

Quality Assurance and Improvement Framework

Guidance for the GMS Contract Wales

2019/20

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Section 1: Quality Assurance and Improvement Framework (QAIF)

The Quality Assurance and Improvement Framework (QAIF) has been introduced as part of the contract reform in 2019, it replaces the Quality and Outcome Framework (QOF), which was originally introduced as part of the new GMS contract in 2004.

The QAIF builds on our experience in Wales of QOF, including our unique approach to incentivise cluster working. Through our programme of contract reform Welsh Government has worked with NHS Wales and the GP professional representative bodies to examine how quality assurance and quality improvement can form part of a reformed contractual framework that benefits patients and general practice.

The QAIF rewards contractors for the provision of quality care and helps to embed quality improvement into general practice.

1.1 Overview

The QAIF consists of three domains; **Quality Assurance**, **Quality Improvement** and the new domain of **Access**.

1.1.1 Quality Assurance (QA)

The 2019-20 GMS contract agreement includes GPC Wales support for national audits in Wales, with appropriate governance arrangements. The Quality Assurance domain has been designed taking account of complimentary engagement in national audits. The QA domain has two components sub domains, **clinical** indicators and **cluster network** indicators.

The clinical indicators for 2019-20 consist of **active** and **inactive** indicators, a concept from the QOF in 2018-19. This will allow Welsh Government and health boards to look further at the data behind the inactive indicators during the year and to evaluate activity.

Clinical active indicators – contains the disease registers, the two flu indicators FLU001W and FLU002W, and the dementia indicator DEM002, as active clinical indicators (81 points);

Clinical inactive indicators - a further ten clinical indicators are inactive, they will be reported on for 2019-20 cycle and paid at full point value (101 points). All other clinical indicators from the former QOF have been retired.

Total points for clinical indicators = 182.

Cluster network – enables the maintenance of a clear link between activity and financial reward through reformed cluster output/activity indicators related to engagement (5 meetings at 40 points), contributing information to cluster IMTPs -due

for completion by September each year, (80 points) and the delivery of outcomes for relevant services (80 points).

Total points for cluster network = 200.

1.1.2 Quality Improvement (QI)

The Quality Improvement domain is based on QI projects the practice will complete.

In 2019/20, practices will undertake a mandatory patient safety project plus another project from the basket of QI projects. To assist in the QI activity, practices will be rewarded for completing an accredited QI training course.

In 2020/21 practices will undertake a new mandatory patient safety project plus two projects from the basket of QI projects.

Total points available QI domain = 185.

1.1.3 Access

On 20 March 2019, the Minister for Health and Social Services announced the Access to In-Hours GMS Services Standards. Underpinned by clear measurable expected achievements by March 2021, these standards are the subject of a national delivery milestone for the Primary Care Model for Wales; the standards set clear requirements on practices in terms of expectations relating to access including an increased digital offering.

Introduction of the Access Standards is backed up by significant new investment into the contract. A part of the investment is through the Access domain within the new Quality Assurance and Improvement Framework (QAIF) and comes with a total of 125 new points.

However, separate payment arrangements and achievement cycles will apply in order to align the Access domain in the QAIF with the delivery milestones for the Access Standards. Details of these are set out in the more detailed Access guidance.

<http://www.wales.nhs.uk/sites3/page.cfm?orgid=480&pid=99340>

1.2 Funding for Quality Assurance and Improvement Framework

The following points will be awarded for achievement:

Quality Assurance domain

Clinical sub domain

- registers and active indicators 81
- inactive indicators 101

Cluster network sub domain 200

Quality Improvement domain

Patient safety project	65
QI project 1	60
QI training (year 1 only)	60
Replaced by QI project 2 in year 2	

Total points for QA and QI **567**

In recognition of the workload pressures practices experience during the winter months, QAIF achievement for the QA and QI domains will be measured at 30 September each year, with the first achievement assessment date being 30 September 2020. The annual QAIF cycle for these two domains is therefore 1 October to 30 September.

The practice achievement payment for QA and QI is to be calculated in accordance with the provisions set out in the Statement of Financial Entitlement (SFE) Directions. The practice registered patient list and average practice registered patient list for Wales for relevant QA and QI indicators will be taken at 1 July.

During 2019-20 work will be undertaken to understand the current activity at practice and cluster level in relation to inactive indicators. Clinical inactive indicators for 2019-20 will be awarded as achieved at full point value.

New Access domain points **125**

Details of the Access Standards, groupings, evidence, reporting, payment arrangements and achievement are set out in the Access guidance. Achievement for the Access domain will be assessed at 31 March each year, with achievement payments paid at 30 June.

The practice achievement payment for access is calculated using the practice points achieved, adjusted by the practice registered patient list against the average practice registered patient list for Wales, taken at 1 January, as set out in the Statement of Financial Entitlement Directions.

Section 2: Quality Assurance

2.1 General information on indicators

Indicators have been prefixed by an abbreviation of the category to which they belong, as per their description under the old QOF scheme. For the purposes of calculating achievement payments, contractor achievement against QAIF indicators is measured on a cycle of:

- 1st October to 30th September.
- in cases where the contract terminates mid-year, the last day on which the contract subsists.

In the case of a contract that has come to an end before the end of September in any relevant financial year, the reference to periods of time are still calculated on the basis that the period ends on 30th September in the financial year to which the achievement payment relates. The SFE sets out the rules that apply to measuring achievement for contracts that end before the end of the QA and QI achievement year.

2.1.1 Disease registers

These are lists of patients registered with the contractor who have been diagnosed with the disease or risk factor described in the register indicator. While it is recognised that these may not be completely accurate, it is the responsibility of the contractor to demonstrate that it has systems in place to maintain a high quality register. Verification may involve asking how the register is constructed and maintained. The health board may also compare the reported prevalence with the expected prevalence and ask contractors to explain any reasons for variations.

For some indicators, there is no disease register, but instead there is a target population group. For example, for FLU001W the target population group is the registered population aged 65 or more.

Indicators in the Cluster network sub domain, the QI domain and the Access domain have neither a disease register nor a target population. These are indicators which require a particular activity to be carried out and points are awarded in full if the activity is carried out. Should the activity not be carried out, no points are awarded.

2.1.2 Verification

For indicators where achievement is not extracted automatically from GP clinical systems the guidance outlines the evidence or type of evidence which the health board requires the contractor to produce for verification purposes. The evidence will not need to be submitted unless requested by the health board. Practices will be responsible for ensuring that any and all required evidence to support the claimed achievement is available on request for examination by the health board.

The Statement of Financial Entitlement Directions set out the reporting requirement for contractors and the rules for the calculation of QAIF payments.

2.1.3 Business rules

The Dataset and Business Rules that support the reporting requirements of the QAIF are based on Read codes (version 2 and Clinical Terms Version 3) and associated dates. Read codes are an NHS standard. Contractors using proprietary coding systems and/or local/practice specific codes will need to be aware that these codes will not be recognised within QAIF reporting. Contractors utilising such systems may need to develop strategies to ensure that they are using appropriate Read codes in advance of producing their achievement report. During 2019/20 NHS Wales expect to move to SNOMED clinical terms as the NHS standard for coding, in line with the NHS in the rest of the UK.

2.1.4 Exception reporting

Exception reporting applies to those indicators in the clinical domain of QAIF where the achievement is determined by the percentage of patients receiving the specified level of care.

“Exceptions” relate to registered patients who are on the relevant disease register or in the target population group and would ordinarily be included in the indicator denominator, but who are excepted by the contractor on the basis of one or more of the exception criteria. Patients are removed from the denominator and numerator for an indicator if they have been both excepted **and** they have not received the care specified in the indicator wording. If the patient has been excepted, but the care has subsequently been carried out within the relevant time period, the patient will be included in both the denominator and the numerator, i.e. achievement will always override an exception.

2.1.5 Exception reporting criteria

Patients may be excepted if they meet the following criteria for exception reporting:

- Patients who have been recorded as refusing to attend review who have been invited on at least three occasions during the annual cycle to which the achievement payments relate.
- Disease parameters due to particular circumstances, for example, a patient who has a terminal illness or is extremely frail.
- Patients newly diagnosed or who have recently registered with the contractor who should have measurements made within three months and delivery of clinical standards
- Where a patient does not agree to treatment (informed dissent) and this has been recorded in their patient record following a discussion with the patient.
- Where the patient has a supervening condition which makes treatment of their condition inappropriate.

Contractors should report the number of exceptions for each indicator set and individual indicator. Contractors will not be expected to report why individual patients were exception reported. However, contractors may be called on to explain why they have 'excepted' patients from an indicator and this can be identifiable in the patient record.

2.1.6 Principles

The overriding principles to follow in the decision to except a patient are:

- A duty of care remains for all patients, irrespective of exception reporting arrangements.
- It is good practice for clinicians to review from time to time those patients who are excepted from treatment, e.g. to have continuing knowledge of health status and personal health goals.
- The decision to exception report should be based on clinical judgement, relevant to the patient, with clear and auditable reasons coded or entered in free text on the patient record.
- There should be no blanket exceptions: the relevant issues with each patient should be considered by the clinician at each level of the clinical indicator set.

In each case where a patient is exception reported, in addition to recording what should be reported for payment purposes (in accordance with the Business Rules), the contractor should also ensure that the clinical reason for the exception is fully recorded in a way that can facilitate an audit in the patient record. This is both in order to manage the care of that particular patient and for the purpose of verification.

Although patients may be excepted from the denominator, they should still be the recipients of best clinical care and practice. For the purposes of managing the care of the patient and for subsequent audit and verification, it is important that the reason the patient meets one or more of the exception reporting criteria and any underlying clinical reason for this is recorded in the patient's clinical record.

Invitations to attend a review should be made to the individual patient and can be in writing or by telephone. This can include a note at the foot of the patient's prescription requesting that they attend for review.

The three invitations need to have taken place within the QAIF period in question. There should be three separate invitations at three unique periods of time. The telephone call invitation may lead to the application of exception criteria 'informed dissent' if the patient refuses to take up the invitation to attend.

The following are examples that are not acceptable as an invitation:

- A generic invitation on the right hand side of the script to attend a clinic or an appointment e.g. influenza immunisation.

- A notice in the waiting room inviting particular groups of patient to attend clinics or make appointments (e.g. influenza immunisation).

2.2 Clinical Domain Active Registers and Indicators

The clinical domain is split into two parts, **active** registers / indicators and **inactive** indicators.

This section focuses on the **clinical domain active** registers / indicators. Establishing and maintaining disease registers is good professional practice and ensures a defined population is identified for undertaking further evidence-based interventions. Disease registers also make it possible to call and recall patients effectively to provide systematic care and to undertake care audits.

Disease registers

Atrial fibrillation (AF)

Indicator	Points
AF001. The contractor establishes and maintains a register of patients with atrial fibrillation	2

Secondary prevention of coronary heart disease (CHD)

Indicator	Points
CHD001. The contractor establishes and maintains a register of patients with coronary heart disease	2

Heart failure (HF)

Indicator	Points
HF001. The contractor establishes and maintains a register of patients with heart failure	2

Hypertension (HYP)

Indicator	Points
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HYP001. The contractor establishes and maintains a register of patients with established hypertension	2
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Stroke and transient ischaemic attack (STIA)

Indicator	Points
STIA001. The contractor establishes and maintains a register of patients with stroke or TIA	2

Diabetes mellitus (DM)

Indicator	Points
DM001. The contractor establishes and maintains a register of all patients aged 17 or over with diabetes mellitus, which specifies the type of diabetes where a diagnosis has been confirmed	2

Asthma (AST)

Indicator	Points
AST001. The contractor establishes and maintains a register of patients with asthma, excluding patients with asthma who have been prescribed no asthma-related drugs in the preceding 12 months	2

Chronic Obstructive Pulmonary Disease (COPD)

Indicator	Points
COPD001. The contractor establishes and maintains a register of patients with COPD	2

Dementia (DEM)

Indicator	Points
DEM001. The contractor establishes and maintains a register of patients diagnosed with dementia	2

Mental Health (MH)

Indicator	Points
MH001. The contractor establishes and maintains a register of patients with schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy	2

Cancer (CAN)

Indicator	Points
CAN001. The contractor establishes and maintains a register of all cancer patients defined as a 'register of patients with a diagnosis of cancer excluding non-melanotic skin cancers diagnosed on or after 1 April 2003'	2

Epilepsy (EP)

Indicator	Points
EP001. The contractor establishes and maintains a register of patients aged 18 or over receiving drug treatment for epilepsy	1

Learning Disability (LD)

Indicator	Points
LD001. The contractor establishes and maintains a register of patients with learning disabilities	2

Osteoporosis: secondary prevention of fragility fractures

Indicator	Points
OST001. The contractor establishes and maintains a register of patients: 1. Aged 50 or over and who have not attained the age of 75 with a record of a fragility fracture on or after 1 April 2012 and a diagnosis of osteoporosis confirmed on DXA scan, and 2. Aged 75 or over with a record of a fragility fracture on or after 1 April 2012	2

Rheumatoid Arthritis (RA)

Indicator	Points
RA001. The contractor establishes and maintains a register of patients aged 16 or over with rheumatoid arthritis	1

Palliative Care (PC)

Indicator	Points
PC001. The contractor establishes and maintains a register of all patients in need of palliative care/support irrespective of age	3

Obesity (OB)

Indicator	Points
OB001. The contractor establishes and maintains a register of patients aged 16 or over with a BMI of 30 in the preceding 15 months.	2

Disease Indicators

Influenza (FLU)

Indicator	Points	Threshold
FLU001W. The percentage of the registered population aged 65 years of more who have had influenza immunisation in the preceding 1 August to 31 March	5	55-75%
FLU002W. The percentage of patients aged under 65 years included in (any of) the registers for CHD, COPD, Diabetes or Stroke who have had influenza immunisation in the preceding 1 August to 31 March	15	45-65%

Dementia (DEM)

Indicator	Points	Threshold
DEM002. The percentage of patients diagnosed with dementia whose care has been reviewed in a face to face	28	55-75%

review in the preceding 15 months.		
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Total Clinical Domain Active QAIF Points	81
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2.3 Clinical Domain Inactive Indicators

The contractor's performance against clinical inactive indicators will not be measured for payment purposes in 2019-20. However, clinical inactive indicators are included in the business rules and data will be collected from GP clinical systems for the purposes of assurance of standards. Work will be undertaken by Welsh Government and health boards during 2019/20 across clusters to understand any variation in recording and where appropriate data will be triangulated against other sources. Health boards will not be verifying achievement and payment for inactive indicators will be made at full point value. All previous QOF indicators not included in the QAIF clinical active or inactive domains have been retired.

Atrial Fibrillation (AF)

Indicator	Points
AF006. The percentage of patient with atrial fibrillation in whom stroke risk has been assessed using CHA2DS2-VASx score risk stratification scoring system in the preceding 3 years (excluding those patients with a previous CHADS2 or CHA2DS2-VASc score of 2 or more) and a record of counselling regarding the risks and benefits of anticoagulation therapy has been made	12
AF007. In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anticoagulation drug therapy.	12

Diabetes Mellitus (DM)

Indicator	Points
DM002. The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 mmHg or less	8
DM003. The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 15 months) is 140/80 mmHg or less	10
DM007. The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 59 mmol/mol or	17

less in the preceding 15 months	
DM012 The percentage of patients with diabetes , on the register , with a record of a foot examination and risk classification; 1) low risk (normal sensation, palpable pulse) , 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer) or 4) ulcerated foot within the preceding 15 months	4
DM014 The percentage of patients newly diagnoses with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register	11

Chronic Obstructive Pulmonary Disease (COPD)

Indicator	Points
COPD003. The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 15 months	9

Mental Health (MH)

Indicator	Points
MH011W. The percentage of patients with Schizophrenia, Bipolar affective disorder and other psychoses who have a record of blood pressure, BMI, smoking status and alcohol consumption in the preceding 15 months and in addition to those aged 40 or over, a record of blood glucose or HbA1c in the preceding 15 months.	12

Palliative Care (PC)

Indicator	Points
PC002W. The contractor has regular (at least 2 monthly) multi-disciplinary case review meetings where all patients on the palliative care register are discussed	6

Total Clinical Domain Inactive QAIF Points	101
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Section 3: Clusters Network Engagement

The Cluster Network domain was previously established under the Quality Outcomes Framework (QOF). From 2019-20 onwards there is a shift in relation to cluster membership with 'mandatory membership of GP cluster network' a core contractual requirement.

The points (200) remains in the new Quality Assurance & Improvement Framework as part of the Quality Assurance domain but will be broken down to link more clearly with output on a network/cluster basis. This brings greater focus around planning for population needs and workforce capacity, with improved alignment to IMTP cycles. This would align with the aims of *A Healthier Wales* in enhancing cluster maturity.

The Primary Care Model for Wales, which supports the vision in *A Healthier Wales*, is predicated on effective collaboration at cluster level to assess population need and to both plan and deliver seamless care and support to meet that assessed need.

Cluster working can be described as: *“A cluster brings together all local services involved in health and care across a geographical area, typically serving a population between 25,000 and 100,000. Working as a cluster ensures care is better co-ordinated to promote the wellbeing of individuals and communities.”*

The Primary Care Model for Wales is predicated on a social model of health and wellbeing and critical to this is the need to work across organisational boundaries in order to maximise all the assets in a community. As well as local health boards and local authorities who have a statutory duty to plan and provide care and support to meet the health and wellbeing needs of their populations, cluster working is also about a range of delivery partners of which GMS contractors are a fundamental component. Other delivery partners include other primary care contractors, local authorities, the third/voluntary sector, care homes.

Indicator	Points
<p>CND014W –.</p> <p>The GP Cluster Network will meet on 5 occasions during the year; the timing of meetings should be agreed around the planning of the HB and ideally, to avoid the period of winter pressure.</p>	40
<p>CND015W</p> <p>Contributing relevant cluster information to the Primary Care Cluster IMTP which will include information on the demand and capacity tool and also the workforce development plan.</p>	80
<p>CND016W</p> <p>Delivering specific cluster determined outcomes which includes</p> <ul style="list-style-type: none"> • engagement in planning of local initiatives, • Completion of the 2 Quality Improvement initiatives at a cluster level where agreed by the GMS practices (as per section 4). • Active participation as evidence of operating an effective system of clinical governance (quality assurance) in the practice e.g. through completion of CGSAT and IG toolkit. 	80

3.1 GP Cluster Network Meetings

The contractor must attend the GP Cluster Network on 5 occasions during the year; the timing of meetings should be agreed around the planning of the health board and to be held at times to avoid peak seasonal workload.

Attendance at these meetings may prove difficult for single handed and small practices (2 or 3 partners) and/or those experiencing significant sustainability issues. The HB will work with GP cluster network representatives to enable practices to engage fully either through having a Practice Manager attending or enabling “buddying” of a small practice with a larger practice and thus reducing the need for attendance at each meeting. Arrangements for an alternative representative will need to be agreed with the health board prior to the meeting. HBs will need to consider the sustainability of local services when considering practice requests and give an explanation to the practice if the request is not agreed. Where a “buddying” arrangement has been agreed the practice must actively engage in the full work of the cluster through e-mail participation/directly feeding in comments etc to the “buddy practice

In addition, for all practices, it may not be practicable in exceptional circumstances to attend a GP Cluster Network meeting. In these circumstances, and with the prior agreement of the health board, the practice may be represented at these meetings by another senior practice employed clinician/administrator.

3.2 Contributing clear information to cluster IMTPs

GMS contractors are expected to contribute to the population needs assessment, demand and capacity analysis and workforce development plan and also to support Cluster IMTPs

This should include:-

- (i) **Planning** – each contractor to contribute alongside their fellow GP practices and in collaboration with the wider cluster partners to the cluster IMTP:
- A population needs assessment;
 - An analysis of current services available to the cluster population and identifying any gaps in provision;
 - A consideration and analysis of current numbers and skills of workforce and its development needs;
 - An analysis of current performance against the phase 2A primary care measures
 - Measurement of local health needs as determined by the cluster.

This can be achieved either through:

- Practices producing a plan to demonstrate how they contribute to the cluster plan,

or

- The GP Cluster Network plan clearly demonstrating how each individual practice has contributed to the plan.

Delivering activities and outcomes

- Engagement in the planning and agreed delivery of local services, as agreed within the cluster action plan, which may also include sharing of data, with appropriate safeguards (being cognisant of practices GDPR responsibilities) and discussion of cluster funding / budgets.
Practices will need to demonstrate how they have engaged in planning & delivery of local services agreed within the cluster plan – This will need to include evidence of wide partnership/ multi-professional / multi-agency working and development of integrated services.
- Engagement with the 2 Quality Improvement initiatives at a cluster level (as per section 4 below), which may involve peer review and the sharing of data

with appropriate safeguards). Evidence of the QI participation will be required.

- Active participation as evidence of operating an effective system of clinical governance (quality assurance) in the practice, through engagement in peer review and through discussion of clinical incidents that had occurred within the practice and local services. Contractors will need to evidence completion of CGSAT and IG toolkit.
- In order to support the delivery of the activities and outcomes of the cluster action plan; practices will share data, with appropriate safeguards, across the cluster in time for each of the cluster meetings. This information is then to be shared with the relevant health board by 30th September to feed in to the IMTP cycle.

Section 4: Quality Improvement

4.1 Overview

The Quality Improvement domain is based on the introduction of a “basket” of quality improvement projects which are to be delivered at cluster level. The basket of projects available for 2019-20 will be:

- a. Patient Safety Programme - Reducing medicines related harm through a multi-faceted intervention for the cluster population.
- b. Reducing stroke risk through improved management of Atrial Fibrillation in for the cluster population.
- c. Ceilings of care / Advanced Care planning.
- d. Urinary tract infection to multi-disciplinary Antimicrobial Stewardship 2019/20

In practice, GMS contractors will be required to agree at cluster level and implement two QI projects in 2019-20:

- Patient Safety – mandatory
- Quality Improvement – choice from b, c, d set out above

Further details on each of the projects are detailed at sections 4.2 – 4.6.

4.2 QI Training

To enable GP practices to develop their approach to quality improvement, the health board will also act in a supportive role, with a focus on quality improvement and development.

The Bronze IQT packages are available for all GPs, and can be accessed through Public Health Wales and the '1000 Lives Improvement' initiative, which supports the development of programme for primary care by providing guidance, training and advice for local, regional and national health teams across Wales.

Further information on how to access the IQT programme is available from a designated IQT facilitator within each health board.

<http://www.1000livesplus.wales.nhs.uk/primary-care/> .

<https://learning.wales.nhs.uk>

The Royal College of General Practitioners (RCGP) also offers the innovative online tool *QI Ready*. *QI Ready* prepares and supports GPs and practice staff to carry out QI activities in their practice. The tool is comprised of an online learning network, which contains complex case studies, a self-accreditation system and QI e-learning modules.

RCGP Wales has three faculties that host educational courses and networking events throughout the regions and North, South West and South East Wales. Many of these events contribute to CPD and professional development. Each health board has an RCGP advocate to promote the values of professional GP practice, and to highlight the resources available through the UK College.

4.3 Patient Safety Programme (Mandatory)

4.3.1 Introduction

This Quality Improvement project aims to incentivise GMS contractors to collaborate at cluster level to take action to reduce the prevalence of risk factors associated with avoidable medicines related harm through the implementation of a multifaceted intervention shown to reduce a range of medication errors in general practice.

4.3.2 Medicines related harm

The prescribing of a medication is the most common intervention in healthcare.¹ In Wales, over 80 million prescriptions were dispensed in the community in 2017 and medication use has increased significantly over time.^{2,3}

Demographic changes, including an ageing population and the increasing prevalence of co-morbidities, have driven increases in the concurrent use of multiple medicines (so called “poly-pharmacy”)⁴ with patients on multiple medicines more likely to suffer side effects from medicines.⁵

Whilst prescribing a medicine has the potential to improve health, it may also be associated with harm which may arise from unintended consequences of therapeutic use (i.e. adverse drug reaction), or medication error (i.e. through inappropriate prescribing, dispensing, administering, monitoring or use).

4.3.3 Interventions to minimise harm

In general, evidence for reducing medication errors is strongest for educational outreach⁶ and pharmacist-led interventions.⁷

Most preventable adverse drug events in primary care are attributable to errors in prescription and medication monitoring,⁸ and changes in practice enabled by information technology have substantial potential to reduce the frequency of these errors.⁹

The pharmacist-led information technology intervention for medication errors (PINCER) study demonstrated how a multifaceted intervention comprising feedback, educational outreach, dedicated pharmacist support and use of information

¹ National Institute for Health and Clinical Excellence. Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes. NG5. 2015

² Welsh Government. Prescriptions dispensed in the community. 2018

³ Gao L et al. Medication usage change in older people (65+) in England over 20 years: findings from CFAS I and CFAS II. *Age and Ageing* 2018; 47(2): 220-225

⁴ Payne RA et al. Prevalence of polypharmacy in a Scottish primary care population. *Eur J Clin Pharmacol* 2014; 70: 575-581

⁵ Pirmohamed M et al. Adverse drug reactions as cause of admission to hospital: prospective analysis of 18 820 patients. *BMJ* 2004; 329(7456):15-19

⁶ Royal S et al. Interventions in primary care to reduce medication related adverse events and hospital admissions: systematic review and meta-analysis. *Qual Saf Health Care* 2006; 15: 23–31.

⁷ Thomson O'Brien MA et al. Educational outreach visits: effects on professional practice and health care outcomes. *Cochrane Database Syst Rev* 2000; 2: CD000409.

⁸ Gurwitz JH, Field TS, Harrold LR, et al. Incidence and preventability of adverse drug events among older persons in the ambulatory setting. *JAMA* 2003; 289: 1107–16.

⁹ Schedlbauer A, Prasad V, Mulvaney C, et al. What evidence supports the use of computerized alerts and prompts to improve clinicians' prescribing behavior? *J Am Med Inform Assoc* 2009; 16: 531–38.

technology can improve quality through improvements in prescription safety and medication monitoring in general practices, at a low cost per error avoided.¹⁰

4.3.4 Requirements of the QI project

The information below provides details of the responsibilities of the practice, cluster and health board to implement the project. The details are as follows:-

At Practice Level

Each general practice will have access to an online prescribing safety dashboard and would meet at the start of each QAIF cycle to discuss the information provided by the dashboard.

General practices will identify a prescribing safety lead, who will be expected to use a range of techniques to help correct the medication errors and prevent future ones. This could include (but not be limited to)-

- Inviting patients to surgery for review;
- Ensuring patients have appropriate tests for known side effects;
- Making arrangements for ongoing review; and
- Educational meetings with prescribers.

At Cluster Level

The intervention will be overseen (with improvements agreed and measured) at the cluster level. Individual general practice data would be aggregated and reported at the cluster and health board level only. Individual general practice action plans would be agreed by the primary care cluster within six months of the start of the each financial year with improvements (as measured by primary care cluster level reports) reviewed.

Clusters will be expected to drive improvement in individual practice outcome measures.

At Health Board Level

The NHS Wales Informatics Service have developed and will deploy a Prescribing Safety Dashboard available to individual general practices which produces aggregated cluster, health board and national reports.

Individual general practice data will be aggregated and reported at the cluster and health board level only. HBs would be responsible for overseeing process measures and using cluster data to assure improvements in outcome measures with cluster level peer reviewing individual practices to drive performance improvement at cluster level.

¹⁰ Avery A et al. A pharmacist-led information technology intervention for medication errors (PINCER): a multicentre, cluster randomised, controlled trial and cost-effectiveness analysis. *Lancet* 2012; 379: 1310–1319

The intervention could be supported by materials (such as prescribing indicator reports) developed by the All Wales Medicines Strategy Group.

4.3.5 Measurement of the implementation of the project

Each GP practice has a GP or Pharmacist nominated as its medication safety lead.

The GP practice has a plan to improve prescribing safety indicators.

The GP practice has participated in a cluster meeting to discuss prescribing safety measures.

The cluster has had a meeting to discuss prescribing safety measures.

Number of medication reviews for patients meeting one or more criteria in the prescribing safety measures.

The outcome we expect from the project are as follows:-

Improvements in the prescribing safety indicators (reduction in numbers at risk).

4.4 Reducing stroke risk through improved management of Atrial Fibrillation in primary care clusters

4.4.1 Introduction

This Quality Improvement project aims to incentivise primary care clusters to take action to reduce the stroke risk associated with suboptimal prescribing of anticoagulant and antiplatelet therapy in primary care.

The intervention would be carried out at each practice but would be overseen (with improvements agreed and measured) at the cluster level

4.4.2 Atrial Fibrillation

Atrial fibrillation (AF) is the most common sustained cardiac arrhythmia and its prevalence is increasing. A patient with atrial fibrillation has a 5-fold increase in the risk of stroke and 20–30% of all strokes are attributed to this arrhythmia. Not only is AF a major risk factor for stroke, but when strokes occur in association with AF, patients suffer increased levels of mortality, morbidity and disability with longer hospital stays compared with stroke patients without AF.

The aim of AF treatment is to prevent complications, principally stroke, and alleviate symptoms.

Pharmacological therapy recommended to reduce the risk of stroke in AF now only comprises of anticoagulants, with clear evidence to support the fact that anticoagulation with vitamin K antagonists (e.g. warfarin) or direct oral anticoagulants (DOACs) reduce stroke and mortality in patients with AF.

Recommended pharmacological therapy to reduce stroke risk

The National Institute for Health and Care Excellence (NICE) clinical guideline 180 entitled [Atrial Fibrillation: Management](#), recommends the use of anticoagulant therapy to prevent stroke in specified circumstances (figure one) with potentially clinically significant reductions in stroke incidence.

4.4.3 Requirements of the QI project

The information below provide details of the responsibilities of the practice, cluster and health board to implement the project. The details are as follows:-

Practice level

Each practice will have access to an online AF dashboard providing computerised feedback on patients identified to be at risk from inappropriate prescribing of antiplatelet therapy or suboptimal use (including no use) of anticoagulant therapy.

Individual practices would be able to see their report alongside anonymised reports for other practices.

Each practice to meet annually to discuss the information provided by the dashboard. All doctors, pharmacists and nurses working at the practice should attend this meeting along with the practice manager and at least one member of the reception staff. Where a member of staff is unable to attend, opportunity will be given for them to see the data, and an opportunity to input views and receive outcomes of the meeting. Local community pharmacists could also be invited to attend.

Individual practices will identify a lead who will be a doctor, pharmacist or nurse working at the practice, to develop and progress actions in the plan.

Following the initial meeting, the practice will be expected to identify AF patients at risk of stroke and undertake structured and documented reviews with a view to improving prescribing and reducing risk.

Cluster level

Individual general practice data will be aggregated and reported at the primary care cluster and health board level only.

Individualised practice data will only be available to the relevant general practice.

Individual general practice action plans will be agreed by the primary care cluster within three months of the start of the 2019-20 financial year with improvements (as measured by primary care cluster level reports) reviewed before 31 March 2020.

Health Board level

Individual general practice data will be aggregated and reported at the primary care cluster and health board level only.

Brief written educational materials explaining AF, stroke risk and different approaches to treatment and risk reduction will be provided to general practices to inform structured reviews to arrive at shared decisions on treatment and which are consistently documented.

4.4.4 Measurement of the implementation of the project

Each GP practice will lead the implementing a stroke reduction action plan.

The practice has had a meeting to discuss the AF dashboard measures.

Number of structured reviews for patients with AF.

The outcomes we expect from the project are:-

% of patients with AF on anticoagulant or with documented shared decision making declined anticoagulant.

4.5 Ceilings of Care/Advanced Care Planning

4.5.1 Introduction

This Quality Improvement project has the aim of increasing the number of patients with long-term conditions, nearing the end of life, who have had an offer to express their wishes and preferences in a most patient-centric way with advance care plans and to ensure these patients receive continuing and acute care in their preferred places of care.

4.5.2 Background

There is ample evidence to suggest that Advance Future Care Plan (AFCP) discussions are not routinely happening when people are living with multiple long-term and life limiting conditions. Even after losing capacity to make their own healthcare decisions, people may retain control over decisions through an Advance Decision (to refuse treatment).

4.5.3 Definitions

Where possible, the term **Advance Future Care Planning** can encompass both all aspects of Advance Care Planning for people with decisional capacity **and** also those with decisional mental capacity as defined by the Mental Capacity Act 2005. For further information visit the Welsh repository for AFCP projects: <http://advancecareplan.org.uk/for-professionals/>

4.5.4 Requirements of the QI project

The information below provides details of the responsibilities of the practice, cluster and health board to implement the project. The details are as follows:-

Practice

- Improve ownership and understanding of *Advance Future Care Plans* by patients, relatives and care providers.
- Measure whether for those patients on a practice's palliative care register a discussion of preferences for treatment, resuscitation, and hospitalisation has occurred **or** has been declined by the patient or care giver near admission (in which case document that it was declined). (Note: such discussions must never be forced onto those who do not wish to have them).
- Provide information on Advance Future Care Planning but also discuss patients' and families' views on future investigations and interventions openly and ascertain any strong views.
- Reduce avoidable and unwanted hospital admissions, including by provision of medication at home to reduce symptom burden, such as injectable anti-sickness medicines, pain medications and other common reasons for admission.
- Improve patient centred care in the patients preferred places of care and place of death.

- Ensure active capture of the patients care preferences in the GP electronic record.
Suggested Read Codes: 8CME - Has end of life advance future care plan
8IAe – Personal Care Plan declined
- Ensure active communication of patient's care preferences to other parties who are or may be involved in the patients care e.g. 111/OOH.

There is evidence to support improved efficacy of AFCP if it is made available on electronic record sharing systems that work for all e-patient record systems. An example is [Co-ordinate My Care](#) in London, which is being adopted in NHS England.

¹¹

Cluster

Support care staff (community practitioners, care and nursing home staff) to respect and take account of what matters to patients and be familiar with AFCPs. Use resources such as <http://talkcpr.wales> videos and video media pads to spread good quality information about ceilings of treatment/intervention.

Deliverables might also include delivering standards as required by NICE Quality Standards, e.g. an SBAR* (Situation Background Assessment Recommendation) report to ensure carer and nursing teams in care homes and community have reviewed the care plan prior to calling OOH, 111 or 999. Include cluster delivered education sessions to nursing home staff and audit of adherence to SBAR.¹²

Health Board

Ensure sharing ownership and auditing of adherence to care plans and existing AFCPs across the health system (e.g. community teams, secondary care).

Establish alignment with new medical examiner mortality review processes and model appropriate 'community MDT review' of place of death and quality of care including auditing place of death consistent with patient's option preference(s) expressed in AFCPs.

4.5.5 Measurement of the implementation of the project

Development of a frailty register by recording frailty score on all nursing home patients and all on active caseload of district nursing to complement existing palliative care registers.

¹¹ *Smith C, Hough L, Cheung C, et al Coordinate My Care: a clinical service that coordinates care, giving patients choice and improving quality of life BMJ Supportive & Palliative Care 2012;2:301-307*¹¹.

¹² <https://improvement.nhs.uk/documents/2162/sbar-communication-tool.pdf>

Audit on quarterly cycle with an audit standard that 95% of those on the frailty or palliative care registers have had an offer of AACP discussion with the patient themselves or their deputy, with clearly defined ceilings of intervention/treatment that have been set out or agreed by the patient, proxy, carers and relatives.

The audit would encompass the capture of whether a discussion on AACP has been offered and been agreed to, or declined. It would capture the documentation of whether the individual had mental capacity to make such decisions, or not. If patient/deputy in agreement with such a discussion, whether an AACP is then subsequently added to GP electronic record with agreed Read Codes, the active communication of the existence of this AACP to other relevant parties e.g. 111/OOH, and the concordance of the patient's actual place of death with their expressed preference(s), i.e. patients may express several preferred options for instance home or hospice. Such an audit may also enquire whether anticipatory injectable medications for symptoms like pain or nausea were made available at home, if this was the patients preferred place of care at the end of life.

Use of SBAR to ensure the AACP is reviewed prior to calling 999/111/00H

The outcomes we expect from the project are as follows:-

- More recording of patient/deputy care preferences in advance
- Reduction in unwanted OOH admissions where a patient/deputy has declined this
- Improved sharing of AACPs across relative parties currently involved in the patients care or who might be in the future and:
 - where this is not achieved, feedback to relevant NHS Wales IT providers to request and embed a system that allows access to all key clinicians, esp input ability for GPs, hospital doctors and senior nurses with read-only access to HCPs like paramedics and 111/999 provider services.
- Feedback on completed projects and examples of practice and outcomes to AACP Strategy Group for Wales.
- Improved concordance of actual place of death with the location preference(s) expressed in AACP.

4.6 Multidisciplinary Antimicrobial Stewardship Urinary Tract Infection (UTI)

4.6.1 Introduction

This Quality Improvement project aims to incentivise primary care clusters to review the diagnosis and management of adults with suspected Urinary Tract Infection.

This supports multidisciplinary collaboration to promote a consistent approach to the management of UTI based on prioritised NICE Quality Standards (QS 90 Urinary Tract Infection in adults, QS 121 Antimicrobial Stewardship).

4.6.2 Antimicrobial resistance

Antimicrobial resistance is a significant threat to health, as outlined in WHC¹³ 2018: *Antimicrobial resistance already imposes a significant burden of morbidity and mortality on the population of Wales through the failure of empiric antibiotic treatment of infections, and the spread of difficult-to-treat multi-drug resistant organisms. Key drivers of AMR Antimicrobial resistance are antimicrobial usage, burden of disease and transmission of resistance.*

4.6.3 Urinary Tract Infections and variation

There is particular concern¹⁴ regarding the increasing resistance to common treatments used in managing Urinary Tract infections:

Treatment for most infections is started empirically before antimicrobial susceptibilities are known. A particular problem with the spread of antimicrobial resistance is that it becomes more difficult to select empirical therapy that will have reliable activity. In Primary Care, the effects are most clearly seen in increasing resistance to empirical therapy in urinary pathogens. There is also on-going concern about Clostridium difficile associated disease arising in the community. The main driver for the spread of both resistance and C. difficile is antimicrobial use; certain antibacterial agents have been particularly implicated in the spread of C. difficile... There is however, significant variability between Health Boards and GP Clusters in both the amount and types of antibacterial used, which suggests that there remains room for improvement.

4.6.4 Requirements of the QI project

The information below provide details of the responsibilities of the practice, cluster and health board to implement the project. The details are as follows:-

Practice level

¹³ <https://gov.wales/docs/dhss/publications/whc2018-020en.pdf>

¹⁴ Antibacterial Usage in Primary Care In Wales 2013/14 - 2017/18 [Report from Public Health Wales Healthcare Associated infection](#), Antimicrobial Resistance & Prescribing Programme (HARP team)

As part of the project each general practice will identify an 'antibiotic lead'. The practice will participate in at least one antimicrobial stewardship quality improvement activity with at least 2 data collections, relating to the diagnosis & management of UTI.

4 audits are available¹⁵ :

- Healthcare professional do not use dipstick testing to diagnose UTI in adults with urinary catheters [NICE QS 90¹⁶ , PHW UTI standards 3&5¹⁷]
See [Wales QI UTI Catheter](#)
- People prescribed an antimicrobial for UTI, have the clinical indication documented in their clinical record. [NICE QS121¹⁸,WHC 18/20¹⁹, UK plan²⁰]
See [Wales QI UTI Indication](#)
- Review of urinary prophylaxis [PHW UTI standards, NICE NG112]
See [Wales QI UTI Prophylaxis 3a](#) and [Wales QI UTI Prophylaxis 3b](#)
- Adults with a UTI not responding to initial antibiotic treatment have a urine culture [NICE QS 90] (this audit should be undertaken with one of the remaining 3 UTI audits) see [Wales QI UTI MSU after treatment failure](#)

Practices will need to meet with allied professionals to discuss the findings where appropriate, such as district nurses, pharmacists or care homes.

All practices will continue to participate in Healthcare Associated Infection reviews as requested by the Health Board, such as Clostridium Difficile investigations

Cluster level

Through this project, the cluster will prioritise the audit(s) to be undertaken, it is assumed most practices in the cluster would undertake the same audit(s). Initial measures and action plan will be discussed at cluster level.

Some data collection may be supported by health boards or antimicrobial stewardship pharmacists, particularly for the urinary prophylaxis topic.

Final practice measures and report will be discussed in the final quarter of the financial year and the aggregated cluster report shared with the health board by an agreed date.

Health Board level

¹⁵ <https://phw.nhs.wales/services-and-teams/harp/urinary-tract-infection-uti-resources-and-tools/> see audit and quality improvement tools

¹⁶ NICE QS90 Urinary Tract Infections: <https://www.nice.org.uk/guidance/qs90>

¹⁷ [PHW UTI 9](#) ' Key Standards for UTI Prevention, Treatment and Management Standard 3&5

The health board will support the QI project and audit selection with appropriate data provision, data collection where possible and educational activities relating to the multidisciplinary management of UTI.

The health board will identify, and share with clusters, key members and committees within the organisation who have responsibility for supporting and ensuring safe and effective care for people within this Quality Improvement project. The final cluster reports will be shared with these stakeholders and with Medical Directors.

The health board will, where possible, provide aggregated cluster and health board reports to the practice to support benchmarking.

4.6.5 Measurement of the implementation of the project

All participating clusters will be required to collate evidence of peer discussions and reflective practice involving the multidisciplinary team (such as, where possible, district nurses, care home, community pharmacy), practice report, cluster report.

Audit specific measures include:

- Proportion of episodes of suspected urinary tract infection in adults with urinary catheters that are investigated using dipstick testing.
- Proportion of episodes of a urinary tract infection not responding to initial antibiotic treatment investigated with a urine culture.
- Proportion of prescriptions for UTI antimicrobials with a coded clinical indication for treatment documented.
- Proportion of people prescribed urinary prophylactic antibiotics for more than 6 months who have had a documented prophylaxis review in the last 6 months

The outcomes we expect from the project are as follows:-

Reduction in usage of antibacterials that may be prescribed for urinary tract infections.

Contribute to overarching NHS Wales Delivery Framework, “I am safe and protected from harm through high quality care, treatment and support” and NHS Delivery measures including the national prescribing indicators for antibacterial items and national reduction expectations for E.coli, Klebsiella sp., bacteraemia cases and for cases of C.difficile disease²¹.

²¹ <https://gov.wales/healthcare-associated-infections-and-antimicrobial-resistance-improvement-goals-whc2019019-0>

Section 5: Access

5.1 Overview

In March 2019, the Minister for Health and Social Services announced the new access standards for GMS services, which we expect GP practices to meet by March 2021. The standards, which were developed in conjunction with LHBs and following consultation with the public and stakeholders, are:

- People receive a prompt response to their contact with a GP practice via telephone.
- Practices have the appropriate telephony systems in place to support the needs of people avoiding the need to call back multiple times and will check that they are handling calls in this way.
- People receive bilingual information on local and emergency services when contacting a practice.
- People are able to access information on how to get help and advice.
- People receive the right care at the right times in a joined up way which is based on their needs.
- People can use a range of options to contact their GP practice.
- People are able to email a practice to request a non-urgent consultation or a call back.
- Practices understand the needs of people within their practice and use this information to anticipate the demand on its services.

To support practices one off investment 3.7 million has been made into Global Sum to support practices in securing and implementing the necessary infrastructure in order to achieve the standards, with a particular focus on telephony.

Details of the 125 points available in the Access domain, the access standards, groupings, evidence, reporting, payment arrangements and achievement cycle and are set out in the more detailed access guidance.

Section 6: Queries Process

Queries can be divided into three main categories:

- those which can be resolved by referring to the guidance and/or FAQs
- those which require interpretation of the guidance or Business Rules
- those where scenarios have arisen which were not anticipated in developing guidance.

Within these categories, there will be issues relating to coding, Business Rules, payment, clinical issues and policy issues and in some cases the query can incorporate elements from each of these areas.

If there are queries which cross the above areas, the recipient will liaise with the other relevant parties in order to resolve/respond. In addition, where a query has been directed incorrectly, the query will be redirected to the appropriate organisation to be dealt with.

QAIF queries should be directed as follows:

- Queries relating to QAIF Business Rules/coding should be sent to: NHS Wales Informatics Service via PrimaryCare.ServiceDesk@wales.nhs.uk
- All other queries relating to QAIF should in the first instance be sent to: Welsh Government via HSS-PrimaryCareMailbox@gov.wales

Section 8: Glossary of terms

Abbreviation	Definition
ACCORD	Action to Control Cardiovascular Risk in Diabetes
ACR	Albumin:Creatinine Ratio
AF	Atrial Fibrillation
AFCP	Advance Future Care Plan
AST	Asthma
BMI	Body Mass Index
BMA	British Medical Association
CAN	Cancer
CHD	Coronary Heart Disease
CHADS ₂	Congestive (HF) Hypertension Age (75 or over) Diabetes Stroke
CI	Confidence Interval
CND	GP Cluster Network Development
COPD	Chronic Obstructive Pulmonary Disease
CQRS	Calculating Quality Reporting Service
CS	Cervical Screening
DEM	Dementia
DEP	Depression
DM	Diabetes Mellitus
DNA	Did Not Attend
DXA	Dual-Energy X-ray Absorptiometry
DOACs	Direct Oral Anticoagulants
EP	Epilepsy
GMS	General Medical Services
GP	General Practitioner

Quality Assurance and Improvement Framework Guidance

GPC	General Practitioners Committee
HbA1c	Glycated Haemoglobin
HCP	Health Care Professional
HF	Heart Failure
HSCIC	NHS Health and Social Care Information Centre
HYP	Hypertension
IFCC	International Federation of Clinical Chemistry and Laboratory Medicine
LD	Learning Disabilities
LHB	Local Health Board
MAT	Maternity
MH	Mental Health
MI	Myocardial Infarction
mmHg	Millimetres of Mercury
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
OB	Obesity
ONS	Office for National Statistics
OOH	Out of Hours
OST	Osteoporosis
PC	Palliative Care
PE	Patient Experience
QA	Quality Assurance
QAIF	Quality Assurance and Improvement Framework
QI	Quality Improvement
QOF	Quality Outcomes Framework
RA	Rheumatoid Arthritis
RCGP	Royal College of General Practitioners

Quality Assurance and Improvement Framework Guidance

SBAR	Situation Background Assessment Recommendation
SCR	Supportive Care Register
SFE	Statement of Financial Entitlement
SIGN	Scottish Intercollegiate Guidelines Network
SMOK	Smoking
STIA	Stroke or Transient Ischemic Attack
TIA	Transient Ischemic Attack
THY	Thyroid
UTI	Urinary Tract Infection