Practice guidance for Supporting Healthy Behaviours QI project 2024-25

Background

GMS has always played a key role in the prevention agenda. Through the course of contract reform, agreement was reached in the 22/23 round to develop a focus on prevention and making every contact count.

The pandemic has exacerbated the challenge of providing health and care services that can support people to manage their condition well enough to avoid significant disease progression and the development of serious complications. This is likely to result in large scale population-level morbidity, mortality, and healthcare utilisation. There is an opportunity to improve outcomes and reduce healthcare demand by focusing on, and enabling, effective prevention of illness at key encounters with primary care. Such contacts include new patient registrations and chronic condition management reviews.

This QI project is focused on specific identified behaviours in newly registered patients and patients with certain long-term or chronic conditions.

These identified behaviours are:

- obesity/high BMI
- high risk alcohol intake, and
- tobacco use.

The long-term conditions are:

- Diabetes (all types)
- Cardiovascular Disease
    - Stroke
    - Heart Failure
    - Ischaemic Heart Disease
    - Atrial Fibrillation
- Hypertension
- Asthma
- Chronic Obstructive Pulmonary Disease

Whilst we want to support patients to make healthier behaviour choices, this QI project encourages primary care clinicians, collaboratives/clusters, and Health Boards to try new ways of delivering services and assess their impact.

This project builds on, and extends, improvement activity under the Unhealthy Behaviours QI project throughout 2023-24.

As in all Quality Improvement projects, it is *not* necessary to demonstrate an absolute improvement after an intervention. However, it is necessary to collect data 'before' and 'after' any intervention and share any learning widely. This will also support contractors and collaboratives to use and evaluate the new Accelerated Cluster Developments.

Aims

The **primary** aim of this QI project is to improve mortality and morbidity caused by the consequences of obesity, alcohol and tobacco use.

The **secondary** aim is to construct a list of interventions, devised and evaluated by contractors and/or collaboratives/clusters, as part of service improvements, and share the learning widely (regardless of whether any changes had positive or negative outcomes).

Objectives

All contractors will complete these 3 Objectives (A, B and C) by the end of the QI period 31st March 2025:

A. **Agreed Read codes** chosen from those listed in the Annex at the end of this document will be used by all practices when:

a) **recording** patients who:
1. are drinking alcohol at an increased or higher risk level;
2. are users of tobacco products;
3. have a high BMI; and

b) **documenting** any supportive interventions offered, such as advice, referral or signposting and clinically important related demographic data (e.g., ethnicity),

B. All these agreed Read codes together will form **a minimum data set** that will be used in two situations:
- in any '**new patient questionnaire**' used for all patients aged 16 or older, who register with the practice
- in **chronic disease reviews for patients with long term conditions**

C. Practices will then **undertake a QI project** aimed at developing and refining their processes for intervention and signposting of those patients displaying identified behaviours to appropriate resources. The QI project will only apply to two cohorts of patients:
1. Newly registered patients
2. Patients attending clinics or chronic condition reviews with the following long-term conditions
    - Diabetes (all types)
    - Cardiovascular Disease
        - Stroke
        - Heart Failure
        - Ischaemic Heart Disease

        - Atrial Fibrillation
    - Hypertension
    - Asthma
    - Chronic Obstructive Pulmonary Disease

Practices will collect data before and after any interventions (e.g., Using IHI Quality Improvement Methodology and by using searches designed for this purpose), and share any learning (whether positive or negative) within their practice teams, collaborative/clusters and more widely.

Areas for Quality Improvement Project Activity

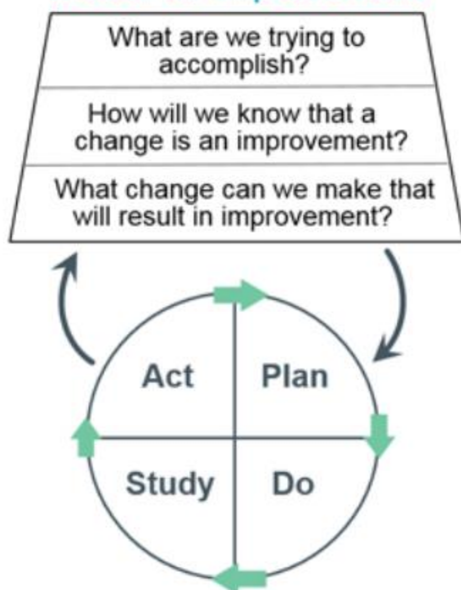
1. Improvement in identification, and recording, of newly registered patients with identified behaviours; appropriately recorded in the clinical record, and any necessary action taken to support behaviour change.
2. Improvement in identification, and recording, of patients with a chronic disease in the above list, who report identified behaviours, and appropriately recorded in the clinical record, and any necessary action taken to support behaviour change.
3. A review of skills and service gaps for intervention at local, regional, and national level.
4. Correction of any such gaps in skills or services in a practice team, or collaborative/cluster if practical.

Further information to support practices in undertaking the project and suggested QI activity is available in the Public Health Wales guide: Supporting Healthy Behaviours: A Guide for General Practice.

Practice Requirements

Practice Level

- Practices will have a named QI Project lead clinician.
- Practices will ensure that the agreed Read codes for BMI/Alcohol/Smoking behaviours will be incorporated into computer templates used for
    - New Patient Registration Health Checks; and
    - Chronic Disease Reviews.
      This may be by adopting a new endorsed National Template or by adjusting their own existing templates to include the national minimum dataset.
- Practices will consider how best to educate and/or signpost patients to appropriate resources for behaviour modification/weight loss, including digital methods and other modalities where appropriate. This should involve exploration of available local and national services and possible liaison with local services (including secondary care and third sector organisations).
- Practices to review Chronic Disease Management clinics in line with national guidance, consider processes for Hba1c testing in at risk individuals and opportunities for onward referral including the AWDPP.
- Practices to adopt a QI methodology, including:



- Review of baseline data
- Review of their processes
- Introduction of tested small cycles of change.

How to Improve | IHI - Institute for Healthcare Improvement
https://youtu.be/nPysNaF1oMw

- Practices to review progress **at least quarterly.**
- Practices will discuss their learning with their GMS collaborative. Minutes of this meeting should be submitted to health boards as confirmation that this discussion has taken place.
- Practices will complete a nationally agreed QI Poster for sharing at the final collaborative meeting before 31/3/2025 confirming conclusion of the project and highlighting outcomes achieved.

GMS Collaborative Level

- Practices to share aggregate practice-level data on identified behaviours.
- Practices to discuss accuracy of data and process for refinement.
- Discuss, share best practice, and consider adaptation of QI processes if applicable across collaborative.
- The GMS Collaborative lead should bring themes for discussion to the wider cluster professionals e.g., to support *Making Every Contact Count* initiatives and signposting.
- The GMS Collaborative or Cluster may consider introducing collaborative/cluster initiatives to benefit the delivery of improved interventions in identified behaviours.
- The GMS Collaborative or Cluster should escalate deficiencies in systems/services or suggestions for system-wide improvement to Pan Cluster Planning Group for consideration of improved commissioning or inclusion in IMTP process.

DHCW Level

- DHCW will support the selection of agreed Read codes and creation of a minimum data set, with associated New Patient Registration Health Check, and Chronic Disease Review templates.
- DHCW will aim to provide either a solution via dataset & business rules for each GP system supplier to implement; or make available pre-authored searches to enable Practices to undertake their own local searches.
- Develop a PCIP tile for displaying required data and for practice upload of project materials for verification purposes.

Health Board Level

- Health Boards to ensure practice completion is verified against agreed indicators/contractual agreement via completion of a nationally agreed Poster shared at the collaborative meeting.
- Health Boards will collate the posters to allow thematic review at national level

Verification and achievement

Practices:

- Practices will need to demonstrate achievement of the Objectives A, B and C by 31st March 2025, by completion of the nationally agreed QI Poster shared and discussed with the collaborative and shared with the LHB. Minutes of the collaborative meeting should also be shared as evidence of the discussion.
- The contractor should ensure that the poster states that the minimum data set is applied in both new patient health check and chronic disease reviews.
- The contractor should ensure that the poster states where the QI activity has resulted improved outcomes.
- A poster template and further guidance for completion will be circulated to practices by end of October 2024.

LHB:

- LHBs will be required to verify that practices have undertaken all actions required to meet Objectives A, B and C, to confirm achievement and award payment.
- This will be done by reviewing each individual practice's nationally agreed QI Poster shared and discussed with the collaborative and shared with the LHB by 31st March 2025.

Minimum Dataset Codes – Recording Behaviour Codes
(incorporating codes from New Patient Questionnaire)

Recording of BMI (BMI calculated by GP system based on recorded height and weight measurements)

Read Code	Rubric	Value recorded
229..	O/E - height	Height in cm
22A..	O/E - weight	Weight in Kg
9NSZ.	Unsuitable for body height measurement	
9NSa.	Unsuitable for body weight measurement	

Clinical system will calculate BMI based on height and weight values and record value against Read code 22K..

Recording of alcohol consumption

Read Code	Rubric	Value recorded
136..	Alcohol Consumption	Alcohol units per week
136V.	Alcohol units per week	Alcohol units per week
136e.	Declines to state current alcohol consumption	

Recording of smoking status (look at old QOF smoking codes if required to capture tobacco product/quantity)

Smoking status:

Read Code	Rubric
1371.	Never smoked tobacco
137S.	Ex-smoker
137R.	Current smoker
137k.	Refusal to give smoking status

QOF Current Smoker codes:

Read Code	Rubric
137.	Tobacco consumption
1372.	Trivial smoker - < 1 cig/day
1373.	Light smoker - 1-9 cigs/day
1374.	Moderate smoker - 10-19 cigs/d
1375.	Heavy smoker - 20-39 cigs/day
1376.	Very heavy smoker - 40+cigs/d
137C.	Keeps trying to stop smoking

137D. Admitted tobacco cons untrue ?
137G. Trying to give up smoking
137H. Pipe smoker
137J. Cigar smoker
137M. Rolls own cigarettes
137P. Cigarette smoker
137Q. Smoking started
137R. Current smoker
137V. Smoking reduced
137X. Cigarette consumption
137Y. Cigar consumption
137Z. Tobacco consumption NOS
137a. Pipe tobacco consumption
137b. Ready to stop smoking
137c. Thinking about stopping smoking
137d. Not interested in stopping smoking
137e. Smoking restarted
137f. Reason for restarting smoking
137h. Minutes from waking to first tobacco consumption
137m. Failed attempt to stop smoking
137o. Waterpipe tobacco consumption

Annex

Minimum Dataset Codes – Referral, Signposting and Advice

Hba1C 42-47 identified in Chronic Disease Clinics

679m4	Referral to NHS Diabetes Prevention Programme
679m3	Referral to NHS Diabetes Prevention Programme declined

Weight management advice

66CG.	Weight management programme offered
66CH.	Weight management plan started
66CJ.	Weight management plan completed
8Cd7.	Advice given about weight management
679P.	Health education - weight management
9N1yK	Seen in weight management clinic
8CA4z	Pt advised re diet NOS
8IAu.	Weight management advice declined

Weight management signposting

8CdC.	Weight management service signposted

Weight management referrals

8HHH.	Refer to weight management programme
8HHH0	Referral to local authority weight management programme
8HHH1	Referral to residential weight management programme
8IAM.	Referral to weigh management service declined

Alcohol advice

6792.	Health ed. - alcohol
8CE1.	Alcohol leaflet given
8CAM.	Patient advised about alcohol
8CAM0	Advised to abstain from alcohol consumption
67H0.	Lifestyle advice regarding alcohol

Alcohol Signposting

8CdK	Specialist alcohol treatment service signposted

Alcohol referrals

8H7p.	Referral to community alcohol team
8HHe	Referral to community drug and alcohol team
8HkG	Referral to specialist alcohol treatment service
8IEA	Referral to community alcohol team declined

8IAJ	Declined referral to specialist alcohol treatment service

Smoking advice

8CAL.	Smoking cessation advice
9N2k.	Seen by smoking cessation advisor
13p50	Practice based smoking cessation programme start date
9Ndf.	Consent given for follow-up by smoking cessation team
8IAj.	Smoking cessation advice declined
8IEK.	Smoking cessation programme declined
9Ndg.	Declined consent for follow-up by smoking cessation team

Smoking Signposting

8CdB.	Stop smoking service opportunity signposted

Smoking referrals

8HTK.	Referral to stop-smoking clinic
8HkQ.	Referral to NHS stop smoking service
8H7i.	Referral to smoking cessation advisor
8T08.	Referral to smoking cessation service
8IEo.	Referral to smoking cessation service declined