Friday 29th October 2021	ITEM: 7
Thurrock Health and Wellbeing Board	
GP Item Part Two. Improvements in primary care Long Term Condition management	
Wards and communities affected: All	**Key Decision:** None
Report of: Vikki Ray – Senior Programme Manager (Healthcare Public Health)	
Accountable Head of Service: Emma Sanford – Strategic Lead (Public Health and Social Care)	
Accountable Director: Jo Broadbent – Director of Public Health	
This report is Public	

Executive Summary

The report provides an outline of the Stretch QOF contract for 2021-22 which seeks to incentivise general practice to make improvements in both case finding and management of selected long term conditions and an update on the LTC profile card with relation to its content and proposed implementation steps.

1. Recommendation(s)

1.1 That the Health and Wellbeing Board note and comment upon the proposed developments in delivering improvements in long term condition management and a renewed LTC profile card.

2. Introduction and Background

2.1 The main objective of this programme is to improve population health and reduce inequalities through improved quality of LTC management in Primary Care. In this paper we detail the plans for the programme this 2021-22 and current thinking for major revisions for 2022-23 financial years.

3. Issues, Options and Analysis of Options

3.1 The Global Burden of Disease (GBD) study shows that the top five causes of early death for the people of England are: heart disease and stroke, cancer, respiratory conditions, dementias, and self-harm. It also reveals that the slower improvement since 2010 in years-of-life-lost is “mainly driven by distinct condition-specific trends, predominantly in cardiovascular diseases and some cancers”. Furthermore, it quantifies and ranks the contribution of various risk factors that cause premature deaths in England. The top five are:

smoking, poor diet, high blood pressure, obesity, and alcohol and drug use. These priorities have guided the NHS prevention programme as part of the NHS Long Term Plan.

3.2 The role of the NHS includes secondary prevention, by detecting disease early, preventing deterioration of health and reducing symptoms to improve quality of life.

3.3 Within Public Health we continue to develop programmes of work and support the NHS to move from reactive care towards a model embodying active population health management, and together with local authority colleagues and voluntary sector partners on the broader agenda of prevention and health inequalities.

3.4 The Annual Public Health Report (2016) quantified the effect that low levels of long term condition management were having on emergency care for specific indicators in Thurrock. Whilst the NHS GP contract 'QOF' (Quality Outcomes Framework) currently pays Practices based on the percentage of patients who receive specific, evidence based interventions and/or treatments, this is capped. The value at which it is capped is dependent upon the indicator. Mostly incentivisation happens for around 70-85% of patients receiving the intervention. Practices generally score around the level that they require for maximum payment. This either suggests that this is an "achievable" level or that Practices do not have the resources to obtain higher with no potential of funding, but has the effect of excluding 15-30% of the population and this excluded group can often include vulnerable groups and those experiencing multiple inequalities who have the greatest potential to benefit from improved quality of care.

3.5 As a result of this a Stretch QOF contract was launched in 2018 and has been reviewed/renewed annually since, incentivising practices to aspire to achieve above the maximum Quality and Outcomes Framework threshold for a subset of indicators. Diseases incentivised for management were informed by a number of long term conditions multiple regression analysis models developed by the Health Intelligence/Healthcare Public Health Team that identified and quantified the impact that significant QOF indicators had on the incidence of serious health events with a view to reducing emergency admissions to secondary care and preventing patients from having major health events, such as a Stroke. These have included Asthma, Hypertension, Atrial Fibrillation, Coronary Heart Disease, Stroke, Depression, COPD, Smoking and Diabetes. The indicators for 2021 – 22 are outlined below.

3.6 Stretch QOF 2021/22 Indicator Set

The indicators have been selected on the basis of the following:

- Public Health multiple regression analysis models indicated these indicators impacted on unplanned care admissions in Thurrock
- The indicator rationale has been nationally recognised as high impact (NICE guidance)
- Stretch QOF appears to be positively influencing general practice to complete the intervention at a rate greater than previously achieved without incentivisation
- Indicators that require a focused effort to address backlog/drop in performance attributable to the Covid pandemic
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3.7 Blood Pressure Management - Blood pressure is a comorbidity in over 70% of the Thurrock population with a long term condition and a significant risk factor for other cardiovascular diseases if undiagnosed or poorly managed. Due to capacity and the required operational running of general practice during COVID there was a reduction in those with a recorded or well managed blood pressure in the previous QOF year, making this a high priority area for focus.

This priority is complimented by the CCG's workstream 'BP at Home' which has supplied 243 BP machines to Primary Care to loan to the most clinically vulnerable/at risk patients to monitor their blood pressures at home.

Indicator	Description
CHD008	The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (NICE 2013 menu ID: NM68)
CHD009	The percentage of patients aged 80 years and over with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less (NICE 2019 menu ID: NM191)
HYP003	The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (NICE 2012 menu ID: NM53)
HYP007	The percentage of patients aged 80 years and over with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less (NICE 2012 menu ID: NM54)
STIA010	The percentage of patients aged 79 years or less with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or Less (NICE 2013 menu ID: NM69)
STIA011	The percentage of patients aged 80 years and over with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or Less (based on NM93)

3.8 Smoking - Smoking is noted as in the top five risk factors contributing to the burden of disease and continues to be the leading cause of premature and preventable death in England. It is also the largest single contributor to health inequalities, accounting for half the difference in life expectancy between those living in the most and least deprived communities. Case finding of smokers particularly in those with cardiovascular disease, respiratory disease and mental ill health is therefore a high priority. It also supports improving recording of smoking status for other programmes in the Thurrock system such as the Targeted Lung Health Check which would benefit from ensuring its full eligible cohort is identified given it invites both smokers and those who have ever smoked for a check.

Indicator	Description
SMOK002	The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (NICE 2011 menu ID: NM38)
SMOK005	The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 12 Months (NICE 2011 menu ID: NM39)

3.9 Case Finding/ Surveillance - Case finding remains crucial in identifying those requiring onward interventions to support good management of their condition. In 2021-22 we continue to incentivise blood pressure checks in those aged 45 and over to case find for hypertension. We also continue to support review of those with identified risk of developing a long term condition or those that are potentially developing greater risks as part of their existing conditions via non-diabetic hyperglycaemia blood testing and atrial fibrillation stroke risk assessments respectively.

Indicator	Description
BP002	The percentage of patients aged 45 or over who have a record of blood pressure in the preceding 5 years (based on NM61)
NDH001	The percentage of patients with non-diabetic hyperglycaemia who have had an HbA1c or fasting blood glucose performed in the preceding 12 months (NICE 2017 menu ID: NM150)
AF006	The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHA2DS2-VASc score risk stratification scoring system in the preceding 12 months (excluding those patients with a previous CHADS2 or CHA2DS2-VASc score of 2 or more) (NICE 2014 menu ID: NM81)

3.10 Quality Management

Ensuring patients newly-diagnosed with depression receive a timely review is crucial for supporting them with the most appropriate treatment regime.

Continuing to incentivise this indicator will also help the performance of other programmes of work to improve mental health in primary care, such as the new Depression Diagnosis Pathway which aims to ensure newly-diagnosed depression patients receive wellbeing calls and has a point of contact whilst waiting for this GP review to take place.

Indicator	Description
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 2014 menu ID: NM82)
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 (Based on NM50)

3.11 New Models of LTC care for the future and how stretched QOF will need to adapt

Thurrock's transformation programme includes looking at models of care for the future, this includes a new model for LTC care in the future (at least in advance of our Integrated Medical Centres becoming operational. Work to date suggests that the main problems we need to solve in designing a new model are:

1. Early detection – we still have many patients presenting in the acute setting due to Long Term Conditions that were not pre-diagnosed in Primary Care.
2. Joined up approaches – we have many patients who receive emergency care for a LTC, are not previously known to Primary Care, and data suggests that following the emergency care a large number do not get appropriately coded on a disease register in Primary Care. This means that we are losing the ability to identify and contact these individuals for any services or interventions we may need to offer to them to reduce their risks of further urgent care or even death. For example offering flu vaccinations or annual reviews. Furthermore, following a major health event individuals are often at their most motivated to make changes to their lifestyle, we could be missing windows of opportunity with these patients.
3. Improved management – There are still far too many individuals on Primary Care Long Term Condition registers whose Long Term conditions are not well managed e.g. Clinical biomarkers are not within recommended thresholds, annual reviews are not being done, patients identified as "at risk" are not being referred to appropriate evidence based interventions.

4. Holistic care – the data shows us that of all individuals who are on registers for Long Term Conditions, in excess of 40% of them have multi-morbidities. We still review these patients in terms of each condition rather than as a whole individual.
5. Lack of a pathway – currently there is no specific LTC pathway, individuals get referred to services in a non-co-ordinated and variable way.

3.12 A new model should aim to resolve these issues. We should look to have multi-disciplinary Long Term Condition specialists who support individuals in a holistic way to manage their condition. A pathway should take a patient through stages of removing barriers before working with them to make lifestyle changes that will better support their best possible health outcomes along with clinical interventions. Existing fragmented care needs to be more accessible, co-ordinated and joined up. Individuals / patients support package should be personalised to what works for them with sustainable self-care at the heart.

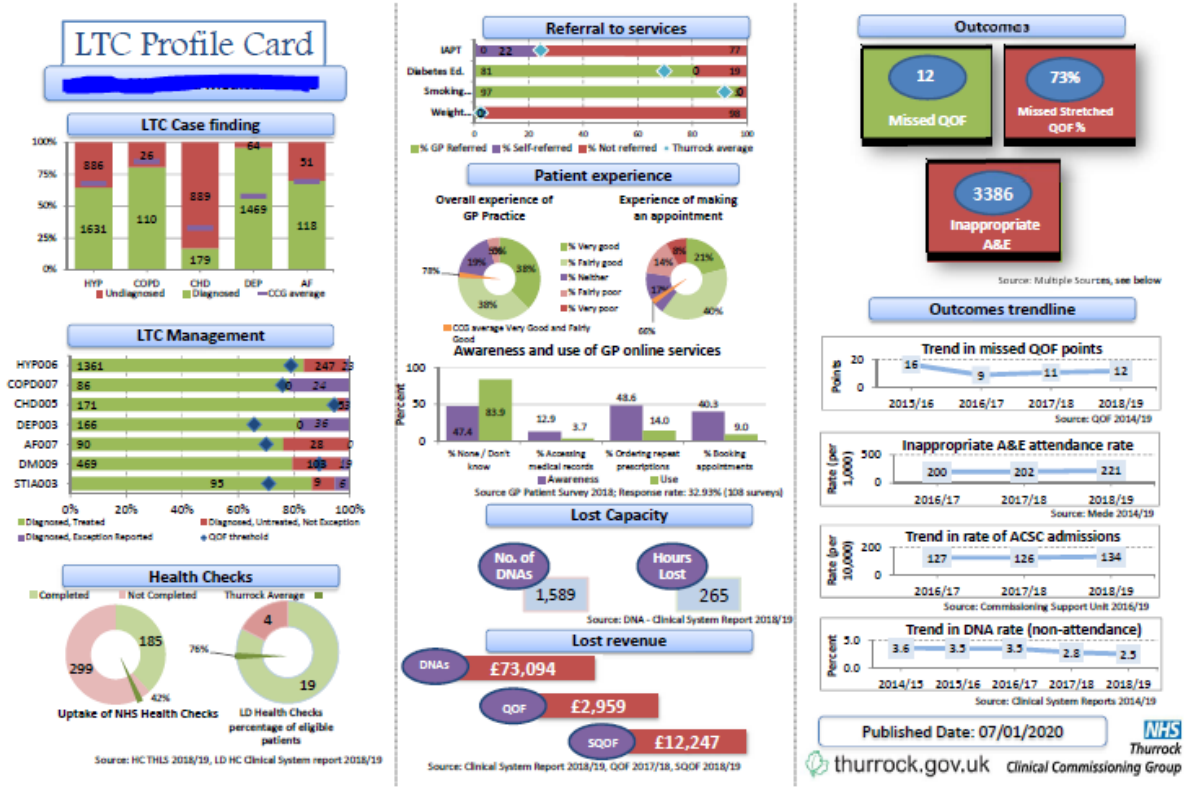
3.13 Alongside this our Stretched QOF programme will need to change, and we have started to think about these changes ready for the 2022/23 financial year. We will no longer top up individual condition indicators and look to move to incentivising a more holistic care approach which looks at individuals as a whole. We will look to bring Healthy Lifestyle contracts and the current stretched QOF contract together to do this. We will also move away from sole reliance on existing QOF indicators in favour of indicators that support this way of working (even if that means we have to generate/calculate our own). A name change will be inevitable.

3.14 The recent investment in Mental Health Primary Care practitioners has brought workers from EPUT into the PCNs so they can work closely with wider health professionals and Peer Workers from Thurrock & Brentwood MIND to improve the way mental health needs are identified and supported. The depression screening work previously described in former Health and Wellbeing Board papers will be re-invigorated in line with some work previously completed on identification of local population groups at most risk of unidentified mental ill-health, meaning it is more likely to find and treat individuals before they otherwise need more urgent care.

3.15 Long Term Condition Profile Card - The Long Term Condition (LTC) profile card was initially created by the Healthcare Public Health Improvement team in 2017 to respond to the high levels of variation within primary care across Thurrock in regards to the individual needs, available resources and overall quality of services.

3.16 Similar to a dashboard, the LTC profile card is a visual overview of each practice, focusing on the LTC case finding and management but also looks at the possible reasons why, such as lack of capacity, increased workload or lack of engagement from the practice population. Furthermore it makes links to secondary care outcomes.

Fig 1. Example LTC Profile card 2019/20

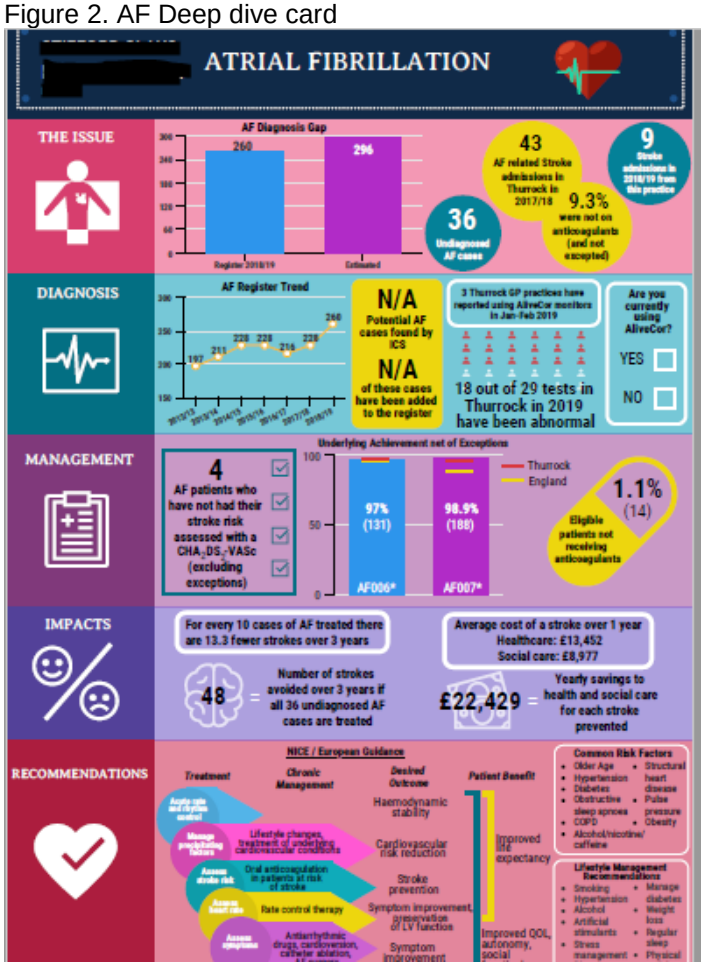


3.17 Development of the profile card for 2021 is underway and proposes the following amendments:

Section	Changes to note
LTC Case Finding	Addition of Obesity (BMI 30+)
LTC Management	Update to reflect Stretch QOF indicators for 2021-22 Visual aid of work to do (patient numbers spanning multiple indicators e.g. number of patients with 8 or more indicators still outstanding)
Outcomes Trendline	Addition of attendance rate for high users (frequent flyers)

3.18 In addition to the LTC Profile card, from 2019 the Healthcare Public Health and Intelligence Teams have been developing some ‘deep dive’ profile cards into particular areas of focus such as Atrial Fibrillation and Mental Health.

Figure 2. AF Deep dive card



3.19 For 2021 Healthcare Public Health are working with Macmillan and wider Cancer stakeholders to develop a deep dive into Cancer care which will support practices and more collectively the Primary Care Networks (PCNs) to work on improvements in early detection and diagnosis as part of their PCN directly enhanced service with NHS England.

3.20 Delivery of the LTC profile card work is not only through sharing the profile card with each practice, but includes visits to the practice, discussions with the practice managers, the GP leads and wider clinical team. It aids identification of agreed priorities and development of individualised action plans for each practice.

3.21 For 2021-22 visits with the refreshed profile cards will be scheduled for late October/early November to discuss progress to date, areas of focus and required support up to March 2022. Some of these will be done via PCN meetings as appropriate, however individual practice visits will still happen if any of the following is true:

1. There is something specific to the practice that needs to be discussed
2. A practice specifically requests

3. A PCN requests that we visit all or some individual practices
4. The CCGs primary care team identifies a practice as being poor in terms of patient satisfaction or quality of care (including CQC reports)

3.22 For the 2022/23 financial year the profile card will need to change in line with the Stretched QOF programme.

4. Reasons for Recommendation

4.1 The Thurrock transformation piece, Stretch QOF and the Long Term Condition profile card form are key programmes of work in improving standards in Primary Care across Thurrock; one of the key public health priorities.

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

5.1 Public Health Leadership team, Thurrock CCG and clinical leads from Primary Care Networks have been consulted on proposals.

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

6.1 This work dovetails with Thurrock Councils corporate priority under people and the proposed Domains 1 and 2 ‘Quality Care centred around the person’ and ‘Healthier for longer’ under the Joint Health and Wellbeing Strategy. The work seeks to address unmet physical and mental health needs and the development of an integrated health and care system that prevents and/or reduces need for health and care services.

7. Implications

7.1 Financial

Implications verified by: Not provided

This will be met within existing agreed budgets across the Public Health Grant and the Better Care Fund.

7.2 Legal

Implications verified by: Not provided

The Stretch QOF contract is commissioned to and delivered by GP practices as it is an enhancement of their existing NHS Quality and Outcomes Framework contract.

7.3 **Diversity and Equality**

Implications verified by: Not provided

This programme of work seeks to improve quality in management of long term conditions and reduce variation in management across patients within GP practices but also to reduce the gap in variation across all practices in Thurrock and therefore supports tackling inequalities.

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

Not Applicable

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):
Not Applicable

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