Standard 4 – Ensure a Pro-active Approach to Health Improvement and early Detection a) Winning Hearts and Minds – 'Healthy Hearts'	
Aims	• To improving the health of the local population • Reduce the rate of premature Cardiovascular Disease (CVD) mortality across Manchester to 50 per 100,000 by 2027 • Reduce the health inequalities associated with poor cardiovascular and mental health outcomes
Delivery	**1.WHM Engagement: develop collaborative approach to delivery of WHM with partners at neighbourhood level focussed on (but not limited to) 3 WHM challenges (see appendices)** a) The aim is for neighbourhoods to understand their local challenges and opportunities, particularly in relation to "the 3 challenges" (see appendices), and agree how to start addressing this from 2019/20. Through Neighbourhood/Locality meetings, practices are expected to engage with the WHM programme to co-produce approach to deliver "Healthy Hearts" outcomes. This will cover practice engagement to setting priorities, identifying clinical leads, development and delivery of education needs to support programme, development/agreement of clinical guidelines, development of communications approach, identifying and agreeing resources required to deliver outcomes, reviewing and peer reviewing baseline, development of project plans and monitoring requirement. For the statin challenge this should include considering any groups of patients that could safely be offered statins at scale (e.g. for statin switch) **2.Hypertension** a) Case finding: Practices to identify patients who are at risk of having hypertension but not yet diagnosed, so they can be offered investigations (3 or more readings >140/90 and where the last reading is still above >140/90). b) Optimisation: Practices to identify patients with last BP over 150, on one medication only and don't have a SBP below 130 in last 12 months to be reviewed and considered for second medication. (search will exclude palliative patients, on medication in last 6 weeks, nursing homes, home SBP <135, AMBP <135, Hypotension, CKD 3-5, Diabetic, white coat hypertension, max doses of medication, BP procedure refused, patients over 80, normal blood pressure code) **3.Lipids/statins** a) Case finding: Using an agreed search tool e.g. QRISK, search the whole population to identify patients who are above 20% risk of a CVD event, who are aged between 40-74 and who have not had CHD, Stroke or TIA. b) Optimisation: Two cohorts will be identified with two different solutions: i. Patients <u>currently taking simvastatin</u> with a cholesterol of >4 (to be offered statin switch to atorvastatin). ii. Patients with a QRISK score of over 20% to be reviewed and offered a statin medication. Practices to take a risk stratification approach to ensure patients most at risks are

	reviewed for a statin first. **4. Atrial Fibrillation** a) Practices to identify known AF patients not receiving treatment and carry out a clinical assessment for appropriateness of anticoagulation. This assessment should then be read coded in patient notes. Patient not suitable for treatment or declines treatment should be read coded with valid reasons. **5.Health Checks** a) Identification of priority groups for health check including o People aged between 40-74 identified **above 20%** risk of CVD event using QRISK2 as a search tool of practice list o Adults with severe mental illness (on SMI register – see standard 2) o People, communities or venues/locations that identified by Neighbourhoods (supported by Health Development Coordinators and Community Health Check Team)[1] b) Practices/Neighbourhoods to systematically invite eligible patients to receive a Health Check either delivered in the community or within the practice prioritising the groups above/most likely to be at risk c) Practices to ensure that people identified as high risk or diagnosed with a condition following a health check are offered appropriate treatment and support Health checks can be delivered via both the GP practices and the community outreach model. The Health Check will be modified appropriately depending on the characteristics of the patient in line with national guidance d) GP practices need to search on EMIS to find eligible patients and invite patients to attend, or health checks can be delivered with an opportunistic approach. If the community outreach team has arranged a health check delivery session in their local area, GPs will receive a request to invite a certain number of patients and as part of this standard. Northenden Medical Practice presently delivers the community health check sessions, and the results are sent to the patients GP so that the practice can enter the results in to the patients EMIS record. A proposal is being considered to use the Health Diagnostics System to carry out the searches and transfer results to the GP practice systems and minimise work for practices.
Reporting	● Activity will be collected through automated reporting templates. ● For NHS Health Check delivery: o If a practice holds a contract with Manchester City Council (MCC) to deliver health checks they should submit claims for all activity they do to MCC through the usual route o If a practice **does not** hold a contract with MCC to deliver health checks they should claim for activity through MHCC as part of the primary care standards scheme

[1] In practice this would mean sending invitations out to eligible people when community health check team are going to be in the area that covers the practice's registered population at a time that has been mutually agreed, and community engagement activity has taken place.

Baseline / Target

By 31st March 2020:

	Baseline (2017-18)	Target
Atrial Fibrillation (AF)	Approx. 1600 patients with diagnosed AF not treated, this is approximately 26% of the AF register.	• To clinically assess 95% of patients with a coded diagnosis of AF, not receiving anticoagulation, and assess if they are clinically appropriate for anticoagulation. Patients to be appropriately coded if not coagulated. • 65% to be on an agreed OAC
Hypertension	58.5% of patients in Manchester below the age of 80 meeting 140/90 treatment target. Approx. 42% (22,392) of patients not controlled within 140/80	• Improvement in the proportion of adults on treatment controlling their blood pressure to 140/90mmHg or below
Statins	Approximately 14,000 patients at High Risk (above 20%) not prescribed a Statin in the last 12 months This is out of 32,000 patients with Q risk over 20% in Manchester	• New and existing patients identified at High Risk of CVD event to be managed with an agreed Statin or clear documentation that a discussion has taken place
Health Checks	Eligible population 111,000 The projected figure for the number of health checks **offered** is **8300** The projected figure for the number of health checks **received** is **4600** In terms of the percentage of the eligible population this equates to: • offered 7% • received 4% SMI health check baseline TBD	• Increase in the number of health checks to 20% offered and 10% received each year. 2018/19 (9 months) Offer 16,500 Deliver 8,000 2019/20 (indicative) Offer 22,000 Deliver 11,000

Standard 4 – Ensure a Pro-active Approach to Health Improvement and early Detection b) Winning Hearts and Minds - "Healthy Minds"	
Aims	• To improve the physical health of people with Severe Mental Health Illness (SMI) • Reduce variation in quality of care, delivery and outcomes across Manchester
Delivery	**Winning Hearts and Minds (WHM) Engagement** ● Through Neighbourhood/Locality meetings engage with the WHM programme to co-produce approach to deliver 'Healthy Minds' Outcomes. This will cover practice engagement to setting priorities, identifying clinical leads, development and delivery of education needs to support programme, development of clinical guidelines, development of communications approach, identifying and agreeing resources required to deliver outcomes, reviewing and peer reviewing baseline, development of project plans and monitoring requirements **Physical Health Assessments ("Health Checks")** ● Primary care teams are responsible for ensuring that people with a SMI receive an annual physical health assessments (to include: BMI, blood pressure and pulse, blood lipid including cholesterol, HbA1c, assessment of nutrition, diet & physical activity, alcohol consumption, smoking status and drug use and appropriate follow-up care. This applies to: ○ patients with SMI who are not in contact with secondary mental health services, including both those whose care has always been solely in primary care, and those who have been discharged from secondary care back to primary care ○ patients with SMI who have been in contact with secondary care mental health teams (with shared care arrangements in place) for more than 12 months and / or whose condition has stabilised. ○ Patients with schizophrenia, bipolar affective disorder & non organic psychosis • Secondary care teams are responsible for carrying out annual physical health assessments and follow-up care for: ○ patients with SMI under care of mental health team for less than 12 months and / or whose condition has not yet stabilised ○ inpatients **Proactive care and support** ● Each GP practice to nominate a lead for mental health (can be practice nurse, nurse practitioner or GP) who will ○ Meet with MH provider (GMMH) quarterly though for larger practices (practices with a list size over 10,000) this should happen more frequently e.g. monthly /every 6 weeks ○ Cross check the people known to GMMH to ensure they are on the SMI QOF register ● To undertake a full annual physical health check as per the standard outlined in the 5 year forward view, following the initial health check completed in MH secondary care. (see Standard 4a) and ensure that patients are supported to engage with national screening programmes

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Ensure that the initial full annual physical health check (undertaken in MH secondary care and those undertaken by PC) results in appropriate follow up in primary care, including to referral appropriate services for physical health care and broader lifestyle and social support for wellbeing as appropriate
Ensure people are added to the relevant LTC QOF register as appropriate
Inform the GMMH link professional if people on the SMI register do not attend appointments and are not engaged with their GP or practice and physical health care
Determine a system, with the MH link worker, which promotes medication concordance and engagement

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<tr><td>Reporting</td><td>

Activity will be collected through automated reporting templates.
Nominate a lead for mental health and inform MHCC upon sign up to the scheme

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<tr><td>Baseline / Target</td><td>
Target – by 31st March 2019

Practice has an identified lead for mental health
SMI Register has been cross-checked and amended as appropriate
Regular review meetings with mental health link worker from GMMH are in place and focus agreed

<table>
<tr><th>For 2018-19</th><th>For 2019-2020</th></tr>
<tr><td>● 45% of all patients on the Practice SMI register who have a diagnosis of schizophrenia, affective bi-polar disorder and non-organic psychosis have had an annual health review in primary care and recommendations are clearly recorded and followed-up as appropriate</td><td>● 55% of all patients on the Practice SMI register who have a diagnosis of schizophrenia, affective bi-polar disorder and non-organic psychosis have had an annual health review in primary care and recommendations are clearly recorded and followed-up as appropriate (subject to changes in National target)</td></tr>
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Standard 6 - Improving Outcomes for People with Long Term Condition(s) a) Diabetes	
Aims	• To reduce the predicted growth in prevalence of diabetes over the next 5 years. • To ensure that all diabetic patients in Manchester receive their annual review in line with National Diabetes Audit and NICE Guidance/Principles. • To improve engagement and empower patients through education to help them self-manage their diabetes.
Delivery	Practices will be expected to: **1.Treatment of Diabetes** • Ensure patients are aware of the Essential Checks and services they should receive annually. • Ensure all 8 review processes are carried out and consistently coded as including foot and eye checks and those patients that do not engage as appropriate (as appropriate). • Ensure an annual foot check is incorporated into the annual review for all patients and that patients with increased risk are referred to/are attending podiatry services according to local guidelines. Provide written information to all patients where required. • Train new staff in foot checks, where appropriate, as they are recruited. • Ensure patients are given the opportunity to participate in care-planning. **2.Identification of Non-Diabetic Hyperglycaemic (NDH) patients** • Continue second round of National Diabetes Prevention Programme. Identify patients as NDH who did not attended the Healthier You programme in the first year. [2] • Practices to work in cluster groups with neighbouring practices to mobilise together working with CCG support teams and Provider. • Cleanse data where appropriate; send invite letters out with an SMS reminder. • Practices to code data received from Healthier You Provider to indicate patient's attendance to programme. • Conduct yearly review of patients of NDH register in concordance with NICE guidelines **3.Participation in local and national programmes** Practices will be required as a minimum to participate in the National Diabetes Audit. **4.Identification of patients with Diabetes or NDH** • Patients with a blood test result indicating NDH will be coded correctly and receive yearly follow up – to include HbA1c blood test. This will include searches for patients with existing HbA1c scores indicating NDH and identifying and reviewing patients at high risk. • NDH registers will be developed and maintained • Eligible patients will be invited to the National Diabetes Prevention Programme

[2] https://www.england.nhs.uk/diabetes/diabetes-prevention/

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<tr><td></td><td></td></tr>
<tr><td>Reporting</td><td>

Quarterly data collection at practice level
Data Quality Team (for National Diabetes Prevention Programme)

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<tr><td>Baseline / Target</td><td>
Baseline: Diabetes 8 Process of Care
<table>
<tr><th>Area</th><th>Apr -17</th><th>Jul -17</th><th>Aug -17</th><th>Sep -17</th><th>Oct -17</th><th>Nov -17</th><th>Dec -17</th><th>Jan -18</th><th>Feb -18</th><th>Mar-18</th><th>Apr -18</th></tr>
<tr><td>Central (%)</td><td>50.6</td><td>47.5</td><td>48.4</td><td>47.4</td><td>47.3</td><td>47.6</td><td>48.5</td><td>48.8</td><td>47.9</td><td>49.7</td><td>51.7</td></tr>
<tr><td>North (%)</td><td>46.2</td><td>43.4</td><td>44.0</td><td>43.3</td><td>42.2</td><td>42.5</td><td>42.5</td><td>42.1</td><td>40.0</td><td>41.8</td><td>44.0</td></tr>
<tr><td>South (%)</td><td>36.6</td><td>32.4</td><td>32.7</td><td>32.7</td><td>33.9</td><td>35.0</td><td>36.6</td><td>37.6</td><td>36.8</td><td>39.0</td><td>40.7</td></tr>
<tr><td>City Wide (%)</td><td>45.2</td><td>41.9</td><td>42.5</td><td>41.9</td><td>41.8</td><td>42.3</td><td>43.0</td><td>43.3</td><td>42.0</td><td>43.8</td><td>45.9</td></tr>
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Target for 2018-2020:

To be determined once latest baseline is determined
Practices to demonstrate an increase year on year

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Standard 6 - Improving Outcomes for People with Long Term Condition(s) b) Management of Diabetes in Preconception Period	
Aims	• To reduce the rate of diabetes (Type 1 and Type 2) related complications of pregnancy in women of child bearing age (16-45) • To ensure that all women with diabetes of child bearing age in Manchester receive brief awareness, advice and guidance on complications in regards to diabetes related pregnancies. • To offer women with diabetes looking to conceive proactive preconception planning care in line with NICE guidance (NG3) • General practices complete education modules to support management of care
Delivery	Practices will be expected to: **Health Care Professional Training** Minimum - The expectation is that: • 1 GP and 1 Practice nurse per practice to undertake CPD accredited Diabetes e-learning module http://www.cpd.diabetesonthenet.com/index.php?area=modules&page=lesson&courseId=86&lessonId=103&type=html5 • Copy of certificate or evidence of completion of course to be emailed to the primary care email box (address above) by 31st December 2018 • Guidelines and requirements of the standard to be shared with all practice staff at team meeting by 30th September 2018. (Date of discussion to be documented). • Report detailing Neighbourhood discussion to be completed and returned by 31st December 2018 Select module: **Preconception Planning and Care** • Develop register with women at child bearing age (16-45) with diabetes to offer advice • Import EMIS Diabetes UK Prescription information on to EMIS (Appendix 10) • Using Information prescription alerts discuss and offer preconception information prescription to cohort patients in annual reviews and opportunistically. Highlighting risk and necessary lifestyle advice. • Code as advice given. • For women trying to conceive in the next year follow pre conception management guidance (Appendix 11). Women who are taking contra-indicator medication and trying to conceive should be offered contraception until seen by the Community Diabetes team for medication review. • After birth – Refer women with pre-existing diabetes back to their routine diabetes care arrangements. Remind women with diabetes of the importance of contraception and the need for preconception care when planning future pregnancies. • Ensure diabetes 8 care processes are achieved, and the patients have been referred to diabetes structured education. **Dissemination of advice** • 100% of practices to be implementing the DUK information prescriptions by 31st December 2018 • Minimum of 50% of eligible patients to have received advice using DUK

	information prescriptions by 31st December 2019
Reporting	• All practices to have undertaken the e-learning module and sent evidence by the end of 30th September 2018 to mhcc.primarycare@nhs.net • All practices to have searched for women with diabetes of child bearing age and created a register by 30th September 2018 • All practices to have activated the information prescriptions (Appendix 12) and actively offering patients advice. • Neighbourhoods to consider how to engage with women with diabetes of child bearing age who do not engage with the practice (not attend annual reviews in the last 15 months).
Baseline / Target	• 100% of practices to have shared and discussed guidelines and expectations of the standard with all clinical practice staff by 30th September 2018. • 100% of practices to have discussed scheme at Neighbourhood meetings to identify how to best engage with women with diabetes of a child bearing age who do not attend annual reviews in Primary care. Practices to identify and engage with local organisations that may be able to support the communications. e.g. Local pharmacists, VCS groups, GUM clinicians by 31st December 2018 • 100% of practices to have completed the e-module training by the end of 30th December 2018 • 100% of practices to have created a register of women with diabetes of child bearing age and to be offering advice by issuing DUK information prescriptions by 31st December 2018 • 100% practices to have offered advice to a minimum of 50% of eligible patients by 31st Dec 2019.