Health and Wellbeing Strategy Reporting Template
Goal 5: Healthier for longer

Objective 5C: The identification and early treatment of long term conditions such as diabetes or high blood pressure will be significantly improved

Goal Sponsor: Director of Public Health - Ian Wake
Objective Lead: Emma Sanford / Mark Tebbs

Health and Wellbeing Strategy Action Plan

OBJECTIVE: 5C Significantly improve the identification and management of long term conditions					**OBJECTIVE LEAD: Emma Sanford / Mark Tebbs**	
Action	**Outcome**	**Action lead**	**Link to outcome framework**	**Delivery Date**	**Progress Report**	**Reference to existing strategy or plan**
A. Hypertension Detection programme : Obtain QIPP sign off for GP	Obtaining sign off for the hypertension detection programme will support increased detection of hypertension and therefore reduce admission rates for avoidable conditions.	Emma Sanford / Maria Payne/ Mark Tebbs	**Outcome Framework indicator 2: Unplanned care admission rate for conditions amenable to healthcare.**	August 2016	Completed. Presented in QIPP meeting-Funds awarded by ICE endorsed	BCF ICE paper – avoidable stroke admissions Public Health Operational Plan
B. Hypertension Detection programme : Develop mobilisation and communication plan	Developing a mobilisation plan for the hypertension detection programme will support increased detection of hypertension and therefore reduce admission rates for avoidable conditions.	Emma Sanford / Monica Scrobotovici/ Mark Tebbs	**Outcome Framework indicator 2: Unplanned care admission rate for conditions amenable to healthcare.**	March 2017 for use of local pharmacies March 2017 for risk stratification	The programme will be piloted in Tilbury and replicated in the whole CCG if proven effective. Mobilisation plan includes 2 streams: pharmacy and risk stratification. Draft specifications file for	

				stream	pharmacies created and will be shared with CCG and partners for input.	
C. Hypertension Detection programme : Deliver and monitor	Delivering the hypertension detection programme will support increased detection of hypertension and therefore reduce admission rates for avoidable conditions.	Emma Sanford / Monica Scrobotovici/ Mark Tebbs	**Outcome Framework indicator 2: Unplanned care admission rate for conditions amenable to healthcare.**	April 2017 onwards	The delivery date was amended to begin in April and continue for a year.	
D. Hypertension Detection programme : Evaluate	Evaluating the hypertension detection programme will aid understanding of what works and better areas for development, thereby supporting increased detection of hypertension and therefore reduce admission rates for avoidable conditions.	Emma Sanford / Monica Scrobotovici/ Mark Tebbs	**Outcome Framework indicator 2: Unplanned care admission rate for conditions amenable to healthcare.**	Quarterly		
E. Hypertension Detection programme: Explore opportunities to use Community hubs as an access point for screening and GP visit.	Delivering this aspect of the hypertension detection programme will support increased detection of hypertension and therefore reduce admission rates for avoidable conditions.	Emma Sanford/Monica Scrobotovici/Jo Pitt	**Outcome Framework indicator 2: Unplanned care admission rate for conditions amenable to healthcare.**	March2017	Met with Kristina Jackson, CEO of Thurrock CVS and discussed possible collaboration ideas to be looked at in more detail. Further lines may be added when these have been further investigated.	
F. Health Checks: Research possibilities to improve targeting of	Knowledge of how we can potentially improve the service to identify and manage more patients with Long Term Conditions. Better targeting of patients and	Emma Sanford / Maria Payne	**Outcome Framework indicator 2: Unplanned care admission rate for**	Start April 2017	This has been downgraded from a detailed equity audit due to time constraints. We feel that we can make recommendations and have	BCF ICE paper – avoidable stroke admissions

Health Checks, including how we target patients and outcomes.	identifying conditions earlier should prevent admissions for avoidable conditions.		**conditions amenable to healthcare.**		the same impact with a smaller piece of research.	Public Health Operational Plan
G. Senior Health Checks: Research literature and evidence around delivery of senior health checks	Inform us of the validity of considering delivery in Thurrock as a means for identifying patients with Long Term Conditions. Researching this option will give us better understanding of the impact this might have on earlier identification of patients with long term conditions, thereby preventing admissions for avoidable conditions.	Emma Sanford / Maria Payne	**Outcome Framework indicator 2: Unplanned care admission rate for conditions amenable to healthcare.**	April 2017	NELFT library services could not find a large amount of evidence to support or not this. We will now look at local/neighbouring pilots to evaluate the effectiveness and weigh up whether it would be best for us to : a) Implement in Thurrock b) Use Medication reviews in this population more effectively c) Target our resource at the older sub-group of the Health Checks age group.	BCF ICE paper – avoidable stroke admissions Public Health Operational Plan
H. Develop LTC Scorecard: Create benchmark group for each GP practice	The development of a benchmark group will allow to better analyse case finding and management performance and identify individualised practice needs.	Monica Scrobotovici	**Outcome Framework indicator 2: Unplanned care admission rate for conditions amenable to healthcare** **Outcome Framework indicator 1: Mean score on an agreed GP**	January 2017	Completed Benchmark groups of 20 similar practices created. This is to lead into the scorecard work.	

			practice-based LTC management scorecard.			
I. Develop LTC Balance Scorecard: Method and Design	Systematically identify variation in identification and management of patients with Long Term Conditions with a view to improve this in the worst performing areas. Developing the scorecard would enable scores to be developed, thereby supporting identification of variation and enabling targeted work to be done with a view to prevent admissions for avoidable conditions.	Emma Sanford / Monica Scrobotovici	**Outcome Framework indicator 1: Mean score on an agreed GP practice-based LTC management scorecard.**	February2017	Key Indicators selected. Design template created. We are currently investigating software that will make the production of this more automated before roll out. Suggested template has been shared with practice managers and the response was positive.	Public Health Operational Plan
J. Develop LTC Balance Scorecard: Deliver and Monitor	The delivery of the Scorecard will include one-on-one discussions with GP practices' staff to enable them to interpret correctly and draw useful conclusions from it.	Monica Scrobotovici/Jo Pitt	**Outcome Framework indicator 1: Mean score on an agreed GP practice-based LTC management scorecard.**	March 2017		
K. Development of other hypertension detection Pilots including feasibility of: 1) Self-testing/testing in the community	The hypertension detection programme will support increased detection of hypertension and therefore reduce admission rates for avoidable conditions.	Emma Sanford/Maria Payne/Monica Scrobotovici/Jo Pitt	**Outcome Framework indicator 2: Unplanned care admission rate for conditions amenable to healthcare.**		April 2017 Time frames to be added to action plan when these have been scoped	

2) Health checks recommendations 3) Use of non-clinical staff in the GP office						
L. Development of other LTC care improvement plans.	The baseline scorecard findings will support identification of variation and enable targeted work to be done with a view to prevent admissions for avoidable conditions.	Emma Sanford/Maria Payne/Monica Scrobotovici/Jo Pitt	**Outcome Framework Indicator 1: Mean score on an agreed GP practice-based LTC management scorecard.** **Outcome Framework indicator 2: Unplanned care admission rate for conditions amenable to healthcare.**		April 2017 Scoping work and timeframes to be agreed once balance scorecards are available	
M. Recruitment of 2 Healthcare Public Health Improvement Managers	The recruitment of 2 full time roles to serve as a liaison between the public health department and primary care will facilitate the communication between the two and will improve the delivery of long term conditions agenda.	Emma Sanford		November 2016	Completed. Many of the projects above are now being worked on by these posts.	

Outcome Framework

Objective	**5C: Significantly improve the identification and management of long term conditions.**							
Indicators	**2016 Baseline**	**2017**	**2018**	**2019**	**2020**	**2021 Target**	**Data Source**	**Reporting Timescales**
Outcome Framework Indicator 1 **Mean score on an agreed GP practice-based LTC management scorecard.**								
This is a new indicator and no baseline data exists for this as yet. However plans are in place to produce this scorecard on a monthly basis from December 2016. It is proposed that two indicators on the scorecard will become future indicators for this objective: **These proposals were made pre-development of scorecard. We intend to re-visit these and make a recommendation by end of March.** 1) % of diabetes patients that have achieved all three of the NICE recommended treatment targets [Adults: HbA1C<=55mmol/mol (7.5%), Cholesterol <5mmol/L and BP <=140/80mmHg. Children: HbA1c <=58mmol/mol (7.5%)] 2) Absolute gradient of the relationship at LSOA level between unplanned hospitalisation for chronic ambulatory care sensitive conditions per 100,000 population and deprivation measured by the IMD 2015 score.								

Indicators	2016 Baseline	2017	2018	2019	2020	2021 Target	Data Source	Reporting Timescales
Outcome Framework Indicator 2 **Unplanned care admission rate for conditions amenable to healthcare.** This quantifies the rate of emergency admissions for conditions that could have been avoided if good quality healthcare had been in place. These are defined using a standard list of ICD-10 codes provided by the ONS. Rates are shown by 100,000 population.	**1940.6** (2015)	1931.7	1922.76	1913.84	1904.92	**1896 [draft target]**		