13 December 2017	ITEM: 15 (Decision 0110448)

Cabinet

Primary Care Improvement Plan

Wards and communities affected:	Key Decision:
All	Yes

Report of:

Councillor James Halden, Portfolio Holder Education and Health

Accountable Assistant Director:

Emma Sanford, Strategic Lead, Healthcare Public Health

Accountable Director:

Ian Wake, Director of Public Health

This report is Public

Executive Summary

This report outlines the new strategic approach to improving the diagnosis and management of patients with long term health conditions in Primary Care that has been developed jointly with partners in the NHS. This approach has received Regional and National recognition and has recently been commended by the Chief Executive of Public Health England Duncan Selbie. Following presentation of the programme at the NHS National Prevention Board in October 2017 by the Thurrock Director of Public Health, The Regional Director of Public Health for Midlands and East has instructed the Public Health England Knowledge and Information Team to replicate the modelling that underpins this programme across the entire Midlands and East region as a precursor to implementation of the approach region wide.

The 2016 Annual Report of The Director of Public Health (APHR) highlighted that a significant cohort of patients in Thurrock are living with long term conditions that remain undiagnosed and therefore untreated. Moreover, the APHR highlighted an unacceptable level of clinical variation in the treatment of patients with diagnosed long term conditions across different GP practice populations.

Both of these issues combine to place individuals at unnecessary adverse health events such as strokes and heart attacks, and leads to preventable demand on key public services including unnecessary hospital admissions and early entry into the council's adult social care system. In short, these problems are bad for our residents and bad for Thurrock tax payers.

By building on complex modelling work undertaken by the Healthcare Public Health Team, we have re-based GP Quality and Outcomes Framework (QOF) indicators used to incentivise our surgeries to manage long term health conditions, to produce a new local framework based on both the levels of undiagnosed disease in each practice population and the extent to which diagnosed patients are managed clinically by the surgery. We are also proposing a 'stretched target' for GP practices with an aspiration that the performance of all surgeries be increased to a minimum of the top quartile of current performance.

The paper details information on this new framework, together with a series of initiatives to assist GP practices to improve performance. The outcomes of delivering the plan on population health are also discussed.

1. Recommendation

1.1 That Cabinet approves this new strategic programme of performance improvement and support for primary care with linked demand management for hospital and adult social care services, as detailed within the paper.

2. Introduction and Background

2.1 This report details an on-going programme of work within GP surgeries in Thurrock, to diagnose and manage patients with long term conditions.

2.2 Thurrock is served by 33 GP practices, commissioned by NHS England. NHS Thurrock Clinical Commissioning Group (CCG) also has a small Primary Care Development Team that work with GP practices as a 'critical friend' to improve clinical quality and strategically manage the Primary Care future provider landscape. In 2016 following a restructure of the council's Public Health function, two Primary Care Improvement Managers were employed to work in partnership with the CCG's Primary Care Development Team and local GP practices to embed best public health clinical practice within our local surgeries.

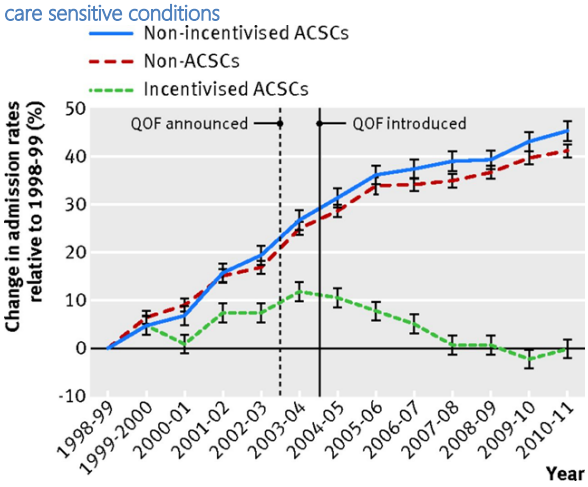
2.3 In 1948 when the NHS was founded, almost half of the population died before their 65th birthday. In 2015 this figure dropped to 18%. However, although living longer, our population is increasingly doing so with multiple long term health conditions. Spend on patients with long-term conditions accounts for over 70% of the entire NHS budget. Effective management of long term conditions is vital in order to prevent patients' health, wellbeing and independence from deteriorating and to prevent them being admitted to hospital or requiring social care packages.

2.4 The Quality Outcomes Framework (QOF) records quality of care information on how patients who are diagnosed with long term health conditions are treated by GP surgery based clinicians. It was set up as an incentive system and GP practices get paid for the percentage of their "diseased population" that they offer certain tests, medication reviews and treatments. The indicators are based on evidence of good quality care for the conditions

including National Institute of Health and Care Excellence (NICE) recommendations.

2.5 A study published in the BMJ in 2015 showed that nationally the introduction of QOF was associated with a decrease in emergency admissions for conditions that were incentivised. (Figure 1)

Figure 1 Effect of a national primary care pay for performance scheme on emergency hospital admissions for ambulatory care sensitive conditions



We can therefore use QOF scores as a proxy for quality of care for patients with Long-Term Conditions.

2.6 The Annual Report of The Director of Public Health (2016) (APHR) highlighted unacceptable levels of clinical variation in the management of long term conditions across different GP practice populations in Thurrock, and suggested that this was driving variation in clinical outcome for patients and rates of admission to hospital and residential care for serious and preventable health events such as stroke. The report recommended urgent action to address this variation.

2.7 The APHR (2016) also identified that a significant cohort of residents were living with undiagnosed long term conditions. By using models developed by Imperial College London that estimate the *expected prevalence* of disease (both diagnosed and undiagnosed) at GP practice population level and comparing these to numbers of diagnosed patients on GP surgery QOF disease registers, it is possible to estimate the numbers of patients living with undiagnosed long term health conditions (Figure 2). The APHR (2016) recommended action to identify and treat patients living with undiagnosed long term conditions, in order to prevent their disease progressing.

Figure 2 Observed and Expected Prevalence of key LTCs in Thurrock

Condition	Diagnosed Prevalence (From GP surgery QOF Registers)	Estimated Prevalence (From Imperial College London Models)	Additional Number of Undiagnosed Patients based on the estimated prevalence
Stroke (2016)	1.51%	3.70%	3,540*
Hypertension (2016)	14.08%	20.95%	10,983

CHD (2016)	2.78%	7.58%	7,521*
COPD (2016)	1.8%	2.22%	642*
Diabetes (2016)	6.3% (17+)	7.9% (16+)	2,109**

Source: PHE modelled estimates 2016, NCVIN 2016, and QOF 2014/15 [*one practice was missing data so true number will be higher / ** applying the QOF prevalence for 17+ to the 16+ population]

3. Issues, Options and Analysis of Options

3.1 In order to drive improvement in population health outcomes on long term conditions, this paper details our strategy to address both diagnosis of undiagnosed long term conditions (case finding) and improvement in management of patients with long term conditions by our GP surgeries, once they diagnosed. The APHR highlighted high levels of case finding and high quality long term condition management within some surgery populations in Thurrock. However this was not uniformly the case across all surgery populations.

3.2 The APHR (2016) detailed a number of long term conditions multiple regression analysis models developed by the Healthcare Public Health Team that identified and quantified the impact that significant QOF indicators had on the incidence of the following serious health events:

- Stroke
- Coronary Heart Disease and Heart Failure
- COPD
- Hypertension (high blood pressure)

Using the output from these models, we have selected seven QOF indicators; improvement of which we estimate will deliver the greatest population health gain. Figure 3 details these indicators and the clinical rationale behind them.

Figure 3 Key QOF Indicators selected for improvement

Indicator Code	Indicator	Clinical Rationale
HYP006	The percentage of patients with hypertension in who the last blood pressure reading (measured in the preceding 12 months) is 150/90mmHg or less	Public Health analyses demonstrates that in Thurrock, 20% of patients with uncontrolled high blood pressure will have a stroke in the next three years
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 anti-coagulation drug therapy	NICE recommends that all patients with AF and a CHA2DS2-VASC >1 be anti-coagulated. Our local modelling estimates that 50% of patients with AF and a CHA2DS2-VASC score > 1 who are not anti-coagulated wil have a stroke in the next three years.
COPD007	The percentage of patients with COPD who have had an influenza immunisation in the preceding 1 August to 31 March	This is a recommendation made by the Chief Medical Officer and Joint Committee of Vaccination Intelligence. Contracting influenza with comorbid COPD can lead to serious health complications and increases the risk of emergency hospital admission.
DEP003	The percentage of patients aged 18+ or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have been reviewed not earlier than 10 days after and not later than 56 days after the date of diagnosis	Untreated co-morbid depression or anxiety with a physical LTC has been shown to increase the risk of mortality, greater morbidity and increase hospital and adult social care usage significantly
CHD005	The percentage of patients with Coronary Heart Disease with a record in the preceding 12 months that aspirin, an alternative anti-platelet therapy or an anti-coagulant is being taken	Both NICE21, 22 and SIGN23, 24 clinical guidelines recommend that aspirin (75–150 mg per day) is given routinely and continued for life in all patients with CHD unless there is a contraindication. This has been shown to significantly reduce the risk of further serious CHD related adverse health events

STIA003	The percentage of patients with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90mmHg	As HYP006
HF003	In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, the percentage of patients who are currently treated with an ACE-I or ARB	Our local modelling estimates that we will prevent two emergency hospital admissions for Heart Failure in the next three years, for every 10 Heart Failure patients we treat with an an ACE-1 or ARB class of drug

3.3 QOF only incentivises GP practices to deliver clinical management interventions for patients that they have diagnosed. As such, a GP practice scoring highly on QOF may not necessarily be managing their practice population to optimum effect, if there are large numbers of patients within it that have undiagnosed long term conditions (i.e. poor case finding). For example, modelling in the APHR (2016) estimated that diagnosing a further 1% of patients with high blood pressure in Thurrock would prevent 65 strokes over three years. In order to account for levels of case finding as well as clinical management, we have re-based the national targets attached to the above indicators such that they consider the total estimated number of patients in each practice population (whether diagnosed or not), and not simply the number of patients on GP practice disease registers.

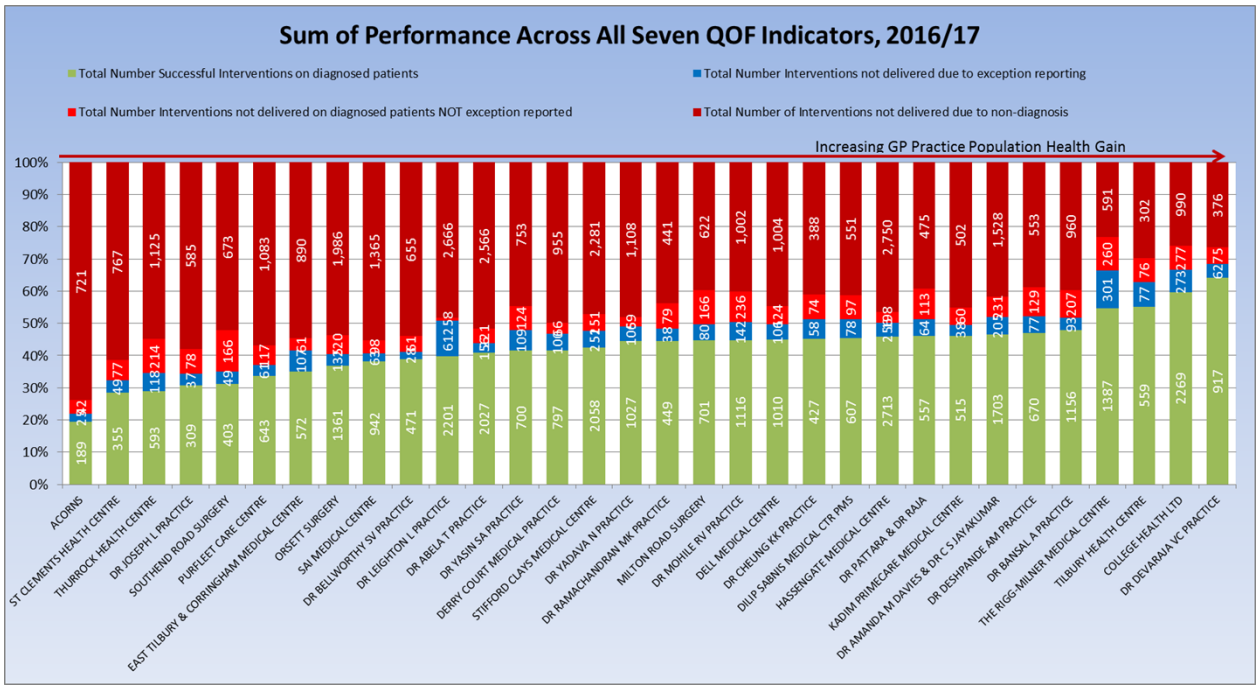
3.4 Figure 4 shows the sum of performance across all seven individual QOF indicators at GP practice population level using the rebased QOF data and as such ranks the success in terms of case finding and clinical management at GP practice population level. Figures 1 to 6 in Appendix A show performance at GP practice population level against each individual metric. Each entire bar represents the total estimated cohort of patients in each practice population with the condition/disease considered (both diagnosed and un-diagnosed). The practice population bars then sub-divided into four colour coded categories:

- The light green section of the bar shows the total number and % of the patient cohort who have been diagnosed and successfully treated. This cohort can be said to be well managed clinically.
- The blue section of the bar shows the total number of patients who have been 'exception reported'. QOF allows surgeries to exception report patients for a variety of reasons, including those who refuse the intervention, fail to respond to three invitations to attend the surgery to receive the intervention or who have another disease/are taking another medication that contra-indicates them from receiving the intervention.
- The light red section of the bar shows the number and percentage of the cohort who have been diagnosed but did not receive the intervention and were not exception reported. Patients may fall into this group because the surgery has not been resourced under QOF to treat them, (QOF generally only pays surgeries to treat up to 70% of the eligible cohort of patients) or if the surgery has failed to offer the treatment/intervention for other reasons. This cohort is at considerable risk of serious adverse health events as they are not being clinically managed against best medical guidance.

- The dark red section of the bar shows the estimated number and percentage of the cohort who are yet to be diagnosed. In many senses, this cohort of the population are potentially most at risk of serious adverse health events, as they unknown to the surgery for the purposes of the intervention.

The further to the right of the graph each practice population falls, the better its likely overall population health outcome on the indicator considered. With the exception of Heart Failure (figure 6, Appendix A) there is considerable variation between different practice populations in terms of levels of clinical management. **However care should be taken before attributing cause for this variation directly on differences in clinical practice between different surgeries. Other factors such as willingness of different practice populations to seek early medical advice for symptoms, differences in levels of under-doctoring, and differences in availability and quality of services provided by other NHS partners including pharmacies and community services may also be key drivers in explaining the variation.**

Figure 4 Performance on all Seven QOF Indicators



3.5 In order to drive up standards in long term condition case finding and disease management across our entire population, we have set a target of increasing performance across all practice populations to that of the top quartile of GP practice performance in the seven QOF indicators set out in Appendix A. (This is to the Heart Failure Indicator as there is little variation in outcome between GP practice populations). The top quartile of performance is shown as a green horizontal dotted bar in figures 1 to 7 in Appendix A. Figure 5 shows current borough wide achievement for each indicator together with the proposed revised standard for all surgeries based on top quartile

performance, and the additional number of patients that will be diagnosed and treated when the new standard is achieved. .

Figure 5 Key QOF Indicators selected for improvement: Current Performance and Proposed Standards

QOF Indicator	Current Thurrock Achievement (re-based to include undiagnosed patients)	Proposed Standard	Number of people in Thurrock needed to diagnose and treat for Thurrock to be at proposed standard
HYP006	56.26%	63%	2214
COPD007	67.02%	76%	348
DEP003	5.60%	14%	546
AF007	54.53%	62%	207
CHD005	33.64%	40%	141
HF003*	90%	90%	0
STIA003	35.70%	43%	498

* The Heart Failure metric does not include undiagnosed patients as no model has been produced by Imperial College London to allow us to calculate this.

3.6 In order to start a conversation with individual surgeries about their clinical practice relating to long term conditions case finding and clinical management, the Healthcare Public Health Team have produced a surgery specific Profile Card for each surgery. An example of this profile card is shown in Appendix B. The LTC profile card brings together a series of high importance information on all the drivers of LTC detection and management in primary care and displays it in a very easy to read format.

3.7 The profile card compares individual GP practices to a personalised benchmark group. The benchmark group consists of 20 practices from across England with practice population demographics including population size, deprivation index and age distribution, most similar to that of the Thurrock GP Practice in question. By comparing a Thurrock GP practice with 20 practices across England serving populations that are similar to their own, the card quickly identifies those indicators for which performance may be particularly good or bad, whilst controlling for variations in performance due to factors attributable to underlying characteristics of the registered GP practice population. This provides an opportunity to direct resources towards addressing genuinely poor performance and making the maximum impact on the health of the population of Thurrock. Similarly it allows identification of surgeries that are performing highly on specific indicators, generating opportunities for the Primary Care Improvement Managers to share this best practice across the borough.

3.8 As of 6 November 2017, 18 of the 31 practices (58%) had received visits from the Healthcare Public Health (HCPH) Improvement Managers to discuss their profile card and to develop an individualised action plan for the following three months. There has been an overall positive response to the visits from GPs

and other surgery staff, with 17 action plans being developed in collaboration with the practice manager and the sometimes the lead GP. The action plans can only include a maximum of three action steps for the practice in order to make the plan realistic and concentrate on the most important issues first. Most of the time, the Practice Manager have reported being unsurprised by the highest priorities identified during the discussion and have welcomed the opportunity for assistance from Public Health to address them. The HCPH Improvement Managers are supporting with best practice ideas, evaluation needs or sometimes simply an organised platform for their plans.

3.9 To further support surgeries in the clinical practice in this area, a range of additional investments are either proposed from January 2018 or already underway, through the Better Care Fund and from the Public Health Grant for initiatives that operate at different levels on the case finding-clinical management dimension (Figure 13).
These include:

- Community based long term conditions 'case finding' programmes including Hypertension and Atrial Fibrillation checks in Community Pharmacies and in the Thurrock Community Hubs

- Siting of blood pressure monitoring machines in GP surgery waiting areas as a further mechanism to diagnose potential hypertension

- Profiling patient's cardio-vascular risk using the QRISK2 clinical tool, and then prioritising invitation for an NHS Healthcheck to those most at risk. invitations to those patients most likely to have undiagnosed cardio-vascular disease

- Providing additional funding to GP surgeries to treat all patients eligible for clinical interventions under QOF, as opposed to the 70% of cohort 'cut off' ceiling under the DH QOF contract, through a local 'stretched QOF'.

- Integrating disease specific community NHS long term conditions clinical management services into a single service linked directly to networks of GP surgeries, and funding additional long term conditions nursing support.

- Integrating current mental health services within transformed long term condition management clinics.

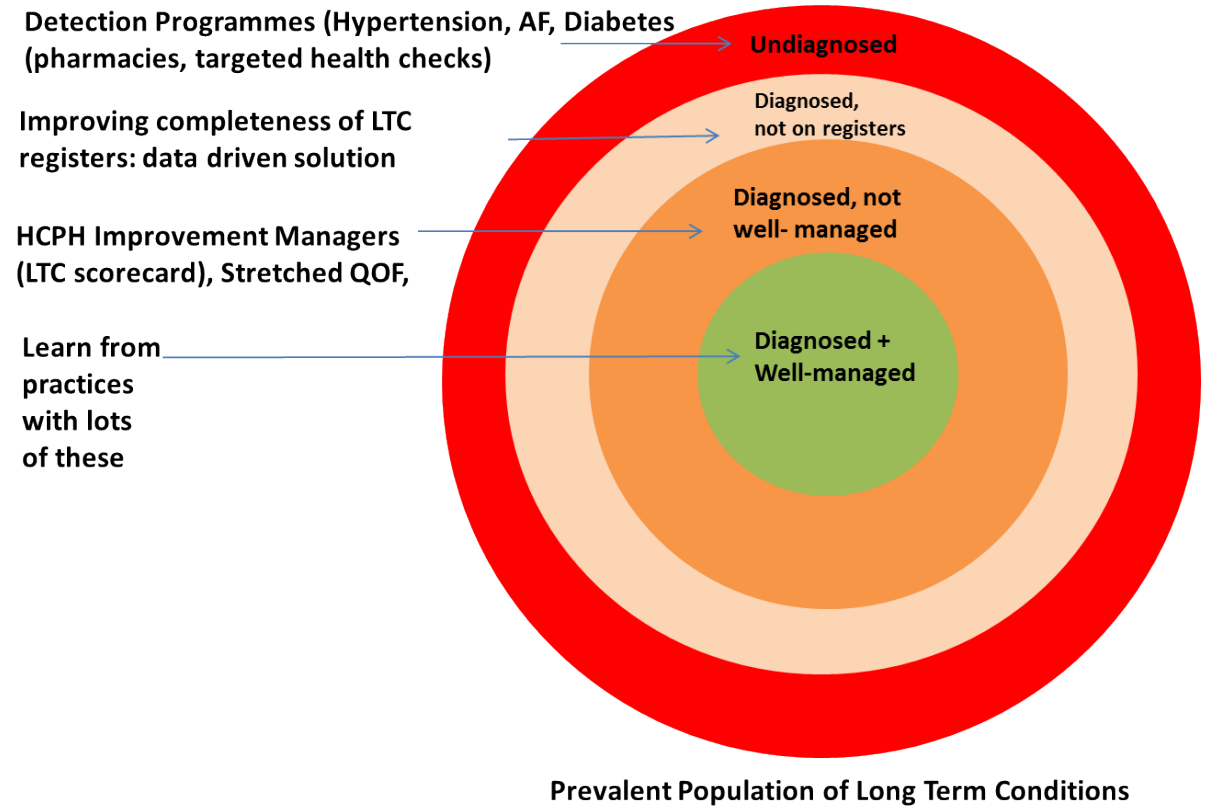
- Providing additional support to surgeries to deliver the NHS flu vaccination programme.

- The implementation of the Mede-Analytics integrated data solution to encompass GP surgery data. Mede-Analytics analyses patient level data held on individual GP practice clinical databases and will allow practice managers and clinicians to quickly identify cohorts of at risk patients, (e.g. patients with AF who have uncontrolled blood pressure or a CHA2D-VASC2 score>1 who have not been anti-coagulated), such that they can be invited into the surgery for review and treatment. It will also assist in

'case finding' for example by identifying patients who may be being prescribed medication for a long term condition, but who have not been included on a GP practice QOF register and therefore will not be being clinically managed systematically.

Detailed business cases relating to each intervention can be found at https://www.thurrock.gov.uk/healthy-living/health-statistics-and-information

Figure 6



3.10 Using the multiple regression analyses models detailed in the APHR, we are able to estimate the impact of this programme of work on our residents health. These impacts are an under-estimation due to current constraints on the availability of some datasets. However, by increasing performance to levels detailed in this report we estimate that amongst Thurrock residents, we will prevent:

- 75 strokes within 3 years, delivering a cost saving to the NHS of £273,000 in initial treatment costs, and a cost saving to Adult Social Care of £317,000 in avoided residential care packages.
- 4,859 hospital admissions for Coronary Heart Disease/Atrial Fibrillation from over a three year period, delivering a cost saving to the NHS of £690,000
- 2,686 hospital admissions for respiratory conditions over a three year period delivering a cost saving to the NHS of £334,000

4. Reasons for Recommendation

4.1 Approving this strategic approach this will support the administration's key priority on improving standards in Primary Care, along with NHS partners' strategic aim to improve the quality and capacity of Primary Care in Thurrock.

4.2 Delivery of this programme of work will have a significant positive impact on the health of our residents living with long term health conditions, will enhance the capacity and capability of our GP surgery clinical teams to manage this cohort of patients, and will deliver system wide savings through reduced demand on hospital and adult social care services.

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 The programme set out in this paper has been presented at HOSC in September 2017 and was widely supported.

5.2 This programme of work has been developed in conjunction with NHS Thurrock CCG's Primary Care Development Team and local GP surgeries and has been discussed and approved by the CCG's Clinical Executive Group.

6. Impact on corporate policies, priorities, performance and community impact

6.1 This programme of work delivers on Objective 5C of the Thurrock Joint Health and Wellbeing Strategy, 2016-2021

7. Implications

7.1 Financial

Implications verified by: **Jo Freeman**

Finance Manager

Additional financial costs arising from this report will be met from a combination of agreed funding set out in the Better Care Fund and investment from the Public Health Grant. The the approach will deliver financial savings in terms of reduced health and social care demand that are estimated to be considerably in excess of the investment made.

7.2 **Legal**

Implications verified by: **David Lawson**

Assistant Director of Law and Governance & Monitoring Officer.

There are no direct legal implications at the stage but legal Services are available for any necessary legal advice as implementation of the plan progresses

7.3 **Diversity and Equality**

Implications verified by: **Natalie Warren**

Community Development and Equalities Manager

The initiatives outlined in this report will tackle health inequalities faced by some GP practice populations by seeking to address variation in clinical outcome for patients with long term conditions.

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

- None

8. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright):

- Annual Report of The Director of Public Health (2016), Thurrock Council. https://www.thurrock.gov.uk/healthy-living/health-statistics-and-information

9. Appendices to the report

- Appendix 1- Performance on Individual Rebased QOF Indicators
- Appendix 2 – Example of LTC Profile Card

Report Author:

Ian Wake
Director of Public Health

Appendix 1: Performance on Individual Rebased QOF Indicators

Figure 1 Performance on Hypertension Clinical Management, QOF Indicator HYP006

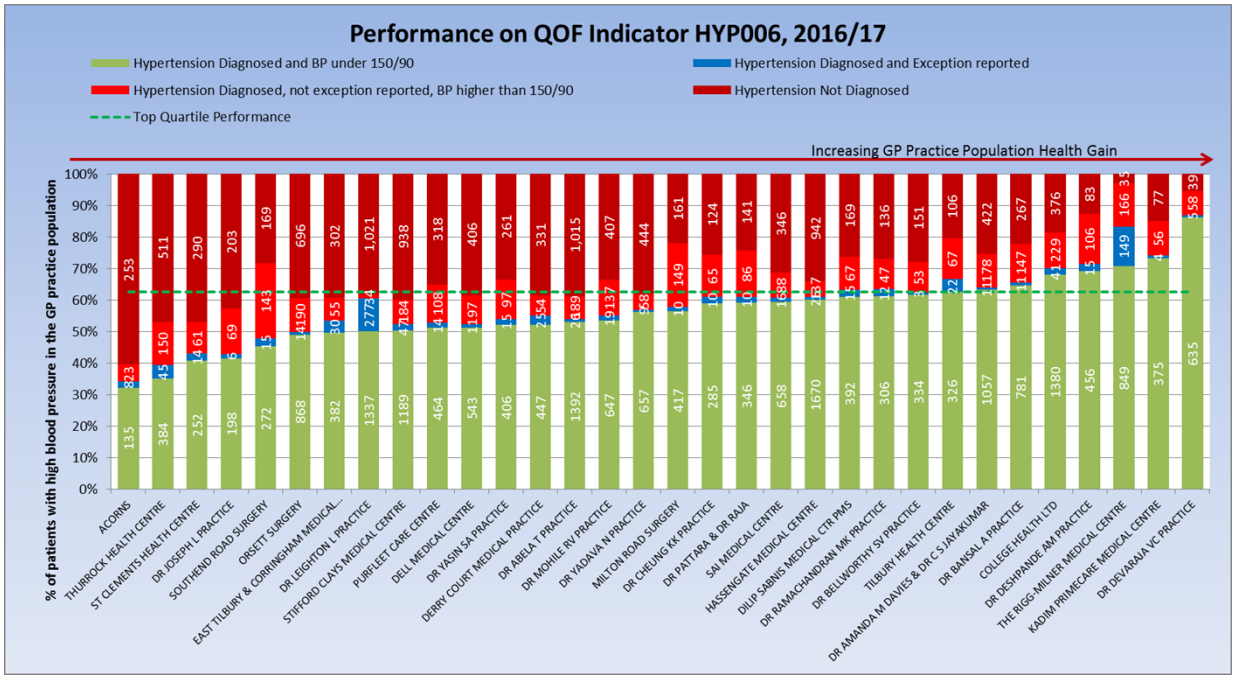


Figure 2 Performance on Atrial Fibrillation Clinical Management, QOF Indicator AF007

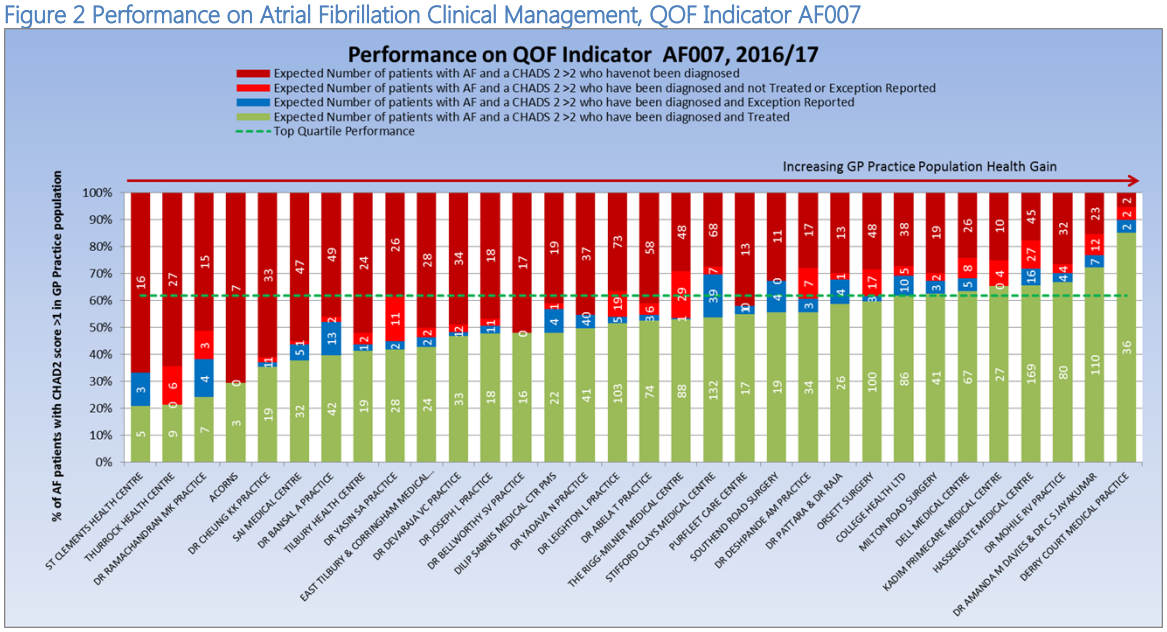


Figure 3 Performance on COPD Clinical Management, QOF Indicator COPD007

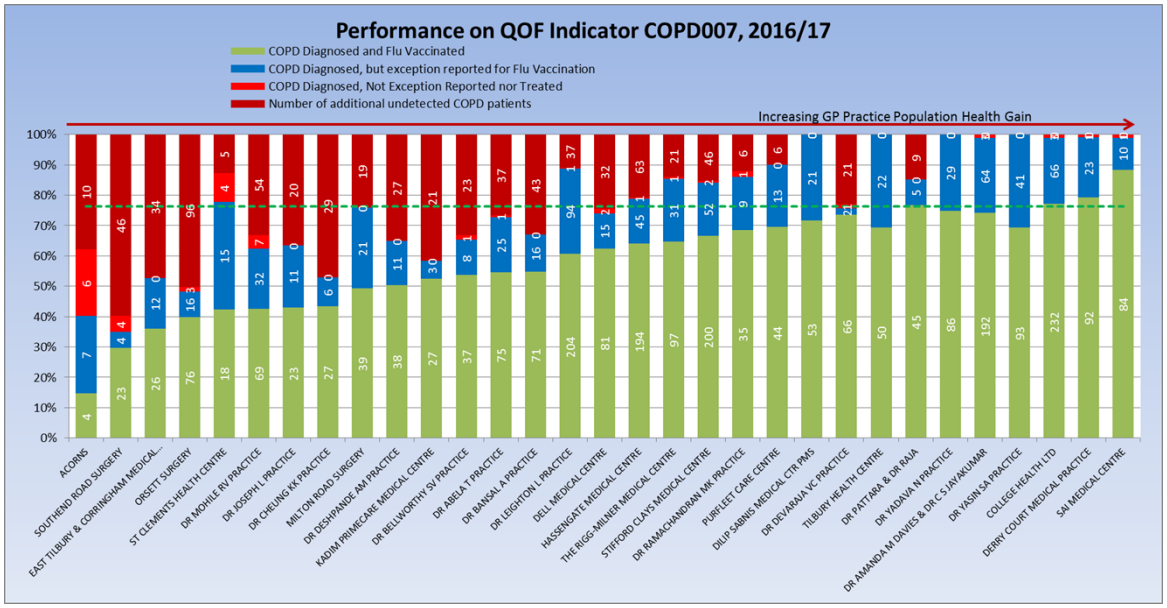


Figure 4 Performance on Depression Clinical Management, QOF Indicator DEP003

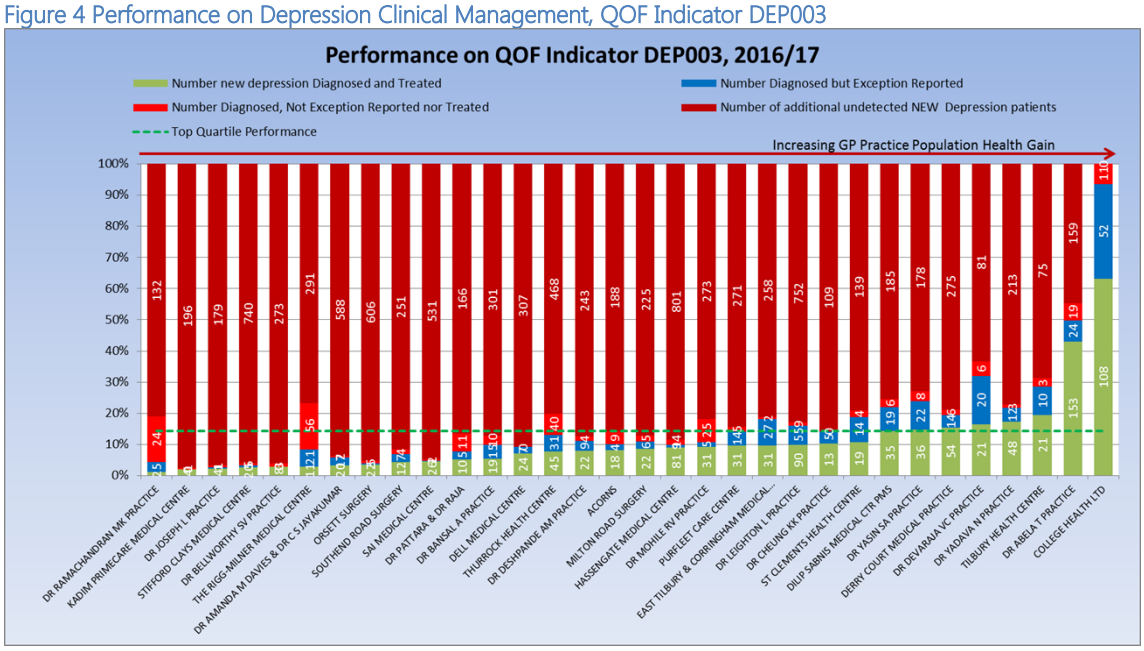


Figure 5 Performance on CHD Clinical Management, QOF Indicator CHD005

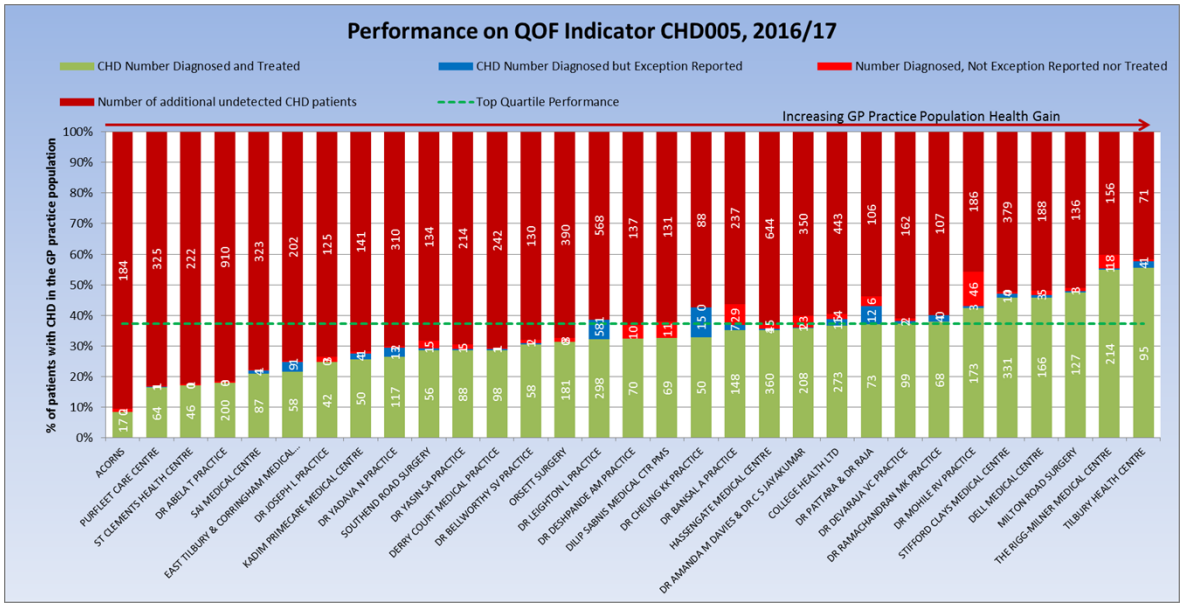


Figure 6 Performance on Stroke Clinical Management, QOF Indicator STIA003

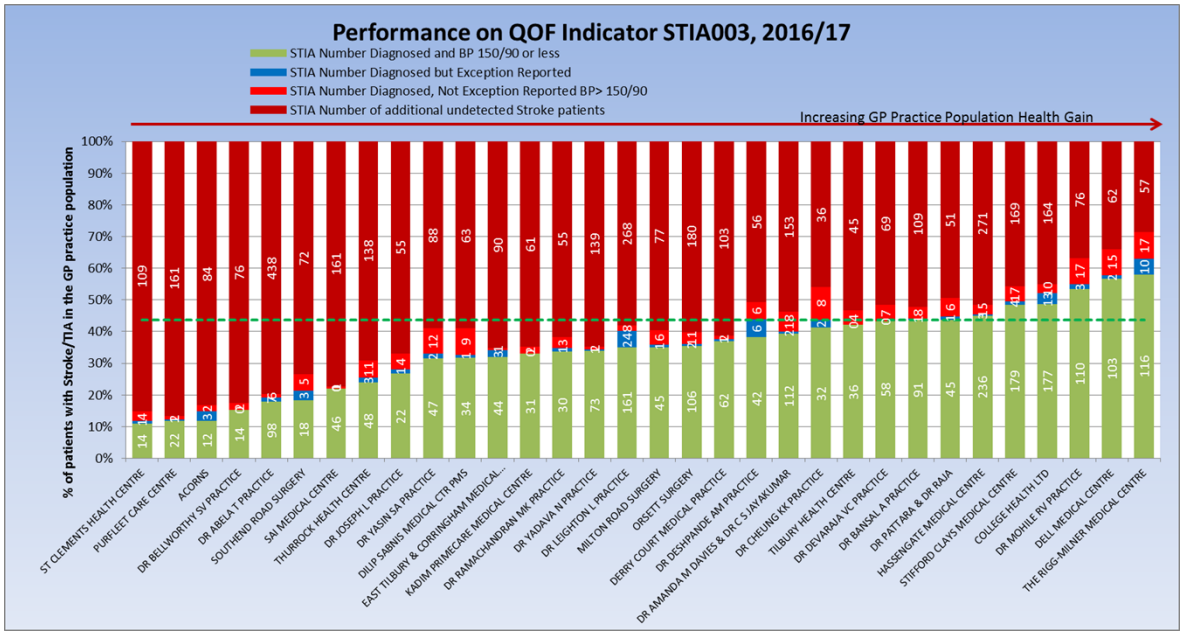
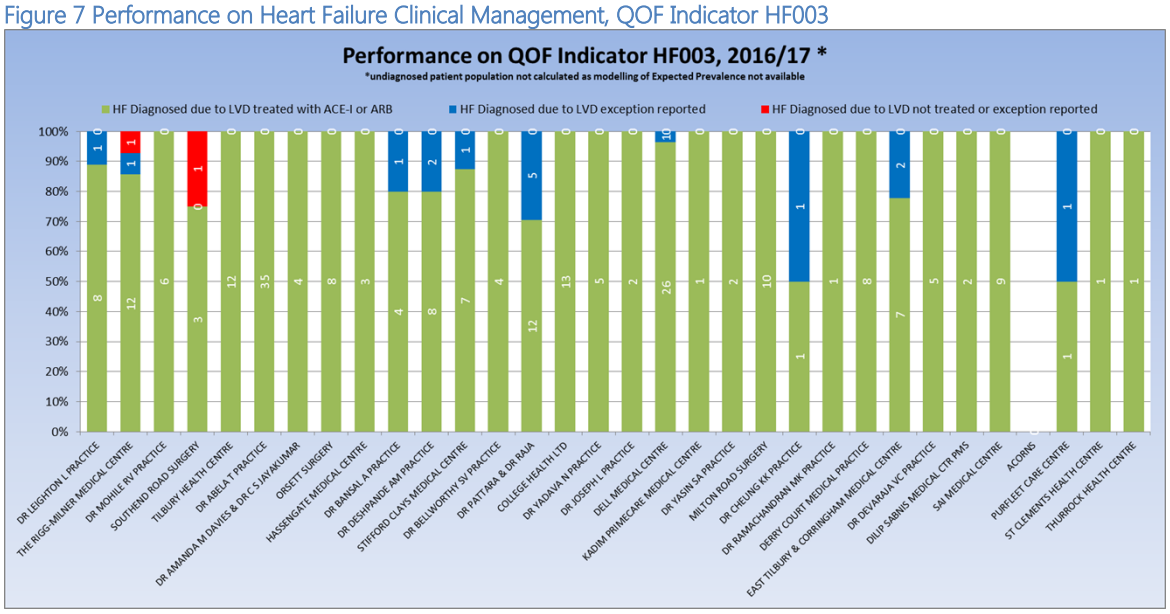


Figure 7 Performance on Heart Failure Clinical Management, QOF Indicator HF003



Appendix 2 – Example of LTC Profile Card