Queen Mary
University of London

LTC Core Contracts 24-25

CEG Tuesdays, 21 January 2025

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LTC Core – Overview of indicators

How many indicators are there?

- 27 indicators in total

What kind of activities are encompassed within?

- Annual review activities
- Prescribing activities
- Referral activities
- For established LTC or for screening/prevention

Queen Mary Whitechapel campus

LTC Core – Overview of indicators

The good news:

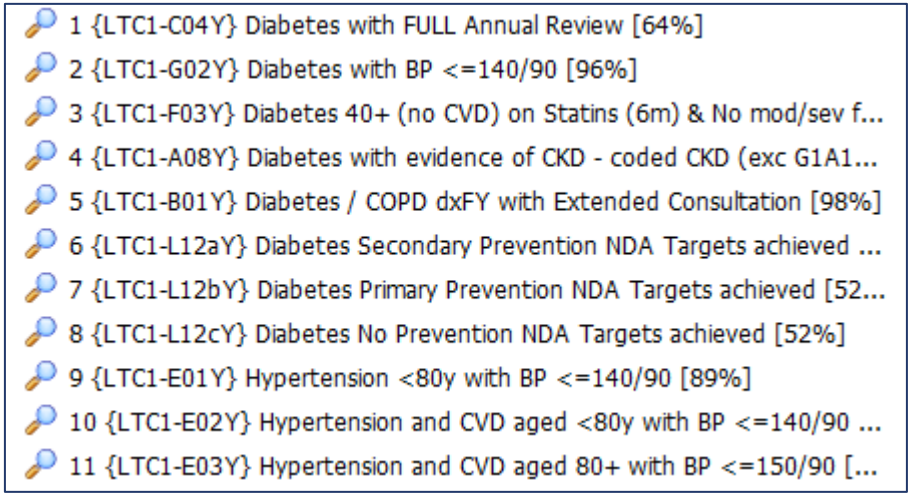
- No big changes to indicators from 23-24

Summary of changes:

- HYP1AY and HYP1BY changed to indicators E02 and E03 (BP control in population with CVD aged 79 or less and 80+) and assigned targets (previously NT)

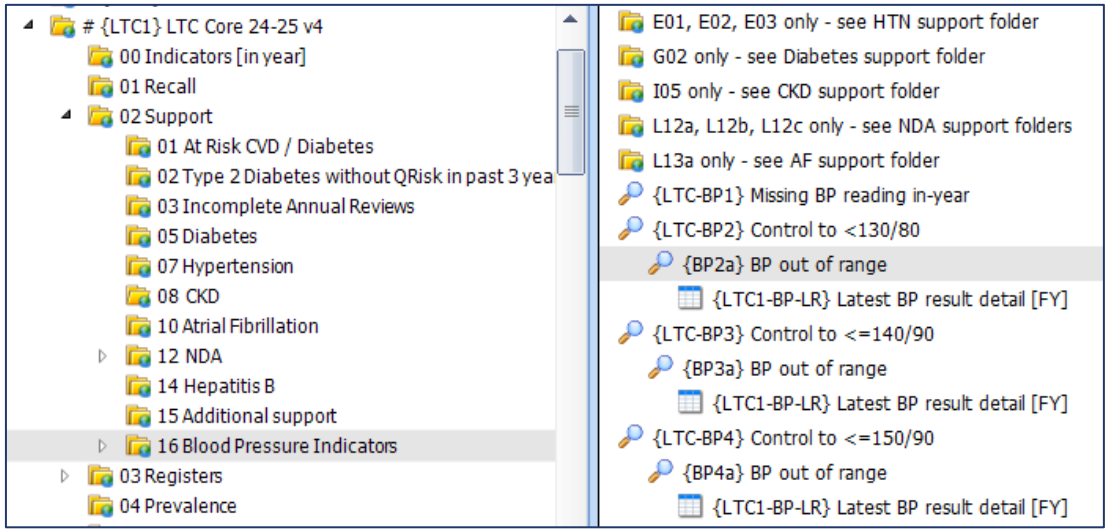
LTC Core – Search suite

Indicators grouped together by disease register/activity:



LTC Core – Search suite

Increased number of support searches:



LTC Core - Indicator deep dive

Indicators related to Diabetes:

1 LTC1-C04Y Diabetes with FULL Annual Review [64%]*

2 LTC1-G02Y Diabetes with BP <=140/90 [96%]*

3 LTC1-F03Y Diabetes 40+ (no CVD) on Statins (6m) & No mod/sev frailty [90%]*

4 LTC1-A08Y Diabetes with evidence of CKD - coded CKD (exc G1A1/G2A1) [52%]

5 LTC1-B01Y Diabetes / COPD dxFY with Extended Consultation [98%]

6 LTC1-L12aY Diabetes Secondary Prevention NDA Targets achieved [60%]

7 LTC1-L12bY Diabetes Primary Prevention NDA Targets achieved [52%]*

8 LTC1-L12cY Diabetes No Prevention NDA Targets achieved [52%]*

LTC Core - Indicator deep dive

LTC1-A08Y Diabetes with evidence of CKD - coded CKD (exc G1A1/G2A1) [52%]

"Evidence of CKD (or missing eGFR/ACR) in a diabetic and coded as CKD. % of patients aged 18-75 yrs with diabetes and either:

- 2 most recent eGFRs (in last 5yrs) below 60, 90 days apart (or more) OR
- 2 ACRS (in last 5yrs) more than 3, 90 days apart or more or
- a single uACR >70, OR
- no ACR/no eGFR [or both*] in FY, who have been coded as CKD."

Idea is to **confirm** or **rule out** CKD

LTC Core - Indicator deep dive

LTC1-A08Y Diabetes with evidence of CKD - coded CKD (exc G1A1/G2A1) [52%]

What are the issues?

1. Quality and Outcomes Framework

The Quality and Outcomes Framework (QOF) aims to improve the quality of care patients are given by rewarding practices for the quality of care they provide to their patients, based on a number of indicators across a range of key areas of clinical care and public health. CKD indicators are included within the QOF, which can serve as a way to create a disease register for those with CKD. However, the CKD indicators are based on:

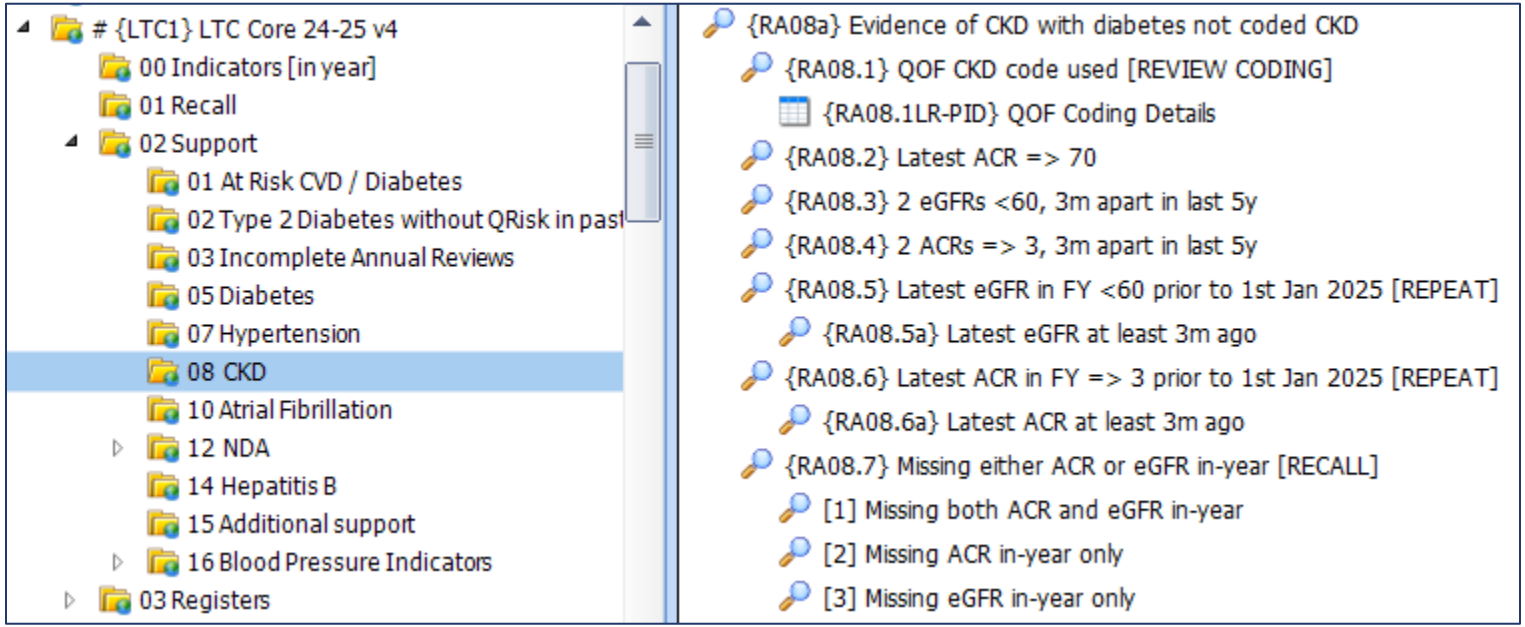
1. CKD stages G3a to G5 (stage 3 to stage 5)
2. Estimated Glomerular Filtration Rate (eGFR) rather than Albumin to Creatinine Ratio (ACR.33.)

Unfortunately, the current CKD indicators used within the QOF do not allow for a specific group of CKD patients to be registered or captured, i.e. those people who have been identified early as having (or at risk of) CKD based on ACR testing as opposed to blood testing. The absence of ACR in the QOF may disincentivise GP practices from conducting ACR testing. The most likely group of people missed from appropriate CKD coding are those who have moderately raised ACRs (3-30mg/mmol) and eGFRs within the mild to normal range (60-90ml/min). It is primarily this group of patients who need to be targeted for early intervention in order to have the greatest impact on CKD prevention.

Updated CKD coding guidelines: https://londonkidneynetwork.nhs.uk/preventing-progression/

LTC Core - Indicator deep dive

LTC1-A08Y Diabetes with evidence of CKD - coded CKD (exc G1A1/G2A1) [52%]



LTC Core - Indicator deep dive

Indicators related to Hypertension (+/- AF):

9 LTC1-E01Y Hypertension <80y with BP <=140/90 [89%]*

10 LTC1-E02Y Hypertension and CVD aged <80y with BP <=140/90 [84%]

11 LTC1-E03Y Hypertension and CVD aged 80+ with BP <=150/90 [91%]

19 LTC1-L13aY AF without HTN - Anticoagulants & Statin (6m) [64%]*

20 LTC1-L13bY AF with HTN - Anticoagulants & Statin (6m) & BP <=140/90 [79%]*

LTC Core - Indicator deep dive

Indicators related to At Risk populations/population screening:

14 LTC1-C01Y At Risk of Diabetes with FULL Annual Review [74%]*

15 LTC1-C02Y At Risk of Diabetes Referred to NDPP/other service [3000]

16 LTC1-C03Y At Risk CVD with FULL Annual Review [79%]*

17 LTC1-F04Y At Risk CVD on Statins (6m) & No moderate/severe frailty [63%]*

22 LTC1-A04Y Aged 65+yrs LTC with Pulse Rhythm [94%]

23 LTC1-A05Y Aged 65+yrs non-LTC with Pulse Rhythm (5yrs) [90%]

24 LTC1-L02Y LTC Review with Audit-C [95%]

LTC Core - Indicator deep dive

Indicators related to CKD:

12 LTC1-I01Y CKD & Hypertension + Proteinuria with ACE-I or ARB (6m) [95%]*

13 LTC1-I05Y CKD <80years with ACR =>70, BP<130/80 (exc mod/sev frailty) [64%]*

LTC Core - Indicator deep dive

Remaining indicators:

18 LTC1-F02Y CVD 18+ on Statins (6m) & No moderate/severe frailty [94%]*

21 LTC1-HEP04Y Hep B+ seen in liver clinic or with FU in FY [39%]

25 LTC1-K03Y Specialist Smoking Cessation Service [11%]

26 LTC1-M01Y Carers 18+ with referrals offered [NT]

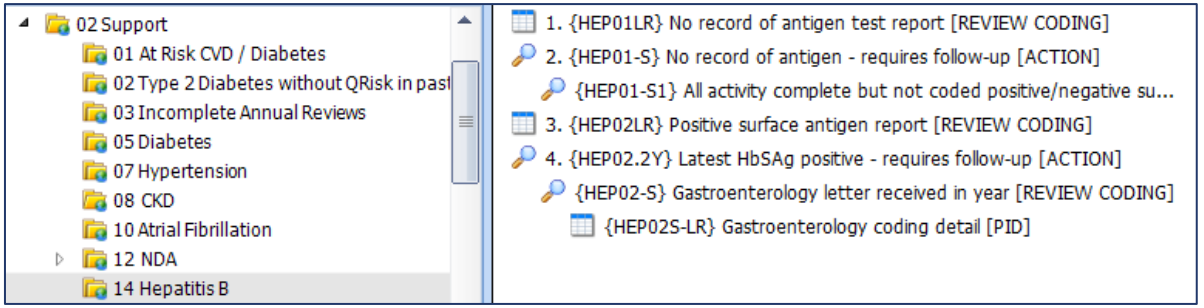
27 LTC1-N01Y Sickle Cell With Annual Review [NT]

LTC Core - Indicator deep dive

21 LTC1-HEP04Y Hep B+ seen in liver clinic or with FU in FY [39%]

Payable activity:

- Referral to hepatology service in-year
- Seen in liver clinic in-year
- Patient declines referral in-year
- 3 attempts to contact patient in-year



[LIVE DEMONSTRATION OF HOW TO USE THE SEARCHES]

Please contact your local facilitator to request a demonstration if required.

Thank you – questions?

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