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<tr><td colspan="2">14 November 2018</td><td>ITEM: 10
Decision: 110484</td></tr>
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<tr><td colspan="3">Further Transformation to Continue Improving Standards in Primary Care</td></tr>
<tr><td>Wards and communities affected:
All</td><td colspan="2">Key Decision:
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Executive Summary

This paper provides an update to Cabinet on the Long Term Condition Case Finding and Management Programme led by Public Health as part of a systematic programme of Primary Care Transformation.

The Annual Public Health Report 2016 identified significant cohorts of patients with undiagnosed long term conditions and unacceptable variation in the clinical management of patients between different GP practice cohorts once their long term conditions had been diagnosed. The report concluded that addressing these two issues would both deliver significant population health gain and save our local health and care system millions of pounds.

A paper approved by Cabinet in December 2017 set out a strategic response to the recommendations made in the APHR 2016, including a range of systematic programmes to improve the diagnosis and management of Long Term Conditions.

This paper provides an update to Cabinet on progress against this programme and seeks Cabinet endorsement for continuation of the programme.

Recommendations

1. **That Cabinet approves progress, changes and additions to the programme of performance and improvement and support for primary care with linked demand management for hospital and adult social care services, as detailed within the paper.**

2. **That Cabinet approves the continuation of funding for this programme throughout the financial years 2019/20 and 2020/21, and then reviews its impact.**

1 Introduction and Background

1.1. This report details the on-going programme of transformation work within GP surgeries in Thurrock, to improve diagnosis and management of patients with long term conditions.

1.2. Thurrock is served by 29 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 to drive up quality and strengthen clinical governance within individual surgeries. The team has played a crucial role in improving Care Quality Commission (CQC) ratings of our surgeries and is also responsible for setting the strategic commissioning agenda with NHS England to 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. Due to the positive reception by local GP surgeries to these posts and because of the size of the Work Plan, a decision was made in 2017 to add a third post to this team.

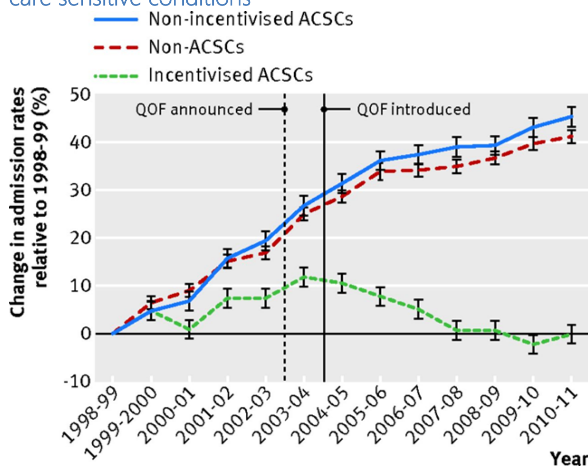
1.3. In 1948 when the NHS was founded, almost half of the population died before their 65th birthday. In 2015 this figure dropped to 18%. However, although living longer, our population is increasingly doing so with multiple long term health conditions. Spend on patients with long-term conditions accounts 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.

1.4. The Quality Outcomes Framework (QOF) records quality of care information on how patients who are diagnosed with long term health conditions are clinically managed by GP surgery based clinicians. It is based on a series of clinical indicators grouped around specific long term health conditions. QOF was set up as a financial incentive system and GP practices get paid for the percentage of their cohorts of patients with specific long term health conditions to whom they offer certain tests, medication reviews and clinical interventions. The indicators are based on published evidence of best quality of care for the

conditions included within QOF, including National Institute of Health and Care Excellence (NICE) recommendations.

1.5. 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). As such, a GP Practice's performance against QOF can be used as an excellent proxy for the quality of care that patients with Long Term Conditions receive.

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



1.6. 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.

1.7. 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)	Estimated 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]

2 Summary from December 2017 Cabinet Report

2.1. In December 2017 a report was presented to the Cabinet which outlined the new strategic approach to improving the diagnosis and management of patients with long term health conditions in primary care.

2.2. The approach set out in the Cabinet Report was developed jointly with our NHS partners and has received Regional and National recognition and commended by the Chief Executive of Public Health England.

2.3. The Cabinet Report committed to a number of actions which fall into two broad categories;

1. Improved diagnosis of patients with long term conditions and
2. Improved management of those patients once they are diagnosed.

A number of data sets were displayed which summarised the 2016/17 position. Unfortunately at the time of writing this report that data has not yet been refreshed, and as such it is not yet possible to ascertain the impact of work over the last 12 months on improving the diagnosis and clinical management of patients with long term health conditions. The 2017/18 QOF data is due to be published by NHS Digital by November 2018.

2.4. Specifically, the 2017 Cabinet Report committed to the following actions as part of a systematic programme of Primary Care Transformation:

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

- Introduction of blood pressure monitoring machines in GP surgery waiting areas as a further mechanism to diagnose potential hypertension (high blood pressure).

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

- Providing additional funding to GP surgeries to treat all patients eligible for clinical interventions under QOF through introduction of a local "Stretched QOF" contract. (The national QOF contract only provides funding for GP surgeries to treat 70% of all eligible patients with long term conditions).

- 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 and resources to GP 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 GP Practice Managers and clinicians to quickly identify cohorts of inadequately managed patients with Long Term Conditions who are at risk of serious health events such as heart attacks or strokes, such that they can be invited into the surgery for review and treatment.

- Commissioning of IT solution focussed approaches to "case finding" patients with long term health conditions who may not be on QOF disease registers and will therefore not be receiving all NICE recommended clinical interventions to manage their condition. For example, identifying patients who are being prescribed an anti-hypertensive medication or who may have a series of high blood pressure readings recorded, but who are not currently included on the surgery's Hypertension (high blood pressure) QOF Disease Register and therefore are not being clinically managed systematically.

2.5. The Cabinet report also detailed the development of an individual practice based long term conditions profile card that benchmarked individual surgery performance on a range of indicators relating to access and long term conditions case finding and management against the 20 GP surgeries in England with the most similar practice populations. The report proposed a programme of quality improvement meetings between Public Health Staff and individual surgery clinicians and development of surgery based action plans based on data contained within each profile card.

3 Progress, achievements and changes

3.1. Long Term Conditions Programme Board has been established to manage the complex set of programmes set out below, as part of *The Better Care Together Thurrock* programme of transformation. The Board is chaired by the Director of Public Health and has senior representatives on it from Public Health, Adult Social Care, NHS Thurrock CCG, Inclusion Thurrock, North East London Foundation Trust and Local Primary Care Providers.

GP practice Profile Cards and Practice Visits Programme

3.2. Following feedback from practices, the primary care team and internal discussions the original benchmark grouping has been removed from the long term condition profile card in favour of comparing achievements to a Thurrock average. It is expected that this will encourage more internal competition and remove confounding factor of differently commissioned services when comparing to external organisations.

3.3. The Healthcare Public Health Team have also removed the capacity indicators that look at the number of GPs and Nurses per head of population to reflect the move away from a traditional staffing model in primary care and towards a more mixed-skill clinical workforce that will include Physiotherapists, Physicians Associates, Paramedics, Practice Based Pharmacists and a range of professionals to address mental ill-health including psychiatric nurses and social prescribers. A new indicator that details the number of appointments available to patients within the Mixed Skill Workforce model will be introduced. Other changes to the card include performance against the new “Stretched QOF” local contract. An example of the new format is given in appendix A.

3.4. As of 30 September 2018, 85% of GP Surgeries in Thurrock will have received a Profile Card Visit from specialist Healthcare Public Health Staff to discuss their individual Practice Profile Card and develop and agree an improvement action plan based on the data held within it. By 30 April 2019 this will be 93%.

3.5. During the second year of delivery, improvements have also been made to the profile card visit programme**.** There will now be two rather than one scheduled visits per year. These will happen shortly after practices have submitted QOF data at the end of the financial year and then again six months later. The visits will now take place during practice meetings in order that the data and possibilities for improvement can be discussed with the entire practice rather than the practice manager and/or lead clinician. At the end of a visit a list of priorities for the practice to work on will be agreed between the Health Care Public Health Improvement Manager and the practice. These priorities will be followed up and integrated into a programme of on-going support between Public Health and the individual GP practice as appropriate between visits.

3.6. The visits following the revised format so far have been received extremely well and the Healthcare Public Health Team have received a significant level of positive feedback. Specific feedback on the profile card and associated GP Practice visits has included the following:

> ***"****gives practices an element of competition"; "helps with our CQC inspection"; "really like outcome trend and inappropriate admissions to hospital"; "shows how we are doing with peaks and troughs"; "it will be great when we get real time data with Mede-Analytics"; "the new card has a much better format"; "very useful to compare to previous year"; "gives us motivation"; "shows we are not wasting our time".*

3.7. Common themes or issues have been identified across Thurrock as a result of profile card visits, and action has been taken to address these for all Thurrock GP surgeries. Examples include the following:

- Issues with the coding of depression on GP Clinical Databases and confusion amongst GP practices relating to when/if a patient should be removed from the QOF register if they do not attend future appointments. **Action:** Public Health are currently assessing the clinical "Read Codes" used (depression or low mood) and developing guidance for practices so all are "read coding" appropriately.

- The need for spirometer[1] training for practice staff which meets the requirement of the new guidance. **Action:** An audit of training was conducted in July to identify need and current practice that identified a significant amount of non-compliance with the new 2020 Guidance. Public Health are working with the NHS Thurrock CCG to develop a new training programme for GP practices to ensure future compliance.

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[1] A Spirometer is a device used to measure the volume of air inspired and expired by the lungs. It is used in the diagnosis and management of respiratory conditions for example Chronic Obstructive Pulmonary Disease (COPD)

- Support practices to reduce number of DNAs (“Did Not Attend” i.e. missed GP appointments). **Action:** Public Health have developed a DNA poster to support practices in relaying the effects of missed appointments to patients. A new text messaging service to remind patients of forthcoming appointments has also been commissioned.

- Need to increase access to healthy lifestyle services. **Action**: Public Health have arranged for weight management classes to be offered at GP surgeries and have commissioned a new IT system that allows direct referral of patients from GP Clinical Systems into our lifestyle modification programmes.

3.8. The visits have also resulted in the easier implementation of programmes in practices, such as stretched QOF, the Flu Vaccination improvement programme, and the detection of hypertension in waiting areas. Practices are generally much more engaged with the Healthcare Public Health team and regularly come to us with ideas as well as issues they are having.

Improving the Diagnosis of Patients with Undiagnosed Long Term Health Conditions

3.9. The NHS Health Check programme offers a free cardio-vascular, mental health and lifestyle risk assessment to all eligible patients aged 40-64 once every five years. As such, the NHS Health Check Programme is the single most important mechanism for case-finding of patients with undiagnosed long term conditions. There has been significant progress towards targeting NHS Checks to those most at risk.

3.10. An integrated IT system that will sit in parallel to the practices’ clinical systems is being implemented to deliver the main administrative elements of health check provision. This will include call/recall of eligible patients; identification and targeting of higher risk patients based on their existing known clinical bio-markers such as age, smoking status, and existing blood pressure history; fully interactive recording of information gathered during the health check into the patient’s clinical record and; direct referral of patients into lifestyle modification programmes. Roll out will take place over the next three months with full coverage achieved by the end of November 2018.

3.11. One of the main aims of this project is to identify those who have high risk factors, e.g. BMI ≥30, smoker, etc., with targeted invites, clear referral pathways into interventions to improve lifestyle factors and reduce future risk, and referrals back into practices to identify and treat with early diagnosis. Uptake

will be increased by priming texts, to make patients aware of invite letters, and follow up calls to book directly into convenient and next available clinics.

3.12. A workplace programme of offer and provision of health checks to employees of local Thurrock businesses is currently underway, along with engagement with voluntary groups and local forums, faith groups, and work with some practices to target patients from BME groups. A programme of wellbeing clinics have also been scheduled with Thurrock MIND offering the NHS health check to eligible service users, carers and volunteers which is due to start end of August 2018. These will run, initially once a month but will be reviewed depending on demand.

3.13. As part of a comprehensive Communications Strategy for Public Health, a recent Council Twitter and Facebook posts advertising health checks produced the highest 'click through' with subsequent follow up calls into the council's Lifestyle Modification Services Single Point of Access to book appointments. This will be repeated throughout the year with further provision of health checks to Council staff. Health Check advertising is also planned within all Thurrock libraries and Community Hubs, with staff trained in MECC to include the offer of health checks. Promotional events are used, where appropriate/possible to offer blood pressure and BMI checks to initiate health check offers to those eligible, with immediate booking of appointments where possible.

3.14. Public Health have commissioned **Interface Clinical Services (ICS),** to undertake a comprehensive screening of data held of GP Clinical Systems as a way of improving long term conditions case finding.

3.15. The programme aimed to identify patients with entries in the medical records that indicate that they may have an existing long term health condition, but who are not currently on a Long Term Condition QOF register and so are not currently clinically managed systematically under QOF.

3.16. All practices in Thurrock will be offered the service in 2018/19. To date, 17 of the 29 practices have participated in the programme.

3.17. To date 8459 people have been identified for further investigation to consider adding them to Disease registers. This includes:

Long Term Condition	Patients Identified
Hypertension	328
Atrial Fibrillation	294
Coronary Heart Disease	240
Heart Failure	183
Strokes	333
Diabetes	433
Asthma	398
COPD	233
Chronic Kidney Disease	1890
Depression	888
Cancer	519

3.18. Assuming a 70% conversion rate (percentage of highlighted patients that have their diagnosis confirmed) the programme will introduce an existing £160,000 of national resource into our local Primary Care economy under the QOF contract that GP surgeries hold with Department of Health. Furthermore, there are associated savings and population health gain that will result through better clinical management of long term condition patients identified and being added to QOF registers. For example, Public Health estimates that the programme will result in an estimated 24 Strokes being avoided over the next three years and an estimated associated treatment cost saving of £190,000.

3.19. An impact report from ICS will follow around October/November to report on the conversion of findings to disease register sizes. Public Health will then look to populate our existing regression models with the results to estimate the health impact of this case finding on hospital admissions and adverse health events e.g. strokes. Furthermore, we will look to quantify the accurate savings to the local health and care economy the ICS has yielded.

3.20. A comprehensive programme of Hypertension (high blood pressure) monitoring in community settings is also being implemented. The Community Hub Hypertension detection programme has been put in place as a means of better reaching those at risk in the community who do not readily access primary care. National evidence also suggests that screening for high blood pressure within community settings reduces “white-coat effect” – a well-established phenomenon whereby false high blood pressure readings result when taken in clinical settings due to the stress that some individuals experience from having their blood pressure monitored by a clinician. Conversely published evidence suggests that residents are more likely to feel more at ease if their blood pressure is monitored in a community setting where they come to relax and interact.

3.21. Five out of the six Community Hubs across Thurrock (excluding Aveley Community Hub), have been equipped with self-testing blood pressure machines. 18 volunteers have been trained across the five functioning hubs to support residents who wish to self-check their blood pressure, with at least two volunteers trained in each hub. The programme has been running since August 2018 and a contract is in place between the council and The Council for Voluntary Services to deliver 600 blood pressure screens over the next 12 months.

3.22. The detection of Hypertension in GP Surgeries programme commenced in February 2018 in three surgeries in Tilbury, with four additional surgeries being added in May of 2018. The programme has sited self-testing blood pressure monitoring machines in GP surgery waiting areas and patients are encouraged to use them to take a blood pressure reading which is then handed to clinicians during their consultation. As of the start of September 2018, 743 checks have been completed, resulting in 52 additional patients being identified as having high blood pressure.

3.23. All GP surgeries in Thurrock are also being financially incentivised through the stretched QOF project - to work towards a 10% increase in the number of patients diagnosed with hypertension.

3.24. A further seven practices across Thurrock that have the highest gaps in the number of people expected to have hypertension, according to the Public health England estimates, have been identified and have agreed to take part in this programme. They will be equipped with waiting area Blood Pressure Machines imminently. It is expected that activity will commence in the identified practices mid - October 2018 onwards, following discussions and agreement of SLAs.

3.25. As a result of the hypertension case finding programme, a total of 833 patients have had a blood pressure check, 337 new cases of hypertension have been diagnosed across the 9 GP surgeries equipped with a waiting area blood pressure machine since March 2018 (new cases on QOF register since March 2018).

Improving the Clinical Management of Patients with Long Term Conditions

3.26. In order to improve the diagnosis and management of Cardio-Vascular Disease, the Public Health team agreed to fund a CVD upskilling programme.

3.27. The Public Health team have invested in a Cardiology Up-skilling Programme for front-line primary care professionals. This programme is accredited by the Royal College of General Practitioners (RCGP) and has been delivered within

other CCGs previously. It consists of 6 training modules, which are being delivered between July 2018 – February 2019, and a final exam. Feedback from attendees at modules run to date indicates that they found the training to be useful and would recommend it to others.

3.28. The 6 modules will cover:
- Heart Failure
- Atrial Fibrillation
- Stable CAD and CV risk assessment and prevention
- Valve disease
- Improving CV outcomes in Type 2 Diabetes
- ECG and Echo report interpretation

3.29. It is anticipated that this training will contribute towards:
- Increased confidence in diagnoses of CVD conditions
- Improved CVD management
- Reduced variation in CVD skills and knowledge amongst practice staff.

3.30. When this training was delivered in Leicester City CCG, a number of positive impacts on clinical outcomes were demonstrated including:
- A 12.5% increase in detected Atrial Fibrillation patients
- A 17.5% reduction in exception reporting of Atrial Fibrillation patients
- 16.5% more high-risk Atrial Fibrillation patients who were then anti-coagulated, leading to a theorised 5.1% reduction in emergency admissions for Stroke
- An increased number of Heart Failure patients with optimised treatment, leading to a theorised 4.1% reduction in emergency admissions for Heart Failure

3.31. In Thurrock 34 clinicians across 23 of the 29 practices will be taking part in the course with 23 intending to sit the final exam. Feedback from modules so far show that all participants would recommend this training to their colleagues with one quoting 'All GP's in Thurrock should hear this'.

3.32. As this training programme is one of several initiatives underway to improve detection and management of long term conditions in Thurrock, it will be difficult to solely attribute such outcomes to this course alone; however the evaluation of the programme planned for March 2019 will aim to demonstrate the effectiveness of the training once it has been completed.

3.33. Complex modelling for the local Stretched QOF contract between Public Health and GP Surgeries has now been completed, and an associated contract developed and signed between the council and majority of GP surgeries in

Thurrock. This provides additional financial incentive and resources for practices to treat 100% of patients eligible for clinical interventions to better manage long term conditions as opposed to the 70% that are funded under the national Department of Health QOF Contract.

3.34. The purpose of this project being to incentivise practices to perform above the maximum 70% national threshold, putting more investment into primary care with a view to improving outcomes for patients and reduce or delay the demand of both expensive hospital acute and adult social care. The scheme is joint funded from the Public Health Grant and the Better Care Fund.

3.35. Diseases incentivised for management were informed partly by 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 serious health events. These include Asthma, Hypertension, Atrial Fibrillation, Coronary Heart Disease, Stroke, Depression, COPD and Diabetes based on the following indicators:

Indicator	Criteria
AST002	The percentage of patients aged 8 or over with asthma (diagnosed on or after 1 April 2006), on the register, with measures of variability or reversibility recorded between 3 months before or any time after diagnosis
AST003	The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions
AST004	The percentage of patients with asthma aged 14 or over and who have not attained the age of 20, on the register, in whom there is a record of smoking status in the preceding 12 months
HYP001	Observed patients on the Hypertension Register/ Expected Hypertension prevalence
BP002	The percentage of patients aged 45 or over who have a record of blood pressure in the preceding 5 years
HYP006	The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less
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)
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
CHD002	The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less
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
CHD007	The percentage of patients with coronary heart disease who have had influenza immunisation in the preceding 1 August to 31 March
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 150/90 mmHg or less
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
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 12 months
COPD005	The percentage of patients with COPD and Medical Research Council dyspnoea grade ≥3 at any time in the preceding 12 months, with a record of oxygen saturation value within the preceding 12 months
COPD007	The percentage of patients with COPD who have had influenza immunisation in the preceding 1 August to 31 March
DM002	The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less
DM004	The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less
DM009	The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 12 months
DM018	The percentage of patients with diabetes, on the register, who have had influenza immunisation in the preceding 1 August to 31 March

3.36. The ‘Stretch QOF’ contract was finalised and presented to the Thurrock CCG Clinical Executive Group in June 2018 and launched as of the 16 July. So far 22 out of 29 practices have signed up to deliver stretch QOF and further sign up is anticipated as a result of direct contact with the practice manager to discuss Stretch QOF or by promotion of the contract via other mechanisms such as the long term profile card visits.

3.37. The projected total spend if all practices signed up and 100% achieved (Based on 16/17 QOF performance) is £248,007. An estimate spend for the contract has been calculated on the basis of 72% of total spend (90% sign up and 80% of stretch QOF target achieved) which equates to £178,565.04. The tables below show the modelled estimated impact of Stretched QOF on three QOF indicators if practices perform at the 70th and 100th centile of 2017/18 performance. They demonstrate the significant impact that the programme

could have on population health and demand management and suggest a very strong return on investment for the health and care system.

Benefits over 3 years if all practices hit current 75th percentile							
QOF Indicator	**Indicator Descripton**	**75th quartile**	**Number of Extra Patients Treated**	**Benefit to the Population**	**Quantity of Benefit over three years**	**NHS Saving**	**ASC savings**
HYP006	Control of blood pressure in those with a diagnosis of Hypertension	85%	903	Fewer strokes	181	£658,106	£762,313
AF007	Anti-coagulation of those with Atrial Fibrillation at high risk of a stroke	90%	152	Fewer strokes	51	£184,629	£213,864
HF003	Prescription of ACE-1 or ARB medication in those with Heart Failure	100%	18	Fewer emergency Hospital admissions	4	£167,810	

Benefits over 3 years if all practices hit current maximum practice performance							
QOF Indicator	**Indicator Descripton**	**Max achievement**	**Number of Extra Patients Treated**	**Benefit to the Population**	**Quantity over three years**	**NHS Saving**	**ASC savings**
HYP006	Control of blood pressure in those with a diagnosis of Hypertension	91%	2114	Fewer Strokes	423	£1,540,683	£1,784,639
AF007	Anti-coagulation of those with Atrial Fibrillation at high risk of a stroke	100%	333	Fewer Strokes	111	£404,484	£468,531
HF003	Prescription of ACE-1 or ARB medication in those with Heart Failure	100%	18	Fewer Emergency Hospital Admissions	4	£167,810	

3.38. SystmOne (GP practice clinical system) reports have been published both to support practices to make quarterly claims and to have an operational overview of their performance/work to do.

3.39. Feedback from practices on the initiative has been positive and together with support from Healthcare Public Health managers, a number of practices are using the contract as a platform to create an organised plan of activity against clinical capacity for the delivery of their QOF indicators. This is shifting the focus to consistent achievement of their practice performance every quarter, and more timely management of disease management indicators for patients, than the more traditional ‘’year-end’ push to achieve the target that is often seen in general practice.

3.40. Early indications based on financial claims submitted by practices under the contract show there are 1217 patients across Thurrock that are eligible for payment under stretch QOF that would not have otherwise received an intervention if the practice had performed up to the maximum QOF performance threshold for payment.

3.41. The Dentistry Diabetes Detection pilot is an exciting addition to the programme of work involving dentist chair-side testing for diabetes in patients who are either “at risk” of developing diabetes (identified by questionnaire in waiting area) or who have existing periodontal disease (shown to strongly correlate with Diabetes onset).

3.42. The pilot is referring those identified as positive in the screen to primary care for confirmation, and directly refers those identified as in the pre-diabetic range to the National Diabetes Prevention Programme (NDPP).

3.43. The small pilot began on the 1 February 2018 for a six month duration with three dentists taking part (some part time), so far 33 patients have been detected as having diabetes or are pre-diabetic and were referred directly to their GP Practice (diabetic) or to the NDPP program (pre-diabetic) for follow up. Due to the success of the small sample, dental nurses have been trained to expand their capacity to screen. Positivity rates have been high, in particular those within the community dental service for transient patients leading to the assumption that there is a gap within this particular cohort of patients.

3.44. Due to the initial success of the programme it has been agreed that an extension of six months be granted in order to create a business case to expand further in to other areas within Thurrock. This will also give additional validity to the evaluation to take to NHSE to potentially roll out within other areas in the region/nationally.

3.45. Further Diabetes detection activity is also being funded through the Public Health Grant in the following settings

- GP extended hours hubs - has been agreed to start in one hub initially in early January 2019
- Primary care using Clinical Pharmacists and/or Health Care Assistants, due to start in January 2019
- Testing during Phlebotomy clinics – expressions of interest have been sent with positive response, contracts being finalised for signature. Due to start in January 2019

Extension of NHS Health Checks programme - started in July, pre risk questionnaire sent with health check offer to determine eligibility for HbA1c testing and so far 2 patients have been identified as having raised hyperglycaemia. There was a slight delay due to GDPR within the HL contract; however we anticipate an increase in future months.

3.46. In collaboration with the Thurrock Council Communications team there is now a Public Health Communications plan for July 2018 until March 2019 which looks

to promote the Nationally scheduled health campaigns but also other communications for services locally and tailored to Thurrock such as:

- Monthly NHS Health check promotion via social media and the NHS messaging facility to increase uptake of the programme
- Stop smoking support that signposts to Pharmacies and the Thurrock Healthy Lifestyle Service and the national 'Stoptober' campaign.
- Monthly social media promotion of Thurrock's weight loss programmes Shift the Timber and NAF Thurrock Healthy Lifestyle Service
- Monthly Blood pressure campaigns to promote the free standing blood pressure machines located in nine GP surgeries for residents to self-check, the benefits to checking blood pressure long term and the September national campaign 'Know your numbers'.
- Monthly promotion of the flu vaccination via social media and internal council communications

4. Next Steps

4.1 Many of the programmes outlined in section 3 are in their early stages and need time to establish. Public Health will undertake a full evaluation of their impact once more outcome data is available.

4.2 Further transformational activity of Primary Care is also planned and will be implemented subject to discussion and engagement with the CCG's Primary Care Development Team and local GP surgeries. Current ideas under development include:

- Creation of a GP Locality Based Practice Profile Card together with quality improvement groups containing clinical leads from all GP surgeries and secondary care consultants to discuss the results and share best clinical practice between a network of surgeries.

- Revising Stretched QOF to make part of the reward for practices dependent on performance at a locality rather than surgery level.

- Specific 'deep dives' on common issues identified from GP practice visits and highlighted in Practice Based Profile Cards, for example triangulation of practice performance on managing depression with prescribing data from the CCG's Medicines Management Team.

- Improved use of the Digital Agenda at Smart Phone Based 'Apps' in empowering patients with Long Term Conditions to self-care.

5. Reasons for Recommendation

5.1 Approving this strategic approach 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.

5.2 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.

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

6.1 The programme set out in this paper has been presented at HOSC in September 2017 and was widely supported. The current paper is intended as an update only and as no significant changes have been made has not been to Health OSC before presentation here. It is however on the forward plan for January 2019 for information.

6.2 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.

7. Implications

7.1 Financial

Implications verified by: **Jo Freeman**

Management Accountant, Social Care & Commissioning

There are no direct additional financial costs arising from this report. All costs of the programme will be met from use of existing Public Health staffing resources. It is expected that the approach will deliver financial savings in terms of reduced health and social care demand. These are in the have been modelled and are set out in the Annual Report of the Director of Public Health 2016, and in the body of this report.

7.2 Legal

Implications verified by: **Sarah Okafor,**

Barrister (Consultant)

On behalf of the Director of Law, I have read the report in full. The recommendations are consistent with the duties upon Thurrock Council under the various Social Care and Health legislative frameworks to joint fund and pool

resources to facilitate improved public health objectives across all residents within the area. Accordingly, there appears to be no external legal implications arising from the recommendations at this stage of the process.

7.3 **Diversity and Equality**

Implications verified by: **Becky Price**

Team Manager – Community Development & Equalities

The initiatives outlined in this report will tackle the challenges variation in diagnosis and management of long term conditions between GP practice populations. In doing so, they will have a positive impact on health inequalities and overall population health.

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 Public Health Report 2016, Thurrock Public Health Service.
- Tilbury and Chadwell: A New Model of Care – The Case For Change, Thurrock Public Health Service, September 2017

9. Appendices to the report:

N/A

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