ROTHERHAM DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT

www.rotherham.gov.uk

Rotherham Metropolitan Borough Council

Contents

Foreword

Good primary and community care is at the heart of a prevention led health and care system. In the UK the majority of NHS interactions are through services such as General Practice, Pharmacies and district nursing, yet much of the focus on the NHS is on acute and hospital care. High quality primary and community care is essential to the prevention of ill health, and the reduction of demands for hospital and social care services. In their February 2024 report Making Care Closer to Home a Reality the King's Fund argue that for the health and care system in England to be effective and sustainable that the focus must shift from hospital care to primary and community care services.

This is reflected in the Secretary of State for Health's 'three big shifts' that he says are necessary for the future of the NHS; a shift from hospital to community; a shift from analogue to digital; a shift from sickness to prevention.

My DPH report this year focuses specifically on the role of General Practice, looking at the importance of the high-quality management of long-term conditions within the community. General Practices play a significant role in both the prevention and management of ill health in the community and are key to ensuring the best outcomes for patients, the most efficient use of healthcare resources and in reducing demand pressures on secondary and tertiary healthcare services and social care. Universal primary care services are also key in tackling health inequalities, but to achieve this we need to move away from a one-size fits all approach and ensure that care and the service offer provided can be tailored to meet local needs.

Finance models need to recognise the need for flexibility in the delivery of care based on population need, and to actively focus on achieving value through the delivery of health outcomes for people rather than productivity outcomes measured by appointments offered and other activity measures.

Rotherham experiences wide inequalities in health, with a 9.2-year gap in life expectancy for men and 10.0 year gap in life expectancy for women between our least and most deprived communities. These gaps are greater still when compared to the least deprived areas in Yorkshire and Humber and of England as a whole. These health inequalities mean that the Rotherham population as a whole experiences more ill health earlier in life, and that too many of our population are suffering multi-morbidity, or the impact of more than one health condition at once. This is bad for Rotherham's people, bad for Rotherham families and bad for Rotherham's economy.

General Practices are uniquely placed within the health system to impact these inequalities in health. Through their mix of GPs, Practice Nurses, Pharmacists, Social Prescribing Link workers and other allied health professionals, and their position within the heart of communities General Practices are able to support people to stay healthy, to identify risk factors and conditions early when they can be reversed or controlled, and to support the good management of ill-health reducing the impacts this can have on people's quality of life and their ability to contribute to their communities.

To achieve all of these goals however General Practice has to maintain a strong focus on quality, and on the outcomes that matter to the communities they serve, and has to be funded sufficiently to meet those needs, both now and in the future as our local population continues to age.

My report this year looks at how demographic changes in Rotherham are impacting demand on General Practices, and considers the capacity that is needed now and in the future to meet that demand, and to deliver evidence based management of ill-health for all those who need it.

Ben Anderson
Director of Public Health
Rotherham

Background – The Rotherham Population

The population of Rotherham borough is 268,400 (2022 mid-year (30 June) estimate of population) with an age structure that is slightly older than the national average. Rotherham has a below average percentage of people aged 18 to 29 as a result of students leaving Rotherham to study elsewhere and young adults leaving the area for work. The high proportion of residents aged 50-64 is largely a reflection of high birth rates in the 1960's and early 1970's.

Demographic change is likely to result in subsequent changes to demand for health and care services. The Rotherham population has increased steadily by about 1,000 people per year from an estimated 259,400 in 2013 to 268,400 in 2022 (+3.5%). This steady increase was a result of more births than deaths occurring locally, coupled with high net inward migration. The oldest age groups are the fastest growing, mainly those aged 75+.

The growth of Rotherham's population over previous decades has been accompanied by improvements in life expectancy, although these improvements have slowed in the most recent decade. The population of Rotherham is projected to grow as well as continue to change in age structure. There will be an overall estimated 277,742 people in 2030 and 290,166 people in 2040, with noted projected increases in those ager 60 years old and above (figure 1).

The total amount of required health care is dependent on the prevalence of disease in an age group, and the number of people who are that age. The prevalence of diagnosed illness generally increases with population ageing for both the reason that many conditions, such as cardiovascular disease and dementia, have an increased probability of development as age increases, and also that many health conditions are incurable so include new incidences per year (incidences are overall greater in number than deaths or remission). The prevalence and pattern of ill health is important in identifying potential demand for NHS services and people living with multiple conditions tend to make more use of health care services and live uncomfortably.

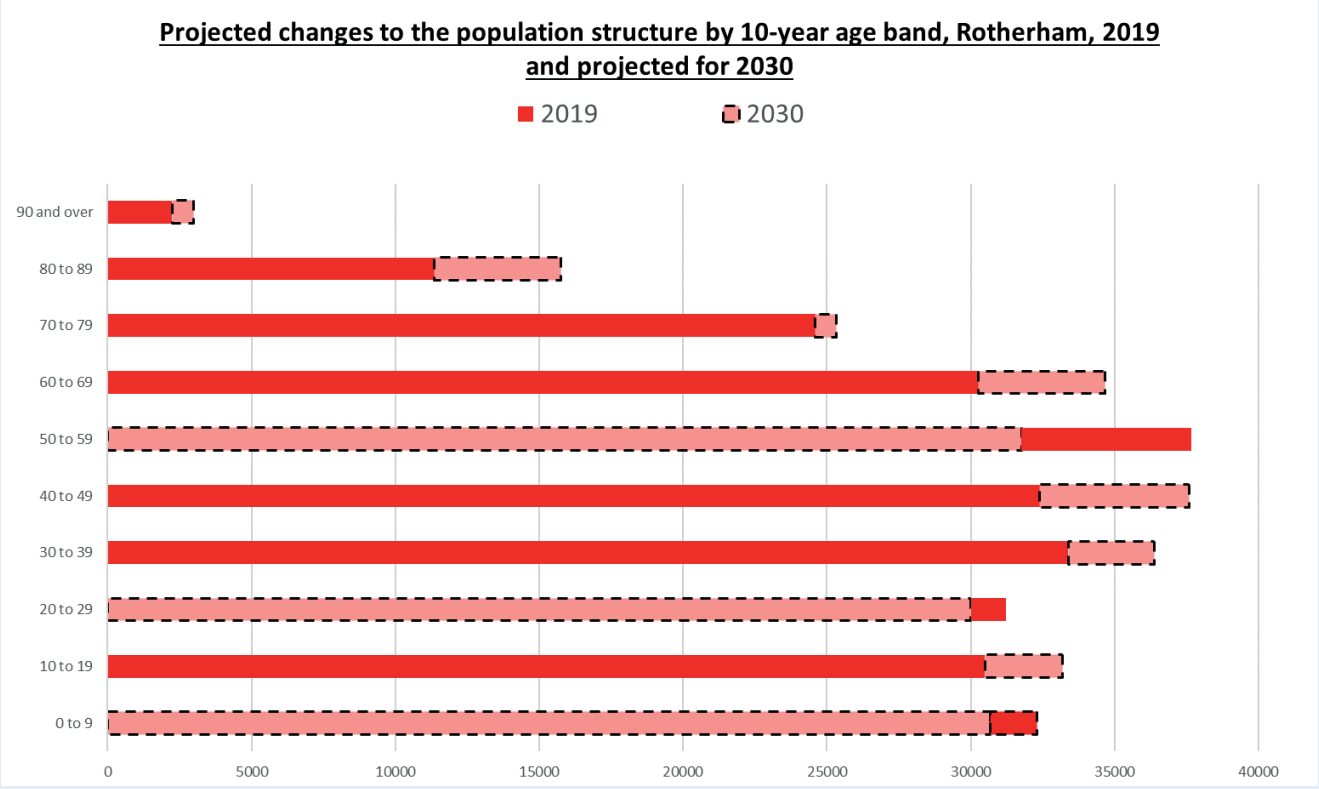


Figure 1: Rotherham population structure 2019 and projected for 2030 by 10-year age band.

Wider determinants and patient activation

General practice services play a critical role in supporting the health of our population, including through instigating interventions for those at risk of ill-health, early diagnosis of long-term conditions and supporting the ongoing management of long-term conditions. However, health outcomes are determined by more than the healthcare that people receive. The environment and circumstances in which people live have a much greater impact on health outcomes than healthcare, and also influence access to services.

Individuals can also have an influence on their health outcomes and staying well. Patient activation is defined as 'understanding one's role in the care process and having the knowledge, skill, and confidence to manage one's health and health care' (Hibbard et al., 2004). The extent to which a patient has the capability, motivation, and opportunity to play an active role in staying healthy and well varies greatly and is determined to a large extent by wider influences such as income, work, education, and other socioeconomic and environmental conditions.

Therefore, although the delivery of general practice services are a key component to improving population health, much of the data presented within this report should be interpreted and understood within the context of these wider contextual factors. It is also clear that how services themselves are delivered can also have an impact on patient activation, and how active patients become in the management of their own health and healthcare interactions.

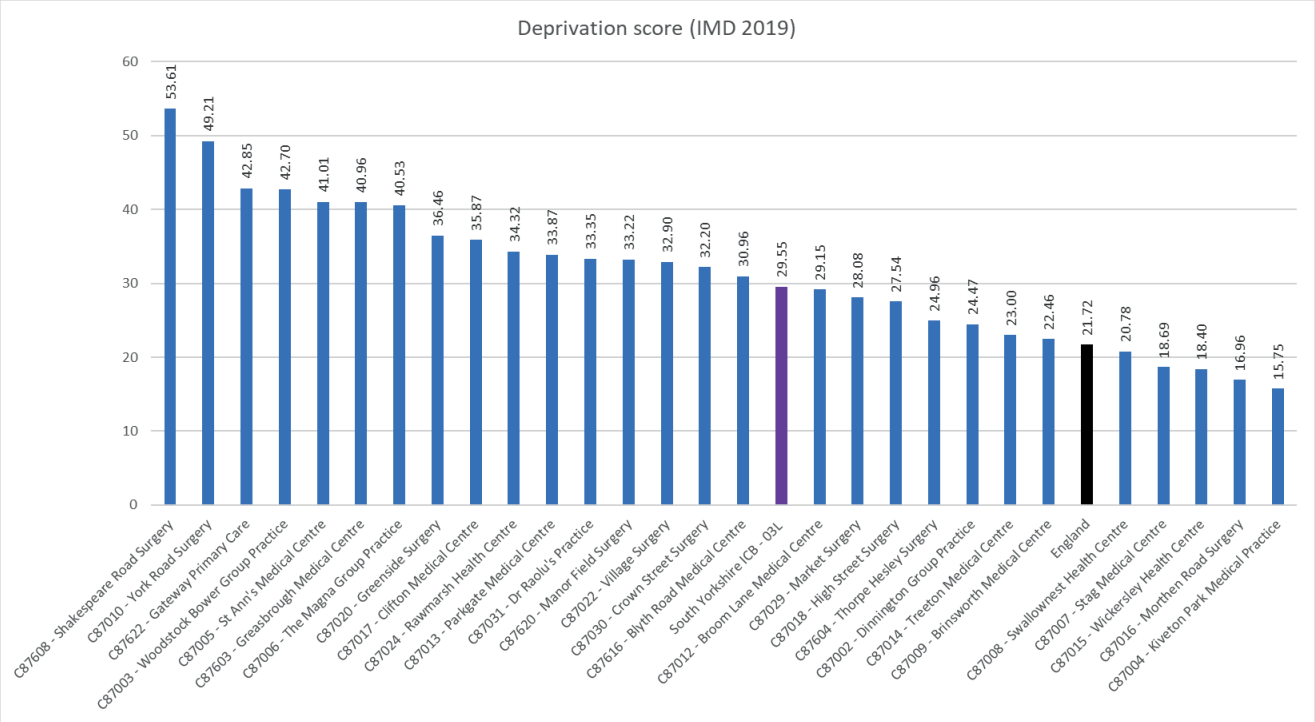
Methodology

This report uses data extracted from NHS Digital reviewing 20 health conditions within five condition groups (cardiovascular, respiratory, high dependency/long term conditions, neurology and mental health, and musculoskeletal). Prevalence for 13 of the 20 conditions explored are above the average for England and the South Yorkshire ICB or Yorkshire and the Humber. Trend data for the previous ten years where available has been used to forecast prevalence over the next ten years for Rotherham. Data has been made available at a level of Primary Care Networks in Rotherham, and General Practices in Rotherham to identify within local area differences. Data for quality outcomes has been reviewed on a Rotherham, Primary Care Network and General Practice level to determine those with met need, unmet need, and exemptions.

Whilst this report reviews health conditions based on general practice data, the Rotherham Joint Strategic Needs Assessment, available here, looks at the current and future care needs and is concerned with wider societal factors that have an impact on people's health and wellbeing such as housing, employment, and health behaviours. These factors have not been used with the data modelled in this report.

Practice deprivation

To try and isolate the prevalence of disease from other wider determinants, we have shown deprivation scores for practices within Rotherham. These scores are based on the registered population of patients at each practice and are weighted according to the proportion from each small geographical area to give one overall score. These scores use the 2019 Index of Multiple deprivation1. Deprivation scores are shown in the below chart (figure 2 and table 1) and are grouped by Primary Care Networks (PCNs) in the table; a higher score represents a more deprived practice. Overall Rotherham General Practices serve populations who are more deprived than both the England and South Yorkshire averages.



1 English indices of deprivation 2019 - GOV.UK (www.gov.uk)

Figure 2: Index of multiple deprivation score, by general practice, Rotherham.

Parent Name	Area Name	Deprivation Score
	England	21.72
England	South Yorkshire ICB - 03L	29.55
Health Village/Dearne Valley PCN	C87005 - St Ann's Medical Centre	41.01
Health Village/Dearne Valley PCN	C87017 - Clifton Medical Centre	35.87
Health Village/Dearne Valley PCN	C87029 - Market Surgery	28.08
Maltby Wickersley PCN	C87031 - Dr Raolu's Practice	33.35
Maltby Wickersley PCN	C87620 - Manor Field Surgery	33.22
Maltby Wickersley PCN	C87616 - Blyth Road Medical Centre	30.96
Maltby Wickersley PCN	C87015 - Wickersley Health Centre	18.40
Maltby Wickersley PCN	C87016 - Morthen Road Surgery	16.96
Raven PCN	C87622 - Gateway Primary Care	42.85
Raven PCN	C87604 - Thorpe Hesley Surgery	24.96
Raven PCN	C87014 - Treeton Medical Centre	23.00
Raven PCN	C87009 - Brinsworth Medical Centre	22.46
Raven PCN	C87007 - Stag Medical Centre	18.69
Rother Valley South PCN	C87022 - Village Surgery	32.90
Rother Valley South PCN	C87002 - Dinnington Group Practice	24.47
Rother Valley South PCN	C87008 - Swallownest Health Centre	20.78
Rother Valley South PCN	C87004 - Kiveton Park Medical Practice	15.75
Rotherham Central North PCN	C87003 - Woodstock Bower Group Practice	42.70
Rotherham Central North PCN	C87603 - Greasbrough Medical Centre	40.96
Rotherham Central North PCN	C87020 - Greenside Surgery	36.46
Rotherham Central North PCN	C87012 - Broom Lane Medical Centre	29.15
Wentworth 1 PCN	C87608 - Shakespeare Road Surgery	53.61
Wentworth 1 PCN	C87010 - York Road Surgery	49.21
Wentworth 1 PCN	C87006 - The Magna Group Practice	40.53
Wentworth 1 PCN	C87024 - Rawmarsh Health Centre	34.32
Wentworth 1 PCN	C87013 - Parkgate Medical Centre	33.87
Wentworth 1 PCN	C87030 - Crown Street Surgery	32.20
Wentworth 1 PCN	C87018 - High Street Surgery	27.54

Table 1: Index of multiple deprivation score, by general practice, Rotherham.

How do we project ill health in Rotherham

Current demand

Data for 2022/23 suggest there are 200,000 diagnosed conditions across the 20 Quality Outcomes Framework (QOF) conditions for patients registered to a Rotherham General Practice (note this does not mean 200,000 unique patients, as a patient may have multiple conditions registered).

Across the five category groups, cardiovascular accounts for 36%, high dependency/long-term conditions account for 25.6%, mental health and neurology account for 23.1%, respiratory account for 13.9%, and musculoskeletal account for 1.2% (figure 3)

The individual conditions with the highest prevalence for 2022/23 were depression with a prevalence of 17.9%, followed by hypertension with a prevalence of 16.6%, diabetes with a prevalence of 8.5%, asthma with a prevalence of 7.8%, and non-diabetic hyperglycaemia (NDH) with a prevalence of 6.6% (figure 4). However, Primary Care Network (PCN) aggregate values for each condition saw a prevalence of up to 20.1% for depression, 18.4% for hypertension, 9.26% for diabetes, 8.6% for asthma, and 8.4% for non-diabetic hyperglycaemia. These conditions were as low as 14.8%, 14.3%, 7.4%, 7.4%, and 6.1% for PCNs respectively. These five conditions account for 67% of total numbers of people diagnosed with unique conditions (134,000 of the 200,000).

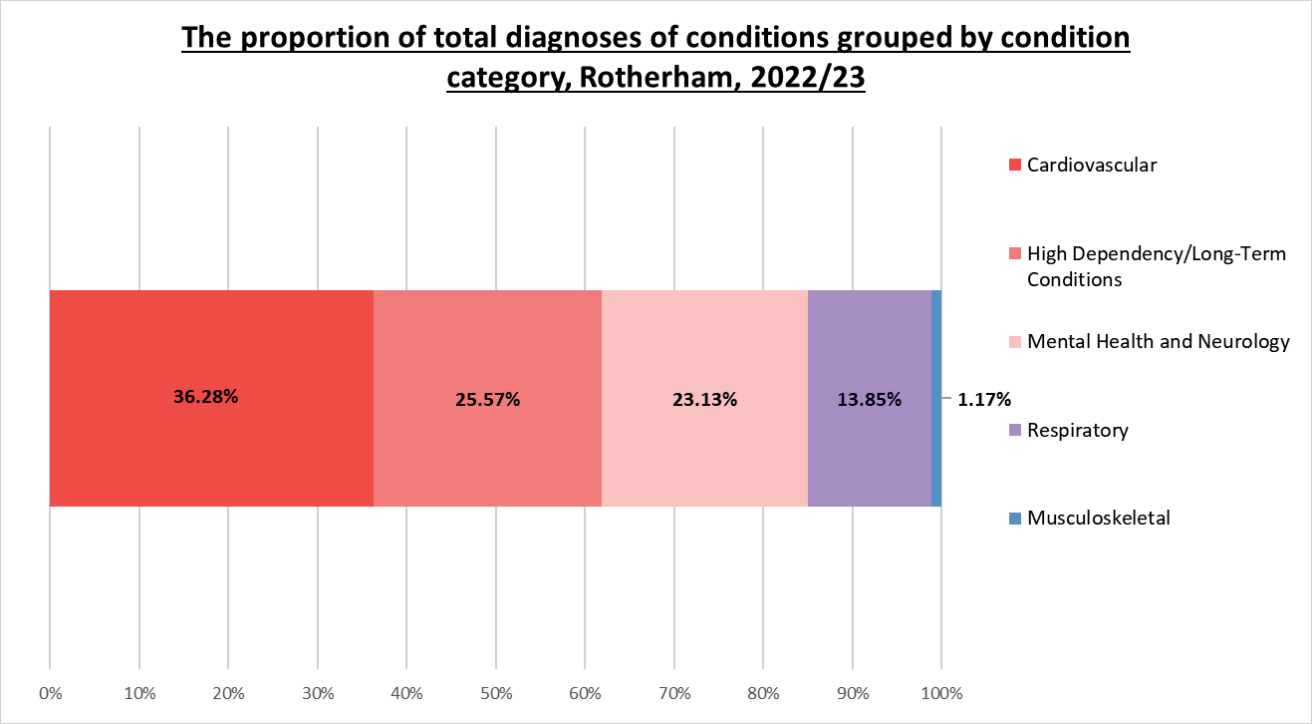


Figure 3: The proportion of total diagnoses of conditions grouped by condition category, Rotherham, 2022/23.

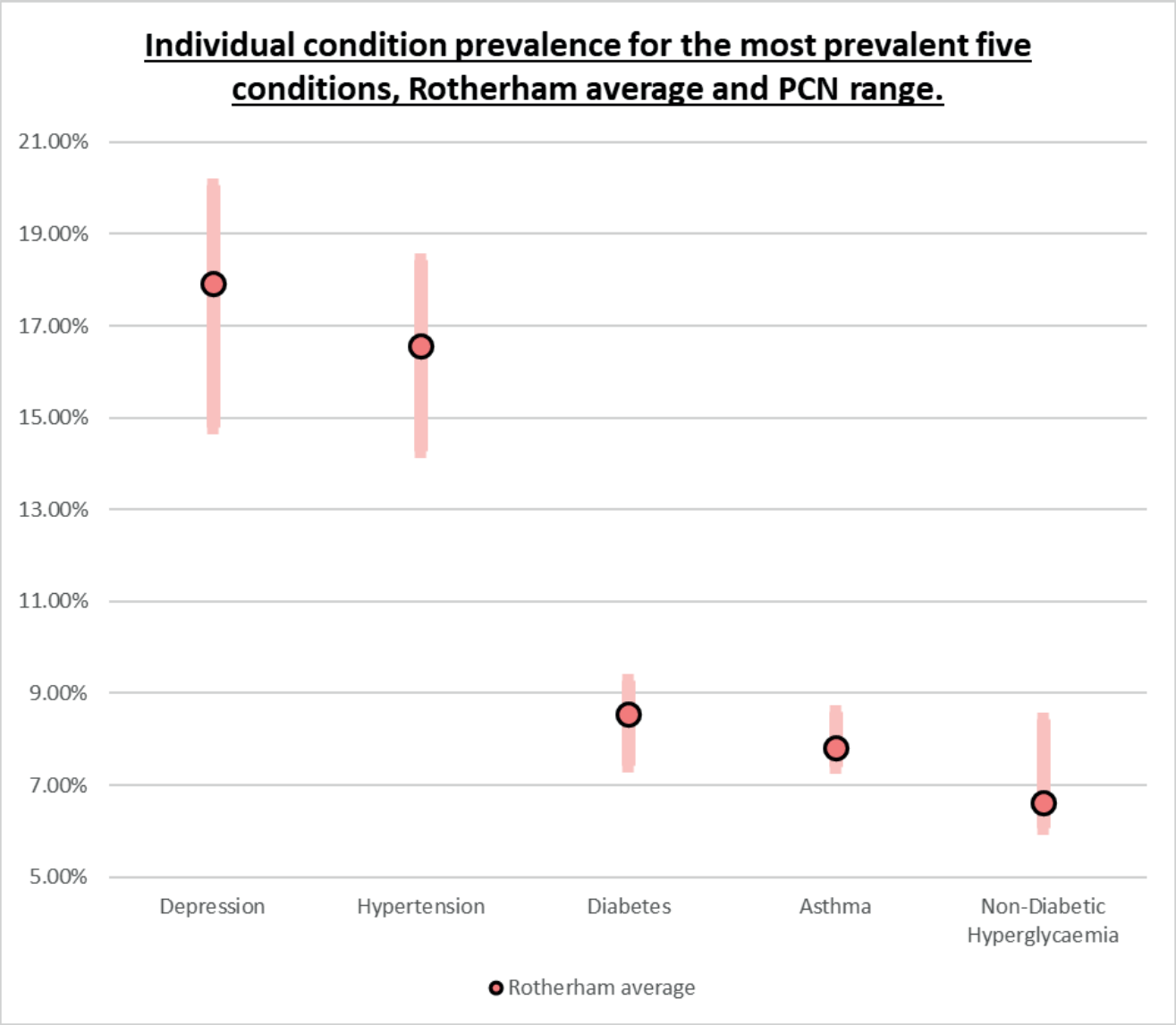


Figure 4: Individual condition prevalence for the five most prevalent conditions, Rotherham average and primary care network range.

Other than the five conditions listed above, all other of the 20 conditions had a prevalence of less than 5 % across PCNs.

Seven conditions had a Rotherham prevalence below 1 % and these were palliative care (0.40 %), osteoporosis (0.44 %), learning disability (0.65 %), peripheral arterial disease (0.72 %), rheumatoid arthritis (0.80 %), mental health (0.95 %), and dementia (0.99 %) (figure 5).

A table showing all 20 conditions and the range within PCNs can be found in the appendix.

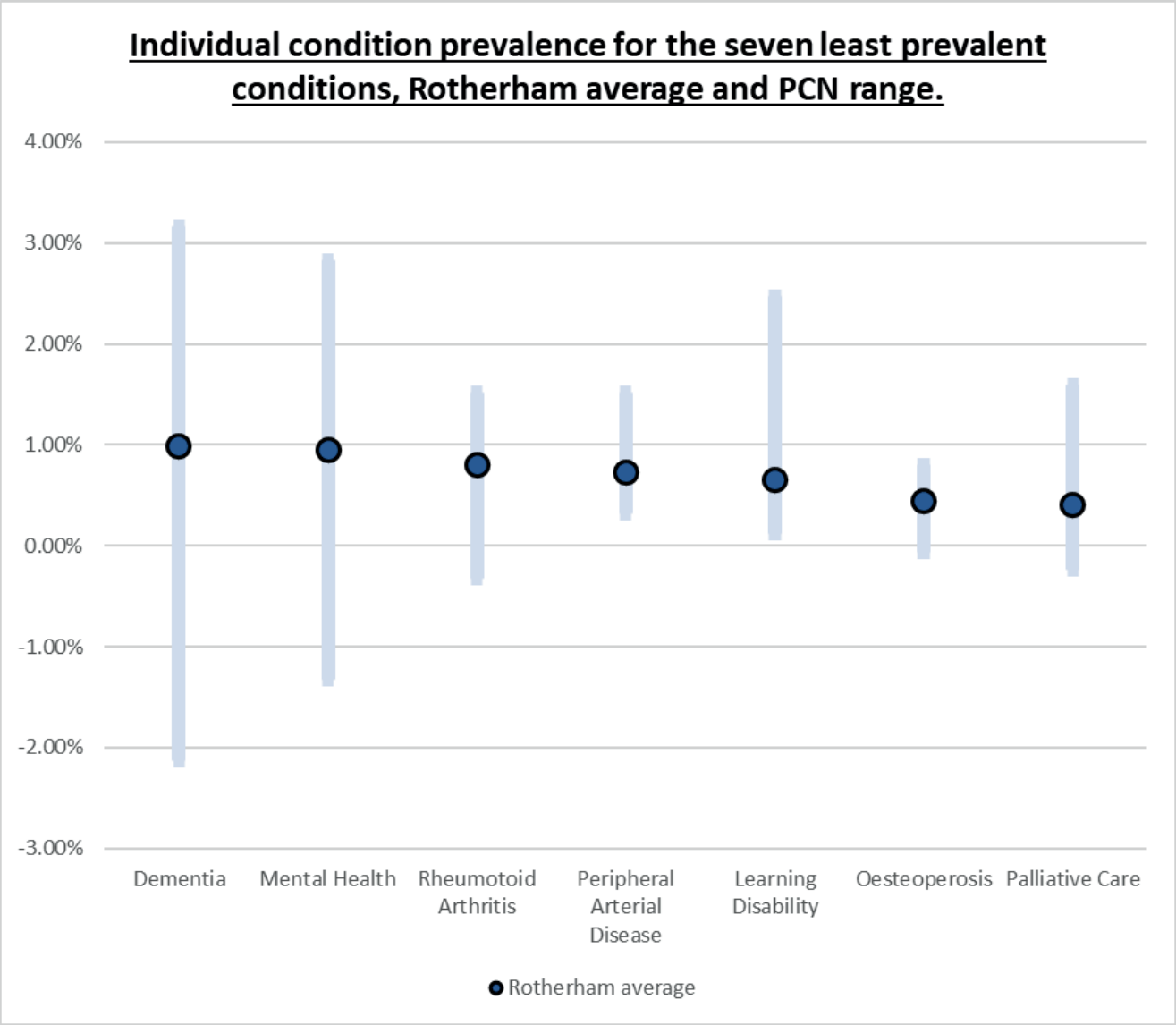


Figure 5: Individual condition prevalence for the seven least prevalent conditions, Rotherham average and PCN range.

How does Rotherham compare to the region and national prevalence?

In order of conditions with the highest prevalence in Rotherham:

- The prevalence of depression in Rotherham was 17.29% in 2022/23, which was 4.1 percentage points above the England average. Rates have been increasing steadily since 2012 when they were 8.86% in Rotherham. However, the prevalence of new depression diagnoses was decreasing from 2015 until 2020 when they increased 0.3 percentage points. In addition to the overall prevalence of depression, data also reports the percentage of patients recorded on a practice register for the first time. Looking at the trend data for newly diagnosed patients can provide insight into the rate at which prevalence increases across PCNs. For example, overall depression prevalence indicates that Rotherham Central North PCN is not increasing as quickly as other PCNs across Rotherham. The data for new depression diagnoses reports that there has been a 1.28 percentage point decrease in patients being newly diagnosed with depression at this PCN over the last 10 years. In contrast, Wentworth 1 PCN has seen the largest increase in newly diagnosed patients from 1.09% in 2013 to 1.63% in 2022. This is the second highest prevalence, with Rother Valley South reporting the highest prevalence of new depression diagnoses at 2.14%.
- In Rotherham hypertension prevalence is 16.56%, which is 2 percentage points higher than across England. Over the previous 10 years, hypertension prevalence has remained consistently 2 percentage points higher than England. Rotherham also has the highest prevalence in South Yorkshire Integrated Care Board (SYICB), which averages 14%.
- Diabetes has been increasing in Rotherham, with 8.54% of the population living with the condition in 2022. This has increased 1.99 percentage points over the last 10 years, compared with an increase of 0.98 across England. Rotherham has the 6th highest prevalence of diabetes in Yorkshire and the Humber.
- Rotherham has the highest prevalence of asthma in Yorkshire and the Humber with 7.8% of the population aged 6 and over recorded as being diagnosed with the condition. Although the recoding method changed in 2020, from including all ages to only individuals 6 and over, the increase in the amount of people with asthma is still visible. Before the method changed, there was a significant increase between 2016 and 2019 from 6.35% of the population to 7.35%.
- Recording of non-diabetic hyperglycaemia has developed over the last 3 years. Prevalence in Rotherham is 6.6%, which is below the England average of 7.1%. However, three PCNs have a higher prevalence than Rotherham and England, which are Health Village/Dearne Valley (8.4%), Rotherham Central North (8.1%), and Rother Valley South (7.9%).
- The prevalence of Coronary Heart Disease (CHD) in Rotherham was at 3.8% in 2022/23, which is above the SYICB average of 3.4%. Over the last 10 years, prevalence in Rotherham has been trending downwards alongside prevalence across England, from 4.4% to 3.8%. However, Rotherham has periods of time where minimal to no change occurs. For example, from 2016 – 2019 prevalence remained at 4.0%, before falling to 3.8% in 2020, where it has remained since.
- The percentage of patients aged 18 and over with Chronic Kidney Disease (CKD) in Rotherham is the lowest in SYICB at 3.6%, compared with 3.9% across all locations.

Rotherham has a lower percentage of patients with CKD than both South Yorkshire ICB and England and has seen a decrease of 1.5 percentage points over the last ten years.

- Amongst adults in Rotherham, 2.94% were diagnosed as having Chronic Obstructive Pulmonary Disease (COPD) in 2022/23, which is the second highest prevalence in SYICB.. Between 2009 and 2022 prevalence of COPD has varied by 0.68 percentage points in Rotherham, compared with England which has only varied by 0.37 percentage points during this time period.
- The prevalence of atrial fibrillation in Rotherham is the highest amongst SYICB, with 2.4% of the population having the condition. Over the last 10 years this has increased by 0.71 percentage points from 1.69%, compared with a 0.52 percentage point increase across the whole ICB.
- Rotherham has the highest prevalence of stroke within the SYICB at 2.32%, compared with 2.19% in England.
- Rotherham has the highest occurrence of epilepsy within SYICB. The prevalence of epilepsy in Rotherham has increased from 0.96% in 2012 to 1.08% in 2022.
- Within SYICB Rotherham has the lowest prevalence of heart failure at 1.03%, compared to the region average of 1.15%. Over the last 10 years, heart failure has averaged between 0.8% and 0.9% until 2018 when it spiked to 1.13%. Since 2018 it has fallen back to 0.97%, but the upwards trend has continued since then.
- Rotherham has the highest prevalence of dementia, 0.99%, across SYICB, which has been declining since 2018 when it was at 1.03%. The dementia mortality rate is highest among females (129 per 1000,000) compared with males (98 per 100,000).
- There is a lower prevalence of severe mental illness (SMI): schizophrenia, bipolar affective disorder, and other psychoses, in Rotherham, 0.95%, than across England 1%. Since 2015, the prevalence of mental health in Rotherham has remained below that of England.
- Prevalence of rheumatoid arthritis (RA) in Rotherham is comparable to England at 0.8%.
- The percentage of patients on Rotherham GP registers with Peripheral arterial disease (PAD) is currently 0.72%, which is 0.1 percentage points higher than England. Although prevalence of PAD is higher in Rotherham than across England, it has decreased from 0.85% in 2013 to 0.72% in 2022.
- Less than 1% of people across SYICB are recorded as having a learning disability on a GP register. In Rotherham 0.65% of residents are recorded to have a learning disability, compared with 0.67% across South Yorkshire ICB. The prevalence of learning disabilities has increased 0.1 percentage points over the last 10 years in Rotherham.
- The prevalence of osteoporosis in Rotherham is 0.44%. While PCN's prevalence varies between 0.17% and 0.65%, all PCNs are below the England average of 1.0%.

Projections

If we combine the projections of the prevalence of conditions and the projected populations for Rotherham, it is possible to estimate the number of people who will be living with a health care condition in the future.

Overall, 36,900 more people are projected to be living with at least one of the nineteen conditions (this excludes NDH due to uncertainty in projection estimates) in 2032/33 than they were in 2022/23. Since 2013/14, we have seen an increase of 37,200, however the proportion within each of the five condition categories have changed. From

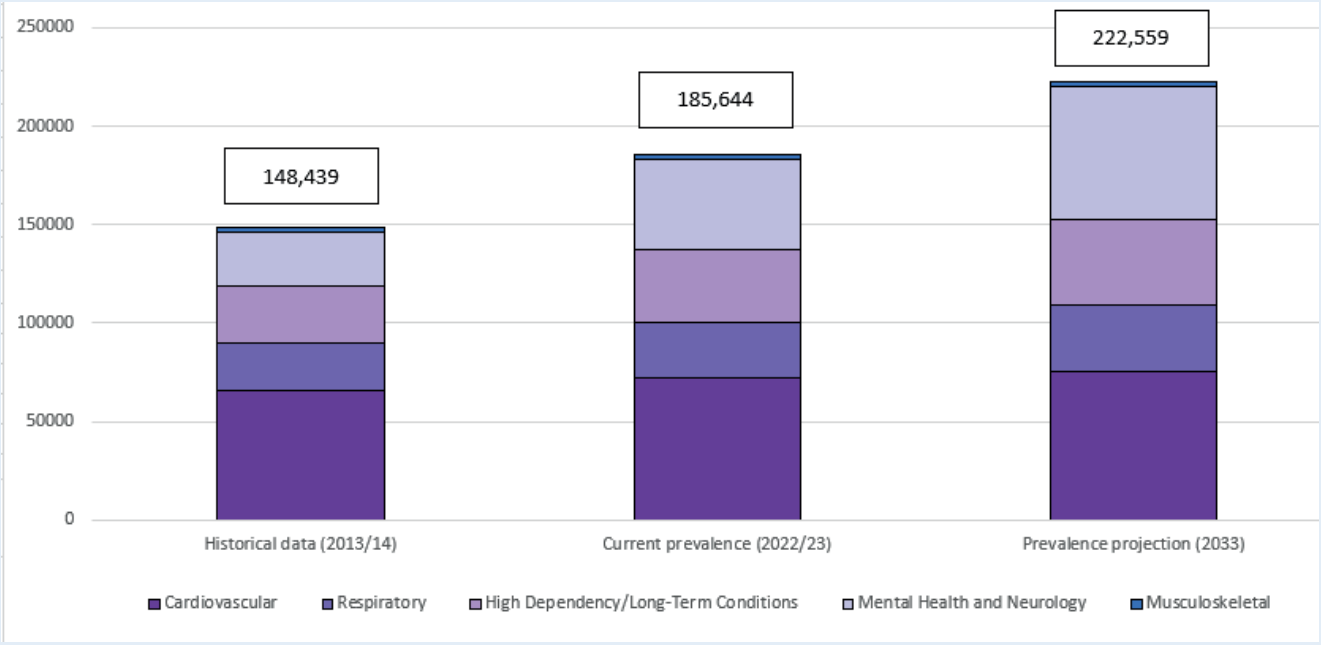


Figure 6: Historical, current, and projected number of unique conditions recorded on general practice QOF registers, Rotherham.

2013/14 to 2022/23, there has been an increased proportion of diagnoses from the mental health category, an increase from 19% to 25%, and there has been a decrease in the diagnoses in the cardiovascular category, a decrease from 44% to 39% (figure 6). These changes in number are dependent on both the increasing prevalence of a condition within an age group, and the increased number of people within the age group.

The prevalence of these conditions increases when the number of newly diagnosed (incidence) is greater than the number of people cured or dying, however, as many of these long-term conditions have no cure, an increased prevalence is indicative of an increased incidence but may also indicate an increased survival rate (i.e., people are living longer with health conditions). Higher prevalence therefore implies an increase in the total number of diagnosed cases of individual conditions which will feed through into a change in the total demand for care and appointment numbers.

We estimated the total number of people diagnosed with the condition by applying trend data from the previous 10-years (where available) to provide a prediction of prevalence and applying this prevalence to population projections in the associated age groups (please note age groups for conditions differ). These estimates are shown in table X.

Projections suggest that 16 of the 20 conditions will increase in prevalence by 2033. The exceptions are: coronary heart disease and peripheral arterial disease which have been positively impacted by falling smoking rates and changing prescription patterns; chronic kidney disease which has been shown to be impacted by recording issues and rather not a decrease in number of people living with the condition; and rheumatoid arthritis which remains similar in projections.

The five most prevalent conditions now depression, hypertension, diabetes, asthma, and non-diabetic hyperglycaemia, will remain the most prevalent conditions with depression projected to reach a prevalence of 26.7%, non-diabetic hyperglycaemia 18.3%, hypertension 16.9%, diabetes 10.8%, and asthma 9.7% (table 2).

Conditions by Group Cardiovascular	**Past Prevalence % (Year)** (2013 unless specified)	**Current Prevalence 2022/23** (%) -	**Predicted Prevalence (%) 2033** (95 % confidence intervals)
Atrial Fibrilation	1.69	2.44	3.40 (3.13 - 3.68)
Coronary Heart Disease	4.31	3.80	3.14 (2.93 - 3.36)
Heart Failure	0.8	1.04	1.40 (1.27 - 1.53)
Hypertension	15.9	16.56	16.94 (16.57 - 17.32)
Peripheral Arterial Disease	0.85	0.72	0.58 (0.46 - 0.71)
Stroke	2.07	2.32	2.60 (2.39 - 2.81)
Respiratory			
Asthma	6.50	7.80	9.69 (8.50 - 10.88)
COPD	2.69	2.94	3.27 (2.91 - 3.64)
High Dependency/Long-Term Conditions			
Cancer	2.12	3.63	5.51 (5.36 - 5.66)
Chronic Kidney Disease	4.60	3.59	2.05 (1.43 - 2.66)
Diabetes	6.55	8.54	10.81 (10.60 - 11.03)
Non Diabetic Hyperglycae-mia	4.46 (2020)	6.62	18.33 (17.97 - 18.69)
Palliative Care	0.35	0.38	0.43 (0.38 - 0.49)
Mental Health and Neurology			
Dementia	0.77	0.99	1.16 (0.81 - 1.51)
Depression	9.85	17.29	26.68 (26.05 - 27.30)
Epilepsy	0.97	1.08	1.20 (1.17 - 1.22)
Learning Disability	0.65	0.66	0.75 (0.49 - 1.01)
Mental Health	0.87	0.95	0.99 (0.94 - 1.03)
Musculoskeletal			
Osteoporosis	0.4	0.44	0.66 (0.15 - 1.18)
Rheumatoid Arthritis	0.89	0.85	0.80 (0.70 - 0.89)

Figure 6: Historical, current, and projected number of unique conditions recorded on general practice QOF registers, Rotherham.

The conditions with the largest percentage point increase are non-diabetic hyperglycaemia* (11.7), depression (9.4), diabetes (2.3), and asthma (1.9) (figure 7). These predictions include a 95 % confidence interval, in which it is predicted 95 % of future prevalence will fall between.

**Please note that non-diabetic hyperglycaemia is a newly reported measure and therefore projections are based on reduced historic data and may appear to increase faster than what would ordinarily be expected.*

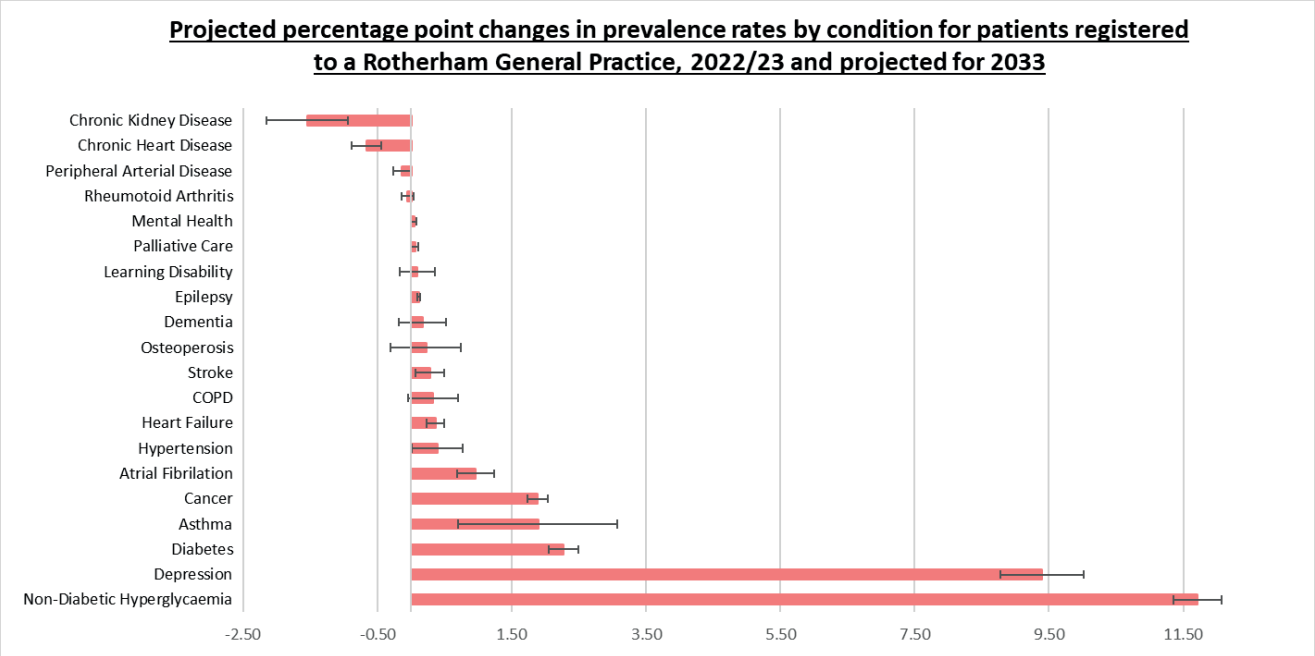


Figure 7: Projected percentage point changes in prevalence rates by conditions for patients registered to a Rotherham general practice.

However, as the population grows, there will be an associated further number of people diagnosed with these conditions, and the conditions which have the largest impact for absolute numbers of people will be increases for non-diabetic hyperglycaemia (25,000), depression (20,000), cancer (5,000) and diabetes (5,000).

Quality analysis

The NHS England 'Core20PLUS5' is a national approach to inform action to reduce healthcare inequalities at both national and system level and provides an approach to reducing healthcare inequalities across target populations. The '5' is a focus on five clinical areas requiring accelerated improvements: Maternity, Severe Mental Illness, Chronic Respiratory Disease, Early Cancer Diagnosis, and Hypertension. These five clinical areas are closely related to our findings from quality analysis detailed below.

Primary prevention through reducing the risk factors associated with ill health, such as stopping smoking and maintaining a healthy weight, will delay the onset of many health conditions. Alongside this, monitoring of health with prompt intervention may also make these conditions easier to manage with reduced complications,, allowing people to have a better quality of life and live longer, even if they do develop illness. The Quality Outcomes Framework is a pay incentive scheme in England designed to improve and standardise general practice. QOF attainment has been used as a proxy for primary care quality for each condition and have been used to identify monitoring of each condition. As there are often multiple targets within each condition management, one has been selected based on National Institute for Health and Care Excellence (NICE) Guidance to assess how many patients needs are being met, how many are unmet, and if there are any exempt from the indicator. The below data reflects those with the target 'met' as a proportion of all eligible (that is the met, unmet, and excluded/exempted) (figure 8). A full table including NICE guidance rationale and targets can be found in appendix 1.

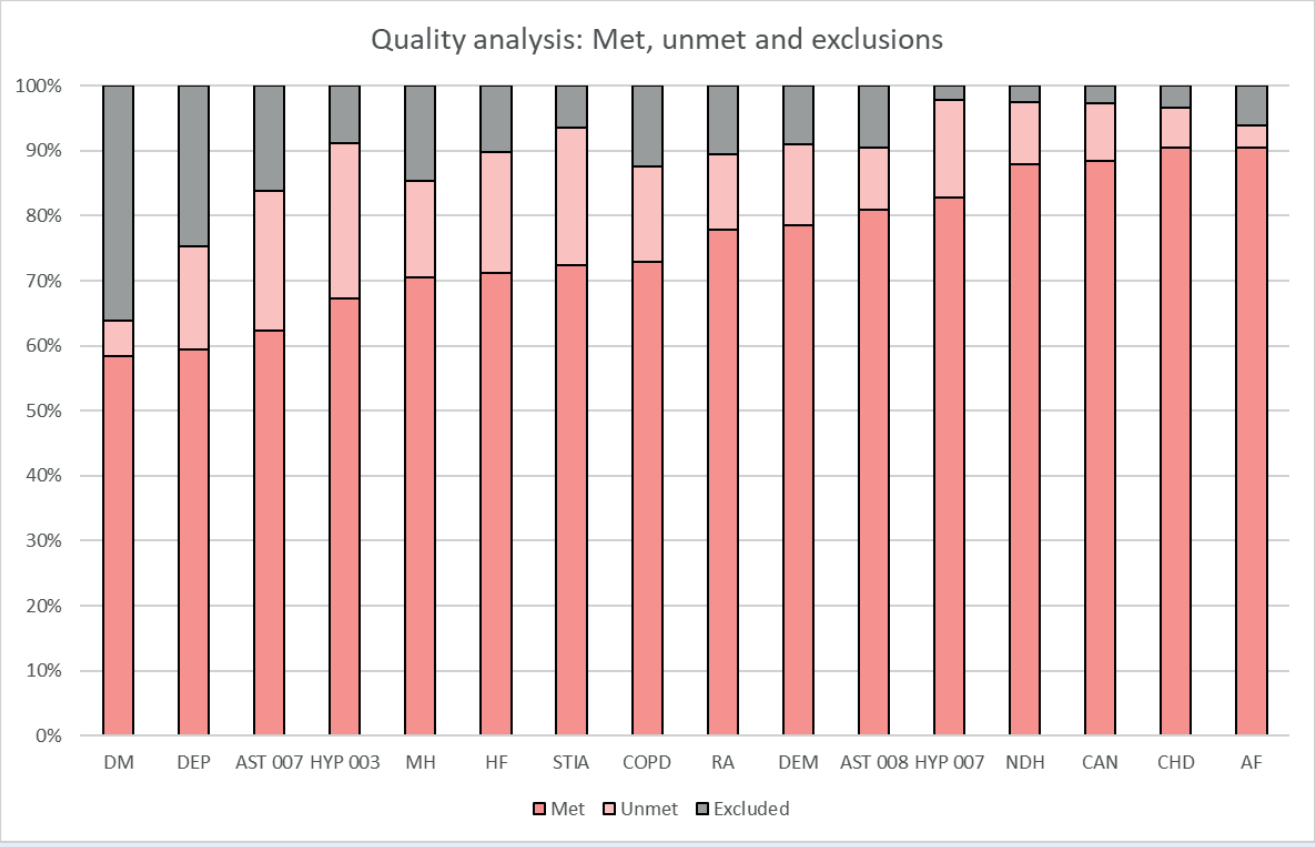


Figure 8: Proportion of patients by condition with met, unmet, and excluded/exempted quality indicators.

Quality analysis by individual condition

As above, the quality data below is based on one, or in some cases two, selected measures within each condition selected using NICE guidance (please see appendix for rationale document). All data refer to data obtained for general practices and primary care networks in Rotherham unless otherwise specified. Denominator data represents all patients on the condition register; therefore, the numerator is the total of people receiving the intervention/assessment.

Please note that although variation is described in terms of general practices and primary care networks, we acknowledge that access to general practice is about more than just the supply of appointments and other factors matter too, such as how people decide what to do about symptoms, their knowledge of health services, the barriers they face to reach services. We also note that quality is influenced by reach of support functions outside of the remit of general practice across place, for example laboratory access for screening and results. Although this report is Rotherham specific, nationally we also experience unwarranted variation across health conditions seen related to age, socio-economic status and ethnicity.

Range between practices

At a practice level, conditions that have the greatest range of the proportion of patients achieving the quality outcome are for heart failure, depression, diabetes, rheumatoid arthritis and cancer (figure 9 shows Rotherham average, PCN range and GP range).

- For heart failure, patients with a diagnosis of heart failure on the register who have had a review in the preceding 12 months, ranges from 7.66% at St Ann's Medical Centre through 97.14% at Rawmarsh Health Centre.
- For, depression, the percentage of patients aged 18 or over with a new diagnosis of depression who have been reviewed between 10 and 56 days, ranges from 5.24% at Crown Street Surgery through 85.31% at The Magna Group Practice.
- For diabetes, the percentage of patients newly diagnosed with diabetes, who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register, ranges from 17.65% at Treeton Medical Centre through 94.03% at Clifton Medical Centre.
- For Rheumatoid arthritis, the percentage of patients who have had a face-to-face review in the previous 12 months, ranges from 34.29% at Shakespeare Road Surgery to 95.70% at The Magna Group Practice.
- For cancer, patients who have a patient Cancer Care Review using a structured template recorded as occurring within 12 months of diagnosis, the range is from 40% at Wickersley Health Centre to 100% at 20 practices.

  As the quality indicator for the following conditions is to maintain a register, these are all at 100% across all practices in Rotherham: Peripheral Arterial Disease, Chronic Kidney Disease, Palliative Care, Epilepsy, Learning Disability and Osteoporosis.

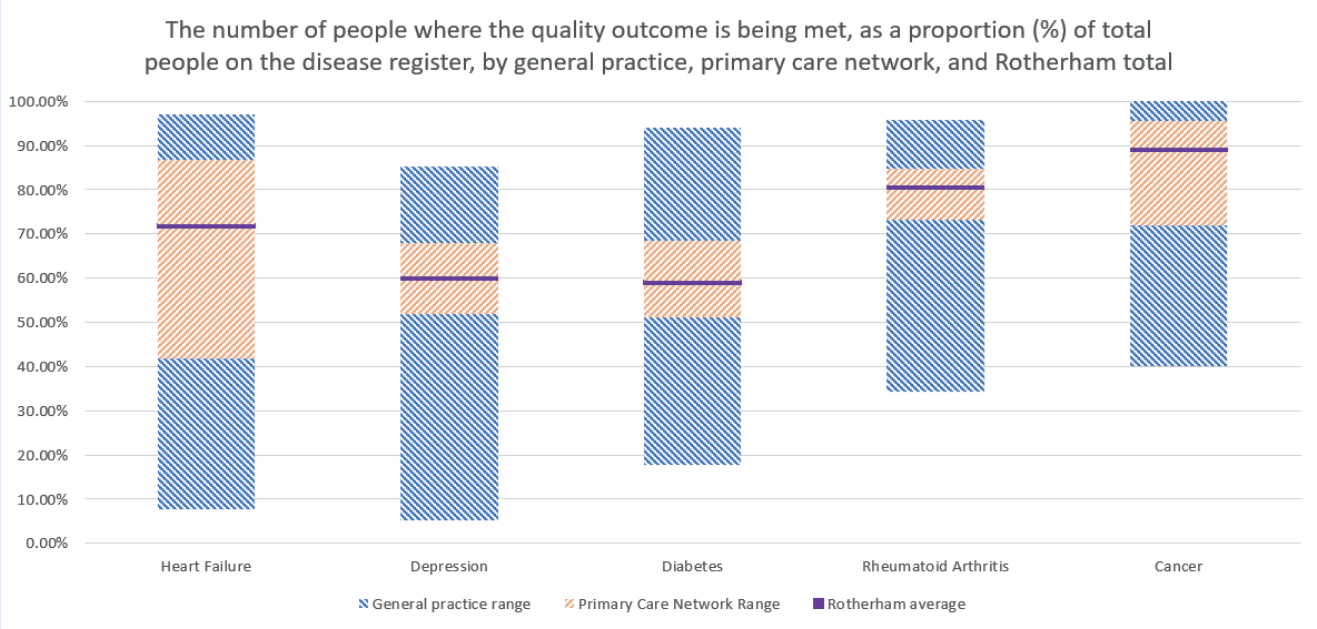


Figure 9: The number of people where the quality outcome is being met, as a proportion (%) of total people on the disease register, by general practice, primary care network, and Rotherham average

One condition with a small range between practices is for hypertension where work has been done resulting in increases in achievement rates and development of a dashboard which highlights to practices missed opportunities. In February 2024, it was noted that there was no inequity between practices achieving CVD threshold.

Conditions with the lowest quality achievement

The conditions that have the lowest quality achievement based on the Rotherham average are diabetes (58.5%), depression (59.4%), asthma (62.3%), hypertension (67.2%) and mental health (70.4%) (figure 10).

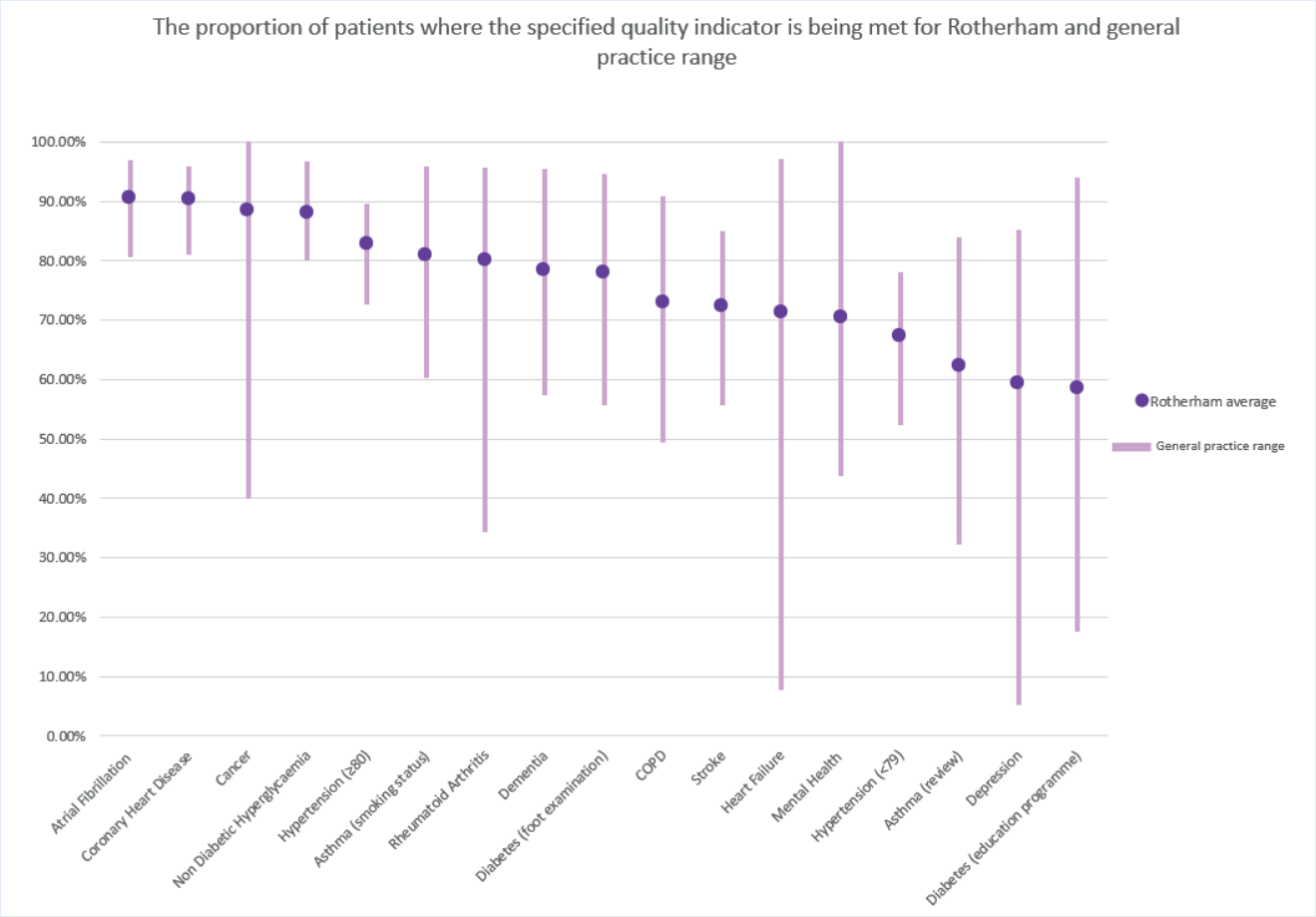


Figure 9: The number of people where the quality outcome is being met, as a proportion (%) of total people on the disease register, by general practice, primary care network, and Rotherham total

Additional assessments

To understand how many additional patients could be receiving an assessment or intervention, we have compared the actual number receiving this as a comparison to the total number of people that would be receiving this if every general practice within Rotherham achieved the same proportion as the highest in Rotherham for that condition.

Across 17 indicators, if every general practice in Rotherham achieved the same value as for the highest practice for that condition in Rotherham, there would be an additional 19,750 people having their condition assessed or additional guidance given. Please note that this is 17 conditions as these conditions are excluded as all practices are at 100%: peripheral arterial disease, chronic kidney disease, palliative care, epilepsy, learning disability, and osteoporosis.

The conditions which could have the greatest additional numbers if the Rotherham highest was met, was for Asthma, Hypertension, Diabetes, COPD and Non-Diabetic Hyperglycaemia (figure 11).

- For asthma, an additional 4,263 patients could have had an asthma review in the preceding 12 months using a validated asthma control questionnaire, a recording of the number of exacerbations, an assessment of inhaler technique and a written personalised asthma plan.
- For hypertension, to meet the Rotherham average, an additional 3,912 patients aged 79 years or under with hypertension would have required the last blood pressure reading (measured in the preceding 12 months) to be 140/90 mmHg or less. For those aged over 80 years old, this would be an additional 607 patients.
- For diabetes, an additional 3,062 patients on the register, would have had a foot examination and risk classification, and an additional 492 would have record of being referred to a structured education programme within 9 months after entry on to the diabetes register.
- For COPD, an additional 1,419 patients would have had a review in the preceding 12 months which included the number of exacerbations and an assessment of breathlessness.
- For Non-diabetic Hyperglycaemia (NDH), it is important to monitor to avoid progression to diabetes. This is monitored by performing a HbA1c test evaluating blood sugar levels over two to three months, or a fasting blood glucose test, which the patient doesn't eat for up to eight hours before the test. An additional 1,235 patients would have been monitored in this way if the value from the highest practice was met.

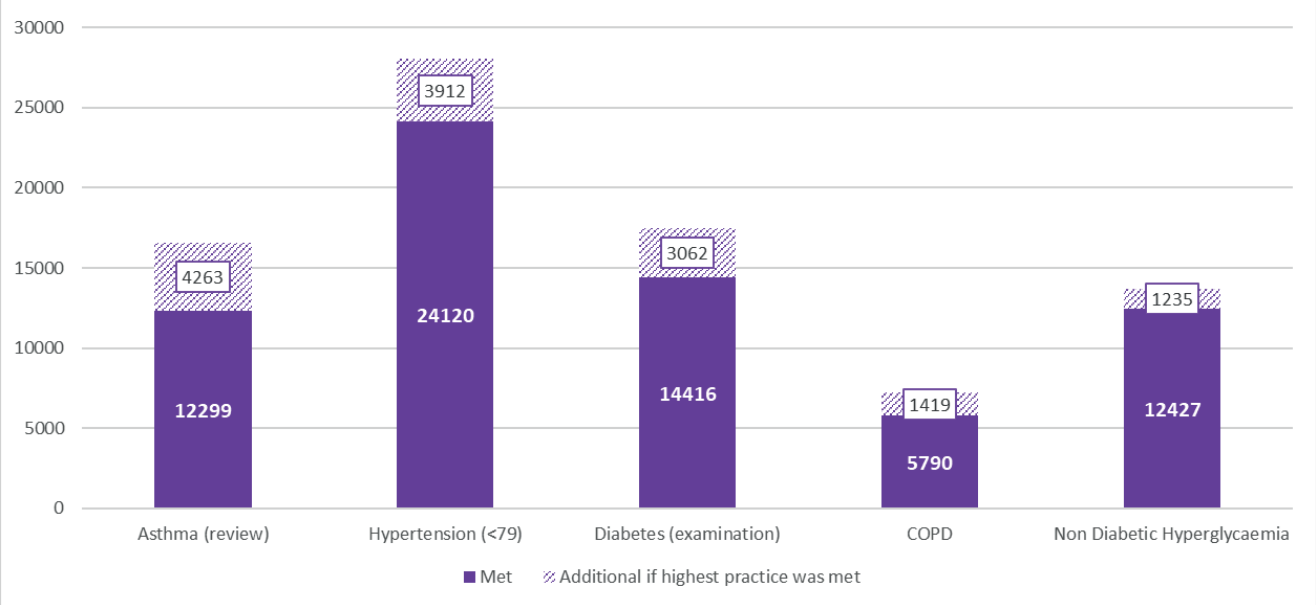


Figure 11: Number of assessments and calculated numb.er of potential assessments if the highest performing practice in Rotherham is met, by condition.

Other conditions

Data have been calculated for all conditions (figure 12).

- The indicator for depression records the percentage of patients, aged 18 and over, with a new diagnosis of depression who have a review between 10 and 56 days of diagnosis. Improvements to bring all practices to the highest percentage, would provide follow up reviews to a further 860 patients newly diagnosed with depression.
- For heart failure, an additional 727 patients would have received a review in the preceding 12 months which would include a review of functional capacity and medication.
- Individuals with mental health conditions are entitled to an assessment of their needs with a mental healthcare professional, and to have a care plan that's regularly reviewed. A care plan is a written agreement of day to day supports needed and who will provide them, such as help with housing or support at home. If all patients were documented as having a care plan they are entitled to, then 633 more care plans would have taken place to be recorded during the year.
- With coronary heart disease being a major cause of death in the UK it is important to know how many patients may be taking preventative measures to reduce the risk of further issues. A common measure is taking aspirin, an alternative anti-platelet therapy, or an anti-coagulant, and an additional 548 patients could be using these preventative medications if the Rotherham highest value was met.
- If the value was met for stroke, an additional 537 patients aged 79 years or under, with a history of stroke or TIA, could have their last blood pressure reading (measured in the preceding 12 months) to be 140/90 mmHg or less.
- Care for dementia patients includes a face-to-face review every 12 months following diagnosis. If all practices were achieving the proportion of face-to-face reviews, then there would be an additional 456 reviews a year with dementia patients.
- An additional 291 patients living with rheumatoid arthritis could have had a face-to-face review in the preceding 12 months if the Rotherham target was met.
- Individuals with Atrial Fibrillation are known to be at a higher risk of stroke therefore, it is important to monitor their risk of stroke as part of their treatment. If all practices were assessing at the rate of the best performing practice, a further 215 patients would have their risk of stroke recorded.
- With 1 in 2 people getting cancer within their lifetime, it is important that patients who are newly diagnosed receive support and guidance. General practices keep records of patients that have had discussions with, and informed of support within 3 months of diagnosis, and patients who receive a Cancer Care Review within 12 months of diagnosis, and if this was as high across Rotherham, as the best performing practice, this would be an additional 126 patients having a review. In collaboration with Macmillan, QOF indicators for cancer for 2023/24 have been updated to focus on the key times when patients feel most vulnerable and should be receiving a CCR to within 3 months of diagnosis and within 12 months of receiving acute treatment.

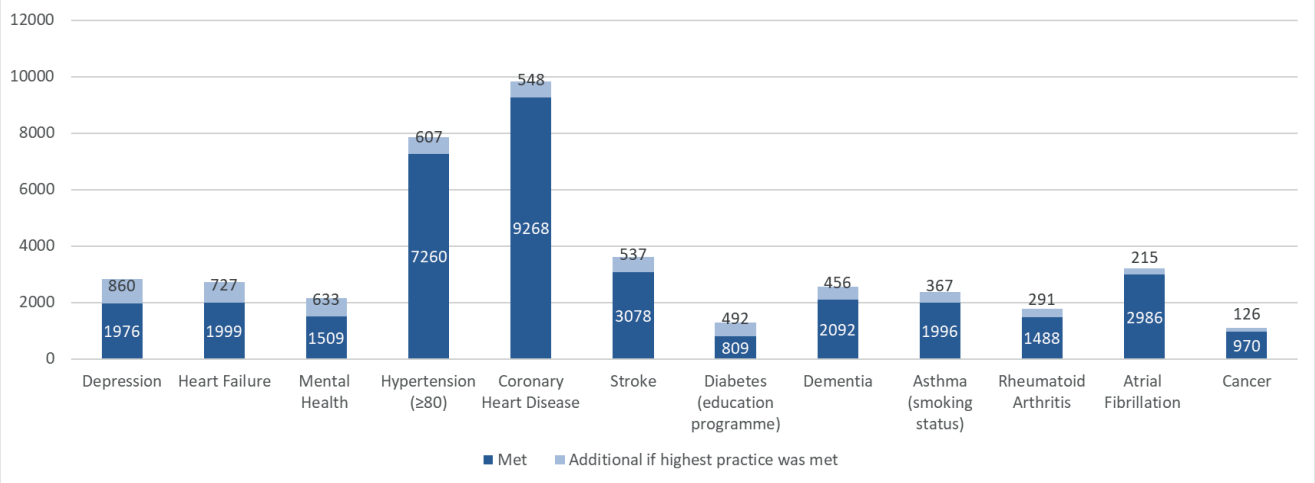
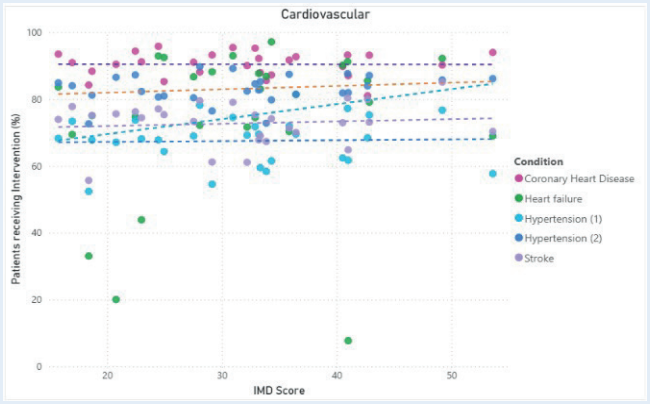
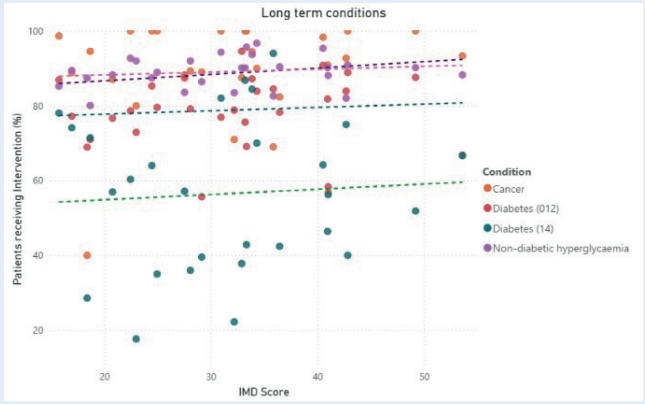


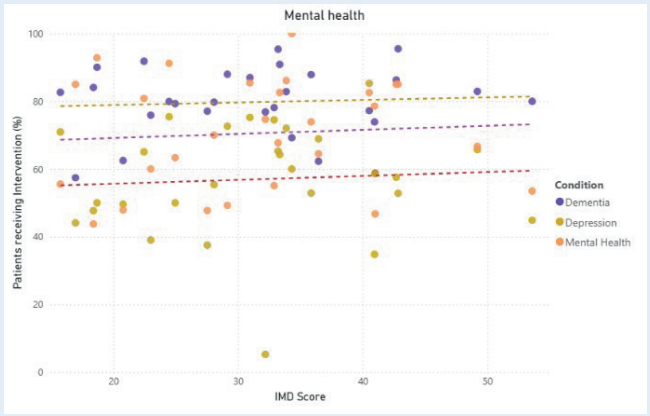
Figure 12: Number of assessments and calculated number of potential assessments if the highest performing practice in Rotherham is met, by condition.

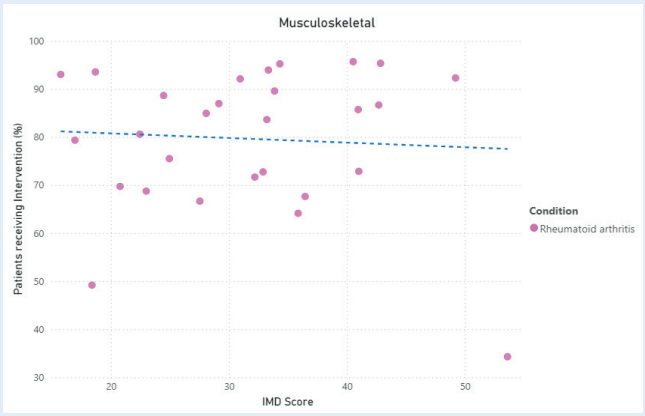
Association between registered patient population and health quality outcomes

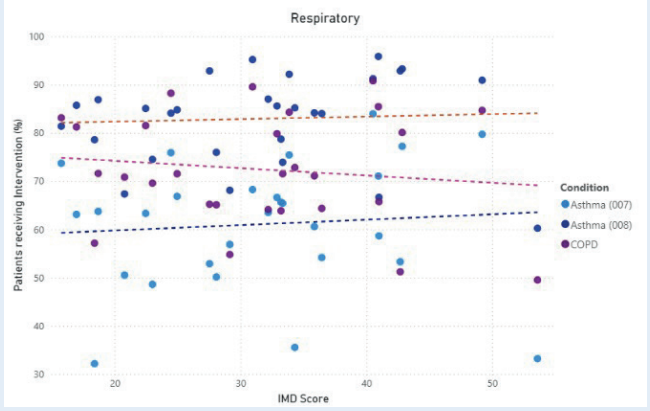
To determine if it is due to difference in patient population that results in changes in outcomes, we have reviewed the relationship between deprivation and quality achievement. As deprivation adjusts for income deprivation, employment deprivation, education, skills and training deprivation, crime deprivation, health and disability deprivation, barriers to housing and services, and living environment deprivation, we may expect any additional differences to be as a result of practice variation. As there appears to be weak or no association between quality outcome and deprivation, it is suggested there are individual practice differences that may be influencing the quality outcomes. Figures below show the association between practice deprivation score and the proportion of patients receiving the interventions identified in the quality analysis.











How could quality impact appointment sufficiency?

Looking at quarterly appointment data over the last 5 years shows that, even with the decline during the COVID-19 Pandemic, the amount of people scheduling appointments continues to increase and from 2019 to 2022 appointments increased by 203,764 (figure 13).

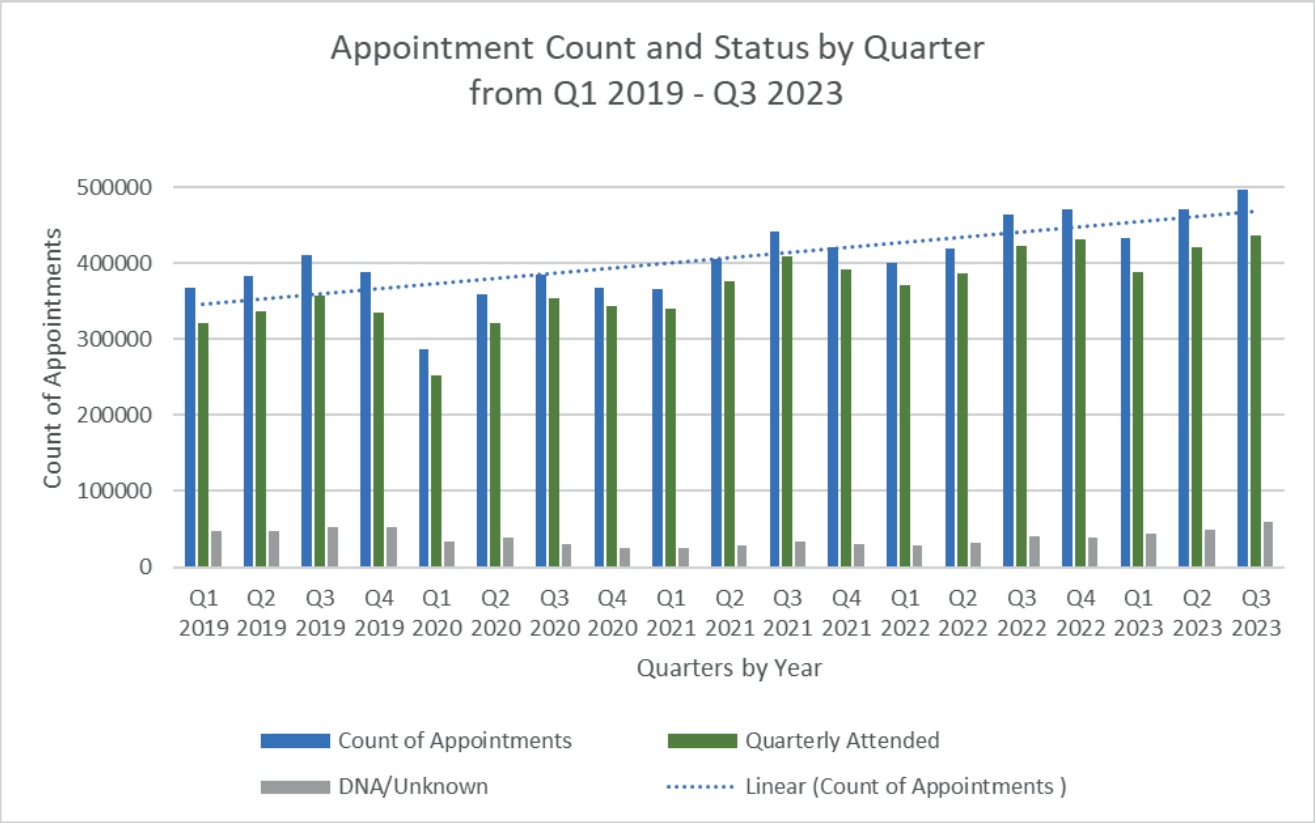


Figure 13: Number of appointments in Rotherham general practice, 2019-2023.

In this report, we have reviewed available information on diagnostic period, estimated contact if a condition is stable, estimated contact if a condition is poorly controlled, exacerbated, or deterioration, and best practice management to determine appointment sufficiency in line with the projected prevalence of individual conditions.

Data was available and applicable for 15 of the 20 conditions, and we have estimated the number of appointments needed if these conditions follow a standard diagnosis and are stable, as per NICE guidance, in comparison to if the condition is exacerbated, or requires additional medical assistance, (please note these are crude, estimated averages and we acknowledge that there will be occasions where fewer, or additional, contacts are required).

Based on 2022/23 QOF prevalence data, it is estimated that stable management of a condition could result in fewer appointments than if poorly managed across most conditions (figure 14).

Achieving this would require a focus on quality coupled with a clear strategy to reach excluded patients and tackle inequalities in access and outcomes.

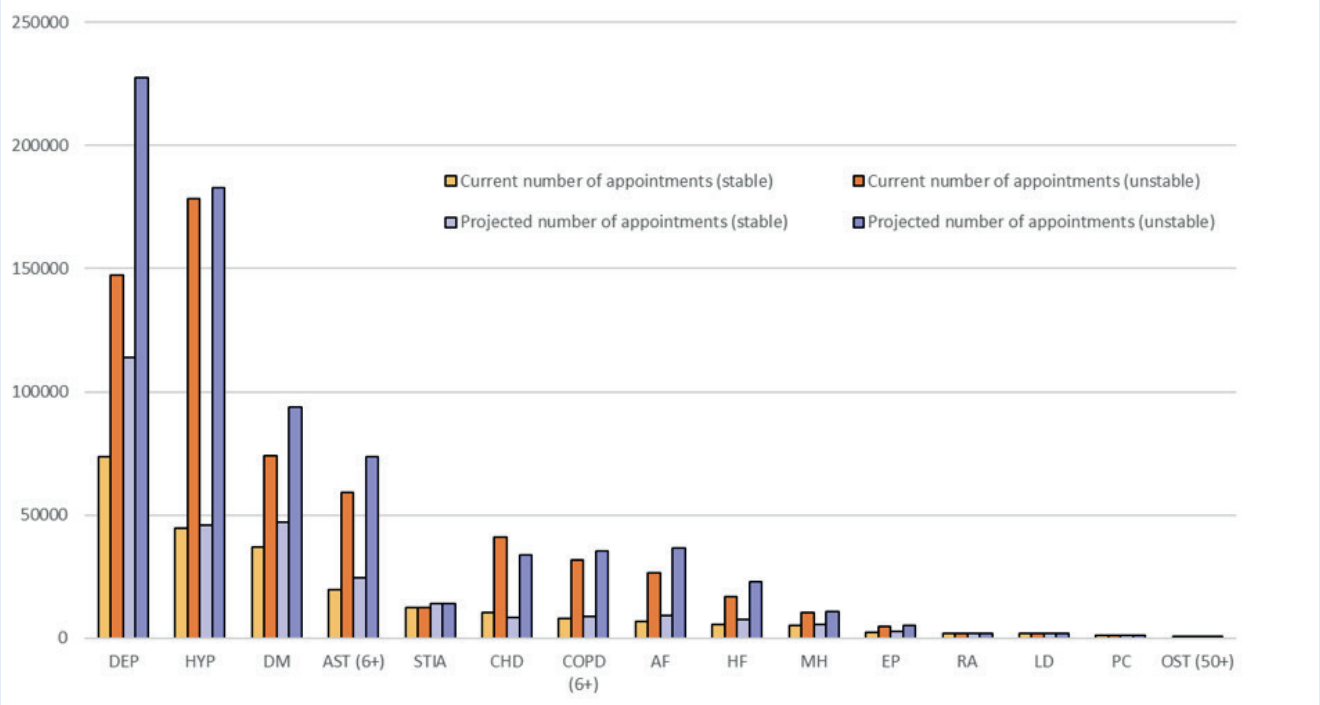


Figure 14: Current and projected number of general practice appointments for selected conditions for both stable and unstable management.

The impact of the Additional Roles Reimbursement Scheme (ARRS) and Pharmacy First

The Additional Roles Reimbursement Scheme (ARRS) was introduced in England in 2019 to support an additional 26,000 staff in general practices by 2023/2024 to improve access to care. Primary Care Networks were initially limited to recruiting to five roles, but this has grown to 17 including, from April 2021, Mental Health Practitioners. Working as part of multidisciplinary teams, the potential benefits to patients were envisaged to be integrated pathway for patients, improved access to specialist mental health support, reduced waiting times, prevention of referral into secondary care, and positive patient experience. In addition, a new Pharmacy First service, launched 31 January 2024, adds to the existing consultation service and enables community pharmacies to complete episodes of care for 7 common conditions following defined clinical pathways resulting in enabling patients to get certain prescription medications directly from a pharmacy, without a GP appointment. It would be expected that both the ARRS roles and Pharmacy First reduce the impact on appointments with GPs and potentially impact the predicted prevalence of conditions.

Finance

General practices

The NHS five year forward view was published in October 2014. This identified important change required to expand and strengthen primary and out of hospital care and identified several immediate steps to stabilise general practice.

The General Practice Forward View (GP Forward View), was published in April 2016. It committed to an extra £2.4 billion a year nationally to support general practice services by 2020/21, and aimed to improve patient care and access, and invest in new ways of providing primary care.

The GP Forward View provided support for practices to build the capacity and capabilities required to meet patients' needs, including support to adopt new ways of working and to develop different ways of managing clinical demand.

In 2019, The NHS Long Term Plan was published, setting out further ambitions for general practice and primary care, building on the ambitions in the GP Forward View. In addition, in January 2019, 'Investment and evolution' was published; a five-year framework for GP contract reform to stabilise GP practice and supporting implementation and delivery of The NHS Long Term Plan. A key feature within the deal was a new Network contract arrangement, contracted as a Directed Enhanced Service (DES) , allowing for groups of general practices coming together as primary care networks (PCNs). PCN populations cover around 30,000 to 50,000 people. PCNs are required to deliver a set of seven national service specifications:

- structured medication reviews,
- enhanced health in care homes (with community services),
- anticipatory care (also with community services),
- personalised care,
- supporting early cancer diagnosis,
- cardiovascular disease case-finding,
- and locally agreed action to tackle health inequalities.

Additional Roles Reimbursement Scheme

A feature of the 2019 contract was the additional roles reimbursement scheme (ARRS) to support the recruitment of 20,000 additional staff working in general practice by 2023/24. At Rotherham Integrated Care Board, as of 31st March 2024, there were a total of 175.9 FTE claims for ARRS roles across the 6 PCNs and 13 staff roles (table 3).

Staff Role	ARRS Claims (FTE)
Care Coordinators	41.6
Pharmacists	33.7
Pharmacy Technicians	16.1
Paramedics	15.7
Mental Health Practitioners	15.6
Social Prescribing Link Workers	13.2
Nursing Associates	12.7
First Contact Physiotherapists	11.0
Physician Associates	8.5
General Practice Assistants	4.8
Trainee Nursing Associates	2.0
Advanced Pharmacist Practitioners	0.8
Dieticians	0.3
Total	**175.9**

Table 3: Additional roles reimbursement scheme, Rotherham, 2023/24..

A data snapshot for the 2024/25 plan shows the spend on ARRS within primary care is £6,695,153.

Financial data in general practice

Data has been reviewed from when Primary Care Medical services were delegated back to Rotherham Clinical Commissioning Group in 2015/16 compared to the 2024-25 plan. The data therefore includes 10 years financial information and 9 years of growth.

In 2015/16, total spend across contractual payments, additional and enhanced services, and quality and outcomes framework was £36,036,006 (please note this excludes additional roles reimbursement scheme and primary care network directed enhanced services as these were not in place at this time). In 2024/25, the spend across all areas above (including PCN DES and ARRS), is £57,246,561, a 58.9% increase from 2015/16. The Bank of England Inflation calculator indicates an average increase of 33.8% in the cost of goods and services between 2015 and 2024, indicating that the overall contract inflation has been tracking just below inflation. However, with additional and enhanced service payments, ARRS funding and QOF funding inflation the overall rise in investment is 58.9%, and additional 25.1% above general inflation levels. It is hard to say how this increased inflation relates to the increased demand identified, but the ARRS and enhanced service programmes have been specifically designed to support the transition required to meet future needs for long term condition management in the community.

The 58.9% growth in general practice compares to a growth in acute services of 58.7% over the same time period, both being above overall allocation growth of 52.6% for the Rotherham CCG/ICB as a whole.

General Practice Primary Care Area	2015/16 spend (£)	2024/25 spend (£)	Growth (£)	Percentage change (%)
Contractual payments	£27,675,621	£36,083,762	£8,408,141	30.4%
Additional and Enhanced Services	£4,842,169	£5,251,149	£408,980	8.4%
Additional Roles Reimbursement Scheme	Not applicable	£6,695,153	£6,695,153	Not applicable
Primary Care Network Directed Enhanced Services	Not applicable	£5,165,133	£5,165,133	Not applicable
Quality and Outcomes Framework	£3,518,216	£4,051,364	£533,148	15.2%
Grand Total	£36,036,006	£57,246,561	£21,210,555	58.9%

Table 4: Financial Information, Rotherham, 2023/24

Recommendations

- To note the rising trend and future projections for demand on General Practice from the long-term conditions analysed in this report and consider the future models of community long term condition management that will be required to meet need over the coming decade.
- To consider the preventative actions required to stem the rising prevalence of these long-term conditions and avoid unsustainable increases in demands across the health and care system, with a focus on the common risk factors of smoking, diet, obesity, high blood glucose and alcohol consumption, and the networks and partnerships required within neighbourhoods to maximise the role of non-clinical intervention.
- To note the level of variation observed between General Practices in terms of QOF outcome achievement and exception reporting rates relating to both the delivery of care processes and the achievement of treatment targets and consider the opportunities for quality improvement to support improved outcomes for Rotherham.
- To use the emerging data and digital capabilities to identify the key areas for performance improvement at practice, PCN and Place level and implement a quality improvement programme to drive quality to that achieved by the top 10% of performers for the chosen indicators.
- Note the above inflation overall increase in the funding to General Practices and consider how this related to the changing demands, and the need for a model of care to develop that will meet future needs, making use of the wider set of primary care roles to target local needs and tackle inequalities through community management of long-term conditions.
- Consider how general practice performance is measured and reported, using local data to move beyond monitoring appointment numbers and QOF outcomes to identify measures that drive quality based on local need and priority outcomes.
- Consider the roles of the Primary Care Alliance and Primary Care Networks in developing and monitoring locally relevant quality outcomes, targeting resources to tackle inequalities and driving quality improvement.