Item No.	Classification:	Date:	Meeting Name:
9.	Open	19 December 2013	Health and Wellbeing Board
Report title:		Developing Integrated Care for People with Long Term Conditions	
Wards or groups affected:		All wards, people with long term conditions	
From:		Tamsin Hooton, Director of Service Redesign, Southwark CCG	

RECOMMENDATIONS

1. The board is requested to:

    a) Note and approve the recommendations for future development of integrated LTC care in the borough
    b) Support the neighbourhood model of care as a key element in integrating care for Long Term Conditions in the borough
    c) Agree a working group on self management to support the HWB strategy and our shared work on Long Term conditions.

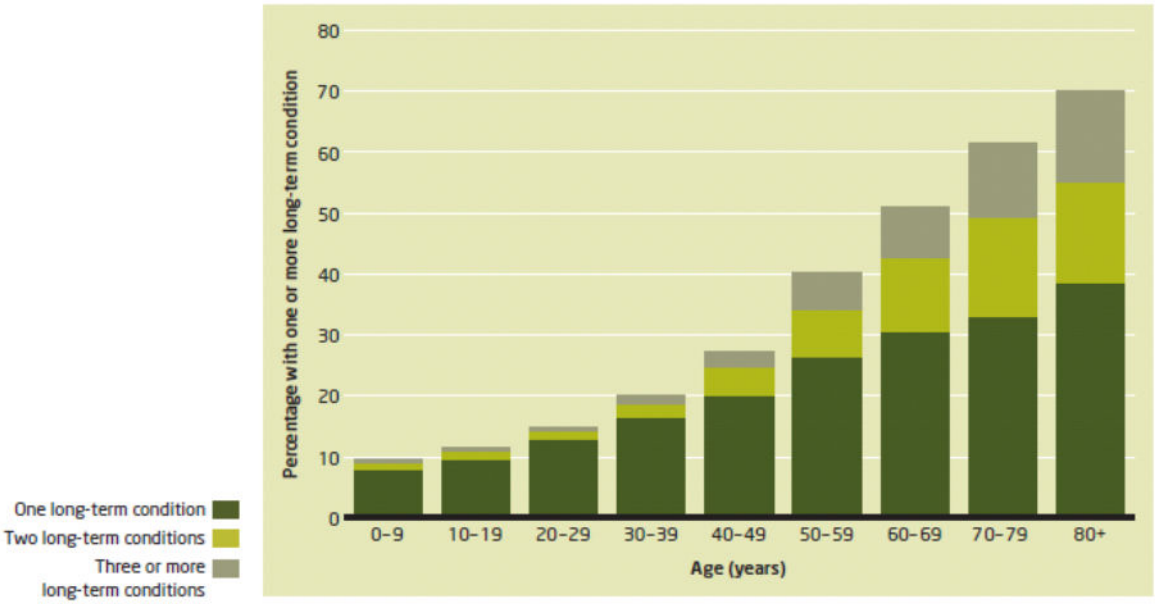
EXECUTIVE SUMMARY

2. This paper summarises current commissioning strategy for long term conditions (LTCs) and proposes a model for developing integrated care for LTCs.

3. Long term conditions are health problems that are not curable but which can usually be controlled by the use of medicines and changes in lifestyle. They include high blood pressure, diabetes, depression and arthritis. It is estimated that nationally up to 70% of health and social care expenditure is spent on people with Long Term conditions. Having a long term condition can have a significant impact a person's quality of life, and increases the risk of needing acute medical care or an admission to hospital. In some cases LTCs are the cause of premature mortality.

4. The risk of having a long term condition increases with age, and many people over the age of 75 have more than one long term condition. In Southwark, prevalence of younger people with a long term conditions is also high, and LTCs are the cause of a significant burden of ill health in people under 75. The table below indicates the prevalence of long term conditions across different age groups on a national basis.

Figure 7 Proportion of people with long-term conditions by age, England, 2009



Source: Department of Health (2012a)

5. There are six key elements in our approach to improving health outcomes and quality of life for people with long term conditions. They are:

   i. **Preventing people developing ill health**, through supporting healthier living including: exercise, maintaining healthy weight, not smoking or drinking at hazardous levels
   ii. **Early and accurate identification** of those people who have developed a long term condition, supported by best practice clinical management
   iii. Supporting people to manage **their own health,** through education and peer support, lifestyle interventions and rapid access to help and advice when needed
   iv. Personalised **care-**planning to meet the needs of each individual, with care plans set in collaboration with the service user in recognition that the citizen is an active contributor to their care
   v. Better **co-ordinated** care**,** with services working together to deliver a person's care plan in a joined up way
   vi. **Reducing health** inequalities in mortality and morbidity

6. This approach to LTC care links to objectives 2 and 3 of the Health and Wellbeing Strategy, which are:

   - Building healthier and more resilient communities and tackling the root causes of ill health
   - Improving the experience and outcomes of care for our most vulnerable residents and enabling them to live more independent lives

   By integrating the way that services are planned and delivered we can deliver the objectives above more easily

BACKGROUND INFORMATION

7. Premature mortality in Southwark from stroke, cardiovascular disease and respiratory disease and cancer is higher compared to London and

England.

8. The GP registers for long term conditions show that as at March 2013 there were: 5,812 people with cardiovascular diseases, 32,104 with hypertension, 11,975 with diabetes, 3,899 with chronic obstructive pulmonary disease, 4,708 with coronary heart disease, 2,757 with stroke, 3,209 with cancer and 5,335 with chronic kidney disease. A patient can be on multiple disease registers so the above figures can not be totaled.

9. The prevalence models published by APHO have shown significant under-detection of conditions such as diabetes, hypertension and kidney disease in Southwark, of up to 50%. This indicates that people in the Southwark population who have a long term condition are not receiving optimal treatment, and this is likely to contribute to poor outcomes, such as high hospitalization and mortality rates for COPD and high rates of admissions for the complications of diabetes etc.

10. These long term conditions have common risk factors, with smoking, physical inactivity, unhealthy diet, obesity and hypertension causing most deaths. For example smoking causes about 71% of all lung cancer deaths, 42% of chronic respiratory disease and nearly 10% of cardiovascular disease.

11. The table below shows the eight high impact interventions that could prevent deaths and ill health from these diseases.

Estimated number of deaths in Southwark that could be postponed in one year

Intervention	**Number of deaths postponed**
1 Brief alcohol interventions for 10% of harmful drinkers	2
2 Smoking cessation (10% of smokers set a quit date) 3	3
3 All untreated people with a previous cardiovascular: event on beta blocker, aspirin, ace inhibitor, statin 4, 5 stroke	CHD 11 Stroke 6
4 All partially treated people with a previous cardiovascular event on beta blocker, aspirin, ace inhibitor, statin 5 stroke	CHD 21 Stroke 11
5 Anticoagulant therapy (warfarin) for all aged over 65 with atrial fibrillation	Stroke 8
6 All people with high blood pressure with no previous CVD event to have additional anti-hypertensive therapy	34
7 Statin treatment for those with hypertension at high CVD risk	15
8 For people with diabetes reducing blood sugars that are over 7.5 by one unit	9

Source: Southwark Annual Public Health Report 2010
Notes to table:
1 The benefits of these interventions are set at the theoretical maximum level and might need to be scaled down in practice. The estimates are not precise and draw on a range of estimated data. But the table

helps focus attention on the interventions that could make a major local impact. Further work is needed using local data where possible
2 for one year, unless stated
3 over two years, more in longer term
4 CHD is coronary heart disease
5 unless contraindicated

Fur further information on the prevalence and detection of long term conditions see Southwark Annual Public Health Report 2010.

12. We have made some good progress on Long Term conditions across the borough in recent years. Improvements include:

- Increase in numbers of patients on diabetes and COPD registers by 10% in 12/13 from the previous year, following incentivisation of case finding in primary care

- Improvements in the management of diabetes care, as measured by biological markers of glycaemic control Quality and Outcomes Framework data for 2012/13 indicates that 68% of Southwark's diabetes register had a hba1c of less than or equal to 8 (64mmol/mol). This was above the London average of 66% and Southwark moved from the fourth national quartile to the second national quartile for the first time for this key measure.

- Reductions in admissions for patients with COPD following investment in respiratory specialist therapists aligned to the Homeward service

- Significant transfer of the care of diabetic patients out of hospital and into primary care and community based clinics. There has been a 16% reduction in diabetic new outpatient attendances at KCH and GSTT between 2011/12 and 2012/13 and an 8% reduction in follow ups over the same period. Reductions in GP initiated referrals into secondary care have continued to reduce in 2013/14.

- Extension of the Community Multi-Disciplinary Team (CMDT) model to accept referrals of patients under 65 with one or more long term conditions

- Development of the Health Checks programmes so detection of people with long term conditions is increased, and there are opportunities for primary prevention of cardiovascular and respiratory disease.

13. Social Care and the CCG held a workshop on Integration in November, which explored the vision for the future integration of services in Southwark. Key outcomes from the workshop were:

- Endorsement of locality/neighbourhood working as the focus for developing integrated care across the borough

- The need to develop more data sharing and use IT solutions to enable integration

- Support for the development of CMDTs as a way of co-ordinating care for the elderly and those with long term conditions

- Desire to develop more pooled budgets to support shared assessments and decision making

- Agreement to develop a narrative for integration for endorsement by the HWB and to support use of the Integration Transformation Fund

14. The Southwark and Lambeth Integrated Care Programme (SLIC) has selected Long Term conditions as one of its priorities. The SLIC workstream on LTCs has not yet really got going, although it has done some work on optimising medicines for people with Long Term conditions, including poly-pharmacy support.

15. The Diabetes Modernisation Programme has been working on diabetes care in Lambeth and Southwark over the last three years and has made a number of recommendations on future service models and on supporting self-management. Those recommendations include developing a wider range of self-management resources, that are offered in a co-ordinated way alongside co-ordinated care.

KEY ISSUES FOR CONSIDERATION

16. There is an emerging vision in Southwark for the development of locality or neighbourhood services as a way of integrating services across the borough. To help build community networks and a more personalised approach, we will organise health and care services on a neighbourhood model around groups of primary care practices. This means that doctors, nurses, social workers, therapists and home carers will be able to build a strong set of relationships and work in a more integrated way, with common objectives to improve health outcomes for their local population and to offer a good experience that promotes better quality of life for local citizens.

17. This model is consistent both with the CCG's Primary and Community Care Strategy, and also with the emerging model of Community Multi-Disciplinary Teams (CMDTs) that has been developed as part of the SLIC work on frail elderly.

18. A detailed model for integrated neighbourhood services for LTCs is still under development and will need to reflect emerging SLIC work on Long Term Conditions. The proposal in this paper is that we develop a model of integration for LTCs that builds on the features of our emerging integration model for the elderly and develops integrated services around neighbourhoods. The proposed model would address the key elements of the commissioning approach to LTCs outlined in section 1.

19. This paper recommends that a model of integrated care for LTCs in Southwark would have the following key features:

- A pro-active and preventative approach, based on continuity of care delivered through GP practices working with neighbourhood health and social care services. Within this, GPs would be commissioned to provide a bundle of services covering identifying, assessing, case managing and providing care for LTCs, and be incentivized to deliver better quality care in relation to LTCs.
- Joint working between primary care, community nursing and social care to deliver care plans for people with LTC

- Integration of community nursing and primary care at neighbourhood level
- A single model of assessment and care co-ordination, with CMDTs acting as the means of organizing multi-disciplinary care for people with more complex needs
- The development of CMDTs to include more specialist medical input where this is required to meet individual's needs. This may need to be facilitated by the innovative use of web-based support and development of integrated IT solutions and better data sharing
- A generic approach to self-management which supports the delivery of personalized care, including support services commissioned in a co-ordinated way across the CCG and Local Authority
- Greater integration between mental health and the physical health of people with long term conditions
- Community based services for LTC management providing evidence-based care out of hospital, building on existing best practice models of community clinics for diabetes, CVD and respiratory, but encouraging these services to support greater case management and multi-disciplinary team working
- Community hubs such as the one planned in Dulwich are developed to bring together diagnostics, peer support and education, and specialist community clinics in one place, providing co-located and holistic approach to LTCs
- Develop approaches to optimizing the use of medicines to control LTCs, including supporting users to understand and take their medicines in line with best practice treatment advice, poly-pharmacy reviews and access to specialist support from primary care prescribers in the management of LTC prescribing

Policy implications

20. To take forward this vision of integrated care we will need to consider whether further organisational integration at provider or budget level is required, or whether we can achieve the desired level of integration through joint commissioning and operational closer working between agencies.

21. Outcomes for integration will need to be developed in consultation with residents and other stakeholders. It is recommended that these outcomes should be consistent with the outcomes agreed for the Integration Transformation Fund, although addition LTC related outcomes may need to be developed.

Community impact statement

22. The CCG has undertaken an equalities impact assessment as part of its work on Primary and Community Care Strategy. The assessment found that the CCG's plans would have a positive impact on health equalities, particularly the plans to develop locality based models of care. The Primary and Community Care Strategy includes plans to improve access to all patients by commissioning the same service offer from all localities, and to support improvements in the quality of care through sharing resources and good practice, and collective models of incentivisation.

Legal implications

23. None at this stage.

Financial implications

24. The financial implications of developing this model will need to be fully scoped. The expectation is that it would be provided from within existing resources and would need to also demonstrate ability to reduce overall expenditure over time to help in delivering CCG and LA balanced budgets.

25. The Council and CCG should consider how the future costs of delivering an integrated model of care will be met across the health and social care economy. Financial levers and incentives to deliver our objectives should be considered. In particular, consideration should be given as to whether a pooled or capitated budget would best support the delivery of improved outcomes and integrated team working. These issues are also currently being considered as part of SLIC work on capitated budgets, which the Council and CCG are involved in.

BACKGROUND PAPERS

Background Papers	Held At	Contact
JSNA	www.southwarkjsna.com	
Primary and Community Care Strategy		Tamsin Hooton
Southwark CCG Commissioning Strategy Plan		Andrew Bland
Health and Wellbeing strategy		Kerry Crichlow

APPENDICES

No.	Title
None	

AUDIT TRAIL

Lead Officer	Andrew Bland, Chief Officer, NHS Southwark Clinical Commissioning Group	
Report Author	Tamsin Hooton, Director of Service Redesign	
Version	Final	
Dated	6 December 2013	
Key Decision?	No	
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	**Comments Sought**	**Comments Included**
Director of Legal Services	No	No
Strategic Director of Finance and Corporate Services	No	No
Strategic Director of Children's and Adults' Services	Yes	Yes
Date final report sent to Constitutional Team		6 December 2013