

| KPI | Target |
|---|---|
| **Reduction in waste and prescribing spend** | Reduce to 75$^{th}$ Centile<br>(Based on weighted prescribing spend)<br>OR<br>Maintain<br>OR<br>Reduce by up to 5%<br>(Dependent on baseline data for each practice) |
| **Reduction in overall antibiotic prescribing** | Maintain position<br>(Dependent on baseline data for each practice) |
| **Reduction in % high risk antibiotic prescribing** | Reduce by 10%<br>(Dependent on baseline data for each practice) |

# The Practice will be expected to…

- Review patients and clinical records to facilitate improvement and change. Part of the review will include identification of non-adherence, waste and overprescribing through medication reviews and practice systems related to medication
- Undertake audits, to ensure safe and effective prescribing, by identifying patients who may be non-compliant with current medication
- Support the safer use of medication via use of the SMASH dashboard and safety searches to actively review patients at risk from their medication
- Prescribe the most cost-effective medicine, in line with national and local strategy and policy
- Apply local standards relating to repeat prescribing processes
- Attend a prescribing educational event (which may be held virtually). A minimum of one GP from each practice to attend. The educational events will require pre-work, which will need to be submitted and peer reviewed at the event
- Participate in the Medicines Optimisation Work streams including those based around safety and cost effectiveness
- Work collaboratively with the Medicines Optimisation Team (MOT), Primary Care Network (PCN) Practice Pharmacists and the local authority Public Health (PH) team

# KPI allocation 2022 - 2023

# KPI % split overview

| Standards | KPI% - 2022-2023 |
| --- | --- |
| 1. Access to General Practice | 10% |
| 2. Ageing Well | 15% |
| 3. Carers | 5% |
| 4. Defined Patient Groups | 3% |
| 6. Health Improvement | 20% |
| 7. Long Term Conditions – Best Care | 15% |
| 8. Membership Engagement | Mandated |
| 9. Prescribing | 32% |
| TOTAL | 100% (of the 40%) |

# KPI % split and Triple Aim application 2022 – 2023

| Standard | Value for Money | Health Improvement | Quality & Patient Experience | KPI | Further % Split |
|---|---|---|---|---|---|
| **Standard 8.** Prescribing | 32% | | | Prescribing spend/reducing waste | 30 |
| | | | | Overall antibiotic prescribing | 1 |
| | | | | High risk antibiotic prescribing | 1 |
| **Standard 2.** Ageing Well | | 15% | | Ageing well assessment | 15 |
| **Standard 5.** Health Improvement | | 20% | | Audit C | 2 |
| | | | | BMI | 1 |
| | | | | NHS Health Check | 12 |
| | | | | High Risk CVD Review | 3 |
| | | | | Screening diabetes/at risk of diabetes | 1 |
| | | | | Smoking Status | 1 |
| **Standard 1.** Access to General Practice | | | 10% | Deliver 80 contacts per 1,000 population | 4 |
| | | | | Deliver 25 face to face contacts per 1,000 population | 4 |
| | | | | Undertake 2 access audits | 2 |
| **Standard 6.** Long Term Conditions - Best Care | | | 15% | Atrial Fibrillation (AF) | 2 |
| | | | | Asthma - children | 2 |
| | | | | Asthma - adults | 2 |
| | | | | Chronic Obstructive Pulmonary Disease (COPD) | 2 |
| | | | | Chronic Kidney Disease (CKD) | 2 |
| | | | | Diabetes | 3 |
| | | | | Heart Failure (HF) | 2 |
| **Standard 3.** Carers | | | 5% | Improve Carers Register | 1 |
| | | | | Annual health checks for carers | 4 |
| **Standard 4.** Defined Patient Groups | | | 3% | Improve dementia prevalence | 1 |
| | | | | Annual reviews for dementia patients | 2 |
| **Standard 7.** Practice Engagement | Mandatory Standard | | | | |
| **Overall split** | 32% | 35% | 33% | | |

# The contract basis

## The principle has always been:

- **60% guaranteed payment – allocated for**
  - **Signing up to the contract**
  - **Implementation of delivery aspects**
  - **Delivering the mandated standard**

- **40% - achievement of the KPIs – allocated to**
  - **Reflect the triple aim of value for money, improved population health and better quality and patient experience of care**

# Penalties

## 2022 – 2023 penalties

1. **5% penalty -** Non-compliance of mandated elements

2. **5% penalty -** Achievement of less than 50% of the total KPIs/available finance

*A practice can be subject to a 10% overall penalty, in the event they fail both of the above criteria.*

# Options for payment and total finance

# Options for payment

The Primary Care Commissioning Committee (PCCC) were asked to consider four options with regards to the financial uplift of the BQC:

1. Maintain the rate at the 2021/22 rate of £113.13

2. Apply a 2% inflationary uplift on the 2021/22 rate to give a rate of £115.39

3. Apply the Global Sum increase of £2.42 to the 2021/22 rate to provide a rate of £115.55

4. Apply the Global Sum uplift of 2.49% to the BQC element to propose a rate of £115.94.

**The PCCC recommends Option 3 which ensures an increase in investment into practices.**

# Bolton Quality Contract Costs 2022 - 2023

**The total investment for 2022 - 2023 is:**

For delivery of Standards 1 – 8 the global sum of £99.70 will be uplifted to:

**(per weighted patient) £115.55**

**The overall investment in the BQC work programme for 2022 – 2023 will be:**

**£5.1 million**

Better Bolton.

Bolton Clinical Commissioning Group