BHR whole system LTC strategy

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Responding to the growing challenge of Long term conditions

March 2019
Not for further circulation

North-East London Local Pharmaceutical Committee
Supporting Pharmacists To Serve The Community Better

Barking, Havering and Redbridge University Hospitals NHS Trust

NELFT NHS
NHS Foundation Trust

London Borough of Redbridge

NHS
Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups

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Executive summary

This strategy was developed across the Barking and Dagenham, Havering and Redbridge (BHR) Health Economy with input from BHR Clinical Commissioning Groups (the CCGs), Barking and Dagenham, Havering and Redbridge University Trust (BHRUT), North East London Foundation (NELFT) Trust and the Public Health Teams from the three London Boroughs.

The partners came together with the common recognition that no one partner in the health economy can address the strategic and practical challenges of Long Conditions alone, and that a joint coordinated approach will be required to effectively identify, treat and support patients with long term conditions in the most appropriate setting of care. In addition the partners acknowledge that as a consequence of an aging population, local demographic factors and lifestyle changes the challenge of LTCs is growing and that action to impact growth and ensure the most efficient use of joint resources to address the challenges of LTCs under these circumstances is required.

Key challenges

Data analysis and clinical input demonstrates that at its core the long term conditions challenges can be articulated in two statements:

1. Prevalence Gap – comparison of national data and Quality Outcomes Framework data recorded by GPs demonstrates that there is a difference between the numbers of patients diagnosed with long term conditions when compared to national forecast data. Patients who are not diagnosed and are not aware that they have a condition will not be accessing the appropriate support and treatment and are therefore at risk of their condition deteriorating and/or of accessing treatment, non-electively as a result. In addition as a result of an aging population and changing lifestyles the prevalence of all in scope conditions is increasing.

1. Settings of Care - Analysis was carried out focusing on the cardiology LTCs and diabetes to understand the burden of cost as a result of LTCs. This analysis demonstrates that a very high proportion of spend on LTCs is spent on non-elective care. While it is recognised that this may be in part due to the relatively higher cost of non-elective care (as opposed to elective treatment) it is indicative of the fact that we are seeing more patients being admitted to Hospital as non- elective admissions, some of which may be avoidable.

A clear vision for LTCs has been developed in response to the above which includes the development of common/single pathways for patients with multiple LTCs, a renewed emphasis on empowering the patient to manage their own condition, improving diagnosis rates and developing a framework to enable measurement of progress in relation to the various programmes of work/projects that we will be delivering.

Executive summary Contd

Our multi-agency strategy has been developed to coincide with the commencement of our system wide LTC Transformation Board, therefore this strategy can be seen to represent a starting point for an ongoing programme of work, directed by the board. The proposed work set out in this strategy is grouped into four thematic areas:

1. Early Identification
2. First Response
3. Managing Well
4. Patients with complex needs who may have more than 1 LTC

Our LTC programme will oversee the work and measure its effectiveness i.e. through performance review of identified KPIs, Outcomes etc

How we will deliver out LTC programmes of work

We have established task and finish groups to develop the various schemes outlined within the strategy. The groups comprise of a range of clinicians and officers from across the health economy.

We will engage with patients and carers when required to ensure that our work is based on feedback from the latter groups..
We are in the process of developing a patient friendly version of our strategy which will outline in simple terms our offer to our local populations.

Introduction

Introduction

The purpose of the our strategy is to set out how we will support those within our population with Long Terms Conditions (LTC). Our three year strategy sets out our key areas of focus and how we will deliver them. In developing our strategy we have aligned our priorities with and embraced the principles underpinning the following national and local drivers;

1.NHS 10 year plan
2.NEL Sustainability Transformation Plan (STP)
3.Joint Strategic needs assessment (JSNA)
4.Health and Wellbeing Strategy.

Our approach focuses on a shift away from a reactive, disease-focused, fragmented model of care and service provision towards one that is more proactive, holistic and preventive with a commitment to working with and supporting people with long-term conditions to play a central role in managing their own care.
How we provide services in the future will continue to involve joining up services across health and social care ensuring that the services we provide are integrated, spanning across primary, community and secondary care delivered by MDT teams where necessary thus providing a co-ordinated and seamless journey through the system for patients.

We know that we need to continue to focus on primary prevention as this will be key to reducing the incidence of LTCs within the population before LTCs occurs. How we do this will involve for example developing a range of universal measures that reduce lifestyle risks or by targeting high risk groups /areas within our boroughs with a higher disease prevalence /risk indicators. We will work jointly with our Local Authority partners, third sector organisations and the community to support individuals who have no current health or care and support needs but may require support in the future.

We know that we need to continue to improve how we undertake early diagnosis and detection, provide timely treatment and on-going management and that this will be crucial to ensure that those with LTCs avoid un-necessary hospital admissions and or re-admissions and are able to manage well when faced with a crisis. We know as per the latter that having the correct packages of support and interventions in place is one of the ways that will help us both empower patients to be equal partners in the shaping their care as well as improve outcomes for this cohort of patients.

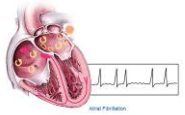
We know that mental health is equally important as physical health and well being and that people with LTC may need a range of support packages which address both in a holistic way. This is why we will continue to ensure that in implementing this strategy that we draw on work happening within our mental health transformation programme so our work is co-ordinated better for those with LTC.

We recognise that this strategy is just the start of our journey and we will continue to work with patients, carers and wider stakeholders to update, prioritise and deliver the various elements of our work.

Introduction – The LTC conditions that will be covered by our strategy (scope)

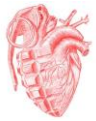
The conditions within the scope of this strategy are set out below. Local and national data demonstrates a growth in the prevalence of all of these conditions, and with it an increase in cost. A coordinated strategic approach is required to impact growth rates, improve care and deliver savings.

Diabetes – A lifelong condition that causes a person's blood sugar level to become too high. It's important for diabetes to be diagnosed as early as possible as it can get progressively worse if untreated. It can also lead to heart disease and stroke, nerve damage, vision loss and blindness and kidney problems.



Atrial Fibrillation - A heart condition that causes an irregular and often abnormally fast heart rate. Those with AF are at increased risk of having a stroke and in extreme cases, it can lead to heart failure.

Chronic obstructive pulmonary disease (COPD) – A group of lung conditions that cause breathing difficulties, typically affecting middle-aged / older adults who smoke. COPD is irreversible but can be managed to slow progression and control the symptoms.



Coronary Heart Disease (CHD) – A major cause of death when the heart's blood supply is blocked often due to a build up of fatty substances in the coronary arteries. This can be caused by hypertension, diabetes, high cholesterol and smoking.

Asthma – A common lung condition which causes breathing difficulties through inflammation of the breathing tubes that carry air in and out of the lungs. Whilst it can be kept under control, it's still a serious condition that can cause stress, anxiety, or lung infection.

Chronic Kidney Disease (CKD) – A condition often associated with getting older where kidneys do not function optimally. This is often caused by high blood pressure, diabetes, kidney infections, and long term / regular use of certain medicines

Hypertension – A condition which rarely has noticeable symptoms. But if untreated, it increases risk of serious problems such as heart disease, heart attack, kidney disease, or strokes.

Vision

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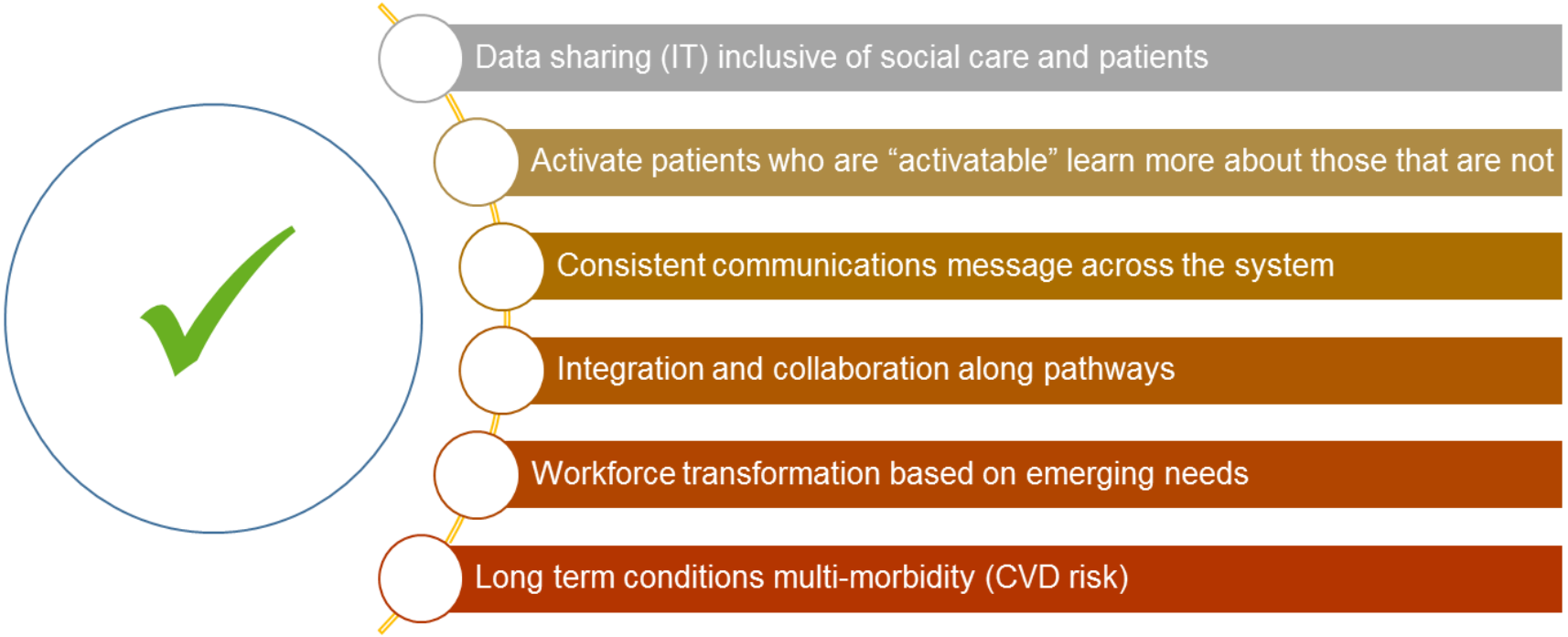
Vision – high level summary



Vision

How we will work to transform care for patients

- Enhancing integrated working across BHR which will help to facilitate a system wide approach from prevention and case finding through to education and care. This will include single pathways for the different “in scope” conditions.
- We will work on LTCs on a system wide basis, ensuring that pathways work for patients on an end to end basis
- Work will be clinically led, with input from partners from all parts of the commissioner/provider spectrum
- We will agree key metrics/outcome measures to measure impact/delivery
- We will involve patients in the development of initiatives

Deliver an LTC Model of Care that will

- Focus on prevention and aim to impact the forecast growth for the “in scope” conditions (see page 8)
- Improve diagnosis rates
- Improve patient education and awareness

What will be different for patients with long term conditions

- People in BHR will receive end to end care for their long term condition, this will include:
  - People at risk of developing a LTC will be informed early and patients will be provided with support to prevent the condition developing
  - Provision of education for patients at risk, on diagnosis and throughout their care
  - Patient care will be provided with care close to home and will, where possible, avoid multiple appointments for patients with more than one long term condition, improving patient access and clinical quality.
- Take a partnership approach between patient and clinician for all LTCs
- Support and information that enables patients to be equal partners in shaping their care with help from health and social care professionals
- Effective preventive care to reduce the risk of complications and other morbidity
- On-going monitoring of their condition to detect and respond to their health and social care challenges early in the course of their condition

How we have developed our strategy

How we have developed our strategy- An overview of our approach

BHR CCGs over the last couple of months have been working jointly with our partners across the health economy and with Local Authority colleagues and patients to look at how best we can continue to improve services for people within our local population with Long Term Conditions.

We have looked in depth at our population needs, disease profiles and trends, in order to understand what we need to address including where we are, what we need to do and how we need to get there. As part of this exercise we have sourced from elsewhere, clinical evidence and best practice of what works well and how we can apply this locally. We have identified a number of themes and areas of focus that we need to address in order to improve and better co-ordinate the services on offer for those with LTC. We will be undertaking further work with patients and carers to obtain their views.

Emerging from this work, has been the development of the following:

- Our vision for supporting people with long term conditions (LTC)
- The LTC conditions that we will focus on (the Scope),
- Our Case for Change-
- Our Model of Care, (drawing from evidence and best practice)
- A range of delivery focused areas for implementation (The How).
- We have established a multi–agency LTC Transformation Board to provide overall direction and oversight

How we have developed our strategy- An overview of our approach

Phase 1: Mobilisation

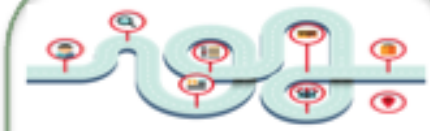
1.Overarching plan with timescales, outputs and roles / responsibilities

2. Define approach to engagement with stakeholders

3. Initial data analysis and interrogation

4. LTC workshop and formation of core 'steering' group(s)

Phase 2: Prioritisation and preparation



1. Map of 'what's happening' across system in areas of priority

2. Prep and coaching sessions with professional / clinical leads

3. Whole population analysis of data and outcomes

4. Collation of national / international good practices

5. Setting up groups at whole system governance pathway

Phase 3A: Development of LTC strategy

Co-production

Workshops and focus group sessions with Programme board, any reference or groups and wider stakeholder workshops

Development of LTC strategy

- *Our goals and outcomes*
- *Growing burden and case for change*
- *Define LTC framework*
- *Agree Priority areas*
- *How: Transformation approach*
- *Estimate whole system impact*
- *Engagement and development of system leadership*

Phase 3B: PID for individual projects

Project initiation document

(For eg: AF identification and management)

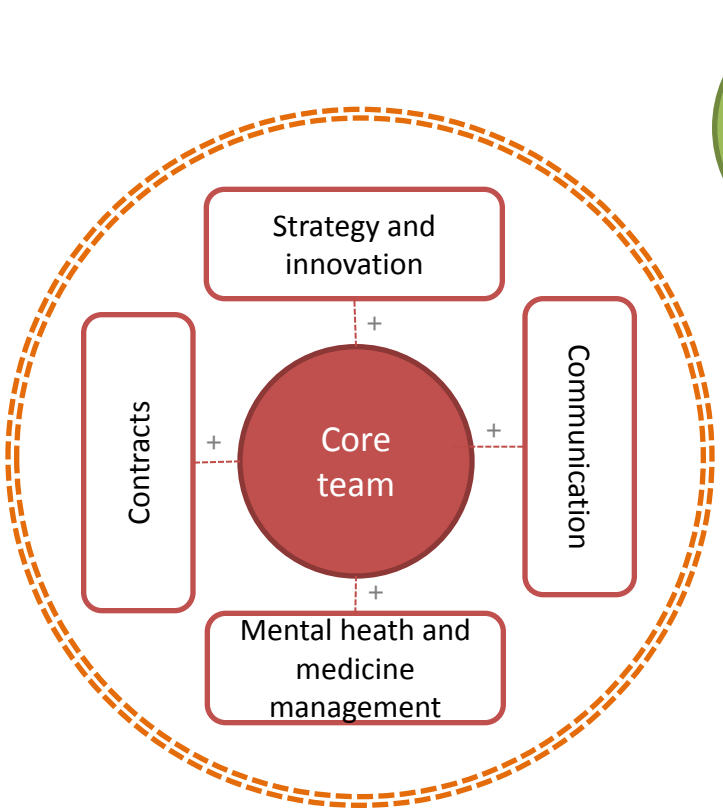
1. Define clear outcomes
2. As Is Map / Issues / gaps
3. **NEW MODEL OF CARE**

- *Key initiatives (what)*
- *Impact assumptions*
- *Delivery - who and how*
- *Achievement of outcomes*
- *'Just do it' initiatives*
- *Work plan for implementation*

Sept 2018 — *October 2018* — *November – April 2019*

Consistent engagement with stakeholders

How we have developed our strategy- Stakeholder map and engagement



Patient reference group

Clinical directors and IJEC

GP reference group

Heath / clinical care cabinet (Check)

LTC board

Organisation champions
BHRUT (2)
NELFT (1)
LA (1)
TBA

Keep engaged
- LPC
- Health watch

TBC
- A
- B
- C

Core team:
1.Clinical leads(s)
2.Project manager(s)
3.Primary care
4.Public health
5.BI
6.Finance
Meets weekly – TBC

Core plus
Provides support to core team
1. Strategy and innovation
2. Comms
3. MH and Med
4. Contracts
5. IT and IG

Core team to engage as required

Reference groups:
Provides advice / direction
1. Clinical directors / IJEC
2. GP reference group
3. Patient reference group
4. Health / CCC

Monthly discussion

LTC prog board:
Provides leadership and decision making
1. Member A
2. Member B
3. Member C
4. Member D
5. E

Monthly discussion

Case for change

Case for Change ('The why') 1

Long term conditions are a growing challenge for the NHS across the UK as a result of an aging population which increases demand for services, some of which require complex interventions. This trend is present in BHR where social economic factors such as the high levels of deprivation in some parts of the health economy and by demographic composition of the population means that some of the population are at greater risk of developing some conditions (diabetes in particular, which can lead to a number of other conditions and co-morbidities).

NHS 10 Year Plan, there is a focus on Long Term Conditions, which in summary covers the following:

- Funding for specific prevention programmes.
- Increased focus over the 5 years of 'shared responsibility for health' ramping up support for people to manage their own health.
- Pharmacists and nurses in Primary Care to case fund and treat people with high risk conditions including AF and CVD more widely. Pharmacists to undertake medicines reviews and help with training patients.
- Access to weight management services in primary care for T2 diabetics and those with hypertension.

In developing our strategy, we have sought to embrace the above themes. Our starting point has been to firstly understand our populations needs. Analysis carried out during the development of this strategy demonstrates three key points:

1. **Prevalence Gap** - There is a significant (detection gap) between the number of patients diagnosed with long term conditions across BHR and those people who have not been diagnosed. Patients who do not have a diagnosis will not be on the appropriate disease registers and will therefore not be receiving treatment, support and medication for their conditions. This increases the risk that their condition will worsen and that they may first present at A&E or admitted in hospital as a non elective (emergency admission).
2. **Co-morbidities** – There are significant number of patients diagnosed with multiple LTCs. We know that patients with four or more LTCs are likely to be complex and will require a greater level of clinical support and packages of care, i.e. Social Care input. As a result of our aging population this cohort is likely to continue to grow; therefore developing bespoke pathways and services is crucial to supporting this cohort in a cost effective way.
3. **NEL Activity** – Analysis demonstrates that a very high proportion of the spend on LTCs is on non elective admissions. While it is understood that non elective activity for patients with LTCs will in some cases be unavoidable the continuation of the level of spend when coupled with an aging population will lead to increase demand for services and subsequently an increase in how much we spend. So we know that, to deliver improved patient quality, reduce cost and deliver savings it is necessary to ensure that a greater proportion of activity is elective, or preventative.

Prevalence Gap

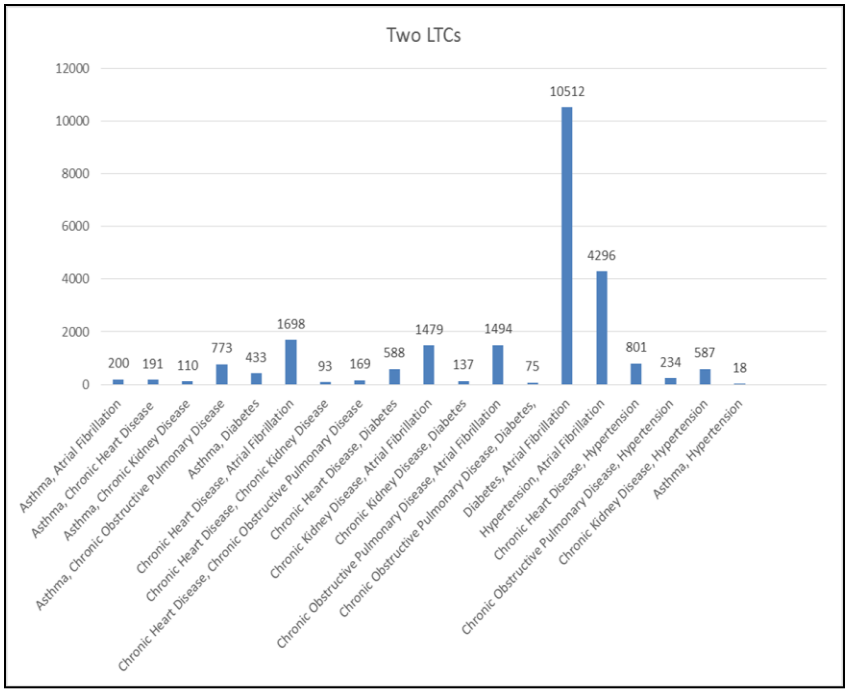
The figures in table 1 below demonstrations there is a significant gap between the expected number of diagnosed patients in the population compared to those patients actually identified with LTCs. There is a risk that patients are not diagnosed early, and do not access treatment earlier in the course of their condition resulting in avoidable unplanned admissions in the future. In addition as a result of an aging population and changing lifestyles the prevalence of all in scope conditions is increasing.

		Borough level patient gap breakdown		
LTC	**Expected Prevalence in BHR**	**B&D CCG (pts)**	**Havering CCG (pts)**	**Redbridge CCG (pts)**
Diabetes	14,019	624	5,983	7,412
AF	6,884	1,456	2,720	2,668
COPD	10,323	3,327	4,624	2,372
Asthma	36,556	9,567	13,055	13,934
CKD	23,028	4,367	10,063	8,598
Hypertension	68,206	14,350	27,470	26,386

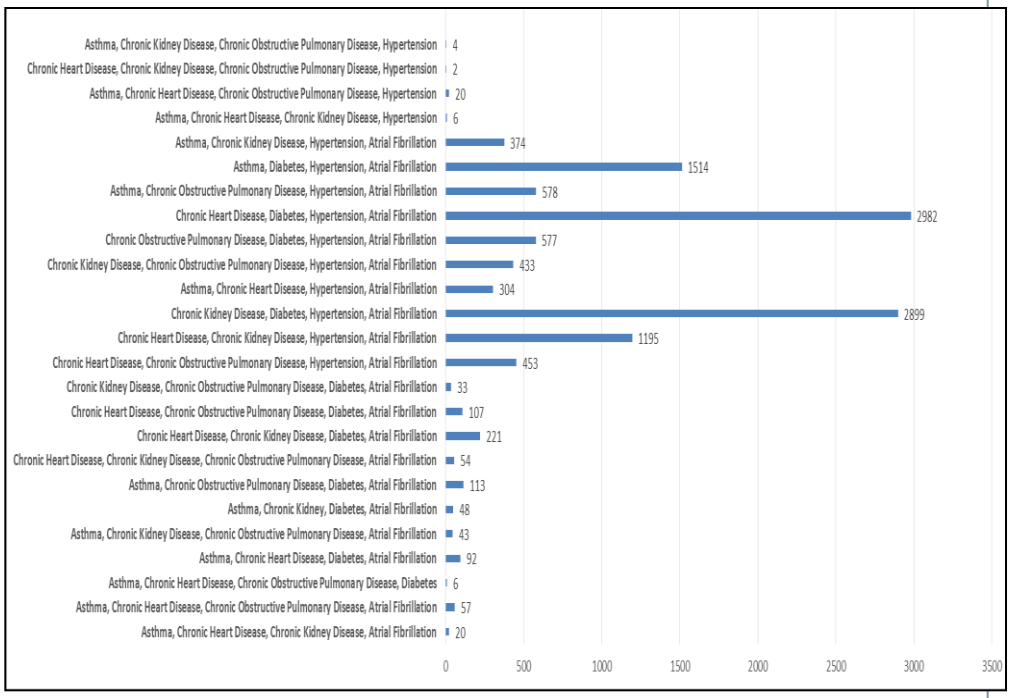
- The overall population of BHR is 776,419, which has been used to calculate the figures shown in the table
- There is a risk of continued increase in diagnosis and patient gap if there is not imminent change

Multimorbidity

Patients with Two LTCs



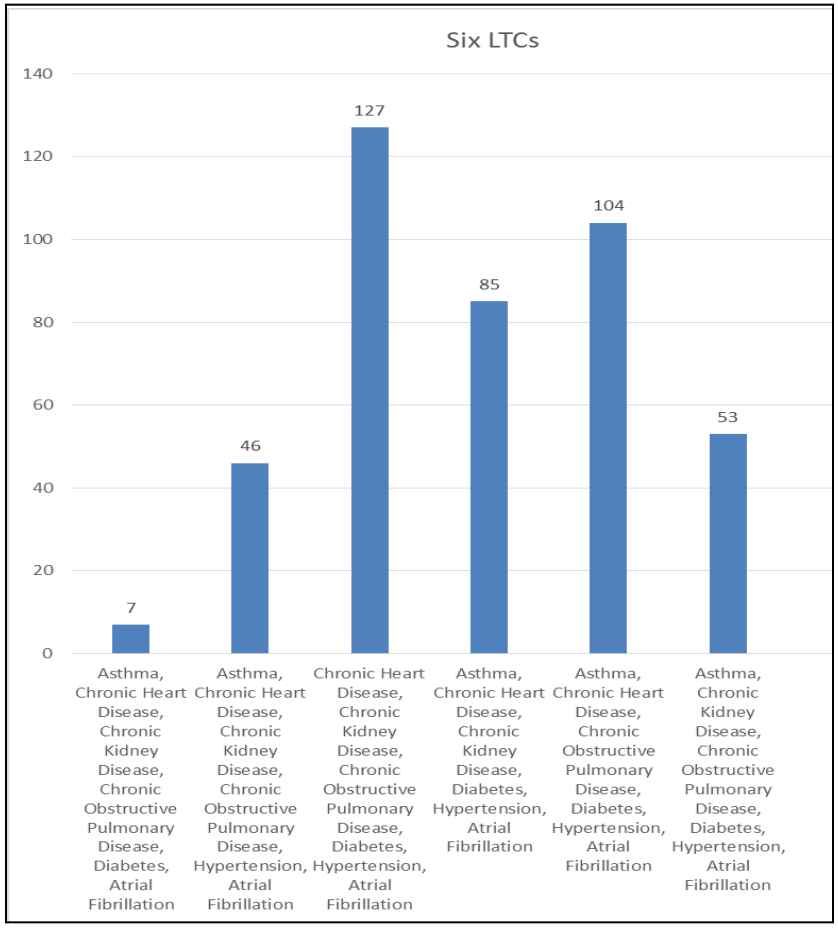
Patients with Four LTCs



- The most common combination affecting more than 10,000 patients is the combination of AF and Diabetes.
- The second highest combination is Hypertension and AF affecting 4,296 patients.
- CHD, CKD and COPD all contribute to the next three highest combinations

- More than 2,900 patients have a combination of CHD, Diabetes, Hypertension and AF
- Over 2,800 patients have a combination of CKD, Diabetes, Hypertension and AF
- COPD continues to be a condition affecting patients with Asthma

Patients with Six LTCs



- CHD, CKD, COPD, Diabetes, Hypertension and AF are the leading six combinations
- Asthma, CHD, COPD, Hypertension and AF is the second highest affecting patients.
- These are your complex, expensive cases for the health system

Whole System burden of LTCs

This analysis includes admissions for both planned (day cases and electives) and unplanned (non-elective) for age group 18+ in BHR CCGs. The analysis is based on SUS+ data and Long term conditions are based on HRG codes identified by clinical leads. The long term conditions shown in this analysis are related to cardiovascular and diabetes conditions only.

Highlights

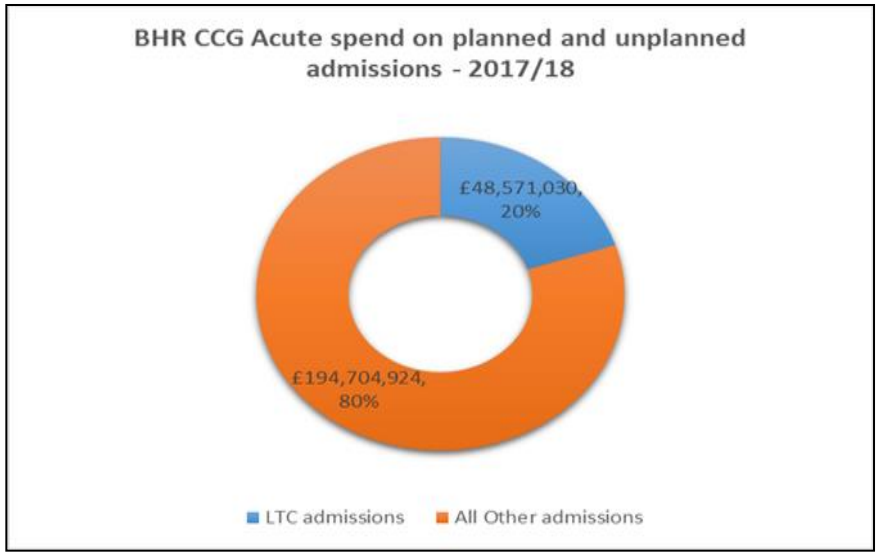
- BHR CCG total spend for admissions both planned and unplanned in 2017/18 is £243m; of which £49m is related to admissions for long term conditions (LTC) (20%). Of the £49m spend for LTC

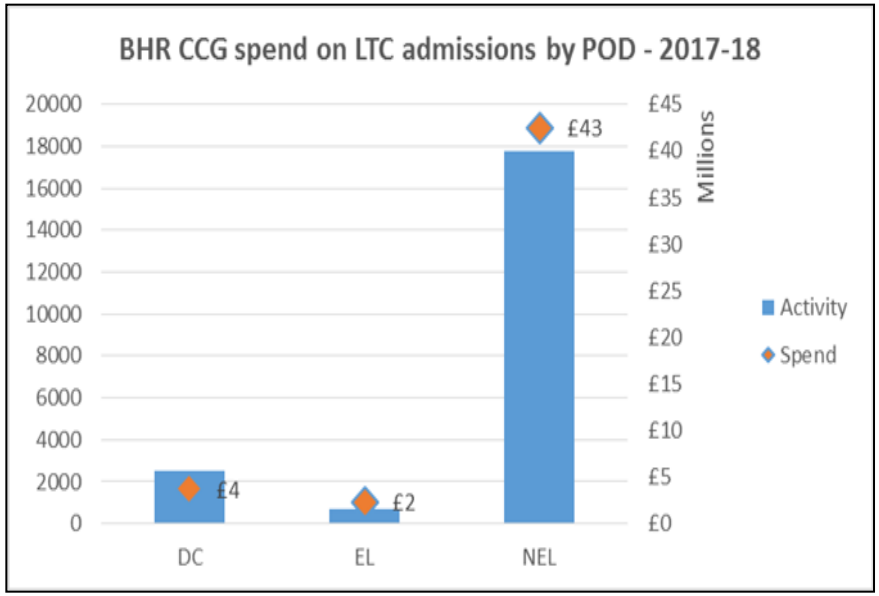
  - 7.7% (4m) is attributed to day cases (DC),
  - 4.8% (£2m) to elective admissions,
  - 87.5% (£43m) is attributed to non-elective admissions.

Planned admissions: Day cases (DC) and Elective (EL) admissions

- Of the £4m spend in day cases, majority of the spend is around cardiac (78%), vascular procedures and disorders (8%), eyes and periorbital (6%).
- Of the £2m spend in elective admissions, majority of the spend is around vascular procedures and disorders (41%), cardiac (24%) hepatobiliary and pancreatic system (13%).

The charts on the right shows the percentage distribution of admissions related to LTC conditions and all other admissions by provider.

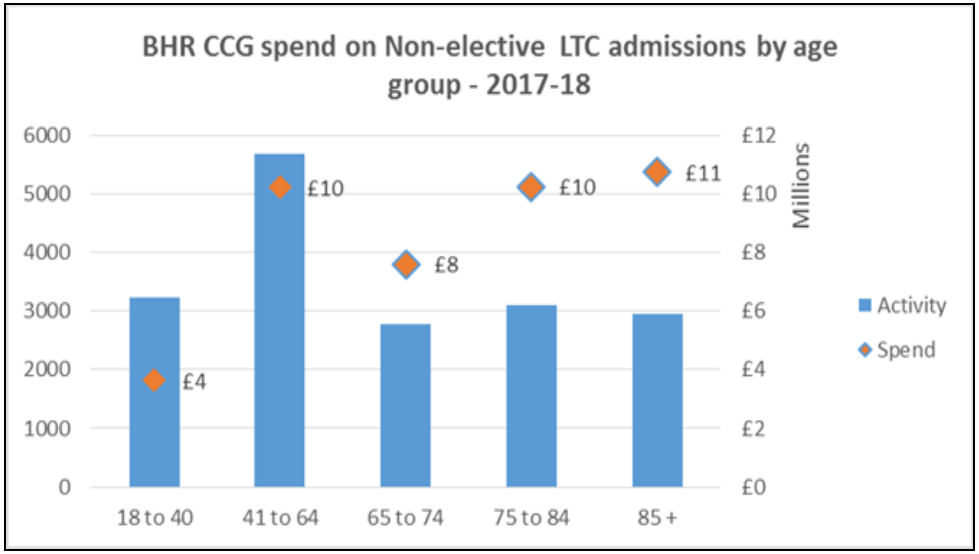




Whole System burden of LTCs

Non-elective admissions

- 67% (£29m) of the non-elective spend in 2017/18 are for admissions related to 65+ age category, of which nearly 50% are for the 75+ age group.
- 33% (£14m) of the non elective spend are for admissions for working age group (age group 18-64).
- There is an increasing trend in 17/18 and 18/19 (based on M6 forecast) toward non-elective admissions related to long term conditions across all age groups.



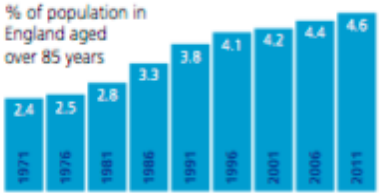
Non-elective admissions	Age_Categories	2015/16	2016/17	2017/18	2018/19 M6 FOT	movement from 15/16 to 16/17	movement from 16/17 to 17/18	movement from 17/18/to 18/19
No of admissions for LTC	18 to 40	1139	1098	1179	1216	-4%	7%	3%
	41 to 64	2751	2593	2827	2904	-6%	9%	3%
	65 to 74	1397	1467	1672	1844	5%	14%	10%
	75 to 84	1846	1876	2125	2402	2%	13%	13%
	85 +	1441	1639	2040	2090	14%	24.5%	2.5%
All other admissions	18 to 40	12902	12658	12774	13238	-2%	0.9%	3.6%
	41 to 64	13511	12790	13374	14316	-5%	4.6%	7.0%
	65 to 74	6505	6132	6517	6694	-6%	6.3%	2.7%
	75 to 84	8073	7738	8040	8390	-4%	3.9%	4.4%
	85 +	7859	7748	9120	9710	-1%	17.7%	6.5%

ENHANCING THE QUALITY OF LIFE FOR PEOPLE LIVING WITH LONG TERM CONDITIONS

NHS England

Long Term Conditions are those that cannot, at present, be cured, but people living with these conditions can be supported to maintain a good quality of life.

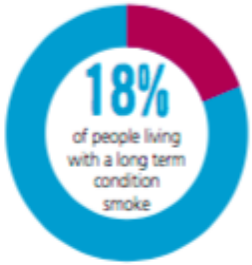
People aged over 85 years are more likely to be living with a long term condition including frailty.



People might be living with more than one long term condition. Of the people who report that they live with long term conditions;

24% have two long term conditions...

...and 20% live with three or more long term conditions.



People who smoke are more likely to have flare ups in their condition and more likely to be admitted to hospital.

Carers are a hugely important asset to the NHS as well as the people for whom they care.

80% of carers said that caring has had a negative impact on their health.

Carers may need support both in their caring role and in maintaining their own physical and mental health

However many conditions people are living with it is important that they feel supported to manage their overall health and wellbeing. They should have a care planning discussion recorded in a written care plan.

72% of people with long term conditions use their care plan to manage everyday health

5.4% of people with long term conditions have a written care plan

People living with a long term condition are less likely to be working than the general population.

72% of the general population are in work

59% of people with long term conditions are in work

35% of people with a mental health condition are in work

Over time the needs of people living with long term conditions may change. Planning ahead is key for people who are approaching the end of life and for those important to them.

People should have opportunities to discuss their wishes and preferences for now, and for the future, and to have these recorded in a personalised care plan.

People living with a long term condition are more likely to use health and care services. They account for:

50% of all GP appointments

64% of all hospital outpatient appointments

70% of all hospital bed days

70% of total health and social care spend

More information about enhancing the quality of life for people living with long term conditions can be found at: www.england.nhs.uk/house-of-care/

Model of care ('The what')

Model of Care – guiding principles

1. Prime focus on Prevention – both primary and secondary
2. Person centered rather than disease centered. Recognising individual as the partner – not a patient
3. Galvanise communities as assets in jointly partnering in how care is delivered whilst activating people to self care and self manage.
4. Focus on multi-morbidity rather than an isolated single disease pathway
5. De-medicalisation of response –a more comprehensive and holistic response – with mental health as equally important as physical health.
6. Breakdown barriers and facilitate joint ownership across the system
7. Consistency of provision of health / care support services across BHR with variation triggered by need rather than historic commissioning decisions
8. Empower frontline staff to define and shape transformation and service delivery
9. Management of health inequalities ensuring services are responsive to local demographic and cultural variation
10. Improved care and experience for people (and their families) approaching end of life

Model of Care – key elements

The model of care encompasses the following key elements:

1. Primary prevention: Improvement in healthy lifestyles and reduction in risk factors through effective involvement in communities, third sector and schools.

2. Early / timely identification of people with long term conditions: This includes:

a) People with no known LTC diagnosed for the first time such as hypertension or diabetes
b) People with one or more LTC but not diagnosed with co-morbidities such as AF
c) People being managed for a condition but not coded as such – which means they are not being proactively monitored and managed
d) People who have not yet acquired a condition but are in stages preceding one such as pre-diabetes

3. Generating holistic 'First response' to people who are diagnosed with LTC

a) Understanding their health, psycho-social aspects and ability / willingness and to manage their condition (activation)
b) Generating a co-designed plan supported by coaching conversation (understanding drivers for change in the person and level of support they require to achieve their own goals)
c) Supporting people with appropriate information for them to manage their heath / well-being

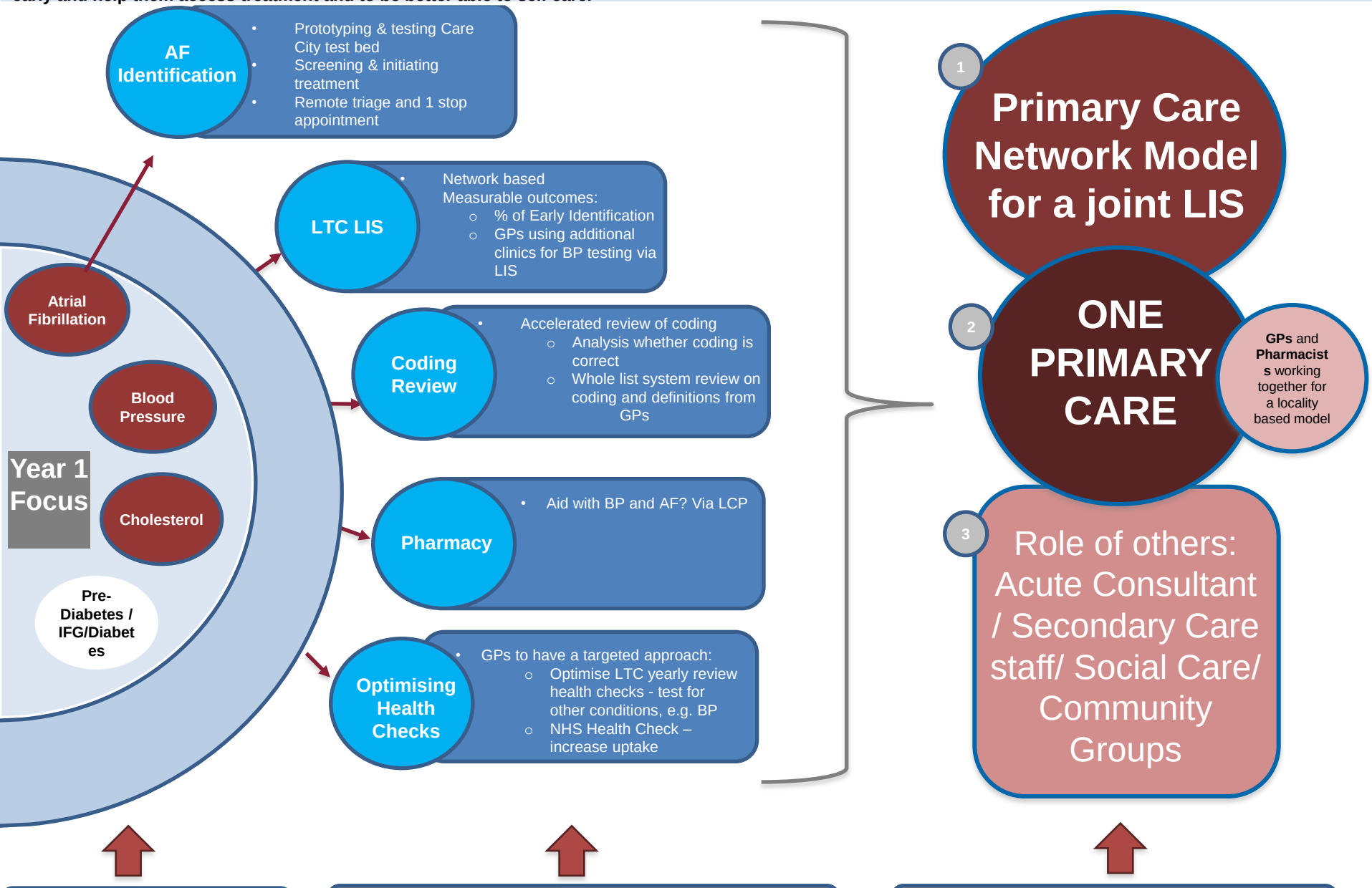
4. Secondary prevention: Optimise support to people who are managing well by provision of tools that are going to make them more resilient and independent.

5. Effective whole system integrated management of people who have multi-morbidity, complex and unstable: A range of measure and improvements in ways or working, relationships and system ownership. Key features include:

a) Optimising and ensuring consistency of community provision across BHR with effective pathways between primary, community and secondary care – ensuring apt involvement of the voluntary sector
b) Multidisciplinary working across the system – such as MDT support across the pathway.
c) Whole system pathways where there is agreement and clarity of roles, joint ownership and ensuring professionals work at the top of their license

Early Identification

Early identification and proactive disease management are key to tackling high hospital admissions, this strategy aims to identify people with in scope conditions early and help them access treatment and to be better able to self care.



Early / timely identification - key features

- Stakeholders from across the system agreed to focus on early / timely identification of Cardio-vascular and diabetes due to the significantly growing burden year on year and the potential opportunity for improvement. Year 1 focus will be timely identification of the following conditions:
    - (Atrial Fibrillation) AF
    - Hypertension
    - Diabetes
- The aim is to harness information, analytics and technology to support timely identification of people i.e opportunistic and targeted screening for those with undiagnosed LTCs i.e AF and Hypertension .The key change is that the responsibility of identifying people and treating them will not be limited to GPs but will expand to capitalise on the expertise on offer from community services and pharmacy
- The opportunity for further identification (prevalence gap) has been summarised below:

	Condition	Prevalence gap (%)
1	Atrial fibrillation (AF)	0.82
2	Hypertension	7.40
3	Diabetes	1.76

Early / timely identification - key features

Our approach to early/timely identification of people will include the following areas:

A. Concerted approach to identification of AF:

- **Building on the care city innovation test pilot:**, we aim to prototype, refine and roll out this model fully in year 1.
- **Target screening for individuals who may be at risk:** In order to ensure greater return, that the approach will be targeted on individuals who are at risk. In order to do that, we will employ a risk stratification framework using existing primary care data either through raising queries in every GP practice (year 1) or using Data Discovery (Year 2 onwards).
- **'One primary care' approach:** Utilising GP practices and pharmacists alike in screening people at risk across the system in year 1. Further expansion of the contact base to areas like dentists, community nursing and other community / secondary resources in year 2 onwards
- **Harnessing technology and innovation:** Considering complexities related to AF identification, we will use technology such as Kadia mobile/ interfacing with IT software in GP practices and pharmacists.
- **Remote triage and one stop appointment (first response):** We will develop an integrated pathway for patients with AF including the establishment of a one-stop AF clinic (hub and spoke model) , with the necessary staff and diagnostics to confirm diagnosis and initiate anti-coagulation where appropriate. The clinic will offer an MDT approach including advice and guidance and will also expand from traditional medical assessment and management to ensuring holistic care planning and social prescribing
- Our LTC primary care LIS for LTC will support the identification and treatment of AF (treatment where practical) in primary care

B. Identification of other conditions such as diabetes (and pre-diabetes), hypertension and hypercholesterolemia:

- **Opportunistic stratified screening utilising points across the system (beyond just GP practices):**) will support identification of people who have an undiagnosed condition.

Early / timely identification - key features

- **Incentive framework for 'one primary care':** We will provide an incentive framework (LTC LIS) where GPs and pharmacists (year 1) can proactively case-find, treat where applicable , signpost people to (or provide) self care information, care planning and ongoing management (first response)

- **Screening in communities:** Provision of testing kits in communities such as mosques, temples, community groups and supermarkets to engage with people who are not known to or engaged with the healthcare system.

- **Screening is just the first step:** Screening with positive or negative results, both, should be accompanied with clear information on 'what to do next'. Social prescribers and links to local community groups will help improve lifestyle and meaningful social connectivity

C. Coding review:

- **Active search on GP systems:** There are a number of people who have a condition and not being coded as such on the GP system. The aim is to proactively search GP systems (using pre-defined queries) to find cases.

- **In the short term:** Initially, this could be achieved by (1) provision of queries to practices who can run it themselves with remote telephone support, (2) visit by a IT or project team member who can run the queries in each practice in quarter 1 (2019/20). Going forward, data discovery or a central database can do the same take centrally on an annual basis.

- **In the longer term**, quarterly / bi-annually data reconciliation across the system to ensure people identified by other parts of the system such as A&E, community services and secondary care are on the LTC register in GP systems.

D. Optimising health check

- **Customised BHR health check:** Considering limitations with the current NHS health checks primarily health checks are not specifically targeted people with LTC and do not cover AF and respiratory conditions, we will embark on a customised health check across BHR (by invitation only) to case find people in these cohort .

- **Targeted approach:** These health checks will be focused on geographical hot spots across localities with high population risk factors thereby effectively targeting individuals who may be at higher risk. However, the same concept will apply to those accessing current NHS health checks who may have no LTC diagnosis.

First Response

This element of the strategy deals with the first contact a health Profession has with a newly diagnosed patient. This is the first opportunity to provide support, enable self-care and provide management. The aim is to have a comprehensive set of tools and enablers we would provide to a person.

1. Identifying ability to self manage (levels of activation using self assessment questionnaire)

Options (TBC)
1. Patient Activation Measure (PAM) High/Medium/Low
2. Well-being Star

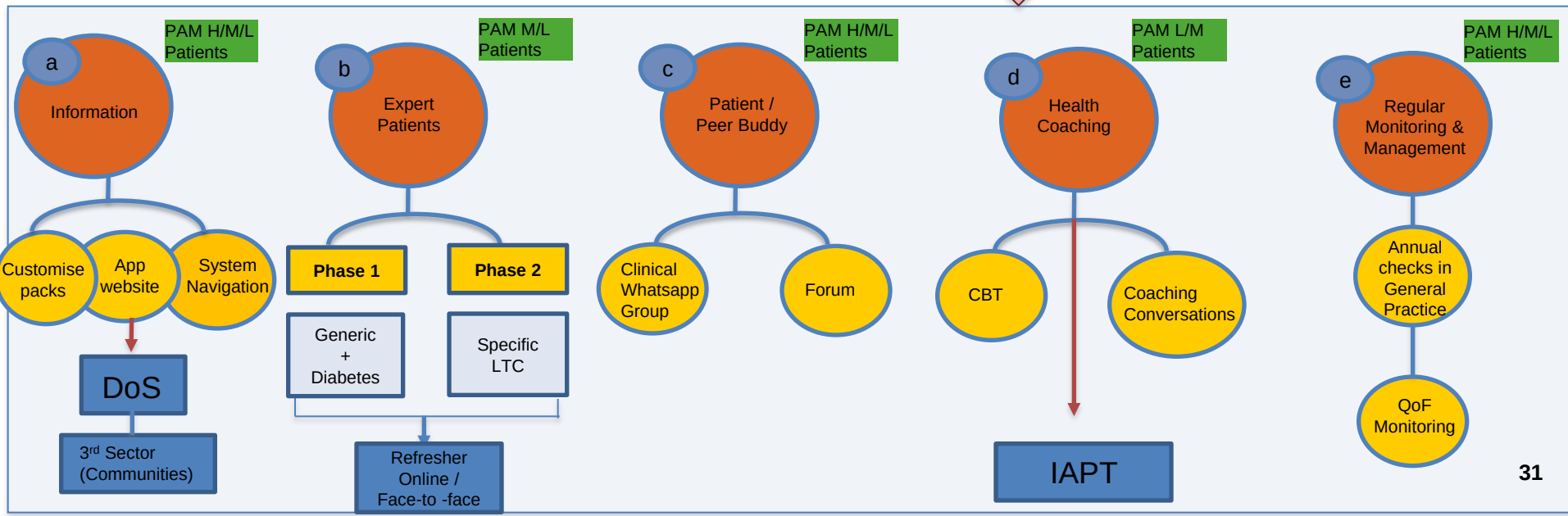
2. Care Planning

- Goals
- Plan
- Activate

- What is the outcome and process for the patient?
- Time to sit and co-develop care plan with patient.
- It could 20-30 minutes session or more.
- GP/Other trained professionals
- Utilising Network LIS
- What enabling support can be offered?

One Primary Care Network Model

Roles of others Acute Consultant / Secondary Care staff/ Social Care/ Community Groups



First response - key features

Identification of conditions in people is only part of the process. Utilising this window of opportunity where we can make a positive impact on people's lifestyle and well-being is critical to long term success. It is acknowledged that support for patients diagnosed with an LTC needs to start early (right at the time of first response) and that they will be supported by health and social care professionals to express their own needs and decide on their own priorities through a process of information-sharing, shared decision-making and care planning.

Our approach to generating a consistent 'First response' that is consistent across the system and responsive to the needs and strengths of the individual includes the following key features:

A. Identifying ability to self manage / activation:

- To ensure that appropriate support is provided to a patient it is necessary to first understand their level of activation, a method of ascertaining this will be agreed/developed. Multiple self instructed tools such as PAM can be used and customised response to people with high, medium and low levels of activation agreed.

B. Collaborative personalised care planning:

- **Collaborative personalised care planning:** Aims to ensure that individuals' values and concerns shape the way in which they are supported to live with and self-manage their long-term condition(s). Instead of focusing on a standard set of disease management processes, this approach encourages people with long-term conditions to work with clinicians/professionals to determine their specific needs and express informed preferences for treatment, lifestyle change and self-management support. Then, using a decision coaching process, they agree goals and action plans for implementing them, as well as a timetable for reviewing progress.

- **Patient brings personal asset and strengths:** The biggest change for clinicians involves recognising that the information about the lived experience and personal assets that the patient brings to the care planning process is as important as the clinical information in the medical record; processes will have to be in place to help the clinicians identify and include the patient's contribution.

First response - key features

- **Going beyond a medical consultation:** Care planning will not be the sole responsibility of the GP. It will be delivered using professionals such as HCA, health coaches, self care pharmacies who will provide time with people and develop from the medical management suggested by the GP/clinician and embark collaborative care planning

- **Network based delivery:** We will align planning delivery with Primary care networks to allow practices to work collaboratively and at scale. First response clinics (please note the term 'clinics' may change) will be located in each network and supported by appropriate professionals thus releasing pressure from GPs. Funding mechanism will include network LIS.

C. Individualised enabling response:

Patient / person is central to our entire response and the sole purpose is to enable the person, building on their own strengths. Depending on the their need and level of activation there are number of types of support that patients can access, as a minimum all patients should receive (in addition to their care plan) an information pack or guidance as to where they can receive information about their condition and an annual check up: this is in effect the core offer. In addition they can also access peer/buddies support, health coaching, social prescribing, as shown below:

Information

- Customised packs for each condition available
- Also available on App and website
- Personalised education for ethnic minorities

Expert patients

- Self-management course that supports people living with, or caring for someone with, one or more long-term health conditions

Patient buddy

- Use a buddy system to support patients who are newly diagnosed or require additional support
- Buddies can be expert patient themselves

Health coaching

- Evidence-based coaching conversation and strategies to actively and safely engage patients in health behaviour change – delivered at networks

Social prescribing

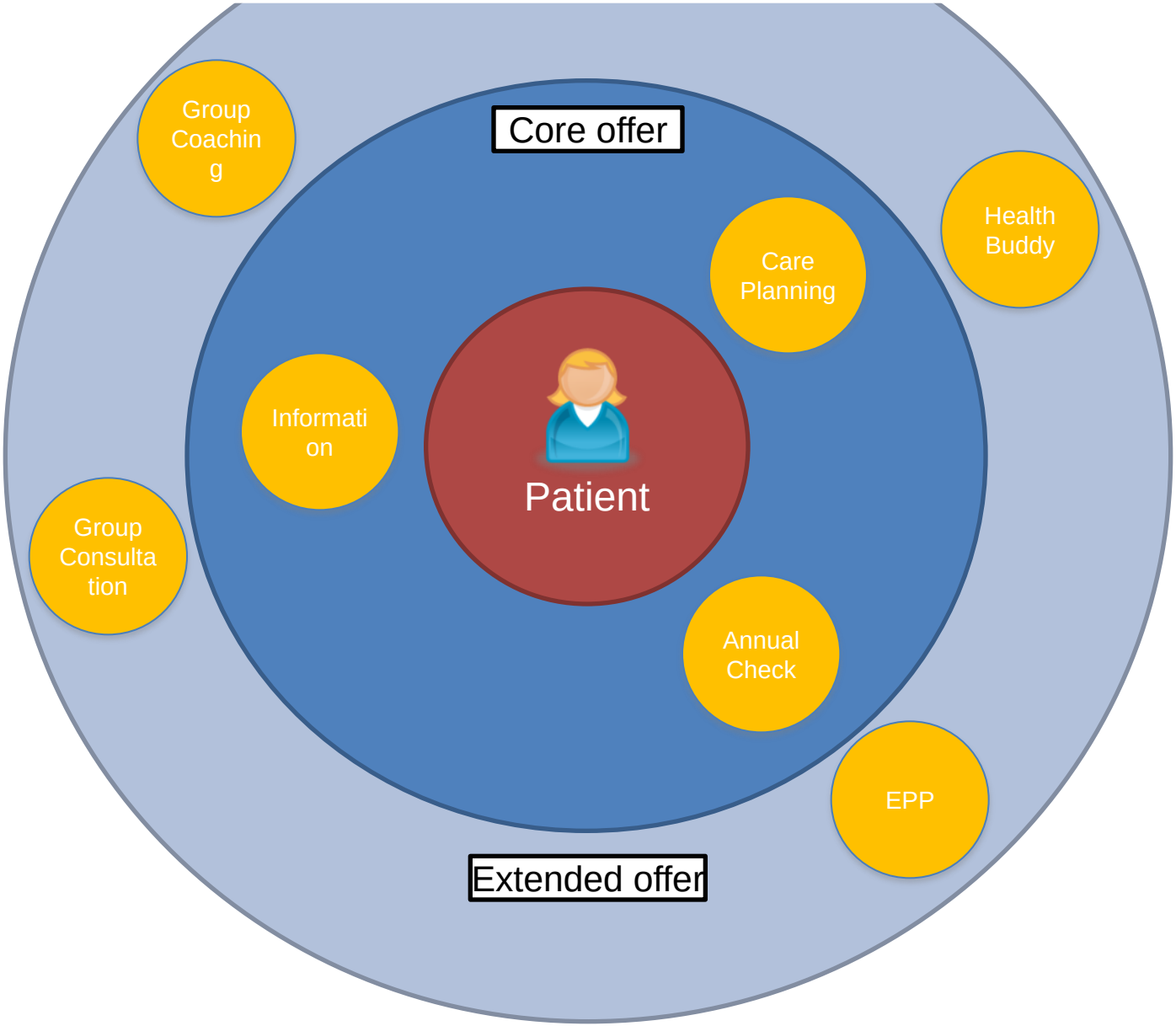
- Linking patients in primary care with sources of support within the community
- Social prescribers and social connectors at practice / network

Regular monitoring and management

- Enhanced target achievement of clinical markers at network level
- One primary care – role of pharmacies

Managing Well

Focusing and retaining patients in this category for as long as possible is vitally important: to proactively manage the condition so it does not deteriorate, and to decrease probability of multiple LTCs occurring.



Managing well - key features

- Patients who are effectively managing their condition may still require support to ensure that their management remains effective. Patients in this cohort will have access to all of the same support as patients in the newly diagnosed group (as set out in First Response), with all patient being provided with a jointly owned care plan, information about their condition and an annual check up.
- In addition these patients can access a wider range of services, in the same way that newly diagnosed patients can.

A. Clinical optimisation of markers at network level:

A key intervention, equally applicable to people who are complex / unstable is to aim for higher achievement of clinical markers i.e. improved glycemic control, sustained improvement in blood pressure readings etc. Achievement of these targets are already captured as part of QOF compliance. However, at a network or sub network level, practices can agree an enhanced or additional targets and a plan to achieve it in a collaborative way. Key aspects of this intervention include building up a sophisticated system of locally-tailored solutions, customising IT searches, register cleaning, patient recall tools, on-screen prompt, and support to poorly performing practices. A few have been elaborated below:

- **Target setting at network / sub network level:** Practice to agree enhanced or additional targets for areas such as cholesterol, BP, HbA1c

- **Agree a joint network plan for optimising clinical markers:** A key step is to understand current achievement and variation between practices. Practices should then work collaboratively to agree a plan which may include allocation of a joint resource (for eg; CVD nurse) to focus on identification, education of practice nurses and provision of clinical care to 'off target' patients

- **Optimising medication and improvement of lifestyle:** Optimising medication such as statins in line with NICE guidelines is just one example. This, coupled with interventions such as care planning, heath coaching and social prescribing will help attainment of better clinical outcomes

- **Data sharing, joint network dashboard and peer support:** Establish data sharing and development of dashboard that allows consistent monitoring of achievement, register management and on screen prompts for cases that require recall or follow up. Introduction of peer review where targets are not managed can be helpful

- **Collaborative working with local pharmacies:** especially to support monitoring of patients who may not engage or compliant. A joint approach between GPs and pharmacists to be agreed (for eg; readings to be taken at time of collection of medicines and use that contact to coach, activate and improve compliance)

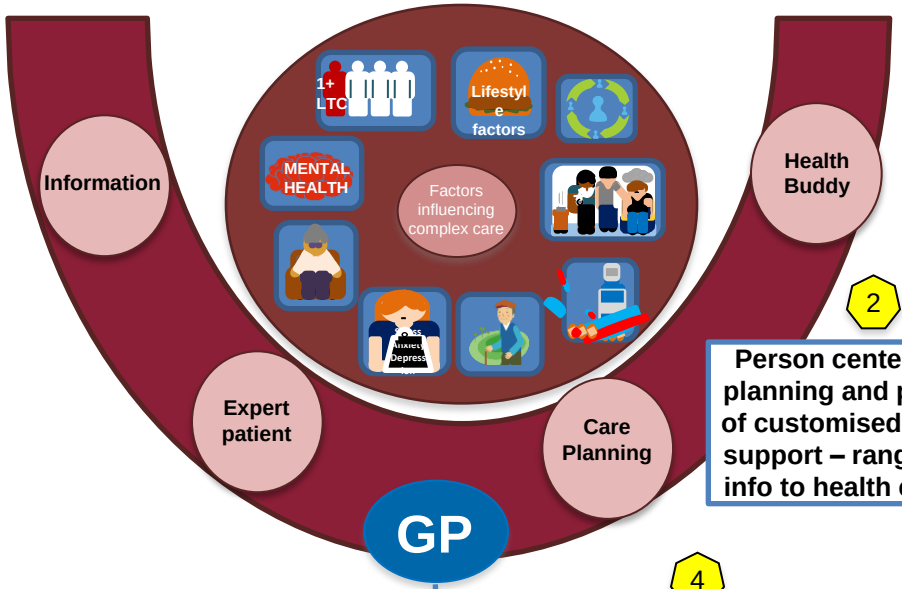
- **Group consultations and coaching:** clinical consultations in a group setting complemented by group coaching supporting better self management, community cohesions and participation

COMPLEX / UNSTABLE

Patients with complex care needs, with a combination of multiple chronic conditions, mental health issues, medication-related problems, and social vulnerability.

1

Identification and prioritisation of patients with higher risk

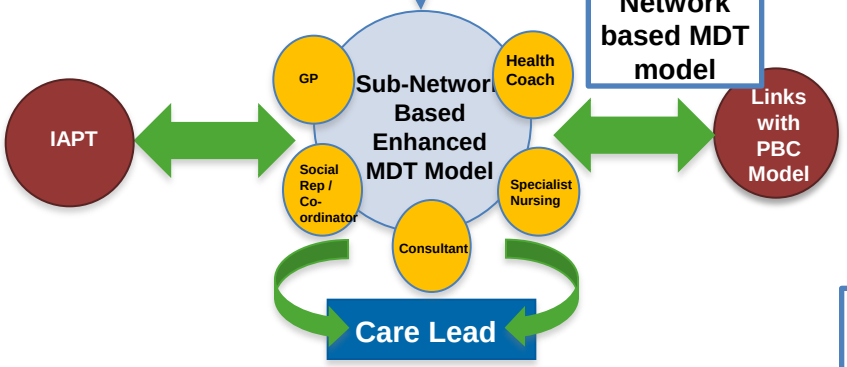


2

Person centered care planning and provision of customised enabling support – ranging from info to health coaching

4

Network based MDT model



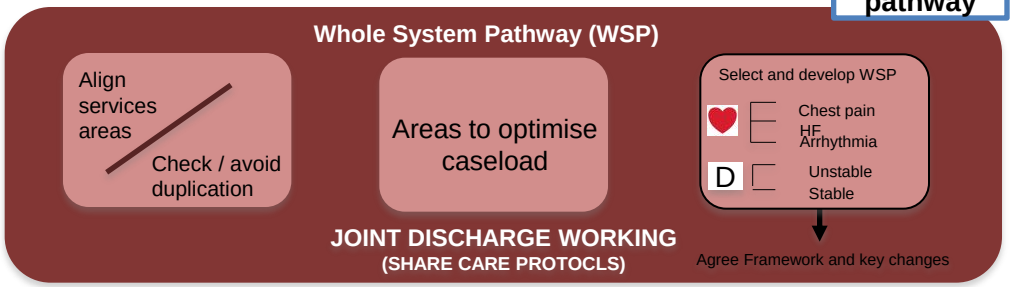
'My Patient to OUR Patient'

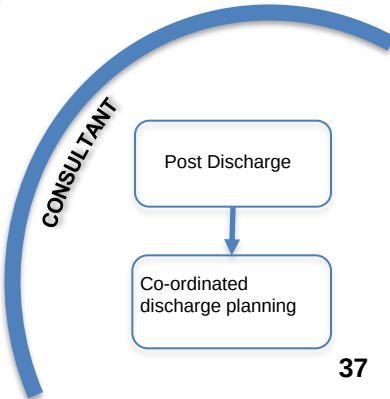
3

Optimising community provision

5

Whole system pathway





Management of complex/unstable – key features

The impact of multi-morbidity is profound. People with several long-term conditions have markedly poorer quality of life, poorer clinical outcomes and longer hospital stays, and are cost intensive group of patients that the NHS has to look after. There is a need for a collaborative care model comprising multi-disciplinary case management, systematic follow-up, and working that is better integrated – for example between primary and secondary care professionals and equally, between mental and physical health professionals.

Management of complex / unstable will include the following key features:

A.'Population management' – identification and prioritisation of patients at risk:

- Proactively identifying individuals who are at risk of deterioration, with the intention of then developing interventions to help slow down the scale of deterioration and avoid the need for institutional care.

- **Use of locally agreed algorithms combined with clinical intelligence:** use of local algorithms or off the shelf risk stratification tools to identify people who show manifestations of instability such as repeat GP, A&E attendance, NEL admissions, uncontrolled clinical markers with psycho-social factors that affect compliance and outcomes adversely. Validating data based searches and complementing it with local clinical / professional intelligence i.e. the knowledge of patients and their medical history will be key for effective management.

B. Collaborative personalised care planning:

- **Collaborative personalised care planning:** Aims to ensure that individuals' values and concerns shape the way in which they are supported to live with and self-manage their long-term condition(s). Instead of focusing on a standard set of disease management processes, this approach encourages people with long-term conditions to work with clinicians/professionals to determine their specific needs and express informed preferences for treatment, lifestyle change and self-management support. Then, using a decision coaching process, they agree goals and action plans for implementing them, as well as a timetable for reviewing progress.

C. Provide care closer to home – I.e. Providing IV Furosemide to patients in the community thereby avoiding unnecessary hospital attendances, admissions. or extended length of stay in hospitals for patients.

For more details , Please see section on First response as this offer will be available to enable management of those with complex needs

Management of complex/unstable – key features

C. Care-coordination/health coaching supported by personalised specialist support:

- **Range of support options for effective care-coordination:** Care planning will be actively supported by care co-ordination and proactive monitoring where needed. Care-coordination and personalised support will include care navigation to various enabling social groups, connectivity with other peers, one to one telephone / face to face follow up consultation to ensure optimal compliance and outcomes, CBT guided coaching conversations

- **Personalised specialist interventions:** Where required, a host of personalised specialist interventions need to be added to the support. A few examples below:
  - ‘Diet shape up’ with a dietician visit to home, assessing eating and lifestyle habits and making a plan for a step by step change
  - Use of personal trainers to help with initiate an exercise regime with intermittent follow up
  - Collaborating with community assets and private organisations as part of (public-private partnership) in delivering interventions

- **Network level delivery team:** Managing people with complex LTC will require more, probably much more than a GP appointment. The clinical advice will have to be supported by individuals such as HCA and health coaches who can closely work with local GPs at a network level. A team of network based health coaches / care lead (check name) will support GPs in that network in proactively managing people with complex / unstable LTC.

D. Network based MDT:

- **MDT at network / sub-network level:** A range of people will require multi-disciplinary input from a range of clinicians / professionals. We will deliver MDT meetings at a network or sub-network level. Patients will be prioritized by GPs supported by risk stratification and complemented by local intelligence, suggestions made by secondary care (LTC consultants) and community staff (such as specialist nursing teams). Patients being discharged from secondary care may benefit from continued MDT input in the community to avoid escalation and readmissions.

Management of complex/unstable – key features

E. Optimising community provision:

- **Consistency of provision across BHR:** There are variations across specialist nursing services across BHR such as eligibility of type of cases (AF vs CHD) and criteria of entry. A key aspect of LTC transformation will be to ensure consistency of service provision, entry criteria and clinical MDT support across all BHR unless guided specifically by local needs.

- **Single BHR team:** The teams across BHR are to merge as a singles team allowing more efficient service provision for example – utilisation of MDT for entire service instead of one area only and much greater coverage from nurse prescribers across the team. Further discussions to be held on potential for a single specialist nursing team covering acute and community together. It is key that the service ensures seamless discharge for patients (e.g. heart failure) where readmissions are deemed high.

- **Optimised service offer:** Multiple opportunities – for e.g.; to include cardiac rehabilitation directly from the community as against only after discharge from hospital. This could mark a significant move towards prevention. Other areas include comprehensive care planning with possibly initiation of medicines. Rationalisation of case load and appropriate risk management in the right place within the system will have to be done hand in hand to ensure appropriate level of case in service. This, alongside additional resources, will support increased capacity in the service. Review of current practices to ensure optimal NICE compliance.

- **Access to information:** Ensuring clinicians have access to records in primary and secondary care will aid efficient and safe service delivery.

F. Whole system pathway and joint clinics: Identification of key pathways such as heart failure and agreement on clinical pathway, roles and responsibility, seamless transition and handover, information sharing, points of opportunity to establish links with community assets. It is absolutely crucial that the whole system agrees to a single pathway rather than multiple organisational pathways. Complying to a mutually agreed pathway will directly impact on patient experience and outcomes, better efficiency and improved staff satisfaction. Joint clinics to be triggered in some areas to test the concept and establish a prototype and process that can be scaled up.

Key interventions and phases of Implementation ('The how')

Key interventions and phases of Implementation ('The how') 1

Year 1

- Implement LTC Network LIS
- Reduce prevalence of AF through targeted and opportunistic screening
- Implement an integrated model of care for AF including establishing a 1 stop shop clinic for AF patients
- Begin to deliver our primary prevention strategy, focusing on Hypertension
- Increase the uptake of health checks
- Continue the provision of education and guidance for healthcare practitioners
- Optimising community services (enhancement and integration of community services). Focus on review of Cardiology, Respiratory and Diabetes services. –
- Whole system pathway development - integration between primary, community and secondary care).
- Provision of IV Furosemide in the community.
- Roll out of Health coaching and Group consultations
- Explore the best way to provide End of Life Care and Palliative Care to those with LTC.
- Undertake a detailed study and review of NEL admissions in order to inform the development of an MDT Model of Care for those with LTC.
- Establish a Performance Dashboard to enable effective performance management against plan, KPIs and outcomes
- Implement a scheme for the clinical optimisation of markers at network level for those patients that are unstable / complex to improve glycemic control/ BP readings, etc and agreeing local targets and a development plan to achieve these.
- Agree a phased target for improving access to those requiring IAPT and Mental Health (MH) services

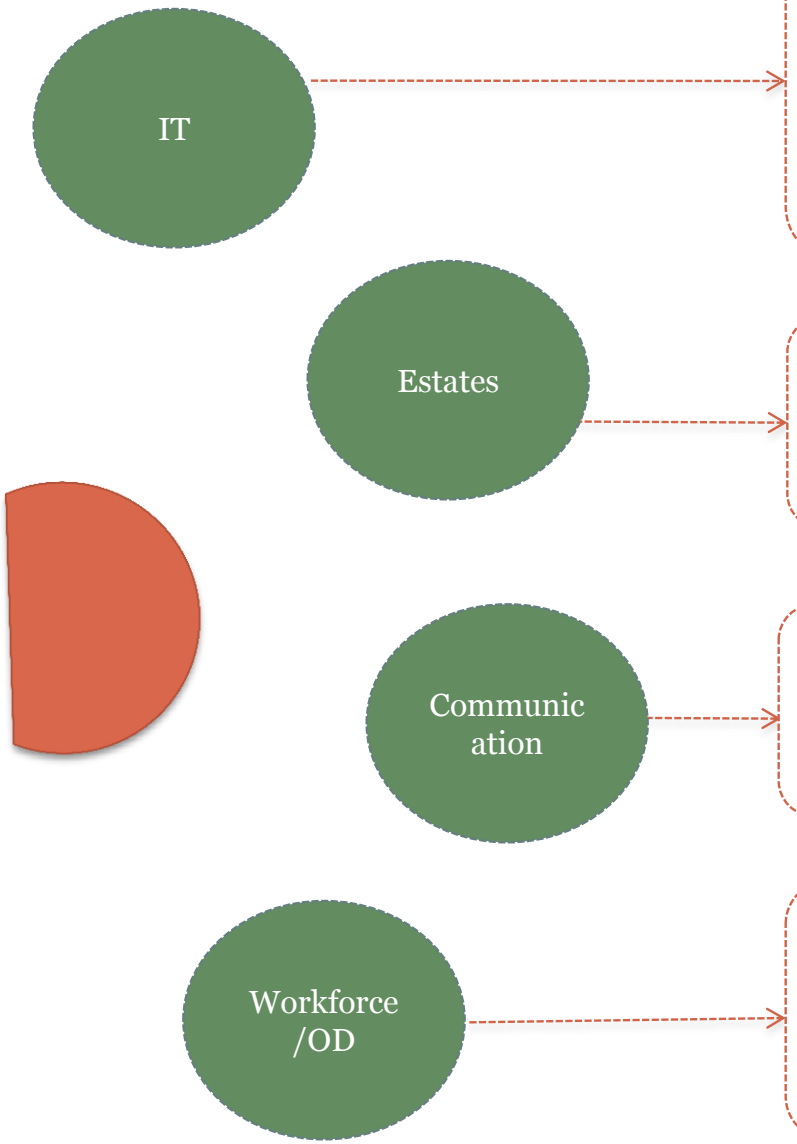
Year 2

- Select and evaluate service interventions implemented in year 1 to inform future planning and roll out. of schemes
- Implement our first response offer to support the delivery of our LTC model of care (see slide 34).
- Implement LTC MDT for the management of complex patients
- Extend MDT offer to other cohorts of patients with LTCs
- Continuation of target screening including the use of risk stratification tools,
- Continue the development of whole system pathways -Implement new models of care across BHR for Cardiology, Respiratory and Diabetes.
- Customise BHR health check to enable case finding, i.e. for AF, Hypertension and respiratory conditions.
- Develop an offer for End of Life and palliative care for those with LTC.
- Extend scheme for clinical optimisation across community provision and services.
- Embed access to IAPT Services for those with LTC.

Year 3

- Select and evaluate service interventions implemented in year 2 to inform future planning and roll out. of schemes
- Further extend MDT to other cohorts of patients with LTC
- Select new priority area to focus on as part of Primary prevention strategy
- Expand areas of focus as part of optimising community services work stream

Key enablers



- Information Governance i.e. Data sharing between GPs and Pharmacies
- System interoperability, for example between and across Provider systems
- Information hosting (coding review)
- Single Point of Access
- Use of technology to deliver innovation and promote new models of care – Virtual MDT Clinics for those with Multiple LTCs
- Improved access to shared diagnostics

- Ensuring estate(s) are fit for purpose
- Locality based networks – does not have to be physical location, services can be provided virtually. i.e. via different use of technology

- Community social marketing
- Working with patients and careers in delivering out LTC strategy
- Educate and provide patients and service users with the tools to self manage and encourage patient activation

- Multi-disciplinary teams
- Role of care Navigators
- Training and development for health care professionals
- Role of the third sector
- Recruitment and retention
- Ensuring there is a mixed skill set of staff delivering the LTC Model of Care, i.e. Health Coach

Task and finish group - 1

1. Early ID and First response

- Early identification, first response and clinical optimisation, AF and Hypertension, – LTC Network LIS
- Optimising health checks
- One primary care (effective use of community pharmacies working in collaboration with primary care for identification and management of patients)
- Health coaching
- Group consultations and coaching
- Self management and social prescribing (developing and promoting tools such as app, dos, info packs, patient/peer buddies and social prescribers(ing) initiatives

Self management tools

Network LIS

Health coaching

Potential sub groups

Task and finish group 2

2. Complex case management, optimising community services and whole system pathways

- Optimising community services (enhancement and integration of community services)
- Whole systems clinical pathway development (includes integration between primary, community and secondary care as the first port of call with joint ownership of patients)
- Management of complex patients – Locality model

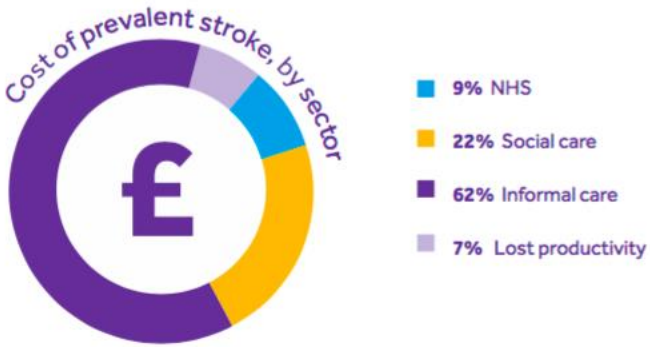
Cost benefit analysis

Current spend on LTC

- The total burden of LTCs traverses health and care boundaries and can impact significantly on a person's psycho-social wellbeing if not managed. People with Long term conditions account for about 50% of all GP appointments, 64% of all out patient appointment and 70% of all in-patient bed days (*source: DH, 2012)*

- Treatment and care for people with long term conditions is estimated to take up around £7 in every £10 of total health and social care expenditure *(source: Kings fund, time to think differently)*

- LTC burden goes well beyond health care spend, for e.g.; analysis produced by Stroke association shows significant burden on social, informal care and lost productivity *(as shown in diagram)*



- For the purpose of local BHR strategy, we have tried to estimate direct impact from LTCs in hospital admissions, out-patient attendances, community services, social care costs and GP attendances (the latter three categories do not have a direct way to measure impact at present and would require whole system data capture to enable that). Work is in progress in form of data discovery that will provide more information on whole system costs.

- Our approach to estimating baseline costs and impact in secondary care included the following key steps:

Step 1: Selection of HRGs that are directly related to LTC (CVS and Diabetes)

Step 2: Refine HRG list with cross-validation from clinical leads

Step 3: Estimation of impact in year 1 and 2

Step 4: Quantum of savings if LTCs properly managed across the system

- Please note that the quantum of savings generated is an estimate (Base case scenario and best case scenario and will need to be refined further as part of individual project (PID) development.

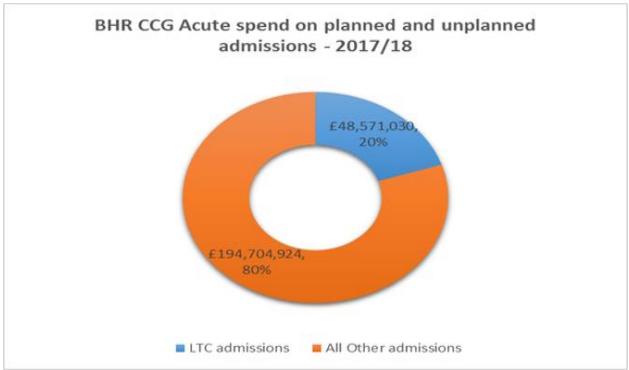
Current spend on LTC – In-patient admissions

The analysis shown in the following slides represents a review of admissions both planned (day cases and electives) and unplanned (non-elective) for age group 18+ in BHR CCGs. The analysis is based on SUS+ data and Long term conditions are based on HRG codes identified by Clinical leads. The long term conditions shown in this analysis are related to Cardiovascular and diabetes conditions only. This report provides a high level summary to instigate further discussion and agreement of priority areas, before we embark on further investigation and deep dive analysis.

Key messages:

• BHR CCG total spend for admissions both planned and unplanned in 2017/18 is £243m ; of which £49m is related to admissions for long term conditions (LTC) (20%). Of the £49m spend for LTC

- 7.7%(2m) is attributed to day cases (DC)
- 4.8% (£4m) to elective admissions
- 87.5% (£43m) is attributed to non-elective admissions.



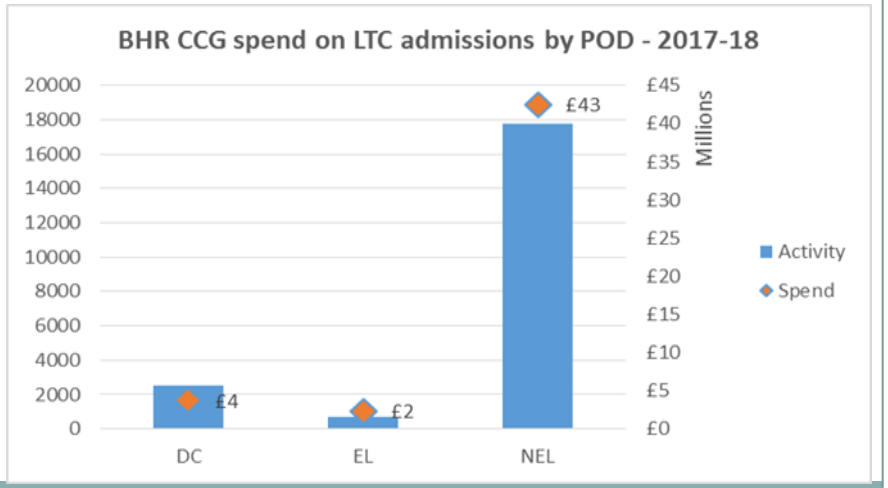
Non-elective admissions

• 67% (£29m) of the non-elective spend in 2017/18 are for admissions related to 65+ age category, of which nearly 50% are for 75+ age group.

• 33% (£14m) of the non elective spend are for admissions for working age group (age group 18-64).

• Increase in trend in 17/18 and 18/19 (based on M6 forecast) for non-elective admissions related to long term conditions across all age groups.

For more details, please refer to the appendix. Please also note that the baseline data will need to be updated to reflect activity in 2018/19



Impact – quantum of savings – non elective admissions

- Two scenarios were created (scenario 1 – base case, scenario 2 – best case) in consultation with clinical leads
- Scenario 1 and 2 assume a reduction in admissions for specific HRGS between 7.5% to 35% in 2 years.
- Conditions such as stroke, heart failure, angina and diabetes with hypoglycemic disorders were deemed to have greater impact than others such as chronic kidney disease.
- Admissions such as cardiac arrest, primary pulmonary hypertension were deemed to have no impact in 2 years - although there was an expectation to see a sustained reduction in most HRGs in a longer period
- The table summarises potential quantum of savings in 2 years. For more details of individual HRGs, please refer to appendix and associated worksheets

Scenario 1			Year 1			Year 2		
	Total activity (NEL)	Total spend (NEL)	% impact	Activity reduction	Reduction in spend	% impact	Activity reduction	Reduction in spend
HRGs with high impact in 2 years	3823	£ 8,653,961	7.5%	287	£ 649,047	12.5%	478	£ 1,081,745
HRGs with medium impact in 2 years	4530	£ 4,015,909	3.5%	159	£ 140,557	6.5%	294	£ 261,034
HRGs with no impact in 2 years	8354	£ 22,231,797	0%	0	£ -	0%	0	£ -
Stroke	1057	£ 7,604,580	8%	88	£ 633,715	17%	176	£ 1,267,430
Total	**17764**	**£ 42,506,247**		**533**	**£ 1,423,319**		**948**	**£ 2,610,209**

Scenario 2			Year 1			Year 2		
	Total activity (NEL)	Total spend (NEL)	% impact	Activity reduction	Reduction in spend	% impact	Activity reduction	Reduction in spend
HRGs with definitive impact in 2 years	2211	£ 5,052,429	15%	332	£ 757,864	20.0%	442	£ 1,010,486
HRGs with medium impact in 2 years	1733	£ 3,955,286	7.5%	130	£ 296,646	12.5%	217	£ 494,411
HRGs with low impact in 2 years	5264	£ 5,705,536	2.5%	132	£ 142,638	5%	263	£ 285,277
HRGs with no impact in 2 years	7499	£ 20,188,416	0%	0	£ -	0%	0	£ -
Stroke	1057	£ 7,604,580	8%	88	£ 633,715.00	17%	176	£ 1,267,430
Total	**17764**	**£ 42,506,247**		**681**	**£ 1,830,864**		**1098**	**£ 3,057,603**

- Please note that these figures are estimates only and will need to be refined further during development of individual project initiation documents.
- Figures used are 2017/18 and will require to be updated by latest figures and prices for 2018/19
- Investments need to be considered on impact on savings and to assess/check potential overlaps with other existing 19/20 QIPP schemes

Impact – quantum of savings – other areas

- Other areas of impact will include:
  - Improvement in productivity in specialist nursing services
  - Reduction in costs of rehabilitation such as stroke and cardiac
  - Reduction in repeat attendances within primary care for people with LTCs
  - Reduction in social care costs and long term residential care
  - Wider economic benefits

Impact on quality outcomes

2

	Area		Potential impact
	Access		
	Efficiency		
	Clinical effectiveness		
	Patient / person experience		
	Staff experience		
	Equality		
	Other		

Dashboard to be developed post LTC board discussions

Key risks – Task Groups will continue to identify and address more operational risks working with Joint CCGS NELFT/BHRUT PMOs to oversee- escalating to LTC board as required.

Risk	Mitigation	RAG
There is a risk that the proposed model of care/interventions across our LTC programme of work does not stem the flow of activity into secondary care and may actually increase activity i.e. screening may led to the detection / identification of more people with LTCs which may require more complex cases needing referral into secondary care.	Development of clinical pathways and referral criteria, MDTs for more complex cases and encouraging patients to self-care/self – management should help mitigate this risk.	
As there are a number of detailed programmes of work emerging from the LTC strategy, there is a risk of insufficient capacity to deliver the work to timescales.	An LTC Senior Programme Manager is now in post since 19th March 2019. A number of T&F Groups have been established to drive project implementation. New Project Support Officer (2.5 days) is now in post since 3rd May 2019. Capacity issues to be reviewed as is required.	
Detailed programmes of work emerging from the LTC strategy requires coordination between and across organisations. There is a risk to delivery to timescales as a result of the need to work across multiple partners.	Our LTC Strategy has been developed jointly with partners with a series of workshops held over the last 5 months LTC Board and Task-Groups established and well attended by all partners. These provide a forum for joint working which enables co-planning, delivery and reaching joint resolution on issues.	
Detailed programmes of work emerging from the LTC strategy require significant financial investment which may not yield the expected returns (ROI).	Our approach is to capacity build where possible, reconfigure models of care and service delivery routes using technology and innovation where identified Detailed financial modelling will be undertaken for most schemes Where investment is needed, business cases will be subject to due diligence as part of PID approval processes.	

Appendix

Potential impact analysis – summary table

- Two scenarios were created (scenario 1 – base case, scenario 2 – best case) in consultation with clinical leads
- Scenario 1 and 2 assume a reduction in admissions for specific HRGS between 7.5% to 35% in 2 years.
- The table summarises potential quantum of savings in 2 years. For more details of individual HRGs
- Figures used are 2017/18 and will require to be updated by latest figures and costs 2018/19

Scenario 1			Year 1			Year 2			Year 1 & 2 - Total		
	Total activity (NEL)	Total spend (NEL)	% impact	Activity reduction	Reduction in spend	% impact	Activity reduction	Reduction in spend	% impact	Activity reduction	Reduction in spend
HRGs with high impact in 2 years	3904	£ 8,755,289	7.5%	293	£ 656,647	12.5%	488	£ 1,094,411	20.0%	781	£ 1,751,058
HRGs with medium impact in 2 years	4700	£ 4,161,236	3.5%	165	£ 145,643	6.5%	306	£ 270,480	10.0%	470	£ 416,124
HRGs with no impact in 2 years	11287	£ 27,970,526	0%	0	£ -	0%	0	£ -	0.0%	0	£ -
Stroke	1065	£ 7,683,979	8%	89	£ 640,332	17%	178	£ 1,280,663	25.0%	266	£ 1,920,995
Total	**20956**	**£ 48,571,030**		**546**	**£ 1,442,622**		**971**	**£ 2,645,555**		**1517**	**£ 4,088,176**

Impact assumptions	Range	Average
High	20%	20%
Medium	10%	10%

Scenario 2			Year 1			Year 2			Year 1 & 2 - Total		
	Total activity (NEL)	Total spend (NEL)	% impact	Activity reduction	Reduction in spend	% impact	Activity reduction	Reduction in spend	% impact	Activity reduction	Reduction in spend
HRGs with definitive impact in 2 years	2262	£ 5,125,997	15%	339	£ 768,900	20.0%	452	£ 1,025,199	35.0%	792	£ 1,794,099
HRGs with medium impact in 2 years	1775	£ 4,024,967	7.5%	133	£ 301,873	12.5%	222	£ 503,121	20.0%	355	£ 804,993
HRGs with low impact in 2 years	5517	£ 6,108,308	2.5%	138	£ 152,708	5%	276	£ 305,415	7.5%	414	£ 458,123
HRGs with no impact in 2 years	10337	£ 25,627,779	0%	0	£ -	0%	0	£ -	0.0%	0	£ -
Stroke	1065	£ 7,683,979	8%	89	£ 640,331.58	17%	178	£ 1,280,663	25.0%	266	£ 1,920,995
Total	**20956**	**£ 48,571,030**		**699**	**£ 1,863,811**		**1128**	**£ 3,114,399**		**1827**	**£ 4,978,210**

Impact assumptions	Range	Average
High	30 - 40%	35%
Medium	20%	20%
Low	5 - 10%	7.50%

Potential impact analysis - HRG list

- The table shows list of HRGs with potential high, medium, low and no impact in two years

Additional information for scenario 2 - HRGs list		
Areas of high impact	1	Heart failure
	2	Hypertension
	3	Angina
	4	Diabetes with Hypoglycaemic Disorders
Areas of medium impact	1	Pulmonary Oedema
	2	MI
	3	Fluid or Electrolyte Disorder
	4	Syncope or Collapse, with CC Score 0-3
	5	Chronic Kidney Disease
Areas of low impact	1	Arrhythmia or Conduction Disorder
	2	Unspecified Chest Pain
	3	General Renal Disorders with Interventions
	4	Single, Amputation Stump or Partial Foot Amputation Procedure, for Diabetes/AD
Areas of no impact	1	Cerebral Degenerations or Miscellaneous Disorders of Nervous System
	2	Muscular, Balance, Cranial or Peripheral Nerve Disorders, Epilepsy or Head Injury
	3	Headache, Migraine or Cerebrospinal Fluid Leak
	4	Intracranial Procedures, 19 years and over
	5	Vitreous Retinal Procedures
	6	Pulmonary Embolus
	7	Cardiac Arrest
	8	Syncope or Collapse, with CC Score of more than 3
	9	Other Acquired Cardiac Conditions
	10	Primary Pulmonary Hypertension
	11	Complex Coronary Artery Bypass Graft
	12	Implantation of Cardioverter Defibrillator
	13	Implantation of Biventricular Pacemaker
	14	Implantation of Dual-Chamber Pacemaker
	15	Percutaneous Transluminal Repair of Acquired Defect of Heart
	16	Percutaneous Transluminal Coronary Angioplasty
	17	Cardiac Catheterisation
	18	Complex Echocardiogram
	19	Hepatobiliary or Pancreatic Procedures
	20	Liver Failure Disorders
	21	Non-Malignant, Hepatobiliary or Pancreatic Disorders
	22	Diabetes with Lower Limb Complications
	23	Acute Kidney Injury with Interventions
	24	Urinary Incontinence or Other Urinary Problems
	25	Ureteric or Bladder Disorders
	26	Percutaneous Transluminal Embolisation of Intracranial or Extracranial Aneurysm
	27	Multiple Open Procedures on Blood Vessels of Lower Limbs
	28	Single Open Procedure on Blood Vessel of Lower Limb
	29	Amputation of Multiple Limbs
	30	Amputation of Single Limb
	31	Peripheral Vascular Disorders
	32	Deep Vein Thrombosis
	33	Percutaneous Transluminal Angioplasty of Single Blood Vessel
	34	Other

Evidence Presentation LTC – information source

What works?

1. Health Coaching - Health Coaching quality framework from Health Education England: https://www.hee.nhs.uk/sites/default/files/documents/Health%20coaching%20quality%20framework.pdf
Why health coaching is beneficial to patients and the NHS: http://www.betterconversation.co.uk/images/Better_Conversation_Chapter1.pdf
Panagioti M, Skevington SM, Hann M, Howells K, Blakemore A, Reeves D, and Bower P(2018). Effect of health literacy on the quality of life of older patients with long-term conditions: a large cohort study in UK general practice. Quality of Life Research 27(5), pp. 1257–1268.
Blackmore A, Hann M, Howells K, Panagioti M, Sidaway M, Reeves D and Bower P (2016). Patient activation in older people with long-term conditions and multimorbidity: correlates and change in a cohort study in the United Kingdom. BMC Health Services Research 16(1), pp.

2. Quality and Outcomes Frameworks QoF - Forbes LJL (2017).The role of the Quality and Outcomes Framework in the care of long-term conditions: a systematic review. British Journal of General Practice 2017;67(664):510-

3. Self-management support interventions with certain component – 1. McBain H, Shipley M, Newman S (2015). The impact of self-monitoring in chronic illness on healthcare utilisation : a systematic review of reviews. 2. Panagioti M, Richardson G, Murray E (2014). Reducing care utilisation through self-management interventions (RECURSIVE) : a systematic review and meta-analysis.

4. Incentivisation - Bilger M, Shah M, Tan NC, Howard KL, Xu HY, Lamoureux EL and Finkelstein EA (2017). Trial to Incentivise Adherence for Diabetes (TRIAD): study protocol for a randomised controlled trial. Trials 18(1):551

5. Telehealth - Hanlon P, Daines L, Campbell C, McKinstry B, Weller D, and Pinnock H (2017). Telehealth Interventions to Support Self-Management of Long-Term Conditions: A Systematic Metareview of Diabetes, Heart Failure, Asthma, Chronic Obstructive Pulmonary Disease, and Cancer. Journal of Medical Internet Research 19(5): e172.

Evidence Presentation LTC – information source

6. Cognitive and behavioural therapies especially improving access to psychological therapies (IAPT) interventions -

1. McCrae N; Correa A; Chan T; Jones S; and de Lusignan S (2015). Long-term conditions and medically-unexplained symptoms: feasibility of cognitive behavioural interventions within the improving access to Psychological Therapies Programme. Journal of Mental Health 24(6), pp. 379-384. (6p). 2
2. . Anderson N and Ozakinci G (2018). Effectiveness of psychological interventions to improve quality of life in people with long-term conditions: rapid systematic review of randomised controlled trials. BMC Psychology 6(1), pp. 1-17

7. Collaboration (people 'working in partnership') in design and participation - Gilbert M, Staley C, Lydall-Smith S and Castle D. J. (2008). Use of Collaboration to Improve Outcomes in Chronic Disease. Disease Management & Health Outcomes 16(6), p381-390. 10p. 4 Charts.

8. Social interventions which link patients from health services to community-based sources of support - Mossabir R; Morris, R; Kennedy A; Blickem C; Rogers A (2015). A scoping review to understand the effectiveness of linking schemes from healthcare providers to community resources to improve the health and well-being of people with long-term conditions. Journal of Health and Social Care in the Community 23(5), pp. 467-484. (18p)

9. Proactive nurse telephone support services and home visits - Davis et al (2015). A Model for Effective and Efficient Hospice Care: Proactive Telephone-Based Enhancement of Life Through Excellent Caring, "TeleCaring" in Advanced Illness. Journal of Pain and Symptom Management 50(3), pp. 414-418
University of Birmingham (2009). Services for long term conditions: evidence for transforming community services. Birmingham: University Press

Health Care Professionals and Systems - Buja, A., Toffanin, R., Claus, M., Ricciardi, W., Damiani, G., Baldo, V., & Ebell, M. H. (2018). Developing a new clinical governance framework for chronic diseases in primary care: An umbrella review. BMJ Open, 8(7) doi:http://dx.doi.org/10.1136/bmjopen-2017-020626