Long Term Conditions

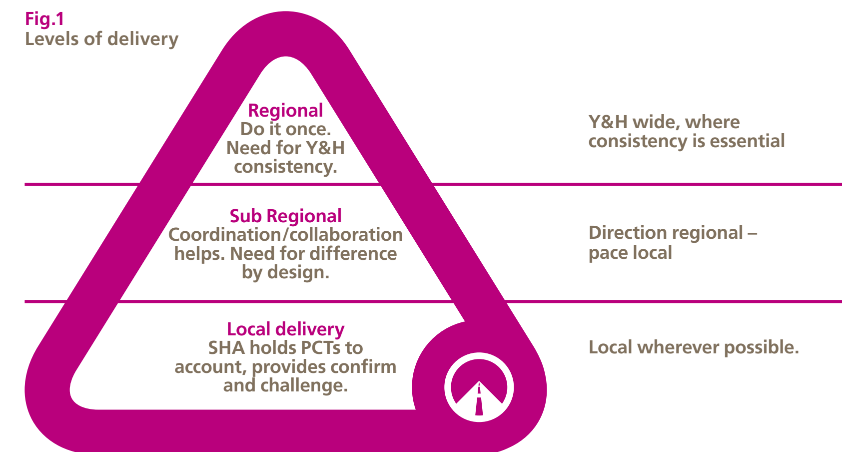


Fig.1
Levels of delivery

What did we say in Healthy Ambitions?*

1

The Long Term Conditions Pathway concentrated their work on three areas:

- Stroke
- Diabetes
- Care of older people with multiple conditions

These areas were chosen as they are areas of concern across the region – for example emergency admissions for diabetic comas were twice as high in some areas of the region compared with others.

They therefore recommended that:

- Personal care plans should be agreed annually with patients to manage their long term conditions
- The NHS should actively identify people in the community at risk from long term conditions and support them to reduce their risk of needing hospital admission
- There should be more support for people to manage their own conditions
- There should be better coordination of care between professionals and across services
- There should be better use of new technology to help self-care
- The NHS should have a greater focus on prevention of conditions such as diabetes.

Who is taking this work forward?

2

Levels of delivery

PCTs across Y&H have worked with the SHA to agree which of the recommendations of the long term conditions pathway should be taken forward locally and which might need action at regional level. This is summarised in fig.2 on the next page.

*Full details can be found at www.healthyambitions.co.uk/long_term_conditions.html

Recommendations & levels of delivery.

Fig.2 Levels of delivery

KEY
● Primary Implementation

Recommendation 1

Care Plans – Through a co-produced care planning approach, patients and their carers should be supported informed and empowered to better manage their condition within their capabilities and enabled to make choices about their care and services. Those who are newly diagnosed should be offered a care plan at the outset.

YH wide implementation

–

YH wide coordination & collaboration

Yes
Regional networks and forums

Local implementation

Yes

Comments

The framework for Care Planning should be agreed and developed regionally and integrated within the self care and choice agendas. The design should be informed by appropriate networks and forums – individually and collaboratively. Where conditions are not represented through networks and forums, they will still require appropriate clinical input.

Recommendation 2

Care choices – Patients should be offered choice following the 'Choice and Personalisation' model approach, which is patient centred and takes into account lifestyle factors. This will allow services to be designed and commissioned allowing patients the independence of choice throughout their contact with services, including residential, intermediate, outpatient and hospital based care.

YH wide implementation

–

YH wide coordination & collaboration

Yes
Regional networks and forums

Local implementation

Yes

Comments

Need to embed model and principles through PCT commissioning, informed by regional networks and forums. 'Choice and Personalisation' is core to any service development.

Recommendation 3

Year of Care (YoC) approach – Commissioners and providers should define patient pathways based on the two models referred to in this report. For example, this should be reflected in a programme of work to roll out excellent stroke services, in line with the National Stroke Strategy recommendations. Diabetes services in particular should be developed using emerging learning from the Year of Care pilots. Both models are exemplars for further work in other LTCs.

YH wide implementation

-

YH wide coordination and collaboration

Yes
Informed by YoC Pilots and regional networks and forums

Local implementation

Yes
Driven through PCTs and PBC Consortia

Comments

PCTs should work with local Commissioning groups to ensure they are fully supportive of YoC approach - and should build on YoC pilots and stroke strategy to ensure excellent service models and pathways for all LTCs.

Recommendation 4

Care Conductor – a role should be developed to help with the management of care for people with LTCs, their families and carers and ensure care plans and care choices are co-produced for better outcomes.

YH wide implementation

–

YH wide coordination and collaboration

Yes
Regional networks and forums

Local implementation

Yes

Comments

This should be jointly supported by health and social care - could be new or existing role. Role should be developed with regional input to ensure consistency of core skills/competencies. Implementation should be local and will require good Partnership Board working with LAs. This work should also link with Mental Health Advocacy.

Recommendation 5

Coordination – Primary care should remain the hub of coordinating and arranging care outside hospital for people with LTCs. Practices should support individual health to improve population health.

YH wide implementation

-

YH wide coordination and collaboration

-

Local implementation

Yes

Comments

This should be driven through local PCTs and commissioning groups. There are clear links to the Primary and Community Care Strategy implementation.

Recommendation 6

Commissioning – Practices and PCTs should commission services based on quality clinical information. Where there are variations, robust monitoring should be used to challenge the quality of disease registers and improve case finding.

YH wide implementation

-

YH wide coordination and collaboration

PHO

Local implementation

Yes with PCTs and Commissioning Consortia/ groups

Comments

There needs to be a consistent approach to information sources and commissioning. Processes and systems need to be in place so that commissioners can be confident that information is accurate – The Primary Care Intelligence dataset work should be seen as an important vehicle for LTCs and will also support the PBC developments in train. Practices to benchmark against exemplar practices.

Recommendation 7

Joint commissioning, joint strategic needs assessments (JSNA), Local Area Agreements and practice based commissioning should be fully exploited in order to design and develop services which reflect the standards, the choices of patients and the clinical and professional knowledge within health communities.

YH wide implementation

-

YH wide coordination and collaboration

-

Local implementation

Yes
Local Partnership Groups

Comments

These should be the core mechanisms for commissioning services and Joint service models with H&SC should be explored further and driven through local partnership board.

Recommendation 8

The use of incentives and/or penalties should be explored to improve better quality information and better commissioning.

YH wide implementation

Scope for Directors of Finance or Commissioning

YH wide coordination and collaboration

Forum needed for this work.

Local implementation

Yes

Comments

There needs to be clear criteria and guidelines around the use of incentives. Need to build quality mechanisms into contracts.

Recommendation 9

Integration and partnership working – Commissioners and providers should work in an integrated way to better support delivery of patient pathways for example: Services such as Intermediate Care that support primary and secondary care, should be speedy, responsive and work with case management. – Specialist Clinical Services (particulary for stroke) and comprehensive geriatric services need to be further developed to meet the needs of the growing elderly population. – There should be a collaborative approach to voluntary, health and social care sector planning.

YH wide implementation

-

YH wide coordination and collaboration

Yes

Local implementation

Yes

Comments

Rules of competition and cooperation need to be explored and clarified further and the PCT Collaborative is leading on this work. Procurement and commissioning of services should stipulate integration and partnership working as a core element to any service. Integration of information and systems is also key to delivering truly integrated services.

Recommendation 10

Care Standards – A common set of standards should be developed to support and standardise care delivery. These should be applicable in all settings, including primary care, secondary care and in particular to ensure quality of care in nursing and care homes.

YH wide implementation

-

YH wide coordination and collaboration

Yes
Regional networks and forums

Local implementation

Yes

Comments

There should be a core set of standards. These could be developed with support from YHIP taking learning from YoC pilots and stroke strategy work. There should be a link to YHPHO to ensure standards are measurable at practice level.

Recommendations & levels of delivery.

Recommendation 11

Core competencies – A core set of competencies should be developed for patients, carers and staff, aligned with the above care standards so individuals and organisations know what to expect from quality service and care provision. These will also help facilitate shift behaviours and culture.

YH wide coordination and collaboration

Role for Workforce Directorate and Deanery at SHA in training and accreditation
Regional networks and forums

YH wide implementation

Role for Workforce Directorate and Deanery at SHA in training and accreditation

Local implementation

Yes

Comments

These should be built into organisational and individuals objectives across health, social care and partner organisations. They should be a core part of any commissioned service specification and embedded locally through KSF indicators and through contracts – should include H&SC elements.

Recommendation 12

A key proposal for reforming adult social care (Department of Health's transforming Social Care Local Authority Circular January 2008) is to give personal budgets to all people receiving social care services. There is scope to see if this could be extended into some aspects of health care also.

YH wide implementation

-

YH wide coordination and collaboration

Yes

Local implementation

Yes

Comments

PCTs could pursue individual or indicative budgets at individual or practice level and local and regional mechanisms should be developed to support further exploration in this area.

Recommendation 13

In order for these recommendations to become reality, it is vital that support is given to providing the necessary joined – up IT, information, premises and trained workforce. The CPG members understand these will be national priorities.

YH wide implementation

NPFIT Board
Y&H Deanery

YH wide coordination and collaboration

Yes

Local implementation

Yes

Comments

PCT CEs could be the SRO for IT solutions within their organisation – informed by clinical networks and national programme for IT – joined up info systems are vital as a core supporting function across health and social care LIFT

PCTs have prioritised the recommendations in Healthy Ambitions in light of the needs of their local community and the current position of their services.

Fig.3 Timescales

Action	
Each PCT area to do baseline assessment (using a common framework) of progress & understanding in respect of;- • Care Planning • Year of Care Model • Choice & Personalisation Model Then sharing of learning via 'best practice' database accessible to all PCTs	By October 2009
Workforce Development:- • Establishment of competency framework to deliver care standards & care planning • Development of Care Conductor role and associated competencies	By September 2009
Social Marketing :- Need to expand to encompass self-care & enablement for people with LTCs	From March 2009
Compilation & dissemination of;- • Predictive modelling • Primary care dataset	By March 2009
Development of care standards & skills & competency framework linked with other NSR pathways e.g. Staying Healthy, MH & EoL care	By October 2009
Development of system of incentives & penalties to achieve Care Standards	By March 2010
Learning event on personal health budgets – linked to development of personalization agenda	By June 2009

Fig.4 Calderdale PCT's approach to tackling long term conditions :

1. Outcomes for the Programme
Reduce the number of Occupied Bed Days utilised by those with LTCs who have frequent admissions to hospital.
Continue to reduce the death rate for CHD in line with national indicators, with a particular focus on reductions within electoral wards with the highest levels of deprivation.
Continue to reduce the death rate for vascular diseases, particularly premature deaths.
Increase in the number of diabetics being diagnosed every month to address the estimated current 1800 undiagnosed diabetes patients within Calderdale.
Maximise the benefits to patients by the development of a self-care programme and provide greater knowledge, improve quality of life and reduce exacerbations.
For approximately 100 COPD patients per annum to receive pulmonary rehabilitation to increase their ability to exercise, reduce exacerbations and improve their quality of life.
2. Deliverables – Generic services to support patients with LTCs:
Commission a patient stratification/risk prediction service to accurately identify patients with LTCs and ensure they are receiving the most appropriate and effective services .
Develop one-stop clinics to provide multi-agency, multi-disciplinary services under one roof to maximise support to patients (long term development)
Establish screening services and assessment (including oxygen assessments) for housebound and hard to reach patients with LTCs to ensure they receive regular reviews of their support needs.
Establish specialist pharmacy services and pharmacy reviews to ensure concordance and for those who need support to manage pain.
In partnership with the Cancer and Palliative Care Programme, commission new end-of life and palliative care services to support those with LTCs who are at the end stage of their disease.
Provide better access to psychological support for people with LTCs
Address any issues arising on waiting times for outpatient appointments for people with LTCs, including reducing waiting times for therapy, social services, community rehabilitation etc
Develop strong links with programme on self care agenda and rehabilitation
Ensure the programme has strong input into developments of early supported discharge service – to ensure patient safety and well-being when they return home
Evaluate and explore opportunities of voluntary and commercial sector role as providers
Commission services from community pharmacy to increase its contribution to the management of LTCs in line with the White Paper 'Pharmacy In England'.
Commission services to develop and implement the new 'Patient Prospectus' offering a menu of options to support self care
3. Specific services to support people with:
Vascular conditions Respiratory conditions Neurological conditions Other LTC

When is it happening?

3
The actions to be taken forward in the first year of implementation for the pathway are shown in fig.3.

Local delivery

4
Working with local providers and partners, PCTs have prioritised the recommendations in Healthy Ambitions in light of the needs of their local community and the current position of their services.

They have all set out the action that they will take to start to turn the recommendations in Healthy Ambitions into reality in their five year strategic plans.

An example of the action being taken by Calderdale is shown in fig.4.

An example from Calderdale PCT

The LTC programme has two ambitions

– to improve the health of those at risk of developing LTCs, by commissioning quality services aimed at prevention and early diagnosis

– to reduce mortality and morbidity for those who already have LTCs, by ensuring better access to treatment and high quality care.

How could you help?

5

Everyone with an interest in improving services can play a part in taking forward the recommendations in the Long Term Conditions chapter of Healthy Ambitions. In fig.5 we have set out some of the suggestions from staff about how people could help implement the recommendations.

As an NHS publication – this section has just focussed on the roles that NHS Staff could play – but we very much recognise that our partners have a big contribution to make if we are to deliver the recommendations of the of the long term conditions chapter in Healthy Ambitions. We know that local authorities have a big part to play – e.g. in supporting more people to live independently and in developing joint care plans and personal budgets. We are committed to working with our partners to help make this happen.

Fig.5 How could you help?

Who	What
Care of Elderly consultants Geriatrics could be:	• Working in collaboration with commissioners (PBC and PCT) to implement agreed pathways of care • Continuing to develop joint or integrated work with social care teams, including use of technology for shared records
Diabetologists could be:	• Managing patients effectively to reduce admissions due to diabetic ketoacidosis reducing amptutation and blindness • Working in collaboration with commissioners (PBC and PCT) to implement agreed pathways of care
Allied Health Professionals and pharmacists could be:	• Working on collaboration with commissioners (PBCand PCT) to implement agreed pathways of care • Continuing to develop joint or integrated work with social care teams, including use of technology for shared records • Continuing to develop closer working as appropriate with voluntary sector providers
GPs could be:	• Utilising the models of care in the pathway report & collaborating with their PBC group to co-design pathways of care that are sensitive to the needs of their individual patient populations
Stroke Consultants could be:	• Working in collaboration with commissioners (PBC and PCT) to implement agreed pathways of care in line with recommendations in the National Stroke Strategy
Respiratory Physicians could be:	• Working in collaboration with commissioners (PBC and PCT) to implement agreed pathways of care • Working in collaboration to take forward the new COPD NSF, due to be published spring 2009
Rheumatologists coule be:	• Working in collaboration with commissioners (PBC and PCT) to implement agreed pathways of care
Cardiologists could be:	• Working in collaboration with commissioners (PBC and PCT) to implement agreed pathways of care
Medical directors could be:	• Understanding and implementing models of care in the pathway report
PBC leads could be:	• Working with PCT commissioners in partnership to design locally sensitive care pathways based on the Year of Care model and informed by local information around quality • Where there are variations, robustly monitoring to challenge the quality of disease registers and improve case finding
Community nurses could be:	• Working in collaboration with commissioners (PBC and PCT) to implement agreed pathways of care
Directors of Performance could be:	• Monitoring indicators to ensure progress is being made and examining impact on selected WCC outcomes
Directors of HR/Workforce Could be:	• Examining recommendations for training health professionals to fulfill new roles required to deliver new services for patients with LTC, e.g. around sefl-care
PPI & Communications leads could be:	• Developing networks for patient and the public involvement in local service design and delivery • Ensuring 'Your Guide' to local services reflects signposting & up to date information to support people with long term conditions • Be aware of/taking forward social marketing recommendations as appropriate
Directors of Finance could be:	• Assessing the financial implications of local plans in response to pathway reccommendations and ensuring appropriate provision with medium term and operational finance plans. Any impact on providers of changes in care pathways or service provision would need to be appropriately communicated consistent with WCC standards and process and extant contracting arrangements

This checklist is illustrative and for guidance only.

Who will make sure that this work happens?

6

Locally

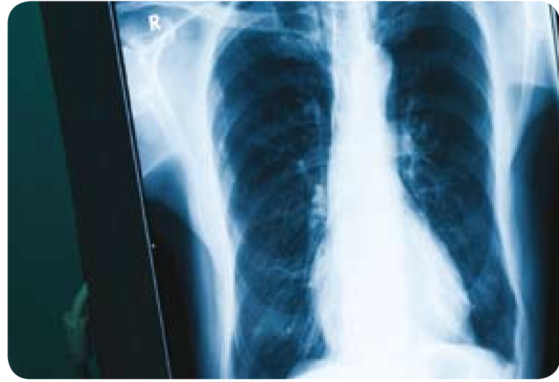
Each PCT is responsible for working with local providers and partners to ensure delivery of recommendations in line with their local priorities and their own strategic plans.

Collaboratively and regionally

Delivery will be overseen by a Pathway Delivery Board – as described in the chapter on governance arrangements.

The regional clinical leads are Eileen Burns, consultant geriatrician, Leeds Teaching Hospitals Trust and Vicky Pleydell, a North Yorkshire GP, they will offer clinical advice and leadership to the lead Chief Executive and SHA Director.

For long term conditions the chair is Ivan Ellul, Chief Executive at NHS East Riding who will act as a sponsor within the wider PCT chief executives forum and assist the clinical lead and SHA Director to promote implementation of the pathway.



How will we measure success?

7
We have developed a "Healthy Ambitions Dashboard" based on a small number of key indicators which taken together can be used to start to measure the success of the Healthy Ambitions programme as a whole (see chapter on performance and metrics). This is underpinned by trajectories which each PCT will set to reflect their local priorities and circumstances and which will show the measurable improvements they are making in each pathway area. This will supplement the "vital signs" indicators and trajectories which support delivery of the targets set out in the NHS Operating Framework and the selection of outcome measures which PCTs have included in their strategic plans. In many cases these measures are one and the same. All of these measures will feature in PCTs annual operating plans to be agreed with the SHA and be the basis for the SHA's performance management regime.

Recognising that the pathway recommendations are many and various we intend to start by tracking progress against the key pathway pledge, which for Long Term Conditions is to halve the number of preventable admissions from diabetes.

We know that this doesn't tackle all the priorities in this chapter. Rates of hospital admissions, adults receiving individual budgets and mortality rates by a variety of long term conditions will be tracked through existing routes. The proportion of adults supported to control their condition, adults receiving individual budgets and adult with good diabetes management are already Vital Signs.

The key indicators we will therefore track in the "Healthy Ambitions Dashboard" will be:

- Admissions and readmissions from diabetes related episode
- Average length of stay for diabetic admissions and readmissions
- Percentage of people with diabetes offered diabetic retinopathy screenings
- Patients with diabetes in whom the last HbA1c is 7.5 or less.

Work has been undertaken to establish baselines for the pledge and by the end of March '09 trajectories for improvement will have been agreed between the SHA and PCTs and will be reflected in annual operational plans.* We intend to publish progress against individual trajectories.

*More details can be found in the chapter on performance and metrics.

Our pledge in taking forward this pathway will be to halve the number of preventable admissions from diabetes.