LONG TERM CONDITIONS:
Managing co-morbidities and identifying risk groups

LOCALLY COMMISSIONED SERVICE
1st April 2018 – 31st March 2021

APPENDICES

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Appendix 1: Background and Rationale for the LTC LCS

Background

A 2011 survey[1] reviewing 1.75 million people showed that the majority of people over 65 have two or more long term conditions (LTC), the majority over 75 have three or more and more people have two or more conditions than one. Indeed in Islington, the Public Health profile on older people shows that 14,600 over 65s have one LTC and 62% of these have 2 or more (equating to >9,000 people). There is predicted to be a 252% rise in people with multiple long term conditions by 2050 and the associated costs of treating patients with LTC are projected to rise to £26 billion by 2050. The burden of ill health is particularly affected by deprivation and the fact that people now are living longer with greater health care needs.

Islington is the 24th most deprived borough in England. We know that in Islington, health inequality (the gap between the health experienced by the richest and the poorest) is largely driven by long term conditions such as cardiovascular and respiratory disease. Earlier identification and management of people with LTCs will help tackle health inequality. However LTCs are not just about physical health. There are around 38,000 people in Islington who have one or more LTC and it is estimated that most of these patients will also experience mental health problems at some point in their lives as a direct result of their LTC.

In the past, Islington CCG (previously operating as Islington PCT and as NHS Islington) in collaboration with the Public Health team (now London Boroughs of Camden and Islington Joint Department of Public Health) has commissioned enhanced services with the intention of better preventing and managing LTCs by providing enhanced primary care services for patients with diabetes and COPD; it has commissioned services which attempt to close the prevalence gap (diabetes, COPD, CKD, hypertension) and it has also commissioned services to support last years of life care. GPs in Islington have provided these enhanced services, however at times the large number has felt unwieldy.

In recognition of the increasing number of patients who have more than one LTC and the desire to treat the whole patient with a more holistic approach, in 2014 it was decided to develop a service that sought to address the issue of co-morbidities, so that patients receive their care as efficiently as possible.

Rationale for developing an LTC Locally Commissioned Service

In 2014 the decision was made to streamline the following Locally Commissioned Services (LCS) – Closing the Prevalence Gap, Diabetes, COPD and Over 75s Health Checks - by creating a single Long Term Condition LCS. The infrastructure for these enhanced services was well established, which was the rationale for banding together these services, along with some small additions. It also complemented the NHS Health Checks LCS commissioned by Public Health.

The current combined service seeks to provide better care for the patient by treating all conditions at the same time, with patient need being the driver rather than individual conditions. Patients are now covered by the same LCS from the moment of being flagged for risk of developing an LTC through diagnosis, treatment and long term management.

The holistic LTC approach also reduces the consultation time burden for GPs and should ultimately result in fewer appointments. The aim is to pay a flat rate per patient based on the number of LTCs they have.

This LCS is in place for up to five years (3 + 2) to allow practices the time to build on and develop the initiatives which have been implemented in the previous contract in order to

[1] The Scottish School of Primary Care's Multimorbidity Research programme, 2011

provide better patient care. It also supports the recruitment planning for any extra staff which might be needed to support this work-stream.

Appendix 2: Earlier Diagnosis of Long Term Conditions - rationale

Life expectancy in Islington remains significantly below the England average. Vascular diseases are a key contributor to the gap in life expectancy between Islington and England. Whilst action to address risk factors for vascular disease within the population (primary prevention) will yield improvements in population health and reduced disease incidence in the medium to short term, vital to improving population health outcomes including life expectancy in the short to medium term is the identification and management of vascular long term conditions. Local analysis presented in the Islington Annual Public Health report 2019 showed that there are large numbers of people living with undiagnosed long term conditions in the borough. The expected prevalence is markedly higher than the diagnosed prevalence for hypertension, diabetes, coronary heart disease, chronic kidney disease, and stroke/TIA.

Figure: Prevalence gaps for long term conditions, Islington, 2019

Note. The expected prevalence for diabetes is an estimation for 2019 based on the Health Survey for England (2012-2014) and ONS population projections. Also, the actual and expected prevalence for CHD and stroke are based on individuals aged 55-79 years.
Sources: Quality and Outcomes Framework (QOF, 2018/19), PHE Fingertips Estimated Prevalences (2015), PHE CKD Prevalence Model (2015), PHE Diabetes Prevalence Model (2015), PHE Hypertension Prevalence Model (2016).

Closing this 'prevalence gap' for these conditions and diagnosing disease earlier will help to reduce premature mortality, prevent disease progression and avoid disease complications.

The Case Finding component of the LTC LCS aims to identify patients with undiagnosed long term conditions. It builds on and complements the NHS Health Checks programme and the work previously undertaken through the COPD LES, and aims to capture patients who are ineligible for NHS Health Checks, including patients on other vascular disease registers and those aged 34 years and below. Patients on vascular disease registers who are ineligible for NHS Health Checks have a limited range of investigations performed as part of their annual QoF check, and may represent a large number of patients who have undiagnosed co-existing conditions.

The case-finding component of the LTC LCS specifically aims to identify patients with hypertension, diabetes and COPD.

Appendix 3: COPD READ codes[2]

Description	EMIS CODE
Smoker	**137, 1372, 1373, 1374, 1375, 1376, 137a, 137b, 137C, 137c, 137D, 137d, 137E, 137e, 137f, 137G. 137H, 137h, 137J, 137M, 137m, 137o** (one-three-seven-small-letter-O)**, 137P, 137Q, 137R, 137V, 137X, 137Y, 137Z.**
Ex-smoker	**137A, 137B, 137F, 137j, 137K, 137K0, 137L, 137l** (one-three-seven-small-letter-L), **137N, 137O** (one-three-seven-big-letter-O),**137S, 137T, 1377, 1378, 1379**
History of cannabis misuse	**1T8%**
Case Finding Spirometry Performed In Practice **PAYMENT CODE: This code does not need to be manually entered as it is embedded in the spirometry template**	**68M**
COPD	**H3, H31, H310, H3100, H310z, H311, H3110, H3111, H311z, H312, H3120, H3121, H3123, H312z, H313, H31y, H31y1, H31yz, H31z, H32%, H36, H37, H38, H39, H3A, H3y, H3z, H5832**
CVD diagnosis codes	**G3*, G5*, G6*, C10*, G2*, G7*, 1Z*, C3***

Symptoms to search for:

Symptoms	EMIS CODE
Breathlessness	**173**
MRC Breathlessness scores 3, 4 and 5	**173J, 173K & 173L respectively**
Breathlessness causing anxiety	**EMISNQBR37**
Breathlessness causing difficulty eating	**EMISNQBR36**
Gastric Reflux	**1957**
Persistent cough	**171B**
Productive cough -green sputum	**1714**

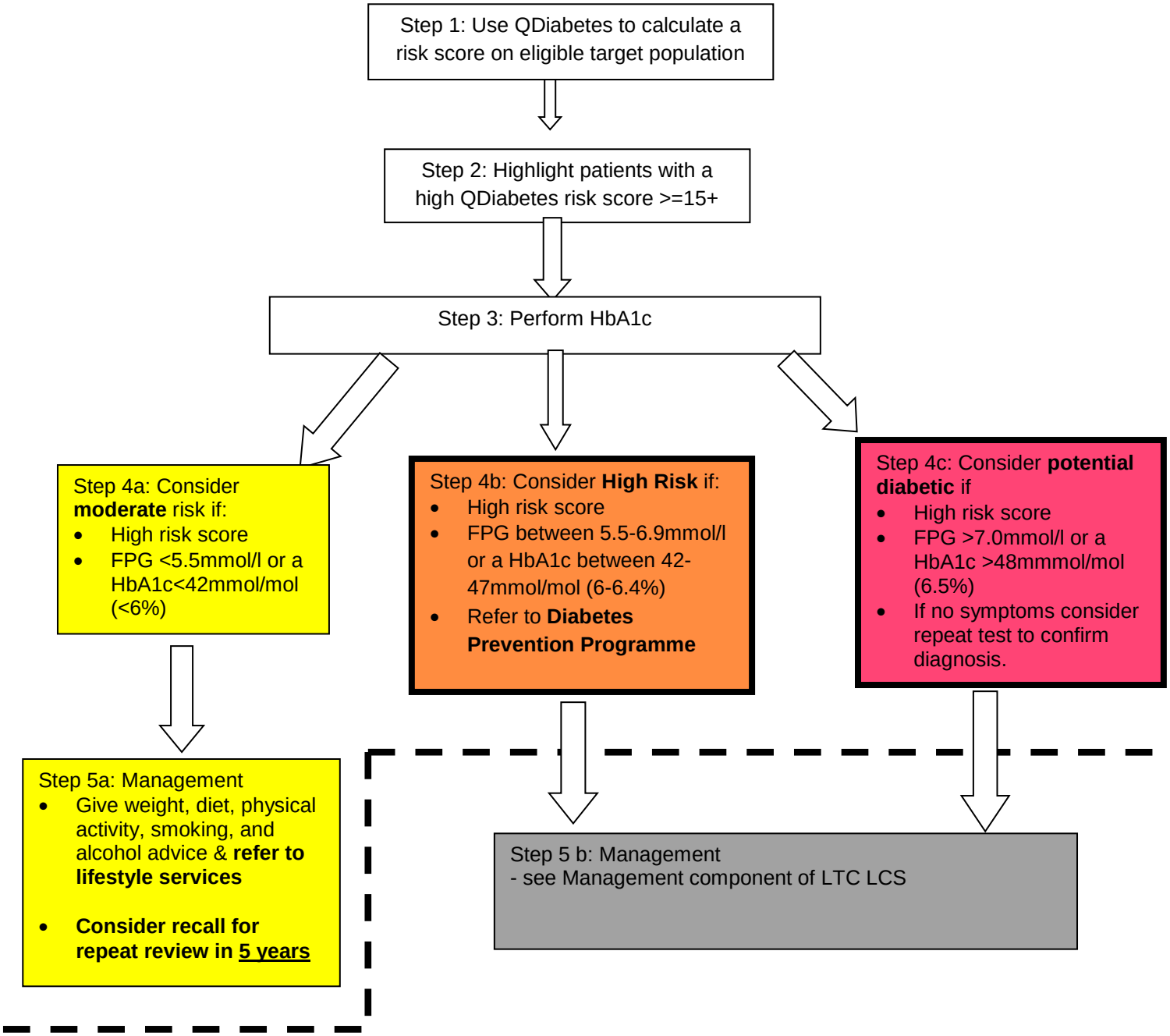
[2] Codes in yellow are payment codes

Productive cough-yellow sputum	**1715**
Coughing up phlegm (Productive cough NOS)	**1716-1 (1716)**
At risk of chronic obstructive pulmonary disease	**14OJ**

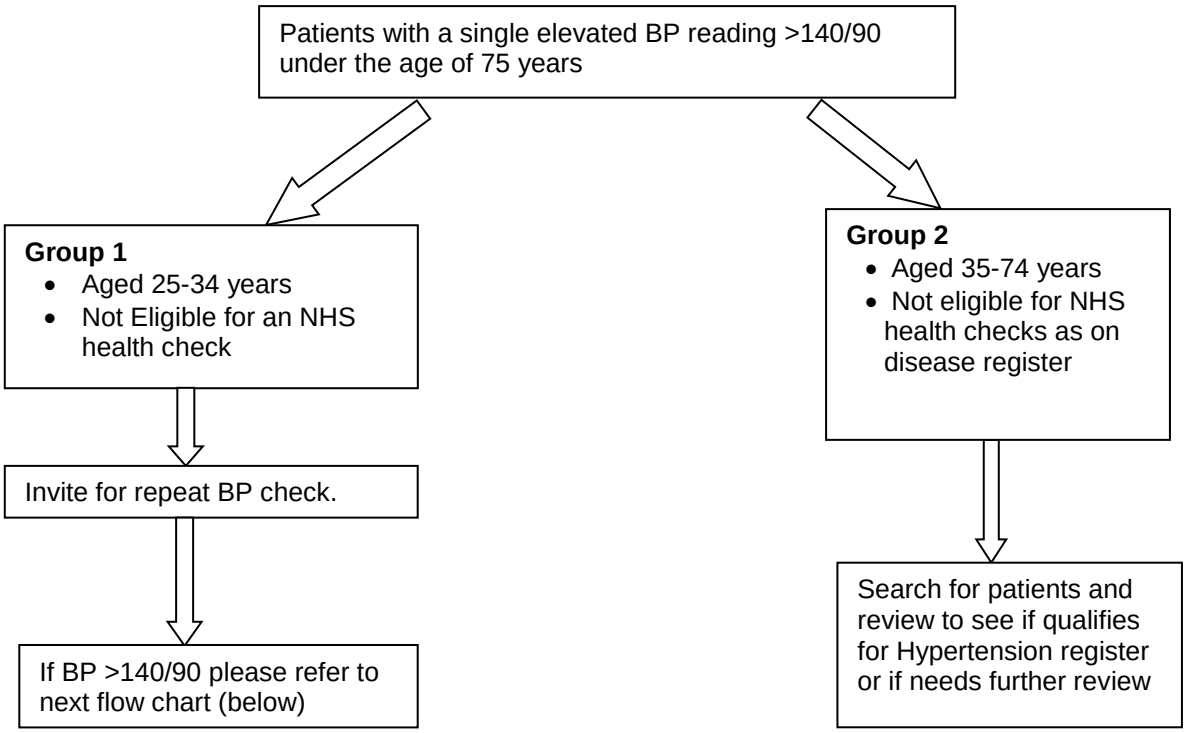
Description	EMIS CODE
Personal care plan completed **PAYMENT CODE: This code does not need to be manually entered as it is embedded in the spirometry template**	**8CMD**
Referral to pulmonary rehabilitation	**8H7u**
Pulmonary rehabilitation declined	**8IA9**
Goals set	**67L**
Patient Clinical Management Starter pack given	**8CR1**
Issue of COPD rescue pack	**8BMW**
Screen for presence of depression	**6896**

Description	EMIS CODE
Very severe COPD **Please note payment for very severe COPD is made based on practice audit return NOT on extraction of code**	**H38**
SaO_2	**44YA**
Pulse Oxymetry	**8A44-1**
Presence of cor pulmonale	**G41z-1**
Need for long-term oxygen therapy	**6639**
Long term oxygen assessment	**745E1**
Assessment for home oxygen therapy	**389A**
BMI	**22K**
Patient's nutritional state (H ed diet)	**6799**
Follow up at 6 months	**66YL**
Practice notified of an emergency admission	**66YE**
Casualty attendance	**66Yd**

Appendix 4: Diabetes pathway

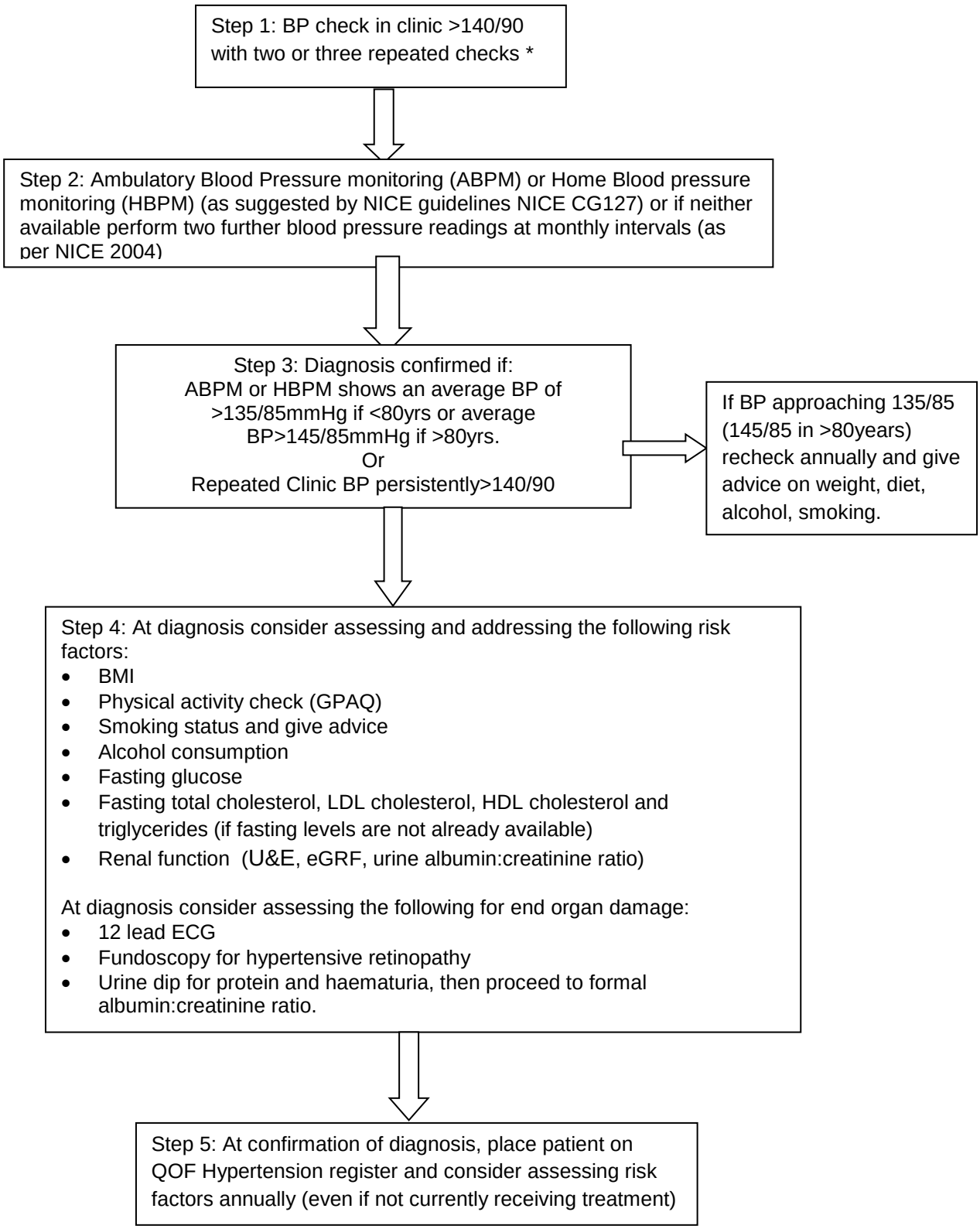


Appendix 5: Hypertension Pathway



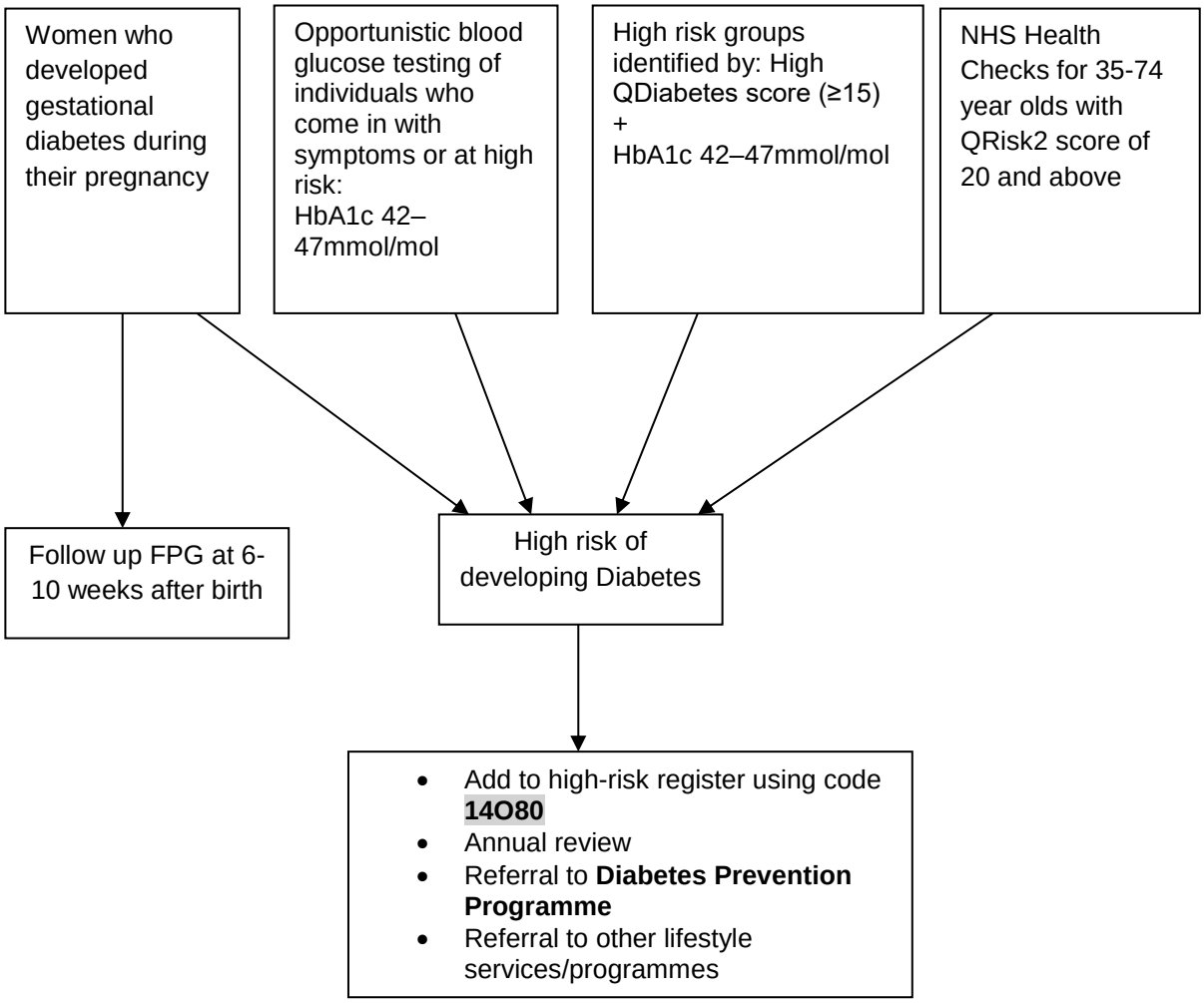
Islington CCG suggests that the blood pressure checks could be done by a health care assistant.

Hypertension diagnosis and intervention pathway



*N/B If clinician is highly suspicious that patient will need hypertensive therapy, consider performing cardiovascular risk assessment and management of risk factors prior to confirmation of diagnosis (i.e. refer to step 4).

Appendix 6: High Risk of Diabetes



Appendix 7: Collaborative Care & Support Planning – example of adapted practice processes

Feedback from Newcastle and Gateshead
David Paynton – National RCGP Clinical Lead for CC&SP

Two surgeries in the more socially disadvantaged parts of the City.

Training and project mapping exercise at the start. Training done by "Year of Care".

Three to five year journey but took 9-12 months to get a routine established.

Key role for administration and HCA with good standardised operational processes.

Starting with a known cohort (usually diabetes and COPD) but one practice starting to pilot C&SP with people with a predominately MSK problem. 8-10% of practice population now supported by C&SP.

Role of social prescribing in the area with Ways to Wellness http://waystowellness.org.uk/ a social enterprise funded via social impact bonds (seven year outcome based contracts). Link worker in each surgery facilitates referral to Ways to Wellness. In Gateshead the link worker is a surgery administrator who also doubles up to support the C&SP systems in the surgery and is seen as a critical success factor.

Many of the C&SP consultations undertaken by Advanced Nurse Practitioners.

Process

- Administrator (also can doubles up as Link Worker to Ways to Wellness) pulls out name based on birthday and sends out invitation for initial information gathering appointment with HCA.
- HCA does relevant tests and tasks according to medical conditions (e.g. bloods, BP, weight etc.) and explains the next steps
- GP and ANP look at results/ records and decide conversation appointment length and who should undertake it (GP/ANP/PN). (This may vary)
- Administration sends out results in the post in a simple person centred template, which also asks the person about what they think is important to them.
- This letter also has suggested appointment time for care and support planning conversation
- Conversation between ANP/GP (20-60 minutes).
- ANP and GP will require some training to support an asset based conversation
- Task can be sent to link to help with social prescribing if required.

Keys to success

A program plan over at least three years.

Whole surgery support especially management together with CCG system support (Ways to Wellness contract and training within a strategic plan.)

Social prescribing supported internally by link worker as part of surgery team.

A formal standard operational plan built into the working week.

Initial training and system support.

Appendix 8: Diagnosing Depression