

## **TELFORD & WREKIN COUNCIL**

**HEALTH & WELLBEING BOARD – 15 MAY 2013**

### **TITLE – TELFORD & WREKIN CCG DRAFT LONG TERM CONDITIONS STRATEGY**

**REPORT OF – NICKY WILDE, HEAD OF COMMISSIONING PRIMARY CARE AND PLANNED CARE, AND JULIA MEAKIN, COMMISSIONING MANAGER, MARKET DEVELOPMENT**

## **PART A) – SUMMARY REPORT**

### **1. SUMMARY OF MAIN PROPOSALS**

With the approval of the Telford and Wrekin CCG Board, the CCG has commenced a programme of work to improve the quality of care delivered to patients and carers in Telford and Wrekin who have one or more Long Term Condition.

This document provides high level details of a strategy (in diagram format) and provides the areas which will form the framework within which the CCG anticipates to work with Partner Organisations. The purpose of presenting the outline to the Health and Wellbeing Board at this early stage is to ensure that there is opportunity to include recommendations from the Board into the Strategy at an early stage and to engage the Board with the on-going work programme.

The intention of the strategy is to provide a framework and action plan to deliver measurable improved outcomes to include improved life expectancy, enhanced quality of life for those with a long term condition and their Carers and a reduction in health inequalities. The strategy will be a concise document, with links to the major supporting documents such as the Joint Strategic Needs Assessment, Health and Wellbeing and CCG objectives and national documentation on improving the identification and management of Long Term Conditions. The principle element will concentrate on an overarching action plan for delivery rather than an extensive “wordy” document. The “Strategy on a Page” can be found at page 6. The strategy covers:-

- Principles
- Prevention
- Identification
- Management planning (3 stages)
- End of Life

The CCG has mapped the CCG Objectives and stakeholder outcomes relevant to Long Term Conditions and these can be found at page 7, however particularly in relation to the Health and Wellbeing Board, the priority of Improving Life Expectancy and Reducing Health Inequalities will be included and will include the Board priorities of:

- Cardiovascular disease (CVD)
- Cancer – although the CCG has a separate work stream for cancer, this will link into the Long Term conditions strategy work
- Lifestyle risk factors smoking, alcohol misuse and overweight and obesity
- Prevention opportunities
- Making Every Contact Count
- Review of the national and local recommendations such as the Health Inequalities National Support Team (HINST) recommendations for CVD and the West Midlands Quality Review for Long Term Conditions

The delivery approach will focus on prevention and earlier diagnosis as well as treating the symptoms. Processes will be established to identify when increased care is required. There will be a strong emphasis on patients being consulted, enabled and supported to self-manage their conditions where appropriate and carers and families will be supported. At the heart of the delivery system, there will be integration of working across health and social care, the third and independent sectors. This will facilitate improvements in care, through eliminating duplications and gaps in service delivery. Consideration will be given to telehealth/telecare initiatives where this is an option.

Processes will be put in place that encourage an understanding of End of Life issues not only those people with long term conditions but also their families, carers, the public, and the health and social care economies. Similar to Cancer, End of Life is a separate work programme which will link in with the Long Term Conditions Strategy.

The Health and Wellbeing Board have quality outcomes which have been identified as a measure for improving Life expectancy and reducing health inequalities which include:-

- Premature mortality rates
- Health Check programme performance indicators (% of eligible population offered and % take up of checks)
- Cancer waiting and treatment times targets
- Management and treatment of patients with CVD in primary care (% of patients treated appropriately for hypertension, high cholesterol and any other relevant LTC indicators)

In addition to these, the CCG will also monitor use of Acute and Community Services for both scheduled and unscheduled care and improvement in outcomes within General Practice, via the Quality and Outcomes Framework and practice level benchmarking.

### Consultation

The consultation and engagement process will be on-going throughout the design and delivery of the strategy and regular updates will be made available as required. To date discussions have been held with:-

CCG Board  
 CCG GP Forum  
 CCG Patient Round Table  
 CCG Long Term Conditions Patient Group  
 GP Practice patient groups  
 Health and Wellbeing Board  
 Public Health Colleagues

CCG Commissioners  
Shrewsbury and Telford NHS Hospital Trust  
Shropshire Community Health NHS Trust  
Robert Jones and Agnes Hunt NHS Trust  
Shropshire and Staffordshire Mental Health NHS Trust  
Shropshire County CCG

The process has been both formal and informal and a plan of recommendations and actions is being formulated based on feedback of the ongoing discussions, national and local recommendations and priorities. It is expected that the final draft for approval will be available July / August 2013. A copy of documentation is also available on the CCG website.

### Progress to date

During the consultation and engagement process and to ensure that improvements continue to be delivered, various work-streams have already commenced such as:-

- Supporting GP Practices with Long Term Conditions and workgroups for Respiratory, Hypertension, Diabetes and Dementia have already commenced
- Risk Stratification to identify patients at risk was commenced in Practices in 2012/13 and this is being further developed in 2013/14 and funding has been secured via the CCG to deliver some actions recommended in the recent West Midlands Quality Review
- Data on Practice level Long Term Conditions is being sent to Practices to provide a benchmark and this will be revisited at the end of the financial year 2013/14 to allow Practice to monitor changes in outcomes.
- GP Practice providing individual patient management plans to support patients to self-manage exacerbations in their conditions
- Engagement and Consultation of initial outline documentation for discussion
- Funding secured from CCG to support the following local developments
  - Pulmonary Rehabilitation
  - 7 day pilot for community respiratory services
  - Anxiety management for patients with severe COPD
  - Supply and distribution of nebulisers
  - Respiratory Consultant to support community nurses
  - Tele-health remote monitoring
  - Diabetes education programmes for type 1 and 2, information and management booklets and Expert patient programme
  - Expansion of community services
  - Pilot for Health trainers linked to GP Practices
  - Pilot for Care navigators linked to GP Practices
  - Direct Access Echo and B-type natriuretic peptide testing
- An action plan for implementation is being developed alongside the consultation and engagement programme. This plan is centred around Principles, Prevention, Identification, Management planning (3 stages) and End of Life allowing it to be easily monitored against the "Strategy on a Page". It also identifies the person and organisation responsible for delivery and the proposed timeframe for delivery. This action plan is being discussed as part of the consultation and engagement programme and Leads are being asked to complete their sections of the plan and return to the CCG Lead.

## **2. FOR INFORMATION**

There are around 15 million people in England with one or more long term condition. The interpretation of a Long Term Condition is a condition that cannot be cured but can be managed through medication and/or therapy. There is no definitive list of long term conditions – Diabetes, Asthma, Chronic Obstructive Pulmonary Disease, Coronary Heart Disease, Mental Health and Neurological conditions can all be included.

The impact on the NHS and Social Care of supporting people with long term conditions is significant with 70% of the health and social care costs being spent on long term conditions. This means that 30% of the population accounts for 70% of the health and social care spend. Long term conditions are responsible for 70% of emergency admissions and 55% of GP consultations. Supporting the 30% of the population who have one or more long term condition is therefore essential for the viability of the health economy.

The paper is submitted for information and discussion.

## **3. RECOMMENDATIONS**

**The Health & Well-being Board are requested to;**

**Receive the key health messages, the draft Long term Conditions Strategy “on a Page” and note actions to date**

**Provide feedback to Telford & Wrekin CCG  
([Julia.meakin@telfordccg.nhs.uk](mailto:Julia.meakin@telfordccg.nhs.uk))**

**Agree that a final version of the strategy with an implementation plan be brought back to Health & Well-being Board for an update in July/August 2013**

## **4. SUMMARY IMPACT ASSESSMENT**

<b>COMMUNITY IMPACT</b>	Do these proposals contribute to a specific HWB Priority?	
	Yes	Improve life expectancy and reduce health inequalities
	Will the proposals impact on specific groups of people?	
	Yes	The strategy will impact on people with a long term condition their families and carers.
<b>TARGET COMPLETION/DELIVERY DATE</b>	A final version of the strategy with an implementation plan be brought back to Health & Well-being Board for an update in July/August	

	2013. The overall strategy will commence its implementation during 2013/14 and will continue to develop and react to changing situations.	
<b>FINANCIAL/VALUE FOR MONEY IMPACT</b>	Yes	The ability to achieve early diagnosis and the stabilisation and optimised management of patients with Long Term Conditions will allow care to be provided in a community setting thus reducing the impact on secondary care services. The QiPP plan for Planned Care for 2013/14 identifies a recurrent net saving of circa £300,000 when supporting services have been put into place.
<b>LEGAL ISSUES</b>	No	
<b>EQUALITY &amp; DIVERSITY</b>	Yes	The adoption of a clear integrated health and social care strategy will ensure that there is equality in the management of all patients with Long Term Conditions
<b>IMPACT ON SPECIFIC WARDS</b>	No	To strategy covers the geographical area of Telford and Wrekin.
<b>PATIENTS &amp;/OR PUBLIC ENGAGEMENT</b>	Yes	To date the strategy has been discussed at the CCG Roundtable and the CCG LTC Patient Group.  In addition Practices, via the GP Practice Forum, have been encouraged to discuss the strategy at their respective patient groups.  Ongoing engagement with patient groups is a requirement of the strategy.
<b>OTHER IMPACTS, RISKS &amp; OPPORTUNITIES</b>	No	

## **PART B) – ADDITIONAL INFORMATION**

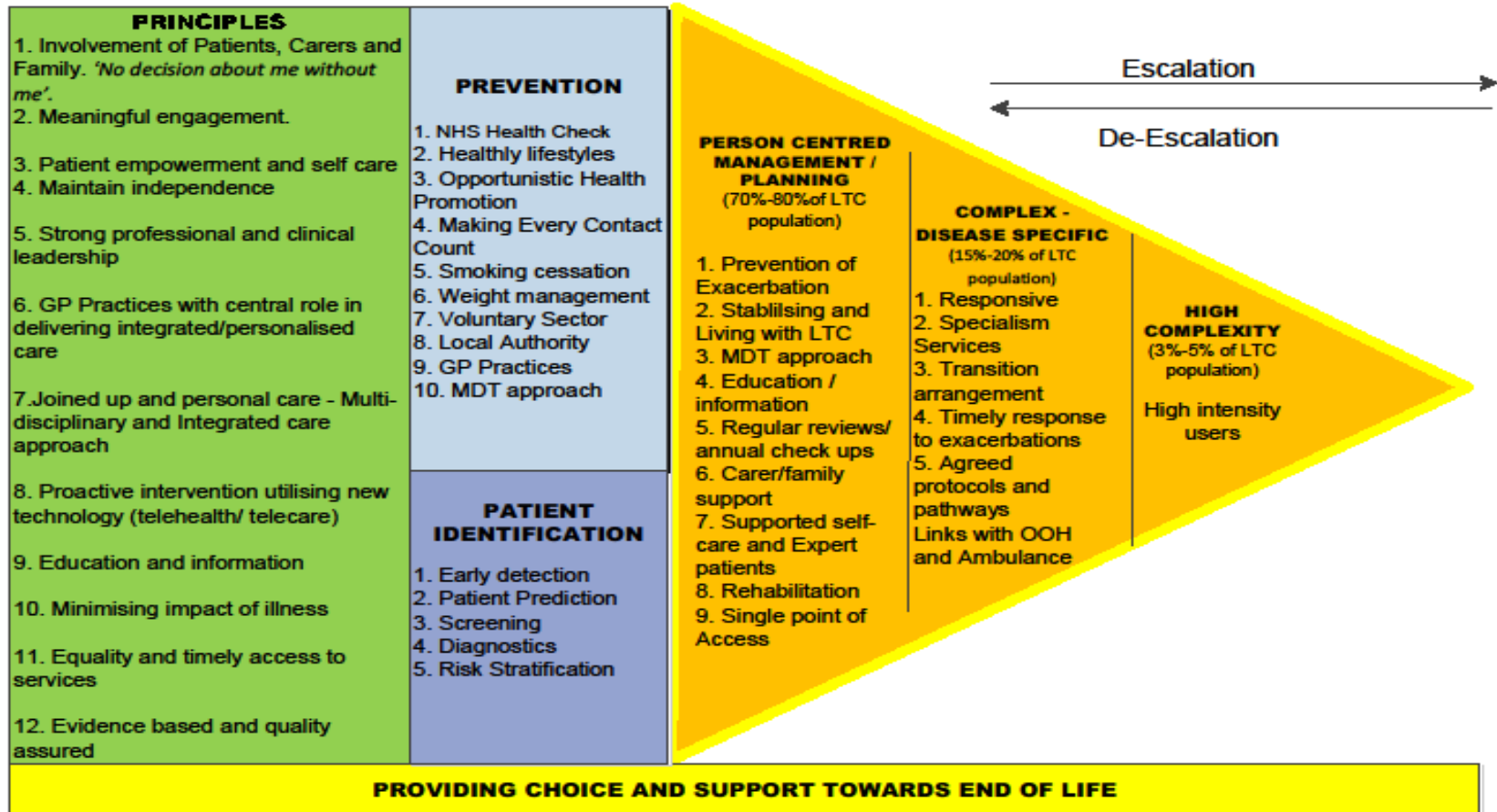
### **5. INFORMATION**

Some specific data for Telford and Wrekin and the projections for our population can be found in the Joint Strategic Needs Assessment; the key messages are set out at pages 6 and 7.

#### **Report prepared by:-**

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## TELFORD AND WREKIN CCG LONG TERM CONDITIONS (LTC) STRATEGY



\*Multi-disciplinary Team = Community teams, GP Practices, Voluntary Sector, Social Care, Mental Health, Medicines Management, Secondary Care, Housing, Schools etc

Mapping CCG objectives and stakeholder outcomes relevant to long term conditions

Telford & Wrekin JSNA key messages for Long Term Conditions		
<ul style="list-style-type: none"> <li>➤ <b>Coronary Heart Disease:</b> It is estimated<sup>1</sup> that 5.6% of people aged 16+ years (approximately 7,849 adults) have coronary heart disease. However, at the end of March 2011 only 3.2% of the general practice population (5,472 adults) were recorded as having a diagnosis of CHD in primary care</li> <li>➤ <b>Hypertension:</b> It is estimated that 30.9% of people aged 16+ years (approximately 39,798 adults) have hypertension. However, at the end of March 2011 only 13.5% of the general practice population (23,059 adults) were recorded as having a diagnosis of hypertension in primary care</li> <li>➤ <b>Chronic Obstructive Pulmonary Disease:</b> It is estimated that 3.4% of people aged 16+ years (approximately 4,418 adults) suffer from COPD. However, at the end of March 2011 only 1.8% of the general practice population (3,136 adults) were recorded as having a diagnosis of COPD in primary care</li> <li>➤ <b>Stroke and TIA:</b> It is estimated that 2.5% of people aged 16+ years (approximately 4,418 adults) have suffered a stroke or TIA. However, at the end of March 2011 only 1.5% of the general practice population (2,656 adults) were recorded as having suffered a stroke or TIA in primary care</li> <li>➤ <b>Dementia:</b> It is estimated that 1,580 people were suffering from dementia in 2010. The numbers of people expected to be suffering from dementia by 2015 is set to increase by 17% to 1,851. At the end of March 2011 only 644 adults were recorded as having dementia in primary care</li> </ul>		
CCG Objective	Telford & Wrekin Health and Wellbeing Strategy – priority outcomes	Commissioning Outcomes Framework
<b>1) To improve quality and service transformation</b>		
Ensuring people have a positive experience of secondary care services by continuing to improve the quality and safety of secondary care services.	Ensure people have a positive experience of health and care services	Domain 4 – Ensuring that people have a positive experience of care; patient experience of hospital care; friends and family test
Ensuring that people have a positive experience of primary care services by continuing to improve quality and safety in primary care by assessing GP and out of hours services	Ensure people have a positive experience of health and care services	Domain 4 – Ensuring that people have a positive experience of care; patient experience of primary care i) GP services ii) GP out of hours services
<b>2) To increase life expectancy and reduce health inequalities</b>		
Reducing premature mortality from cardiovascular disease by further improving the management and treatment of CVD in primary care	Improve life expectancy and reduce health inequalities	Domain 1 – Preventing people from dying prematurely; Under 75 mortality rate from CVD Domain 2 – Enhancing quality of life for people with long term conditions; proportion of people feeling supported to manage their condition
Reducing premature mortality from cancer	Improve life expectancy and reduce health inequalities	Domain 1 – Preventing people from dying prematurely; under 75 mortality rate from cancer Domain 2 – Enhancing quality of life for people with long term conditions; proportion of people feeling supported to manage their condition
Meeting the needs of the ageing population, specifically around mental health and dementia services	Support people with dementia	Domain 2 –; estimated diagnosis rate for people with dementia
Addressing long term conditions management and treatment, specifically around COPD and Diabetes	Improve life expectancy and reduce health inequalities	Domain 2 – Enhancing quality of life for people with long term conditions; unplanned hospitalisation for asthma, diabetes and epilepsy in under 19's Domain 3; Helping people to recover from episodes of ill health; emergency admissions for acute conditions that should not usually require hospital admission; emergency admissions within 30 days of discharge from hospital
<b>3) To encourage healthier lifestyles</b>		
Addressing the obesity rates in adults and children	Reduce excess weight in children	Domain 1: preventing people from dying prematurely
Reducing the number of alcohol-specific admissions (including in children)		
Improving access to information regarding lifestyle advice and ensuring services are delivered through front line staff e.g. through every patient counts		
Reducing smoking-attributable hospital admissions and deaths by smoking intervention programmes		
<b>4) To support vulnerable people</b>		
Ensuring carers have appropriate access to health and prevention services	Improve carers' health and wellbeing	Domain 4; Ensuring that people have a positive experience of care; friends and family test
Ensuring patients recovering from episodes of ill health or following injury have access to rehabilitation and re-ablement	Support people to live independently	Domain 3; helping people to recover from episodes of ill health ; emergency readmissions within 30 days of discharge from hospital

