

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)

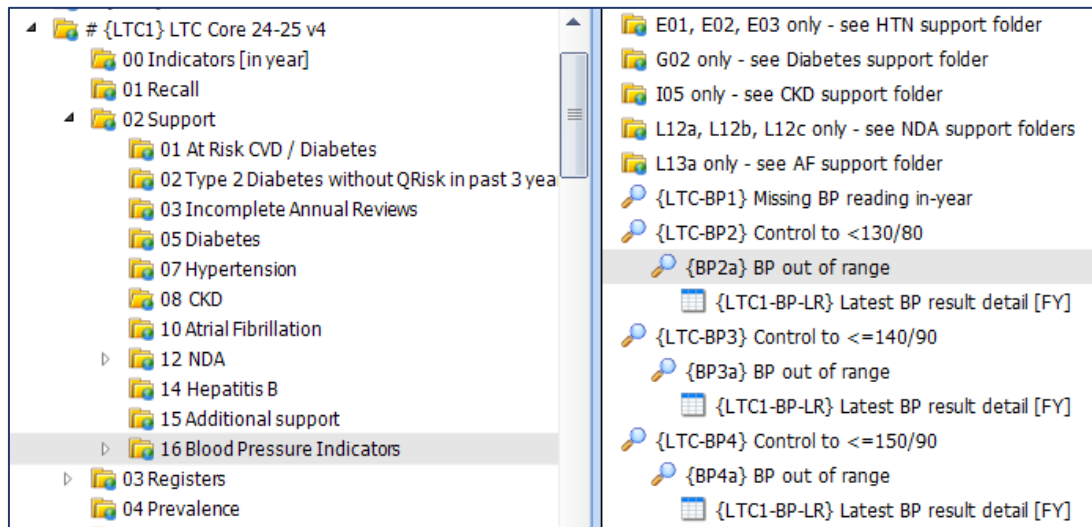


Indicators grouped together by disease register/activity:

- 1 {LTC1-C04Y} Diabetes with FULL Annual Review [64%]
- 2 {LTC1-G02Y} Diabetes with BP $\leq 140/90$ [96%]
- 3 {LTC1-F03Y} Diabetes 40+ (no CVD) on Statins (6m) & No mod/sev f...
- 4 {LTC1-A08Y} Diabetes with evidence of CKD - coded CKD (exc G1A1...
- 5 {LTC1-B01Y} Diabetes / COPD dxFY with Extended Consultation [98%]
- 6 {LTC1-L12aY} Diabetes Secondary Prevention NDA Targets achieved ...
- 7 {LTC1-L12bY} Diabetes Primary Prevention NDA Targets achieved [52...
- 8 {LTC1-L12cY} Diabetes No Prevention NDA Targets achieved [52%]
- 9 {LTC1-E01Y} Hypertension $<80y$ with BP $\leq 140/90$ [89%]
- 10 {LTC1-E02Y} Hypertension and CVD aged $<80y$ with BP $\leq 140/90$...
- 11 {LTC1-E03Y} Hypertension and CVD aged $80+$ with BP $\leq 150/90$ [...

LTC Core – Search suite

Increased number of support searches:



The screenshot displays a search suite interface. On the left, a folder tree is shown under the root folder '# {LTC1} LTC Core 24-25 v4'. The tree includes folders for '00 Indicators [in year]', '01 Recall', '02 Support', '03 Registers', and '04 Prevalence'. The '02 Support' folder is expanded, showing sub-folders for '01 At Risk CVD / Diabetes', '02 Type 2 Diabetes without QRisk in past 3 years', '03 Incomplete Annual Reviews', '05 Diabetes', '07 Hypertension', '08 CKD', '10 Atrial Fibrillation', '12 NDA', '14 Hepatitis B', '15 Additional support', and '16 Blood Pressure Indicators'. The '16 Blood Pressure Indicators' folder is selected and highlighted.

On the right, a list of search results is displayed. The results include:

- E01, E02, E03 only - see HTN support folder
- G02 only - see Diabetes support folder
- I05 only - see CKD support folder
- L12a, L12b, L12c only - see NDA support folders
- L13a only - see AF support folder
- {LTC-BP1} Missing BP reading in-year
- {LTC-BP2} Control to <130/80
- {BP2a} BP out of range (highlighted)
- {LTC1-BP-LR} Latest BP result detail [FY]
- {LTC-BP3} Control to <=140/90
- {BP3a} BP out of range
- {LTC1-BP-LR} Latest BP result detail [FY]
- {LTC-BP4} Control to <=150/90
- {BP4a} BP out of range
- {LTC1-BP-LR} Latest BP result detail [FY]

LTC Core - Indicator deep dive

Indicators related to Diabetes:

- 1 LTC1-C04Y Diabetes with FULL Annual Review [64%]*
- 2 LTC1-G02Y Diabetes with BP \leq 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:

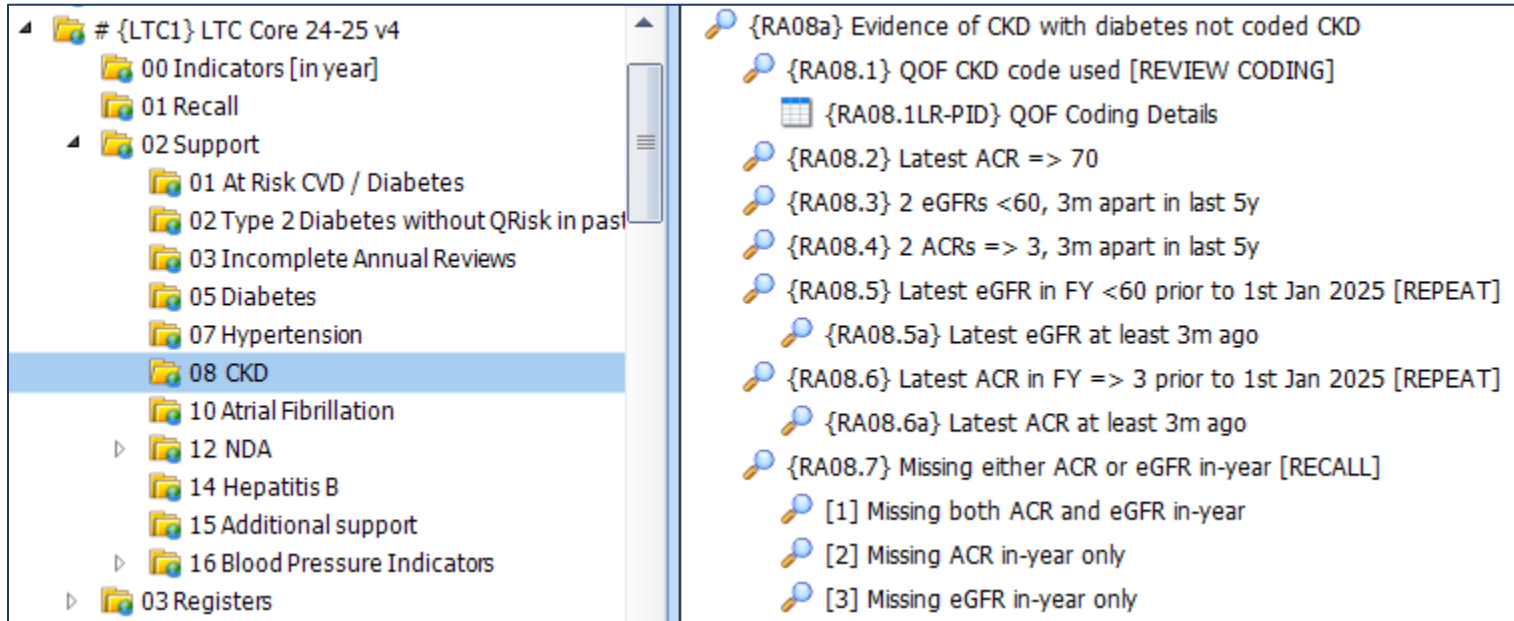
1. CKD stages G3a to G5 (stage 3 to stage 5)
2. Estimated Glomerular Filtration Rate (eGFR) rather than Albumin to Creatinine Ratio (ACR.33.)

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%]



The screenshot displays a software interface with a folder tree on the left and a list of indicators on the right. The folder tree is expanded to show the '08 CKD' folder. The list of indicators includes:

- {RA08a} Evidence of CKD with diabetes not coded CKD
 - {RA08.1} QOF CKD code used [REVIEW CODING]
 - {RA08.1LR-PID} QOF Coding Details
 - {RA08.2} Latest ACR => 70
 - {RA08.3} 2 eGFRs <60, 3m apart in last 5y
 - {RA08.4} 2 ACRs => 3, 3m apart in last 5y
 - {RA08.5} Latest eGFR in FY <60 prior to 1st Jan 2025 [REPEAT]
 - {RA08.5a} Latest eGFR at least 3m ago
 - {RA08.6} Latest ACR in FY => 3 prior to 1st Jan 2025 [REPEAT]
 - {RA08.6a} Latest ACR at least 3m ago
 - {RA08.7} Missing either ACR or eGFR in-year [RECALL]
 - [1] Missing both ACR and eGFR in-year
 - [2] Missing ACR in-year only
 - [3] Missing eGFR in-year only

LTC Core - Indicator deep dive

Indicators related to Hypertension (+/- AF):

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

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

11 LTC1-E03Y Hypertension and CVD aged 80+ with BP $\leq 150/90$ [91%]

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

20 LTC1-L13bY AF with HTN - Anticoagulants & Statin (6m) & BP $\leq 140/90$ [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]

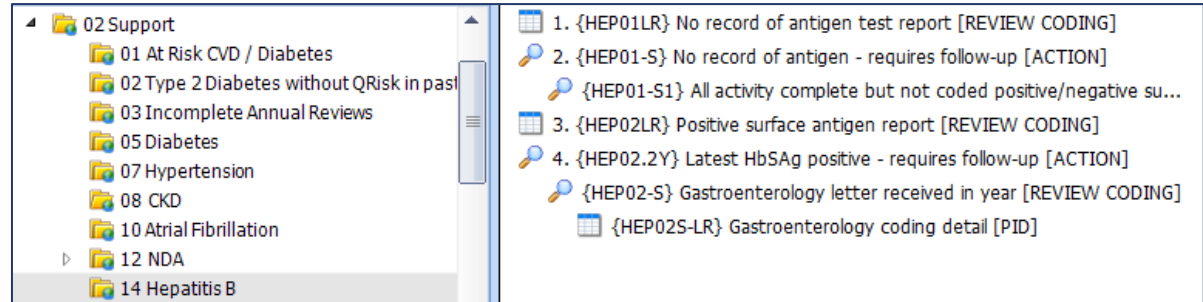


LTC Core - Indicator deep dive

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



02 Support

- 01 At Risk CVD / Diabetes
- 02 Type 2 Diabetes without QRisk in past
- 03 Incomplete Annual Reviews
- 05 Diabetes
- 07 Hypertension
- 08 CKD
- 10 Atrial Fibrillation
- 12 NDA
- 14 Hepatitis B

- {HEP01LR} No record of antigen test report [REVIEW CODING]
- {HEP01-S} No record of antigen - requires follow-up [ACTION]
- {HEP01-S1} All activity complete but not coded positive/negative su...
- {HEP02LR} Positive surface antigen report [REVIEW CODING]
- {HEP02.2Y} Latest HbSAg positive - requires follow-up [ACTION]
- {HEP02-S} Gastroenterology letter received in year [REVIEW CODING]
- {HEP02S-LR} Gastroenterology coding detail [PID]

[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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