LONG TERM CONDITIONS PLANNING FRAMEWORK 2013-16

1. INTRODUCTION

Around 2 million people in Scotland have at least one LTC, and one in four adults over 16 reported some form of long term illness, health problem or disability The human costs and the economic burden of long term conditions for health and social care are profound. Sixty per cent of all deaths are attributable to long term conditions and they account for 80% of all GP consultations. People with long term conditions are twice as likely to be admitted to hospital, will stay in hospital disproportionately longer and account for over 60% of hospital bed days used. Most people who need long term residential care have complex needs from multiple long term conditions.

2. NATIONAL CONTEXT

2.1 National policy highlights the need to improve prevention, identification and the treatment of long term conditions, and the major contribution this has to reducing inequalities. There is a national commitment to ensuring that patient experience drives change and improvements in care.

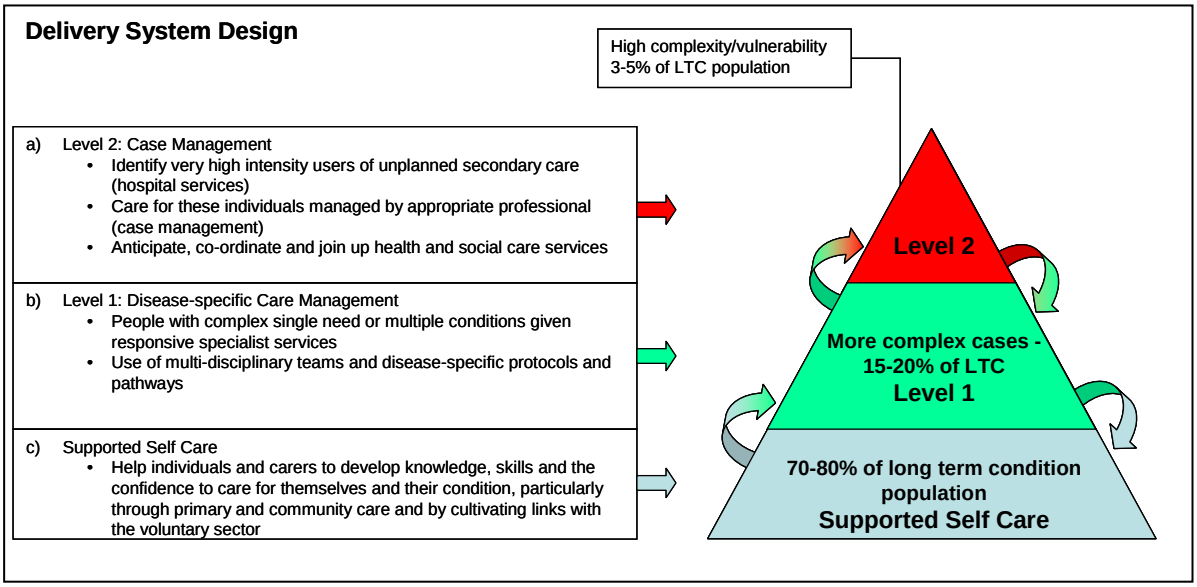
National policy also promotes the continued development of anticipatory care, supported self care and the development of community services to underpin shifting the balance of care. Underpinning this direction is the Quality Strategy, with the three central ambitions that care should be person centred, safe and effective

3 LOCAL CONTEXT AND PROGRESS

3.1 NHSGGC's long term strategic framework for LTCs sets out the direction of travel to 2015, in respect of how we propose to deal with the challenge of responding to the needs of people with LTCs

3.2 The LTC framework provides a model with which to support the stratification of LTC into levels of need, promoting anticipatory care approaches, supported self care and self management and the central role of CH(C)Ps in developing community services and shifting the balance of care. It aims to make integrated care management approaches mainstream and more consistent. It highlights the importance of effective patterns of consultation in primary care for those with one or more LTCs, and the further development and use of tools to identify and support those at highest risk of admission to hospital.

LTCs Model of Care



4. LOCAL CONTEXT, SERVICE AND PERFORMANCE

4.1 The extent to which individuals report the debilitating effect of living with a long term condition and coverage by CHP area is shown in Table 2 below, an extract from the Health & Wellbeing survey of 2011.

Table 2 Adults aged 16 plus

CHCP	Sample	% LTLI
Glasgow City NE sector	811	21.0%
Glasgow City NW sector	913	17.0%
Glasgow City South sector	1074	20.5%
Glasgow City CHCP	*2798*	*19.5%*
East Dunbartonshire	537	17.9%
East Renfrewshire	463	12.3%
Renfrewshire	898	12.0%
Inverclyde	450	23.1%
West Dunbartonshire	584	22.3%
NHSGGC *	6094	18.8%

** includes part of South & North Lanarkshire not shown above (sample sizes not robust)*

4.2 A major challenge facing LTC care is the nature and extent of multimorbidity and the fact that traditionally our health systems are focussed on delivering single disease specific models of care. Around a quarter of people with an LTC have three or more problems. 42% of people with three or more chronic diseases have activity limitation. The number of chronic diseases in people with LTCs increases with age. In 65-74 age groups the average number of chronic conditions is 1.7. The scale of this challenge is highlighted below in

Table 3 which shows the number of individual's with a concurrent diagnosis of up to 5 long term conditions.

Table 3: Concurrent diagnoses within GGC Enhanced Services Programme 2010/11						
No of Patients	***CHD***	***Stroke***	***HF***	***Diabetes***	***COPD***	***No of Patients***
5	Δ	Δ	Δ	Δ	Δ	125
4	Δ	Δ	Δ	Δ		380
4	Δ	Δ	Δ		Δ	206
4	Δ	Δ		Δ	Δ	207
4	Δ		Δ	Δ	Δ	263
4		Δ	Δ	Δ	Δ	23
3	Δ	Δ	Δ			920
3	Δ	Δ		Δ		1215
3	Δ	Δ			Δ	763
3	Δ		Δ	Δ		1530
3	Δ		Δ		Δ	900
3	Δ			Δ	Δ	744
3		Δ	Δ	Δ		130
3		Δ	Δ		Δ	110
3		Δ		Δ	Δ	238
2			Δ	Δ	Δ	104
2	Δ	Δ				4150
2	Δ		Δ			4661
2	Δ			Δ		7291
2	Δ				Δ	3942
2		Δ	Δ			535
2		Δ		Δ		2816
2		Δ			Δ	1561
2			Δ	Δ		701
2			Δ		Δ	616
2				Δ	Δ	1707
1	Δ					31325
1		Δ				14758
1			Δ			3041
1				Δ		32992
1					Δ	20232
Total Patients						**138186**

4.3 Progress in last 3 years of the Framework

Progress has been made in improving LTC care, in particular in the areas highlighted below,

- **Systematic Delivery of Best Practice Care** – Protocols and guideline development is well embedded within each specialty area, with a corresponding scrutiny on uptake and application across the system

  There is more work to be done on demonstrating and performance managing adherence to guidelines by measuring the impact on health outcomes for patients.

- **Reducing Demand** – Early supported discharge teams, specialist nurse and AHP support are in now more widely in place place to deliver early discharge and support closer to home or in the community. However delivery of a shift in the balance of care is not yet visible.

- **Primary care**: we have a comprehensive programme of locally enhanced services covering individual diseases.

- **Complex care/anticipatory care** interventions designed to avoid exacerbation/slow disease progression and the need for admission are in place but we do not yet have a comprehensive approach to anticipatory care and discharge planning

- **Supported Self Care** A supported self care framework has been developed. We need to do more to enhance the contribution of voluntary sector organisations to support self management and also represent the views of people with long term conditions and their unpaid carers

- **Psychological Support for people with LTCs** Overall, around 30% of people with LTCs experience poor mental health, compared with only 9% of other adults; We need to do more to engage with patients around psychological support and respond to what they are telling us they need.

5. LTC FRAMEWORK IN SUPPORT OF NHSGG&C CORPORATE PRIORITIES

5.1 Early Intervention , Preventing Ill-Health; and Anticipatory Care

- Developing preventative approaches is critical to the future sustainability of health and social care system. The need for early intervention and prevention of ill health is a major driver for NHSGG&C. and critical to reducing the demands placed on health care resources. Over the next three years we need to deliver an increase in prevention and early intervention. We will promote an integrated spectrum of prevention activities woven throughout all clinical care and encourage prioritisation of activities which offer the strongest evidence of effectiveness.

Better knowledge of and awareness of their long term condition helps people understand their symptoms and experiences and helps improve their long term health and wellbeing. The role of the care professional is to encourage self confidence and the capacity for self management and to support people to have more control of their conditions and their lives and promote their efforts to enhance their health and wellbeing. This means having a shared approach to setting goals and problem solving, and signposting people to the type of support and information they need. A supported self management framework has been developed to facilitate the systematic implementation of this approach. A supported self management action plan is core to MCN business and includes a disease specific, tailored approach to the framework. The existing emphasis on promoting and maintaining good health sits alongside the need for wider programmes around healthy weight, alcohol, tobacco use at a population level. Lifestyle factors are placing a huge and increasing burden on NHSGGC. Investing in effective measures to improve lifestyle and even modest improvements in lifestyle (particularly smoking) are likely to yield savings in resources for NHSGGC.

The NSGGC Anticipatory Care Planning Group is developing a framework to guide the planning and prioritisation of the different elements of preventive healthcare.

The framework is based on three principles:

- Focus on the factors that make the biggest contribution to our total burden of disease and to inequalities in health.
- Promote an integrated spectrum of prevention activities woven throughout all clinical care.
- Encourage prioritisation of activities which offer the strongest evidence of effectiveness.

EARLY INTERVENTION AND PREVENTING ILL HEALTH/ ANTICIPATORY CARE		
Outcomes	**Change/Development Required**	**Measures**
Individuals will have a clearer understanding about their condition and their role in managing it with a resulting increased capacity to look after themselves.	The supported self care framework will be systematically applied within each LTC Each MCN will develop a programme to further develop and support the key components of the SSC framework – education and support, access to health and wellbeing services, voluntary sector support , support for carers Existing LES's will be reviewed and an LTC LES will be developed based on common risk factors in order to improved the management of co-morbidities and co-ordination of care for those with more than one condition As part of the LES review, each MCN will support the identification of the evidence for effective interventions at primary, secondary and tertiary level and influence any necessary change in practice as a result	No of LTC patients participating in LTC LES

Care will be needs led and person centred	A screening programme to routinely identify LTC patients at risk of admission will be implemented in each CHP We will develop programmes to allow us to intervene earlier for more patients An integrated care management programme will be applied to avoid deterioration and the need for hospital stay Existing pathways and protocols will be reviewed to ensure that there are clearly defined stages and measures delineated at appropriate stages in the pathway to help people avoid complications or slow down the progression of their condition. Through application of the Supported self care framework, individuals will be provided with the rights skills, knowledge and understanding of their condition to recognise and better cope with a flare-up or exacerbation "Engagement" lesson/best practices learned from "Keep Well" will be shared and taken forward into the CDM./ LTC programmes	Monthly 'Sparra' (or similar risk identification tool) lists of patients at high risk to admission will be reviewed at CHP level and appropriate action identified Increase in number of individuals with a care management plan

5.2 Shifting the Balance of Care

Delivery of the LTC Framework is based upon systematic, planned and coordinated care across sectors where delivery of care is person centred and based around the needs of the individual. Our aim is to identify how we deliver more care for people with long term conditions outwith the acute settings and by so doing, reduce the need for admission and ensure early discharge.

A key challenge continues to be the integration of our services to ensure a seamless transition from primary to secondary care to facilitate a more holistic approach to the management of LTC care by all partners. Communication with the range of stakeholders is critical to informing the improvement of this process, including the need to forge effective relationships with 3rd Sector organisations

We need to implement an integrated system of care across primary care, hospitals, social work, community and voluntary sectors, facilitated by information systems that support sharing of data;

For those with particularly complex needs who require a more intensive level of care, or 'care management', a co-ordinated and proactive approach will contribute to improved quality of care for the individual with the potential to lead to a reduction in hospital admission. Our LTC aim is to maximise flexible and responsive care at home incorporating support for carers.

SHIFTING THE BALANCE OF CARE		
Outcomes	**Change/Development Required**	**Measures**
Improved access to care and treatment through changes in the location of services	Maximise flexible and responsive care at home, with support for carers	A reduction in acute bed days consumed by each LTC
Improved experience for individuals and carers who want to remain at home	LTC pathways will be systematically reviewed to identify the most appropriate care setting and care provider	

	Earlier identification of individuals who might benefit from interventions to sustain independence and avoid or delay deterioration or exacerbation of illness	
	Extension of the scope of services provided by non medical practitioners outside the acute hospital setting	Increase in 'specialist' interactions in community previously delivered only in acute setting
	Increase care planning to increase anticipatory care and reduce the number of falls and health crises at home	Increase in number of iIndiviudalised care plans
	Continue to explore the potential for Telecare to positively impact both on maintaining health for the individual together with positive effect on healthcare resources	Increase in number of individuals able to interact with their healthcare provider via remote monitoring of their health symptoms and aspects of daily living
	Development of support programmes aimed specifically at unpaid carers so that the role of the carer is identified and supported	Each LTC will have a carer's framework incorporating key disease facts and information to be tailored to individual in conjunction with supported self management needs

5.3 Reshaping Care for Older People

Our population is ageing. Over 50's are predicted to increase from 30% to 38% of population between 2008 and 2033. Dependency ratio's will increase to 2040. These are predicted to vary from 44% in Glasgow City to 91% in East Dunbartonshire. Older singer person households are predicted to rise and will account for 54% of households by 2031. Long term conditions become more common with age. Drivers of demand for our older population are chronic disease and frailty (including cognitive impairment) and projected significant growth in the numbers of people with dementia – (estimated 25% increase per decade). By the age of 65, nearly two-thirds of people will have developed a long term condition. Older people are also more likely to have more than one long term condition: 27% of people aged 75-84 have two or more such conditions. Older people are most at risk of fragmented care and are often in touch with multiple services – GPs, community health services, mental health services, social care and housing.

There is also significant variation in life expectancy and healthy ageing, as demonstrated in the table below . We need to ensure that effective management of LTCs is an integral part of the way we plan and care for older people

The systematic delivery of an integrated care management approach is the LTC model of care response to the complex care needs of the frail and elderly

Healthy Life Expectancy (female)

	Life Expectancy	**Health Life Expectancy**	**Expected period 'not healthy'**
East Renfrewshire	80.9	73.9	7.0
East Dunbartonshire	80.2	72.9	7.3
Inverclyde	77.5	68.7	8.8
East Glasgow	75.5	61.5	14.0
North Glasgow	74.7	61.6	13.1

Reshaping Care for Older People		
Outcomes	**Change/Development Required**	**Measures**
A systematic and integrated multi-agency care management approach is in place across CHPs Improved experience for individuals and carers	We will implement proactive integrated care management Systematic delivery of anticipatory care planning - with care packages that can respond quickly to changing circumstances	Increase in number of individualised and integrated care plans in place
	Rapid and easy access to community services	
	Increase care planning to increase anticipatory care and reduce the number of falls and health crises at home	

5.4 Improving Quality Efficiency and Effectiveness;

There are major challenges in delivering improved quality efficiency and effectiveness. In order to deliver the most effective and efficient care we need to ensure systems of care reflect multimorbidity as the norm and move away from single disease specific focus. This is a major driver in the shift to shape services and support around the needs and wishes of the patient. Services are currently organised around single disease pathways. Increasingly patients present with multiple morbidities and problems that do not fit a single pathway. Patients are frequently attending multiple appointments and services in hospital and community with care often provided in a fragmented manner. Care and setting for care, acute hospital or community, should be based around patient need not only what suits the service. Achieving the LTC priorities highlighted in the preceding sections will enable the more effective use of resources and support the addressing of demand pressures.

IMPROVING QUALITY, EFFICIENCY AND EFFECTIVENESS		
Outcomes	**Change/Development Required**	**Measures**
LTC pathways and care delivery systems redesigned to reflect the need for a comorbid as opposed to single disease specific approach to better meet the needs of the patient	We will deliver our LTC LES programme based on best value principles and maximum health outcome A streamlined comorbidity LTC LES will be developed and delivered in primary care with a frequency determined by the identification of an individual's risk factors We will identify the evidence for effective interventions as part of the LES delivery review Use the LES data for effectiveness enquiry and to assess compliance with disease specific pathways Secondary care LTC systems and processes will reflect revised primary care LES arrangements	Reduction in number of patient visits required for LES review – in primary care Key disease specific pathway indicators will be routinely reported to the MCNs on quarterly basis to facilitate dialogue with primary care and identify need for targeted approaches where outcomes are not optimal Reduction in primary and secondary care review appointments All pharmacies will deliver CMS –

	Follow-up appointments to secondary care clinics will be based on need Patients will be supported to better manage their own medicines, whether in the community or in hospital Community Care Team (PPSU) will collaborate with CHCPs to support achievement and measurement of these outcomes and changes	50% patients ***** receiving CMS 80% of practices participating in electronic repeat prescription transfer No of people with >6 medicines receiving medication reviews and polypharmacy reconciliation (*****Estimate based on historical trends - subject to national financial negotiations)
Individuals feel more supported to deal with the psychological impact of dealing with a LTC	We will produce guidance and resources to support the adoption of models and approaches which offer a range of emotional and psychological support to people living with a long term condition at different stages of their condition	Reduction in no of patients referred to GP for depression/anxiety via the LES
We will reduce hospital admissions and bed days of patients with primary diagnosis of COPD, Asthma, Diabetes and CHD	There will be clear pathways between primary, acute and social care There will be services, systems and processes in place to allow rapid response and re-entry to secondary care from the primary care pathway in case of need A comprehensive review programme will be developed for each LTC disease specialty to focus on hospital admission, discharge and bed day usage	Target 2% reduction each year of Framework. Continued referral to pulmonary rehabilitation with record of completion rates for the programme - Referrals, availability, location (COPD). Proportion of COPD admissions followed up by the Early Supported Discharge Service. Increase in Provision of Inhaler Technique advice/information (Asthma). Cardiac Rehab - Reduction in the percentage of patients referred for but decline or fail to complete the full cardiac rehab program. . Community Heart Failure Clinical Nurse

		Specialist service - A rise in the percentage of newly diagnosed stable heart failure patients signing up for and completing the new community based structured education program Reduction in admissions with Ketoacidosis and Hypoglycaemia e.g. acute diabetic emergencies a minimum of 75% of patients with diabetes have a foot risk score 90% active foot ulcers to be reviewed at multi-disciplinary clinics (Diabetes) A % increase in attendance at structured patient education in each CHCP area (Diabetes and Pulmonary Rehab)

5.5 Tackling Inequalities

Determinants of health. The impact of health inequalities on LTCs closely follows the pattern of the effects on general health. There are stark differences in health and health outcomes across different social groups, which challenge the way we organise our services to close the health gap with significant differences in healthy lfe expectancy. Higher prevalence rates for coronary heart disease, stroke, diabetes and COPD are recorded in areas of deprivation than in more affluent areas. In 2005, it was recorded that those living in the most deprived parts of Greater Glasgow (Deprivation Category 6/7) were almost twice as likely to report that they have a long-term limiting illness (26%) than those living in the least deprived parts (DEPCAT1/ 2: 14%).

Poverty and vulnerability continue to be significant drivers of ill health and the way people access services in GG&C. 35.5% of our population live in the most deprived quintile. This may rise with the recession and welfare changes. The onset of multi-morbidity occurs 10-15 years earlier in people living in the most deprived areas compared with the least deprived areas.

Ethnicity also has a direct effect on health inequalities. The incidence of Type 2 Diabetes has been shown to be as high as 8% in South Asian population of Glasgow compared to 3% in the indigenous population. This figure rises to as high as 40% in the South Asian 70+ age group**.** Over the next three years we need to identify action to ensure that tackle these inequalities.

TACKLING INEQUALITIES		
Outcomes	**Change/Development Required**	**Measures**
We will narrow the health inequalities gap through a clearly defined programme of action agreed by each MCN	We will ensure that the consideration of inequality impacts are embedded in all appropriate workstreams	Increase in attendance of patients from the BMW community
	The design of tailored and targetted interventions aimed at specific groups known to be difficult to engage/hard to reach Identify populations at risk of unmet need.	Reduction in number of young males failing to attend follow up appointments Increased access for asylum seeker community
	Identify and address key failure points in the pathway of care which mitigate against vulnerable individuals accessing healthcare	Reduction in DNA rate

	Each MCN will support and be advocates for an increased knowledge and understanding of the inequalities and discrimination facing our population by collecting and using available data and research We will work towards routinely collecting and scrutinising data reflecting inequlaties and unmet need, establishing new data systems where necessary	Development of a standardised Inequality sensitive practice report which is routinely collected within each MCN
	Each MCN will incorporate into pathways where appropriate opportunities for referral for financial/welfare advice and support the spread of awareness of inclusion services in clinical practicel	Increase in number of financial/welfare advice referrals

6. WORKFORCE & RESOURCE IMPLICATIONS

There are a range of challenges facing our workforce which largely mirror our LTC challenges. We have an ageing workforce which impacts on a range of professions in both acute and community, as well as on carers.

There are recruitment challenges with some hard to recruit professions.

Access to medical care is rapidly a 24/7 requirement and medical workforce increasingly required for 24 hour cover.

There are reductions in junior staffing with increasing need for senor staff/senior doctors hours to provide 24/7 care – this is challenging for current service models.

We need to support our workforce to meet future changes and balance specialist and generalist; acute and community workforce teams.

Workforce re- modelling is increasingly necessary to define the changing roles required to meet both the resource demands on the service, and the challenge arising from a new LTC polyclinic approach.

Detailed work is required to define the specialist and subspecialist input required.

FINANCE IMPLICATIONS

Ageing population; rise in emergency admissions and growth in chronic disease attendances and admissions with resultant rise in prescribing costs are various drivers highlighted within this LTC planning framework that contribute to an increased demand on resource allocation and demand a multi-faceted response.

The MCN financial framework has been developed identifying a range of potential areas worthy of further exploration to identify ways of maximising service efficiency and productivity. This programme will be developed further within each MCN.

A programme budgeting and marginal analysis approach has also been developed to provide a basis to scrutinise LTC spend in different sectors. This has not significantly progressed due to difficulty in accessing GP LTC base data. The new data sharing agreement with primary care which is currently being concluded will support and enable ramping up this work allowing progress to be made.

PATIENT EXPERIENCE

There is a strong commitment within LTC and MCN programmes to seek patient views on current and proposed service developments. We will continue to try and improve communication and shared decision making in order to support good patient care.