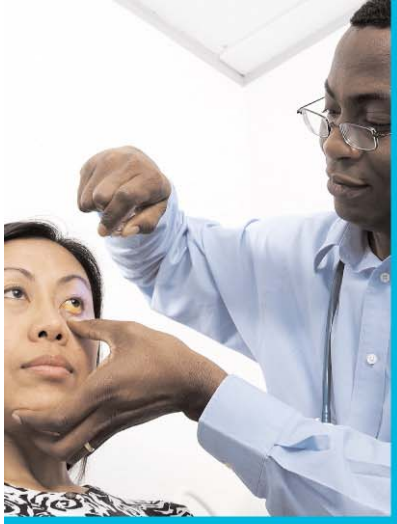
Enclosure 2

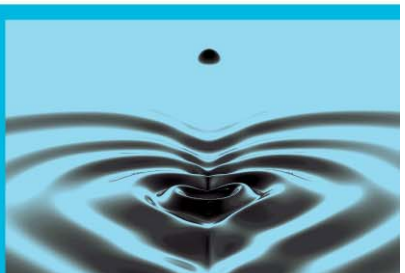
NHS Dudley

heart of local health



Long Term Conditions Strategy

November 2010



Contents

1. FOREWORD

This Strategy will set out the commissioning priorities for where services require improvements in long term conditions and includes the priority areas as identified by the Long Term Condition (LTC) Local Implementation Teams (LITs). This will be achieved via the development of evidence based pathways and by meeting the requirements set out in QIPP (Quality, Innovation, Productivity, Prevention) for LTC's.

- Summary of the plan
- Lay groundwork for what is to follow
- Refer to PCT vision

There has been tremendous and constructive engagement with partners which is paramount to driving services forward effectively and ensures quality care closer to home for patients.

The strategy is being launched at a time of major changes within the NHS and Social Services. We consider that this is an opportunity to effect positive change to deliver and improve services for people with long term conditions.

In the last year there have been many achievements driven forward by the LITs for the management of long term conditions including:-

- The COPD LES (Local Enhanced Service) has changed the way care is managed for patients suffering from COPD and via education, personalised care and self management has produced a decrease in COPD acute admissions.
- For Stroke there has been the launch of the Early Supported Discharge scheme to reduce stays in hospital and continued implementation of thrombolysis guidelines to reduce the impact of stroke.
- The Virtual Ward has been piloted. The evaluation has shown GP's and community nursing teams that care for patients who are risk stratified onto a 'virtual ward' improve the care management of patients and prevent hospital admissions
- A Community Neurological Team is now in place (specialist nurses, physiotherapists, psychologist, and pharmacy prescriber). This team is caring for patients with MS and Parkinson's disease and other neurological conditions

The challenge ahead is to ensure that the management of long term conditions is to take an individualized and holistic approach to the patient. This strategy outlines the key components that Dudley NHS need to implement in order to achieve services that are high quality for the patient and ensuring they are efficient and seamless.

Dr Liz Pope
Long Term Conditions Clinical Lead, NHS Dudley

Programme Lead - Long Term Conditions, NHS West Midlands

It currently costs approximately £9.1 billion to care for people with Long Term conditions in the West Midlands region , this equates to £345 million (70% of total health care budget and includes planned and urgent care DH [1]) for Dudley PCT. It is predicted that the prevalence of long term conditions will increase due to our ageing population and changes in lifestyle choices. The Department of Health has estimated that by 2025 there will be 42% more people in England aged 65 or over and that the number of people with at least one Long Term Condition will rise to 18 million. By 2025 the population of the West Midlands with a long term condition over 65yrs will have increased from 993,458 to 1,227,500 people.

Bearing this in mind it is essential that all organisations have a strategy in place now to deal with the expected burden of an ever increasing population of people living longer with long term conditions. In a world of decreasing resources and a predicted workforce shortage, it is paramount that we plan now to equip health and social care, patients and carers to make best use of everything available to them, including assistive technology, comprehensive personalised care plans and access to effective ways to improve self management.

We must use all available knowledge regarding our populations wants and needs to plan integrated care that has proven qualitative and clinical outcomes that represent value for money. The key to success is understanding what is needed and how to "get it done", the people best to lead this are patients and carers themselves in partnerships with their health and social care contacts.

The strategy for Dudley PCT addresses all these issues and should be welcomed, success will be measured by the changes achieved in outcomes delivered such as reduced hospital follow-ups, reduced emergency admissions, reduced GP visits, improved medication compliance, increased self management, improved clinical outcomes, reduced overall costs and ultimately improved quality of care for patients.

I whole heartedly support the LTC strategy for Dudley PCT and would recommend the approach to other areas within the region.

Joanne Harding
Programme Lead – Long Term Conditions, NHS West Midlands

[1] Department of Health: *Improving the health and well-being of people with long term conditions. World class services for people with long term conditions – information tool for commissioners.* January 2010

LONG TERM CONDITIONS EXECUTIVE SUMMARY

Vision	Values	Strategic Objectives	2010/11 Goals	Prioritised Initiatives		Performance Measures	Critical Success Factors
To improve the health and well-being of people with long term conditions	We will work to continuously improve services for people with long term conditions We will embrace partnership working We will value our patients as equal partners in care	Provide population stratification and case management Implement integrated, generic management strategies for people with multiple conditions Ensure consistent high quality condition/ disease management Support self care and manage health inequalities Ensure everyone with a LTC is supported through Care Planning To develop seamless pathways for LTC's	To deliver on outcomes for QIPP LTCs 1 Risk stratification 2 Generic strategies for people with multiple conditions 3 Prevent disease progression 4 Support self care 5 Personalised care plans 6 Maximising tele-health 7 Workforce development	Implement the BUPA risk tool to identify and manage people at high risk of admission & establish cohorts of LTCs for other targeted interventions		Whole population analysis Outcome analysis	Practice sign up to BUPA tool Clinical engagement across primary and secondary Support from health information Patient and public engagement Partnership working across the health economy Appropriately trained and skilled staff Winning hearts and minds of key stakeholders for innovative and new ways of working Implementation of evidence based practice Design and Commissioning of Improved care pathways Continual evaluation and feedback mechanism Alignment with Urgent & Planned Care Strategies
				To provide active case management via the Virtual ward Develop LTC Care Pathways and pilot projects of key pathways		Reduction in acute admissions	
				Vascular checks; Obesity pathway; Falls pathway; COPD education & management (LES); Diabetes education (LES); Stroke early supported discharge		Public Health monitoring for vascular, obesity and falls; LES monitoring; reduced length of stay	
				Self-help project & directory, Self care strategy, EPP courses to be catered for specific diseases		Uptake of EPP courses	
				Training programme on personalised care plans for all clinicians involved in management of LTCs		Monitor number of personalised care plans for LTCs; uptake of training on PCPs	
				New Tele-health pilot for heart failure utilising 50 units for a more effective pilot study		Reduce acute admissions, LOS, A&E attendances, heart failure team interventions	
				Training on risk stratification. Collaborative project on workforce transformation for COPD, Diabetes, End of life Care, Stroke		Staff with right skills in the right place	
			The prevention, early detection and management of patients with LTCs:- • Coronary Heart Disease • Diabetes • Cancer • Respiratory • Renal • Stroke • Neurology • Dementia	CHD:	Redesign Cardiology OPA Provision AF GRASP Tool (LES)	Reduce cardiology OPA activity LES monitoring	
				Diabetes:	Redesign Diabetes pathways Think Glucose	LES monitoring Reduce LOS Diabetes	
				Cancer:	To raise awareness of cancer and reduce mortality rates	Monitor action plan milestones	
				Respiratory:	Identification of under diagnosis of COPD and Asthma Implement National COPD Strategy and NICE COPD	LES monitoring Reduction in acute admissions	
				Renal:	Increase home therapy for renal placement therapy; implement end of life care pathway, address prevalence gap	Monitoring practices and acute activity	
				Stroke:	To ensure stroke patients receive specialist management and care and access early supported discharge	Reduce stroke LOS	
				Neurology:	PC Neurology Team to increase referrals and reduce OPA DGH by 5% per year. New pathways for MS & PD	Neurology PID Reduce OPA activity	
				Dementia:	Implementation of Dementia Pathway	QoF and QIPP monitoring	

3. VISION

Our vision is to provide equitable, high quality, services for people with long-term conditions. Our aim is to enhance the population's health and wellbeing and to do as much as we can to prevent people developing long-term conditions wherever possible.

We want to develop a comprehensive and systematic approach to the management of people's conditions in order to reduce levels of dependency and to improve the use of healthcare resources for the benefit of the wider population.

Our vision for long term conditions services will be realised through plans being delivered by our established local implementation teams.

Patients with a long-term condition will:-

- receive personalised care and be actively supported to manage their condition
- receive well planned services that are of high quality and improve outcomes and meet all identified needs
- benefit from the use of technology wherever possible and from the effective deployment of clinical teams to maintain their health and well-being

Our vision is for services that:-

- better identify and manage risk
- offer generic strategies for people with multiple condition
- prevent disease progression
- support self care
- develop personalised care plans in a partnership between patients and clinicians
- exploit assistive technology, e.g. telehealth, wherever possible and appropriate
- are delivered through a highly skilled workforce well trained and educated in the particular needs and circumstances of people who live often with long-term and life limiting conditions

This strategy models long-term conditions management to the clinical pathway tiered approach. Different levels of management, care and support will be shaped to the different levels of need that people present with.

We will strive to ensure that we commission services and develop pathways to maintain people at levels 0-3 as described in Figure 1 below. Where people need services at level 4, commissioners will work with key stakeholders and partners to ensure that transition and support into and out of level 4 is as seamless as possible.

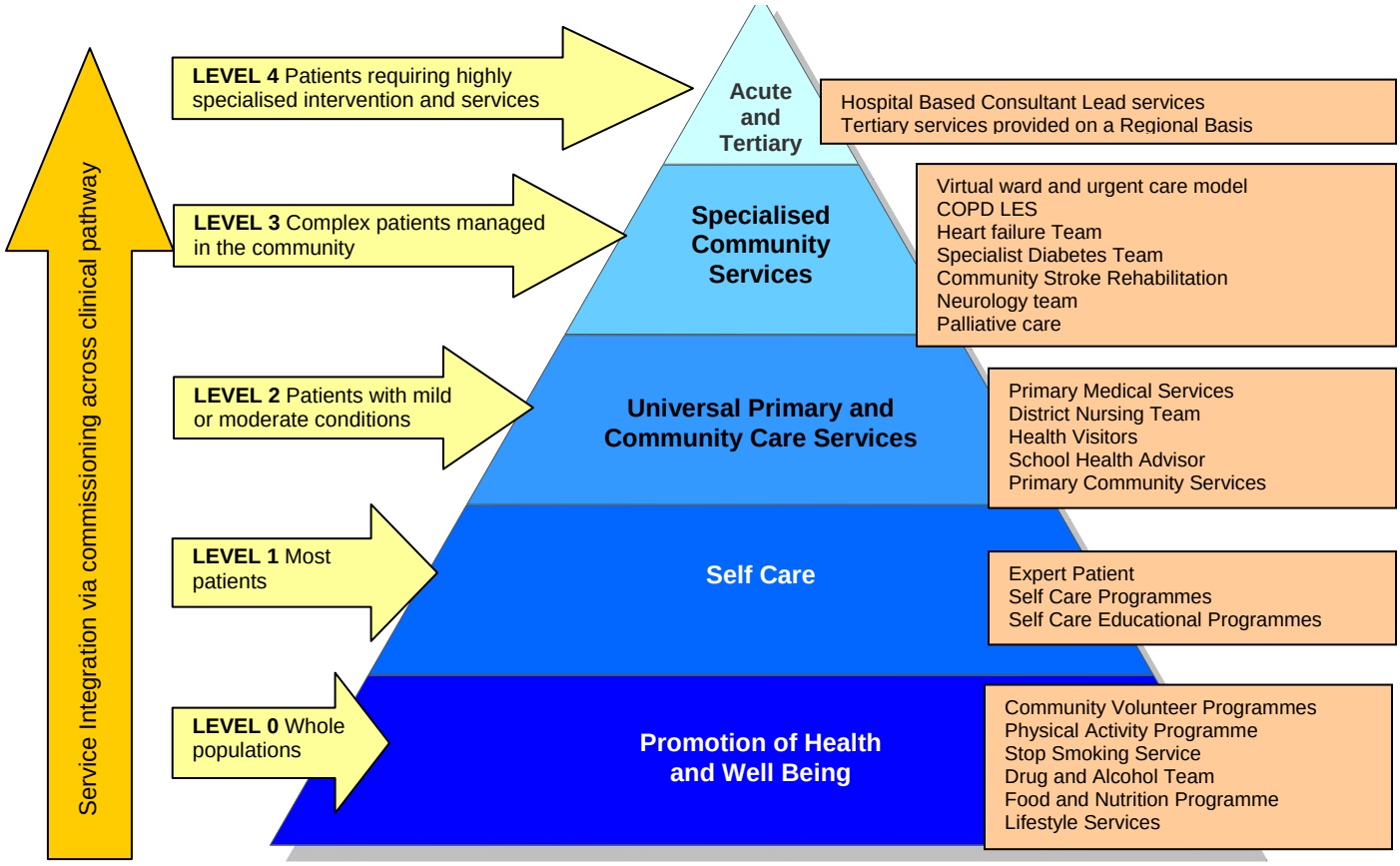


Figure 1

This strategy sets out our priorities and the work programmes we will pursue for the most significant long term conditions in the following areas. It will be updated in light of emerging needs analysis on an ongoing basis.

- CHD
- Diabetes
- Neurology
- Renal
- Respiratory
- Stroke
- Cancer
- Dementia

4. CONTEXT

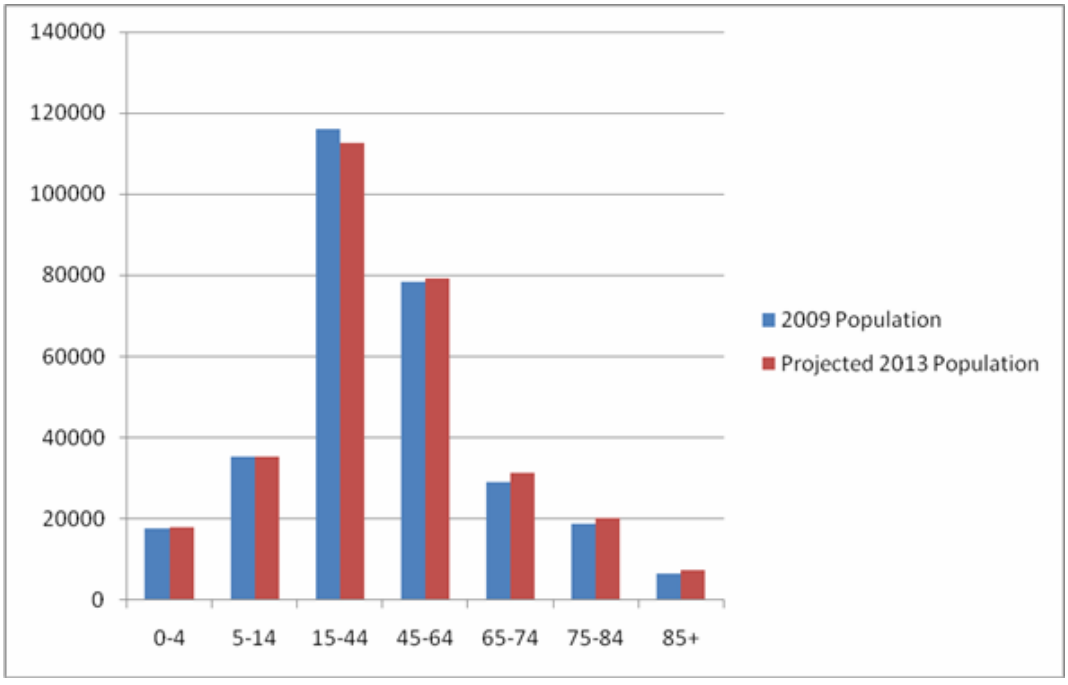
Long term conditions (LTCs) are defined as 'conditions that cannot at present be cured; but can be controlled by medication and other therapies'[2].

Evidence from the Department of Health continues to support the clear messages about LTCs:

- People with LTCs are intensive users of health and social care services, including community services, urgent and emergency care and acute services
- Numbers are predicted to increase because of factors such as an ageing population and certain lifestyle choices that people make
- Ill health among the working population places a significant burden on health and social care
- There are huge benefits to the population and financial savings to be made if health and social care communities invest in effective LTC management

4.1 Population Demographics

The PCT's internal analysis of population growth between the years 2009/2013 shows the following:-



[2] Department of Health. (online) www.dh.gov.uk/en/Healthcare/Longtermconditions/index.htm

	0-4	5-14	15-44	45-64	65-74	75-84	85+	Total
2009 Population	17483	35341	116069	78283	29094	18648	6576	301495
Projected 2013 Population	17867	35242	112615	79369	31399	20218	7285	304052
Population Change	1.02	1.00	0.97	1.01	1.08	1.08	1.11	1.01

It can be seen that the younger age group populations are relatively stable; there is a decrease in the projected population in 15-44 age range whilst the population in the older age groups is increasing. This is significant as the numbers of people with long term conditions and co-morbidities increases with age and thus there is a disproportionate impact on utilization of health resources.

Looking beyond 2013 to 2020, the overall population of Dudley is predicted to rise by 2.6% (8,000). There is, however, a disproportionate rise expected in the 65+ and 85+ age ranges of 24% and 52% respectively.

4.2 Long Term Conditions and Population

The following factors are also relevant for this long term conditions strategy:-

- One in five people in Dudley (just over 58,000) reports having a long-term condition which limits daily life
- Three times as many people in manual jobs have long-term conditions compared with people in the most highly paid jobs
- Ill health is a major issue for the over 75s, with nearly two-thirds saying they have a long-term condition
- Of the 35,000 carers in Dudley, over 7,000 provide more than 50 hours unpaid care a week – many carers are caring for people with long-term conditions or disabilities and many of these carers have long term conditions themselves
- People with LTCs are intensive users of health and social care services, including community services, urgent and emergency care and acute services
- Ill health among the working population places a significant burden on health and social care
- The life expectancy for the people of Dudley has continued to rise, but the gap between the most and least deprived wards has widened from 6.6 years at baseline to 8.6 years in 2006-2008.
- Mortality from cardiovascular disease, cancers and respiratory disease contribute most to this differential for both men and women. For men mortality from digestive diseases and external causes are also big contributors (**see also Health Inequalities strategy)**
- National policy continues to emphasise that people with long-term conditions need to be managed proactively with services coordinated around their needs. The number of people with a long-term condition is expected to continue increasing, as the number of older people increases and as unhealthy lifestyles manifest themselves into long-term conditions.

4.3 Major Health Risks for People with Long Term Conditions (See also Dudley Health Inequalities Strategy)

The following major health risks are identified in the PCT's strategic plan *At the Heart of Health*:-

- The two biggest causes of premature mortality are circulatory diseases and cancer.
- Inequalities are greatest for circulatory disease, with some areas of Dudley lagging 10 years behind the Dudley average. Reducing smoking rates is likely to have the biggest impact
- Accident rates are no lower now than ten years ago and there has been an upturn in mortality rates from accidents for women aged 65+
- Monitoring of disease prevalence in the community has improved, though some diseases were still being under-diagnosed (stroke, diabetes and chronic obstructive pulmonary disease (COPD)
- The most important lifestyle factor affecting health is still smoking, though the smoking rate is falling.
- Alcohol misuse has been rising at a faster rate than the average for England but there are a number of interventions in place to address this (see also Alcohol Strategy)
- Obesity prevalence continues to rise with current estimates suggesting there are 50,000 adults in Dudley with obesity (see also Obesity Strategy)

4.4 Prevalence of Major Diseases

The data below shows the unmet need for a set number of long term conditions. This strategy will aim to improve uptake of initiative and awareness schemes that improve access to treatment where clinically appropriate**.**

Table 1 – Numbers of patients with long-term conditions that are not receiving recommended clinically effective treatments to improve their health. (Based on 2009/10 QOF Outcomes Data)

Clinical indicators (from QOF)	No. of patients not treated to the QoF standard (excludes exception reports)	No of registered eligible patients	Dudley achievement in 2009/10
Blood pressure management of patients with coronary heart disease (150/90 or less). CHD6	**1,422**	12,390	88.52%
Patients with coronary heart disease who have been prescribed a beta blocker in the last 6 months CHD10	**2,568**	10,276	75.01%
Cholesterol management of patients with TIA or stroke (5mmol/l or less). STR8	**1,175**	5,304	77.85%
Blood pressure management of patients with hypertension (150/90 or less). BP5	**11,976**	51,112	76.57%
Patients with diabetes whose blood sugar level is under control (HbA1c is 8.0 or less (or equivalent test). DM24	**2,828**	13,363	78.84%
Blood pressure management of patients with diabetes (145/85 or less).	**2,988**	12,881	76.33%

DM12			
Patients with asthma who have had a review in the last 15 months. AST6	**4,287**	18,235	76.49%

Table 2 below gives the percentage ratio of the number of people on the register and the modelled prevalence (NHS Comparators) for 2009/10. Comparing the observed and expected registers for a population can give an indication of areas with potential under-diagnosis. For all the major diseases Dudley PCT achieves a registered population less than the 100% expected according to the modelling. However there was some variation between the actual number of patients diagnosed with the major diseases in 2008 - 2009 within some GP practices and the expected number of patients with these diseases. Where practices have significantly different numbers of patients from the number expected it could possibly be due to poor data reporting; a need to improve case finding; or alternatively a lower or higher actual prevalence in that GP practice population for example with hypertension.

The PCT will concentrate on these areas to ensure we achieve maximum registration per disease group and in turn maximise the potential for reducing health inequalities in the borough.

Table 2 - Actual versus Modelled Prevalence - 2009/10

Disease	QOF prevalence register	Modelled prevalence register	Percentage ratio for Dudley	Modelled Projected Expected Prevalence (estimated numbers) 2015 (1)_
CHD	12,614	13,992	90.2	17,930
Hypertension	52,412	78,948	66.4	85,954
Stroke	5,813	6,498	89.5	7,041
COPD	4,837	9,374	51.6	13,430
Diabetes	14,285	18,227	78.4	Not available
Treated Epilepsy	2,181	2,188	99.7	Not available
Asthma	18,675	28,702	65.1	Not available

Sources: QOF Data for prevalence register sizes, Doncaster QOF Analysis Tool for modelled prevalence

1 Source: APHO Disease Prevalence Model Projections (http://www.apho.org.uk/resource/view.aspx?RID=48308 Accessed January 2010), based on ONS mid-year 2006 population projections applied to PCT populations.

The 5th column shows projected expected prevalence, for four of the major diseases using national disease prevalence models and gives an indication of the level of changing need based on demography. The projections are calculated using the ONS population projections adjusted for PCT registered population and assume that age-specific community disease prevalence will not change significantly over the period.

4.5 Actions to Address Under-Diagnosis in Dudley (As indicated in tables 1 and 2)

The following actions are being undertaken:-

- All practices have been sent their **QOF figures** for long term conditions, matched against the national mean average. Practices are being requested to produce an action plan for the QOF indicators that are below the national average
- The **risk stratification** tool will identify some people with various conditions that practices have not identified
- The Respiratory LIT has initiated a **pilot to increase identification of chronic obstructive pulmonary disease (COPD)** as part of the national COPD Strategy. An audit is to commence across Dudley with 800 people assessed for COPD
- The Respiratory LIT and Respiratory Nurse are implementing plans via education and training to increase the identification **of people with asthma**
- **Vascular checks** will identify people at high risk of vascular disease and offer intervention to reduce risk, but also people who are possibly undiagnosed for atrial fibrillation, chronic kidney disease (CKD), diabetes, hypertension, familial hypercholesterolaemia and COPD
- The prevalence gap for **CKD** will be identified via the QOF and plans drawn up in practices to address CKD issues identified

4.6 Patient, Public and Carer Engagement

This strategy is designed to deliver the aims and objectives outlined in Dudley's Strategic Plan *At the Heart of Local Health*. Consultation events with local people informed that strategy. They told us that they want:-

- an increased say in how and where they are cared for,
- to be helped to make informed choices through the provision of better more easily accessible information,
- more care closer to home, and
- improved access to diagnostic and other services where and when they need them

Patient and public expectations of health services are at their highest. Patients are more aware of the choices available to them, more understanding of the NHS obligation to deliver those choices, and more able to challenge when things go wrong. We welcome this increased 'patient power'.

In respect of long-term conditions:-

- The **neurology strategy** was developed in partnership with service users, carers and health economy partners including the voluntary sector. Workshops were held to understand the lived experience of carers, service users and frontline staff to enable real issues to be captured and addressed in developing improved services. A series of patient outcomes evolved from the workshops and actions to take these forward.
- Service users and carers have been engaged in forums to understand local issues and drive the commissioning intentions for re-designing the dementia pathway.

- The Dudley Healthcare Forum contributed ideas to the development of the **breast screening service, bowel cancer screening and specialised cancer treatment.**
- An audit that was conducted with service users to ensure that **diabetic** patients receive the appropriate care, treatment and advice they require in a timely manner.
- The **Dudley Stroke Association's** annual event presents opportunities to consult with people on changes to services and ascertain the service user's views. There is also patient and carer representatives that sit on the Dudley Stroke Group to enable their involvement and feedback.
- Patient representatives work very closely within the **CHD** LIT and play an active role in the Black Country Cardiovascular network.

This strategy will build on the picture drawn following consultation the priorities contained in *At the Heart of Local Health*. We will build on established mechanisms of involving patients and the public to ensure that commissioners continue to be updated about what people want and what they think about the care we commission on their behalf. General stakeholder engagement programmes will be established to capture broad themes.

The PCT recognises and continues to promote the contribution of carers to supporting people with long term conditions.

- We will continue to support carers via grants to Crossroads and the Dudley Alzheimer's Society
- We are progressing with the appointment of a carers coordinator post in Dudley Group of Hospitals
- We will continue to run 'Looking after Me' courses for carers in support of the Expert Patient Programme. Starting in 2011 the local carers' organization 'Insight for Carers' has been commissioned to run additional courses.

4.7 The PCTs Mental Health, Urgent and Planned Care Strategies

Many of the goals identified in this strategy will be supported by delivery programmes in other PCT strategies. The planned care strategy identifies programmes of work to support people with long-term conditions, some of which are included in the summary of planned care QIPP programmes. Joint work programmes between planned, long-term conditions and urgent care will deliver a reduction in hospital attendances and admissions for people with a long-term condition, chiefly through new ways of identifying the risks for those people of needing acute care and of establishing new ways of addressing that risk in the community such that crisis situations and need for acute intervention is minimised.

The impact of mental health on a person's sense of well-being, and the impact of long-term conditions on a person's mental health, is well understood. Chronic physical illness can have a life-changing effect on an individual's wellbeing, functional capability and quality of life. Depression and/or anxiety disorders (as either a cause or a consequence of the physical illness) may exacerbate the perceived severity of the physical symptoms and add to the person's distress.

Patients often present with physical symptoms, when in fact they are suffering from an underlying common mental health condition such as depression and/or anxiety disorder.
Unless the relationship between physical and mental health is recognised the results include:-

- users with depression and/or anxiety disorders may adversely affect adherence to medical treatment;
- increase unhealthy behaviour such as smoking, substance misuse, and poor diet, which leads to poorer outcomes for those suffering with chronic diseases;
- delay in the accurate diagnosis, and therefore in the treatment, of depression and anxiety disorders
- unnecessary suffering for the patient
- high health service costs

In Dudley an IAPT (Improving Access to Psychological Therapies) service has been developed in primary care and community services settings for those users with anxiety and depression who previously did not receive treatment. There are also clinical psychology services for specific long term conditions.

The Dudley Long Term Conditions Board is addressing services to support psychology input and how this can be taken forward by the LIT's. It will include options for a generic programme and a tiered approach.

5. FINANCE & ACTIVITY

The PCT is facing significant financial challenges and needs to make savings in order to achieve its financial targets. The savings targets up to and including 2013/14, which need to be cash releasing, are as shown in Table 3:-

Table 3 – PCTs Savings Target

	PCT Savings Targets
2010/11	5,739,000
2011/12	13,488,000
2012/13	8,787,000
2013/14	6,240,000
TOTAL	34,254,000

5.1 Activity and Spend Analysis for Long Term Conditions

Table 4 below gives the baseline admissions for long term conditions for 09/10 and the prediction for admissions for the eight key long term conditions over the next 3 years. Dementia and Stroke have the largest percentage increase because the majority of activity is for patients over age 65. This age group is expected to grow the most over the next 3 years.

Table 4 - Activity and Spend Analysis for Long Term Conditions

Long Term Condition	2009/2010 £	2012/2013 (projected) £	Increase £	Increase %
Stroke	3,183,234	3,423,097	239,863	8%
Cancer	8,212,669	8,635,237	422,568	5%
Neurology	1,146,073	1,175,581	29,508	3%
CHD	4,458,570	4,736,662	278,092	6%
Respiratory	1,435,250	1,530,676	95,426	7%
CKD	307,686	318,273	10,587	3%
Diabetes	428,752	443,884	15,132	4%
Diabetes potential complications	10,301,807	10,959,710	657,902	6%
Dementia	449,592	491,108	41,516	9%
Total	**29,923,634**	**31,714,228**	**1,790,595**	**6%**

- 2012/13 projected costs have been calculated using projected population figures

5.2 QIPP plans

NHS organisations at regional and local level have QIPP plans in place to address the quality and productivity challenge. Supporting these are national work streams designed to help NHS staff successfully deliver these changes. The LTC strategy's contribution to the PCT's savings targets is shown below in Table 5:-

Table 5 – Long Term Conditions QIPP Plan

Plans	Forecast 2010/11	2011/12	2012/13	2013/14	Cumulative Total
	£	£	£	£	£
Neurology	0	20,000	20,000	20,000	60,000
Cardiology - ECG	28,720	0	0	0	28,720
Specialist Speech & Language Therapist - adults with Dementia	0	0	26,033	28,094	54,127
AF LES	0	52,040	20,000	0	72,040
Community Cardiology Service	0	180,277	0	0	180,277
Total	**28,720**	**252,317**	**66,033**	**48,094**	**395,164**

5.2.1 Long Term Condition QIPP Priorities

In addition to the savings identified above, LITs continue to address other priorities under the long term conditions umbrella. Opportunities to identify further savings will be explored going forward. Each of the LITs will report to the Long Term Conditions Board on how they are addressing the following long term condition priorities

1) Risk stratification
2) Generic strategies for people with multiple conditions
3) Prevention of disease progression
4) Support for self care
5) Personalised care plans
6) Tele-health
7) Workforce development

Please see **Appendix 2** for the QIPP programmes addressing these priorities.

6. GOALS

6.1 Stroke

Recent investment programmes

- Early Supported Discharge and The Community Stroke Coordinator to reduce rehabilitation bed days and reduce impact on social care.
- Continued implementation of Thrombolysis guidelines to reduce the impact of stroke

Key Actions/Deliverables for Stroke LIT 2010/11 and beyond

- To develop a Best Practice payment scheme to ensure more patients spend 90% of their admission time on a stroke ward and more patients scanned on or within 1 hour
- To consider a LES or commission for 6 monthly and annual reviews to ensure better follow up and goal planning for stroke patients
- To embed the early supportive supported discharge scheme as a permanent solution
- To develop better links with West Midlands Ambulance Service re "FAST" for handover of patients in acute and alerted for arrival in Accident and Emergency / Emergency Admission Unit

6.2 Cancer

Recent investment programmes

- Improved access to palliative care to reduce admissions at end of life
- Increase use of 'Do Not Attempt Resuscitation' forms to reduce inappropriate emergency admissions

Key Actions/Deliverables from Cancer LIT 2010/11 and beyond

- To develop and deliver social marketing campaigns to raise awareness of 6 cancers (breast, cervical, skin, bowel, prostrate, lung) to increase cancer awareness, to manage at an earlier stage of diagnosis and increase 1 year survival
- To embed the breast screening age range is extended from 47-73 to decrease breast cancer mortality.

6.3 Neurology

Recent investment programmes

- Multi Disciplinary Team (MDT) community care neurology team in place to improve access and coordinated care closer to home (key commissioning intention from Dudley Neurology Strategy)

Key Actions/Deliverables from Neurology LIT 2010/11 and beyond

- To reduce neurology out-patient activity by 5% per year over the next 5 years

- To develop Multiple Sclerosis pathway for Disease Modifying Therapies at Dudley Group of Hospitals rather than at University Hospital Birmingham where treatment is currently located. place
- To commence a pilot of a MDT clinic with consultants and community neurology team members to ensure integrated quality assessments and improved working
- To improve communication of local neurology services via a Dudley neurology website to go live by end of 2010
- To commence a pilot of personalised care plans for neurology patients
- To support younger neurology patients via a patient support group led by the psychologist.

6.4 Coronary Heart Disease

Recent investment programmes

- Primary angioplasty (STEMI) pathway implemented
- High risk CHD checks completed and Vascular screening "NHS Health Checks" commenced
- Re-commissioned the Community HF Echocardiography service to ensure a high quality and cost effective service.
- Increase number of 4-week smoking quitters

Key Actions/Deliverables from CHD LIT 2010/11 and beyond

- To re-design current cardiology out patient services provision to increase capacity, by delivering a primary care based solution for non-complex cardiac conditions at 50% of current service cost
- To commence a 6 month Randomised Control Trial pilot assessing the economic value of using Tele-health for Heart Failure patients.
- To undertake an atrial fibrillation local enhanced service which focuses on the identification, stroke risk stratification and appropriate treatment to reduce strokes.
- To develop a hypertension pathway
- To conclude pilot of Electrocardiogram and event monitoring within practice December 2010

6.5 Respiratory

Recent investment programmes

- The COPD LES has reduced admissions to hospital and produced significant savings
- There was a pilot for paediatric asthma/eczema and allergy clinic that was evaluated successfully

Key Actions/Deliverables from Respiratory LIT 2010/11 and beyond

- To implement as part of the National COPD Strategy a 'Missing Millions' (previously undiagnosed COPD) pilot that has commenced: Audit of 800 patients via GP surgeries, community pharmacists, Dudley Stop Smoking Service
- To implement the new NICE guidelines for COPD Mild, Moderate, Severe and Very Severe

- To improve diagnosis of asthma in Dudley via an education and training programme.
- To take forward an application via SHA End of Life workforce projects for an end of life care lead/nurse for COPD
- To redesign of pathways for children with allergy, asthma and eczema to improve services and patient outcomes and reduce costs

6.6 Chronic Kidney Disease

Recent investment programmes

- Implementation of a local pathway for the assessment, diagnosis, management and referral of patients with CKD
- Structured education programme for clinicians in CKD management

Key Actions/Deliverables from CKD LIT 2010/11 and beyond

- To increase home therapy for renal placement therapy (via QIPP and West Mids renal network)
- To implement an end of life pathway and include a conservative management pathway
- To reduce the prevalence gap of CKD via working with practices and ensure action plans are in place to address the prevalence gaps.

6.7 Diabetes

Recent investment programmes

- Structured Education programme for all newly diagnosed diabetics
- Care Homes Education Support Worker and a BME Education Support Worker in place
- A local enhanced service (LES) for the provision of oral glucose tolerance testing in primary care has been commissioned
- Provision of a paediatric insulin pump service

Key Actions/Deliverables from Diabetes LIT 2010/11

- To redesign Diabetes pathways and LES
- To take forward the 'Think Glucose' scheme as part of a national CQINN scheme to reduce length of stay in hospitals by education and training to non-specialist medical teams for identification of diabetes and timely referral to specialist diabetes teams.
- To embed the Foot Care pathway for early identification of complications and reduce major surgery including amputations.

6.8 Dementia

Recent investment programmes

- Investment in Dudley Alzheimer's Society to support Carers looking after someone with a diagnosis of dementia

Key Actions/Deliverables from Dementia LIT 2010/11 and beyond

- Completion of a dementia pathway for early intervention including working age dementia to include:-
  1) Primary care screening and identification
  2) Assessment and personalised care plan undertaken by appointment of a specialist dementia nurse in primary care
  3) Ongoing support with care coordinator assigned linked to family and carer support
  4) Specialist intervention via old age psychiatrist for anti-dementia medication
  5) Psychology support

- To implement an action plan for the National Dementia Strategy 17 key objectives (see Dudley Mental Health for Older People and Dementia Strategy)

7. MONITORING DELIVERY

The long-term conditions programme will be monitored by the LTC Board and via QIPP performance monitoring processes both internally and via the Black Country Cluster framework. The work covered by this strategy will also be the subject of scrutiny via the newly formed health and social care CEO level strategy meetings.

Measures of success and Key Performance Indicators will be devised in order that success can be measured and reported upon.

8. CRITICAL SUCCESS FACTORS

8.1 The following areas are critical to successful delivery of this long-term conditions strategy:-

- Practice sign up to BUPA tool
- Clinical engagement across primary and secondary
- Support from health information
- Partnership working across the health economy
- Appropriately trained and skilled staff
- Won over hearts and minds of key stakeholders for innovative and new ways of working
- Implementation of evidence based practice
- Effective design and commissioning of improved care pathways
- Continual evaluation and feedback mechanism
- Alignment with Urgent, Planned Care and Mental Health Strategies
- Patient education and self-care

8.2 Role of the Local Implementation Teams

The direction of travel and supporting evidence from both the Department of H and SHA for long term conditions is to have a combined approach focusing on the 7 priorities in the QIPP to bring about the effective management of long term conditions. Thus each of the LTC LITs will be tasked with ensuring that their action plans address the LTC QIPP priorities and programme, identify new areas for raising quality, reducing cost and also to review their pathways using the following integrated approach to prevention and care

1. Community prevention
2. Pre-screening
3. Early diagnosis
4. Forging foundations of care (early care treatment)
5. Rolling review e.g. those who well controlled and those that are more complicated such as mild and severe COPD
6. Early escalation
7. Curbing complications

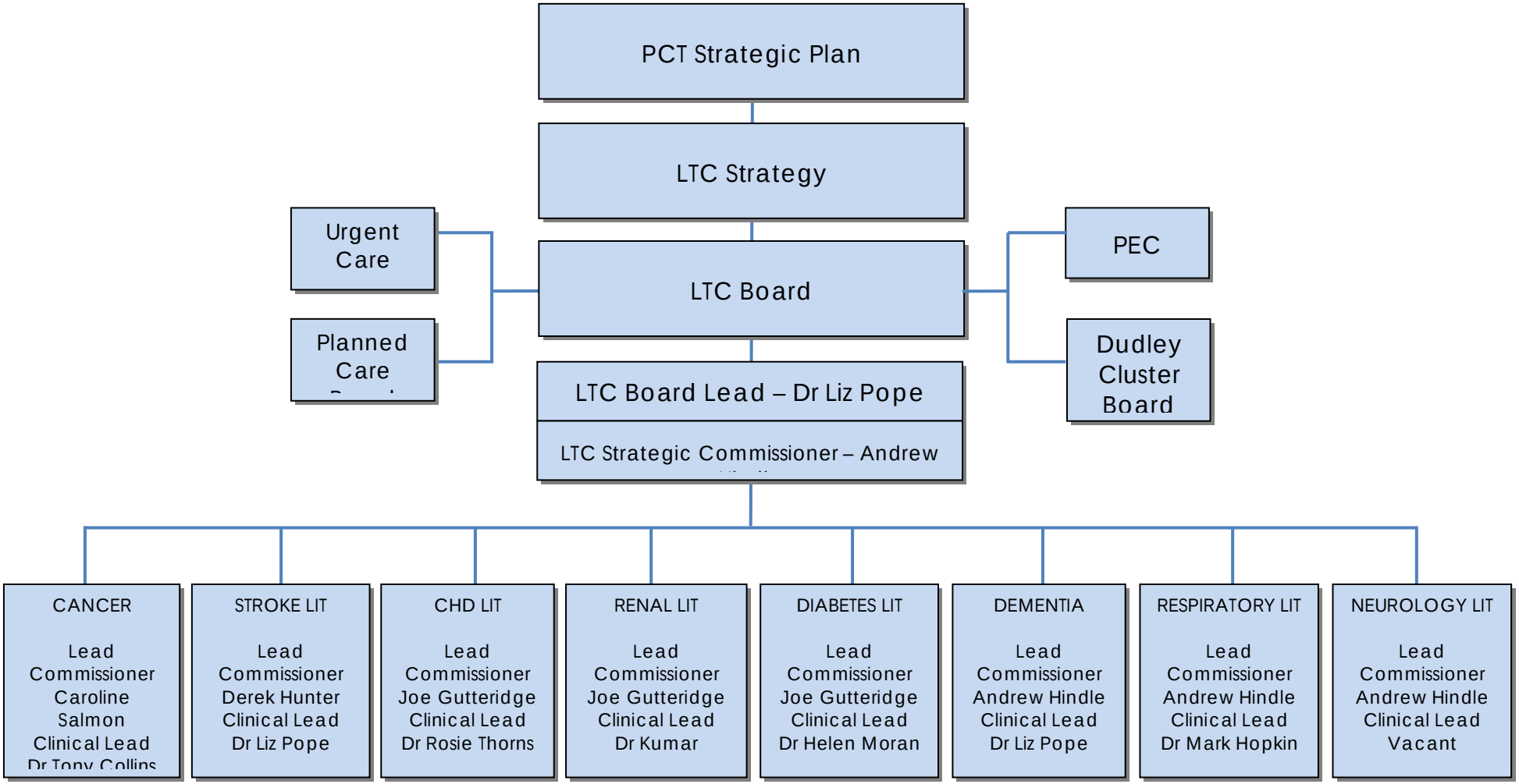
8. Avoidable admissions e.g. hypo-glycaemia and hyper-glycaemia
9. Unavoidable admissions e.g. excess bed days
10. Rationalized long term care (Patients with co-morbidities not amenable to treatment)

By adopting this approach patients can be monitored and moved up or down the scales. (**see appendix 3** for an example of a matrix for diabetes)

Work programmes will be delivered to ensure these critical success factors are put in place.

APPENDIX 1

LTC STUCTURE



APPENDIX 2

Long Term Conditions and 7 QIPP Priorities

LTC QIPP Priority 1: Population stratification & case management

By 2012 health communities must implement appropriate tools to stratify the population of people with long term conditions and identify those with complex health or social care needs and at highest risk of emergency admissions and readmissions. Health communities should then implement effective integrated and coordinated case management across health and social care to maintain or improve the individual's quality of life and health status and reduce the use of emergency or unplanned care.

NHS Dudley current status as of 2010

- West Midlands Risk Stratification Tool is being utilised in Dudley with early intervention for and risk management of long-term conditions. It will combine data from, hospital Out Patients, A&E, Hospital In patients and also GP Primary Care. This will enable the identification of patients at high risk of hospitalisation and facilitate targeting of resources to prevent unnecessary admissions. There will be a focus on the top five long-term conditions (Diabetes, COPD, CHF and Asthma). This will:-
  - identify risk: likelihood for an individual using health services
  - stratify: a whole population analysis that predicts future demand up to 12 months
  - identify: find high risk and high-reward opportunities
  - target: allocate resources with a view towards the future and target resources effectively
  - review: use intelligence to guide the next steps

Programmes

- **Virtual Ward**
  The virtual Ward was established to treat and maintain "high risk" patients as defined by the risk stratification tool. The Case Management will use Predictive Risk Modelling to admit and discharge patients from the caseload. (See additional information on the Virtual Ward in the **Urgent Care section**)
- Review the new all encompassing risk stratification model and ensure all practices sign up to maximize benefits. An action plan is in progress with PBC (Urgent Care lead) to get the remaining practices to sign up and input data to review and manage patients appropriately (Currently 87% of population is on the risk stratification tool)
- To obtain HCS data reports on cohorts and specific long term conditions e.g. epilepsy to enable targeted actions on patients with a likelihood of secondary care utilization
- To work with medicines management on the risk stratification tool on reviews of people with a high score and polypharmacy issues
- To analyze the risk stratification data from specific post codes where there are nursing and residential homes for an action plan approach in conjunction with health partners to reduce use of secondary care services

LTC QIPP priority 2: Generic strategies for people with multiple conditions / Commissioning and providing joined up, personalized and integrated services

This means that services should be integrated and coordinated, based around provision of care for individuals with multiple needs. It involves primary, community, and specialist healthcare providers and social care professionals working together.

NHS Dudley current status as of 2010:

NHS Dudley has pathways for all long term conditions that improve patient care, cost efficiency savings and are adhered to across the health economy

A number of pathways are being developed and re-designed for long term conditions including respiratory, neurology, stroke, diabetes, dementia, heart failure and cardiology. The specific actions from the LTC LIT's are outlined in the section headed 'Goals'

Programmes

- New and existing pathways will be monitored via the LTC Board and ensure that key QIPP priorities are addressed including integrated and joined up care, self care and personalised care plans**.** (See also Virtual Ward pilot above for management of people with multiple conditions)
- A borough wide community intermediate care service has commenced utilizing the multi-disciplinary team and will support patients with long term conditions in their own home. It is being delivered in partnership with the local authority and will be in addition to the bed based service **(see urgent care section)**

LTC QIPP priority 3: Prevent disease progression

This involves proactive and timely interventions from appropriate teams for everyone with a Long Term Condition.

NHS Dudley current status as of 2010

NHS Dudley has a robust programme in place for preventing disease progression for all long term conditions

Vascular checks

- Dudley vascular checks programme has commenced to prevent disease progression. The associated software provides tools for early intervention and risk management for people at risk of CHD and undiagnosed diabetes and hypertension.
- There is ongoing monitoring for the key targets that have been set; preventing heart attacks/Strokes, prevention of diabetes and numbers of health checks offered and completed

Obesity pathway

- Implementation of the obesity pathway- at all levels – prevention and weight management pathways for the overweight and obese
- There is ongoing monitoring for the key targets that have been set; reduction in adult obesity prevalence and referrals to services

Falls Pathway

- The falls pathway is being finalized with implementation of a falls clinic within DGOH
- A project with the West Midlands Ambulance Service is being taken forward for falls and Category C calls in order to have appropriate interventions in Dudley. The programme will be training for 'First Person on the Scene' and will involve social care teams, sheltered housing wardens and residential/nursing home staff to intervene when there is a Category C call to the Ambulance Service and support the older person who has had a fall

COPD

- A Local Enhanced Services scheme (LES) has been introduced for COPD patients. The LES includes monitoring and education of patients with COPD to prevent disease progression and is proving to avoid hospital admissions
- The 'Missing Millions Pilot' is part of the national COPD strategy and a pilot has commenced in Dudley action to identify people with COPD within Dudley not yet known to general practice

Stroke

- An Early Supported Discharge service is being piloted. This pilot will be evaluated and if proven to be good quality, productive, and cost-effective, a permanent service will be developed

Cancer

- Social marketing campaigns to raise awareness of 6 cancers is to commence in 2011

Dementia

- A GP training programme is to commence in 2011 across Dudley for improved identification and early stage diagnosis to ensure appropriate management and anti-dementia medication is initiated.

Alcohol, **Tobacco Control activities & Stop Smoking Service, physical activity promotion, food and nutrition programmes and**

the healthy towns programme are also running in Dudley to prevent disease development and progression

LTC QIPP priority 4: Support self care

Health communities will provide people who live with long term conditions support to develop confidence and competence in managing their own health, in order to improve their quality of life and clinical outcomes.

NHS Dudley current status as of 2010

Self –care and self management is mainstreamed into the care of all patients with long term conditions and is aligned with personalised care plans

Programmes

Self-Help Project

- NHS Dudley is participating in the SHA sponsored programme led by Self-Help Nottingham, the aim of which is to maximise the support to and development of self help groups and to produce a directory of Self Help Support Groups listing contacts and resources for individuals living with a range of conditions. A project group is driving the plans forward. The web-based solution will be added to the Directory of Services

Self-Care Strategy

- A Dudley Self Care Strategy is being developed by public health. This will include a map of all self care initiatives and educational support programmes

COPD LES

- Following one to one discussion with a trained health care professional in COPD patients are encouraged to take responsibility for their condition, enabling patient empowerment and using clearly defined self managed plans

Diabetes

- There is an education programme for patients with diabetes to help them manage their conditions more effectively

Expert Patient Programme

- NHS Dudley is extending expert patient programmes and carers programmes in order to deliver improved patient self care, via six week courses, which focus on reducing illness behaviour and improving patient information, empowerment and responsibility
- There is ongoing monitoring for the key targets that have been set for course completions
- To work with voluntary groups to extend the service further
- To look at developing EPPs for specific diseases. A stroke EPP is starting in October in conjunction with Dudley Stroke Association

Personalised health budgets:

- Dudley NHS is participating in a cross health economy 'personalised health budget' pilot for people with LTC's to improve patient choice, patient experience and empowerment and reduce hospital admissions via a bespoke community care package

LTC QIPP priority 5: Personalised care plans

Health communities will need to ensure that people with long term conditions are offered the opportunity for a systematic and planned assessment of their current overall care, their ongoing needs and goals, and to plan their forthcoming period of

care. The outcome of this care planning appointment will be reflected in a personalised care plan, the primary owner of which will be the patient.

NHS Dudley current status as of 2010

That all patients with a long term condition in Dudley have a personalised care plan that has been developed in partnership with the patient

Programmes

- Adapting personalised care plans (via LIT's and community nursing services) using SHA templates
- The LTC LIT's will be requested to produce action plans which includes implementation of self management/personalised care plans.
- Training programme to commence in the autumn via SHA
- A selected number of staff will be on the train the trainer course to ensure cascading to all appropriate staff
- Nursing metrics are being achieved for personalised care plans in community services
- To ensure there is a focus on the implementation of personalised care plans (DH target for 2010 that everyone with a LTC is offered a 'personalised care plan'). Strong evidence on the benefits to patients and reduced NHS resources

LTC QIPP priority 6: Using Tele-health

Every person with a long term condition(s) should routinely consider using appropriate technology to help them or their carers, as well as health and social care professionals better manage their condition.

NHS Dudley current status as of 2010

- To evaluate the forthcoming tele-health for heart failure pilot. If this is successful for tele-health it will need to be mainstreamed for heart failure and considered for other long term conditions in order to avoid hospital admissions and support self-management

Programmes

New extended pilot study to support people with heart failure using 'safe systems'. The objective is to establish the future cost savings of deploying telehealth monitoring to all heart failure patients considered eligible for telehealth within Dudley PCT

- 6 month pilot to commence in mid November 2010

Dudley NHS are also exploring a pilot using 'Simple tele-health' and the Florence software with mobile phone technology.
A possible pilot with COPD end of life care patients is being considered in-conjunction with the SHA / Investing for Health.

LTC QIPP priority 7: Workforce development

The professionals who work with people with long term conditions need to be appropriately skilled to support the use of technology, promote self management and implement effective disease management using risk stratification.

NHS Dudley current status as of 2010

The objective is for all health care professionals who care for people with long term conditions are fully skilled in the use of appropriate technology, promoting self management and effective disease management.

Programmes

- The PCT will be running training on risk stratification for users and super users
- Training commenced and facilitated via BUPA for users and super users

In support of the workforce development needs, locally we have a collaborative project (supported by workforce deanery transformation funding) looking at workforce transformation in relation to the following 4 pathway areas:

- COPD
- Diabetes
- End of Life care
- Stroke

To date this group has achieved or is progressing the following outcomes:

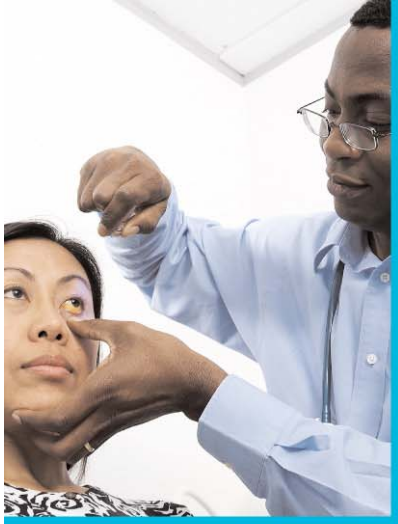
- Established a framework for effective collaborative working
  - Steering Group established
  - Working groups and Local Implementation Groups attended by project lead for identified care pathways
- Mapped the current workforce for the pathways identified in order to underpin workforce planning & development
  - Hospital admission data and map of medicine used to identify gaps in service
- Scoped management & staff capacity to deliver new care agenda
- Mapping existing skills and competency levels in order to provide a gap analysis which will inform training plans and education commissioning intentions
  - Working with Wolverhampton University to carry out a detailed analysis of competency/skill gaps
- Identifying opportunities for innovation in implementation of workforce roles
  - Identification of new ways of working, looking at the use of link workers
- Working with commissioners of service to produce action plans for workforce development which link to service development

  Ongoing, especially in light of the TCS agenda

Appendix 3

Diabetes Matrix

Level	Target Group	Recommendations
1: Community Prevention	Entire Local Population	GP, Local Authority, Employers, Community to promote healthy lifestyle choices: eg HEALTH Passport, Change 4 Life
2: Pre-Diabetic Screening	At risk groups within the local population	GP screening for at risk individualised: questionnaire, HbA1c%, GTT (dependant on group)
3: Early Diagnosis	Pre-diabetic population, Known impaired glucose tolerance, newly diagnosed DM	GP: monitors and manage those with IGT, IFG and newly-diagnosed diabetes
4: Forging Foundations	Newly diagnosed: excellent care; lifestyle etc preventing complications	GP: Individualised care-planning and excellent clinical care according to current best practice and NICE
5: Rolling Review	**5A:** Well controlled with few risk factors to manage. High quality care **5B:** Complicated, higher risk, poorer quality care	GP: "Year of care" or all main clinical needs embedded within an Annual Review: feet examination, eye examination, BP, Cholesterol profile, Urine Albumin etc
6: Early Escalation	Uncontrolled clinical and social factors at high risk of complications, admission or morbidity:	GP: Aggressive management of difficult to control risk factors, consider referral or seek advice.
7: Curbing Complications	**7A:** Patients with known complications/conditions: **7B:** Patients with unpredictable complications:	GP and Shared care: advice sought from best local advice, consider specialist referral
8: Avoidable Admissions	Hypoglycaemia, DKA, Foot ulceration and infection,	Specialist Acute Care with Diabetes input: "Think Glucose" management to reduce Length of Stay. Discharge to GP or Shared care to continue
9: Unavoidable Admissions	Patients with advanced disease and complications:	Specialist Acute Care with Diabetes input: "Think Glucose" management to reduce Length of Stay. Usually Shared care with GP/Specialist to continue
10: Rationalised Long Term Care	Patients with co-morbidities not amenable to treatment:	GP or Specialist or Both to rationalise care: review clinical targets, outcomes and medication. Co-ordinate care acceptable to patient/carers. High quality End-of-Life Care



NHS Dudley

heart of local health

If you have any questions about this strategy please contact:

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