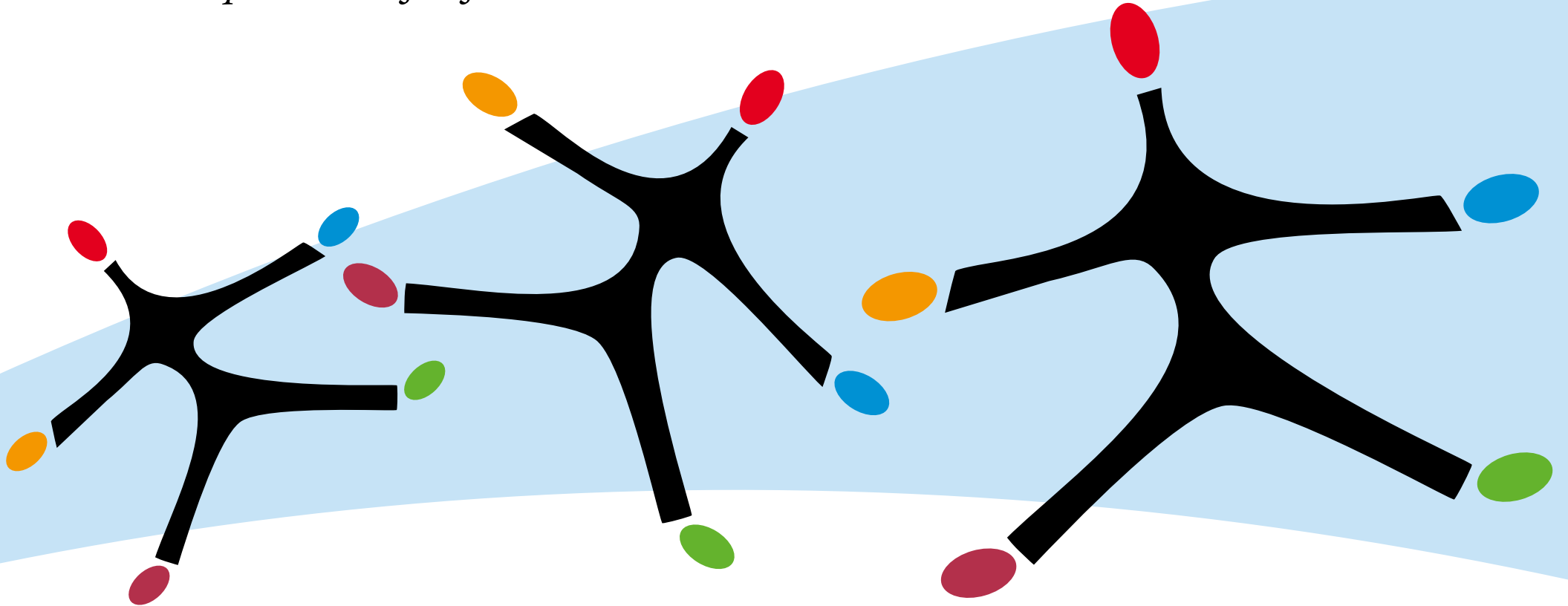


Raising the Profile of Long Term Conditions Care

A Compendium of Information



DH INFORMATION READER BOX

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Description	This document updates the first compendium of information on LTCs, published in May 2004. It will further inform all those who are involved in both commissioning and providing care and support services for people with LTCs. It focuses on the outcomes that people with LTCs said they want from services and describes how more effective management of LTCs in a number of areas is delivering high-quality, personalised care.
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Raising the Profile of Long Term Conditions Care

A Compendium of Information

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“Delivering improvements for people with long term conditions isn't just about treating illness, it's about delivering personalised, responsive, holistic care in the full context of how people want to live their lives. Our journey to achieve this has started, our challenge is to continue to take it forward and the evidence compels us to do this.”

David Colin-Thomé,
National Director for Primary Care

“The best care and support is delivered by professionals working together as part of teams to meet the needs of communities, groups and individuals. There are huge benefits for everyone – NHS, local authorities, third sector, but most of all for all of those people whose lives can be transformed by being given the support that's right for them.”

David Behan,
Director General for Social Care

Section **One**

Introduction

Who should read this compendium?

This document updates the first compendium of information on long term conditions (LTCs), which was published in May 2004,¹ with the latest available evidence.

We hope that it will further inform all those who are involved in both commissioning and providing care and support services for people with LTCs. We think it includes noteworthy messages, particularly for commissioners of care, about the continuing importance of improved management of LTCs.

It also focuses on the outcomes that people with LTCs have said that they want from services and describes how more effective management of LTCs in a number of local communities is delivering high-quality and personalised care. Finally, it summarises the key systems and levers that are crucial to driving forward further improvements in care for people with LTCs.

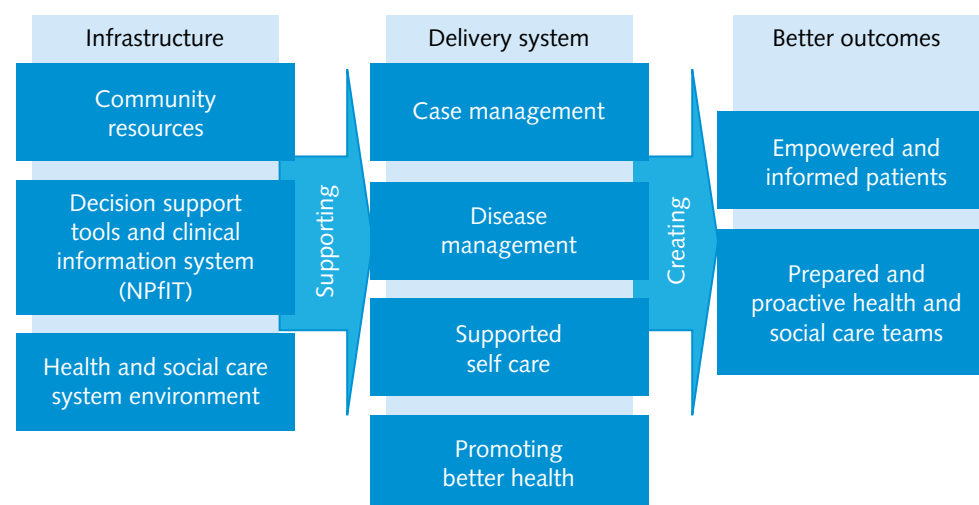
Overview

The latest evidence 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 due to 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.

The Long Term Conditions Model published in January 2005² provides a framework to help local health and social care communities improve the care of people with LTCs.

The NHS and Social Care Long Term Conditions Model



Section **Two**

High-level outcomes for people with long term conditions

In recent consultations,³ people have voiced their opinions about what matters most to them in the care and the services they receive. A number of common themes and key messages have emerged.

People want services that will support them to remain independent and healthy and have increased choice. They want far more services to be delivered safely and effectively in the community or at home; and they want seamless, proactive and integrated services tailored to their needs. These views have been taken into consideration to draw up the following high-level outcomes for people with long term conditions (LTCs):

- 1. People have improved quality of life, health and well-being and are enabled to be more independent.**
- 2. People are supported and enabled to self care and have active involvement in decisions about their care and support.**
- 3. People have choice and control over their care and support so that services are built around the needs of individuals and carers.**
- 4. People can design their care around health and social care services which are integrated, flexible, proactive and responsive to individual needs.**
- 5. People are offered health and social care services which are high quality, efficient and sustainable.**

Feedback from *Your health, your care, your say* consultation⁴

- Of nearly 1,000 participants at the National Citizens' Summit, 86% of people thought that professionals in their local GP practice should provide more support to help them take care of their own health and well-being.
- Some 61% said that being given more information about their health and the services available to them locally would make a big difference. They particularly want to know more about the availability of social care services.
- Half of all people with LTCs were not aware of treatment options and did not have a clear plan that lays out what they can do for themselves to manage their condition better. As a consequence, a significant proportion of all medicines are not taken as directed.

Department of Health MORI Survey 2005⁵ – supporting statistics

- Some 82% of those with a LTC say that they already play an active role in their care but they want to do more to self care.
- More than 90% are interested in being more active self carers.
- More than 75% say that if they had guidance/support from a professional or peer they would feel far more confident about taking care of their own health.
- More than 50% who had seen a care professional in the previous six months said that they had not often been encouraged to self care.

Section Three

Why focus on long term conditions?

In England, 15.4 million people have a long term condition (LTC)⁶

The Quality and Outcomes Framework (QOF) is the annual reward and incentive programme detailing GP practice achievement results. The QOF awards GP practices achievement points for, among other things, managing some of the most common LTCs such as diabetes and asthma.

QOF 2006/07 prevalence counts⁷

LTC	NUMBER AFFECTED
Coronary heart disease	1,899,000
Heart failure	420,000
Stroke and transient ischaemic attack	863,000
Hypertension	6,706,000
Diabetes	1,962,000
Chronic obstructive pulmonary disease	766,000
Epilepsy	321,000
Cancer	489,000
Severe mental health conditions*	380,000
Asthma	3,100,000

*Severe mental health conditions includes all people with a diagnosis of schizophrenia, bipolar affective disorder and other psychoses.

LTCs are those conditions that cannot, at present, be cured, but can be controlled by medication and other therapies. The life of a person with a LTC is forever altered – there is no return to ‘normal’.

Other LTCs also include:

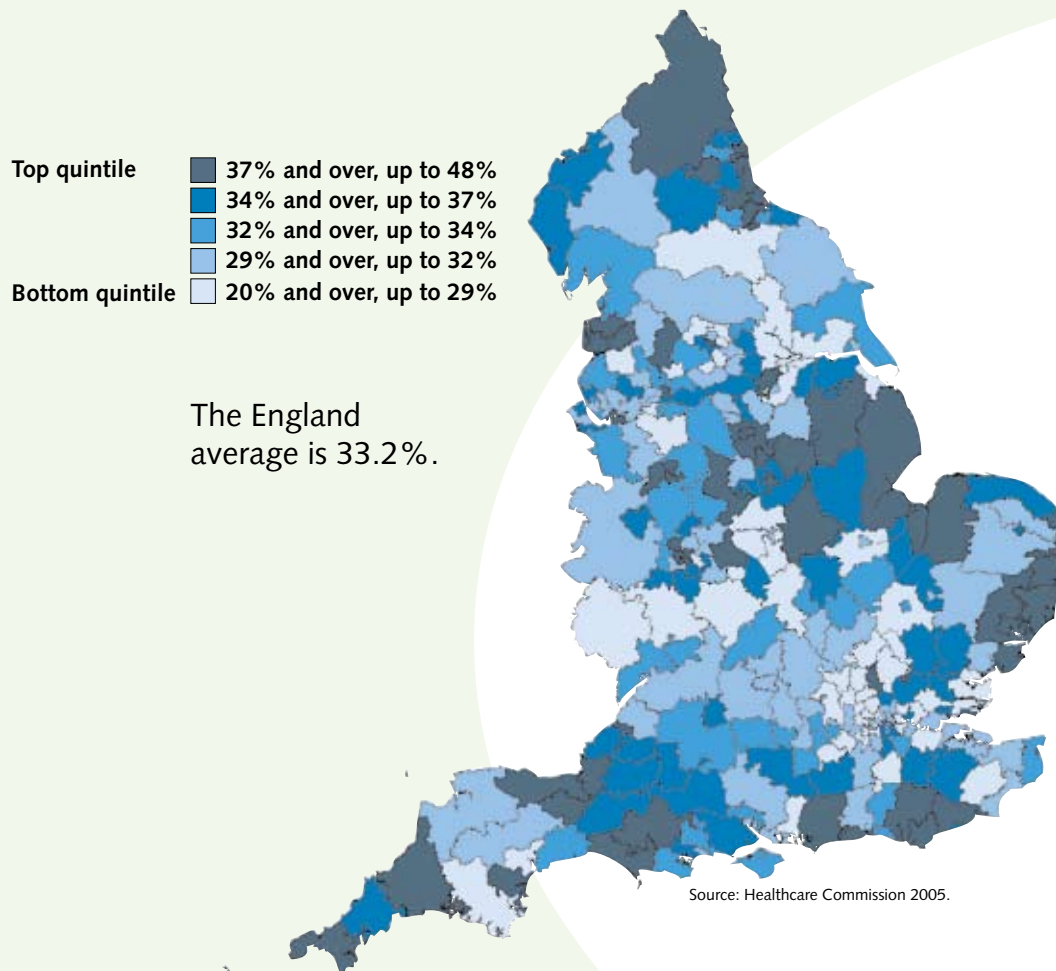
- chronic kidney disease
- dementia
- schizophrenia
- depression
- multiple sclerosis
- Parkinson's disease.

Please note that all data in this section refers to England unless otherwise stated.

There are significant variances in the prevalence of LTCs

Current prevalence of LTCs in England

Percentage of population suffering from a LTC, by PCT



Prevalence of LTCs varies across regions. There is no single factor that has a significant correlation with prevalence, suggesting that there are a number of factors driving the variations, including age, socio-economic status, lifestyle choices and rurality.

Age is the most significant driver of prevalence of LTCs

The probability of having a LTC increases with age, as the graph indicates.

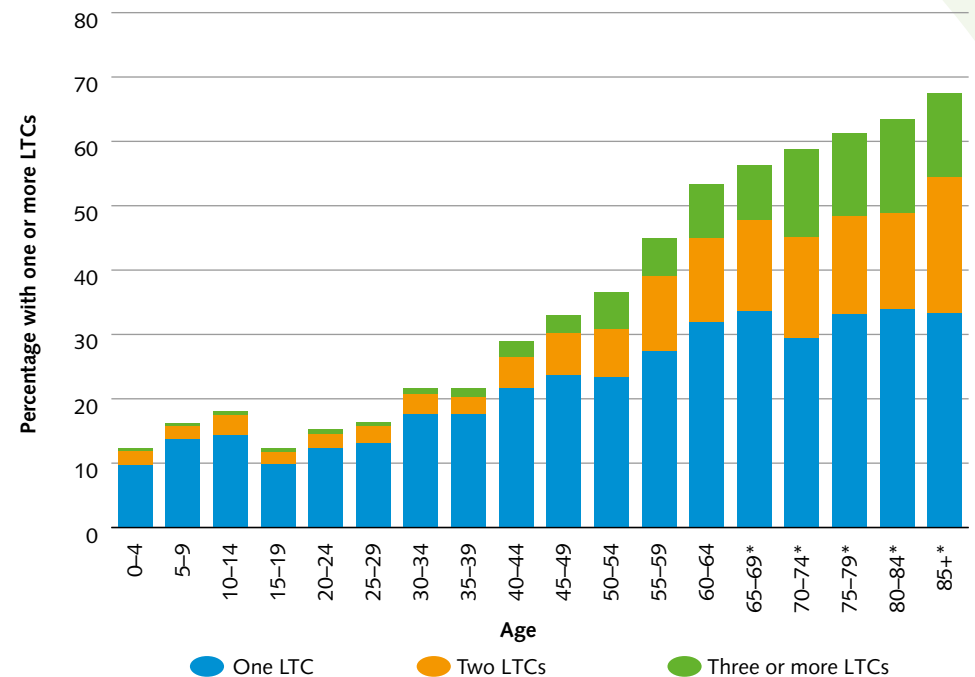
- Some 17% of those aged under 40 say they have a LTC.
- Some 60% of those aged 65 and over say they have a LTC.

The ageing of our society is driven by a number of factors, including:

- ageing of the baby boom generation
- the increase in life expectancy
- reductions in birth rates.

Health and social care systems need to consider the effect of the ageing population on the future demands on resources.

Proportion of people with LTCs by age



Sources: General Household Survey 2005 and population census estimates 2004 for England.

* For those aged 65 or over an adjustment has been made using 2001 census data to account for those living in communal establishments.

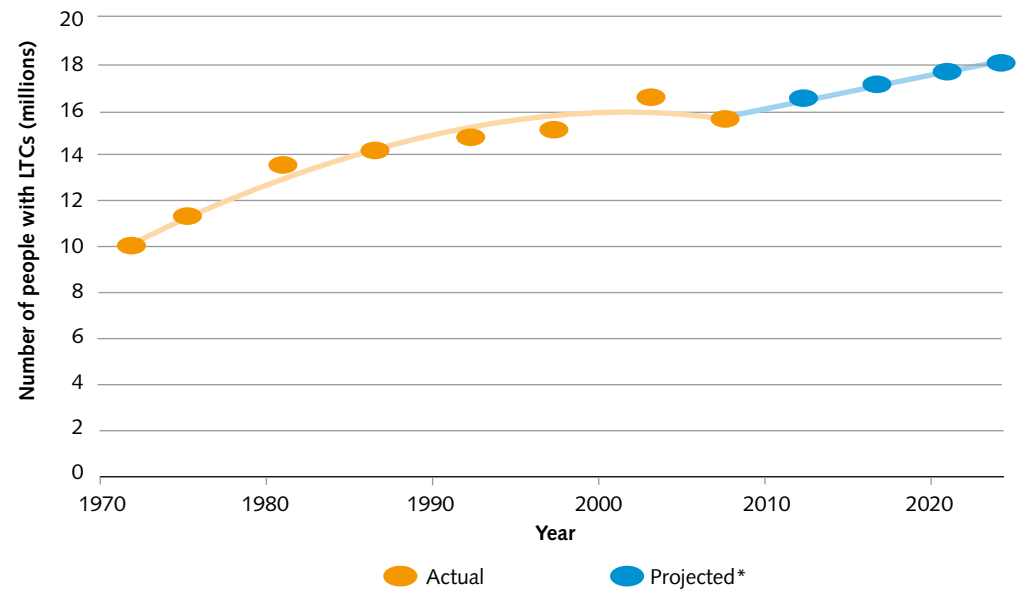
The number of people with a LTC will continue to grow

Future prevalence of LTCs

Due to an ageing population, it is estimated that by 2025 there will be 42% more people in England aged 65 or over. This will mean that the number of people with at least one LTC will rise by 3 million to 18 million.

Health and social care services will need to be responsive to meet this increase in demand and focus more on earlier detection and better prevention – all key to improving health outcomes for people with LTCs and providing more cost-effective care.

Number of people with at least one LTC in England



Source: General Household Survey 2005 for England.

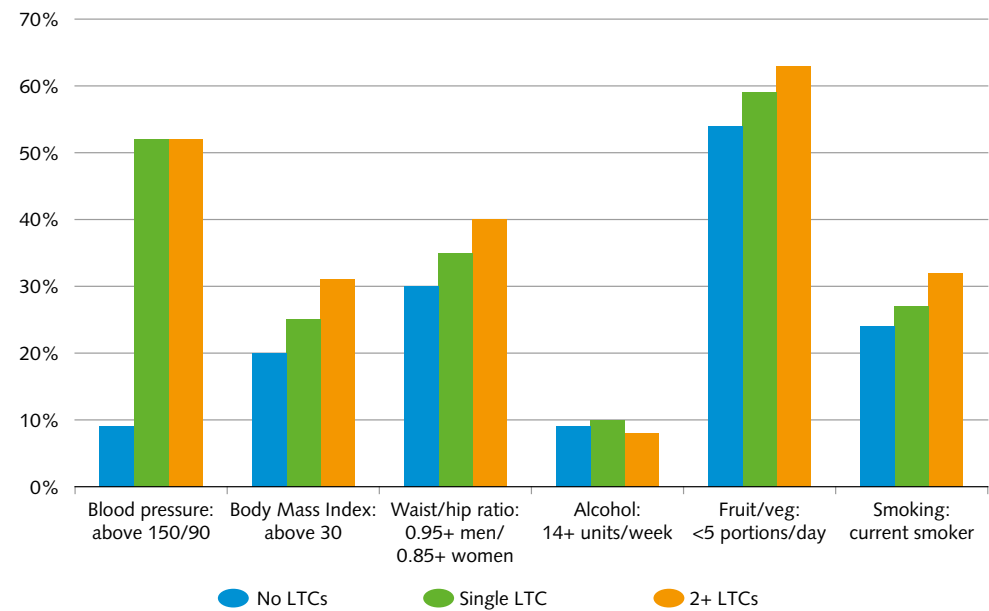
* The projected figures take into account the ageing of the population but not increases in risk factors such as obesity.

People with LTCs should be supported to make healthier lifestyle choices

The greater an individual's sense of self worth, the more they will want to take care of their health and the more likely they are to work and become socially included.

We need to promote the benefits of healthier lifestyle choices and support people to make those choices.

Risk factors and lifestyle choices by number of LTCs



Source: Health Survey for England 2005 (age-adjusted rates).

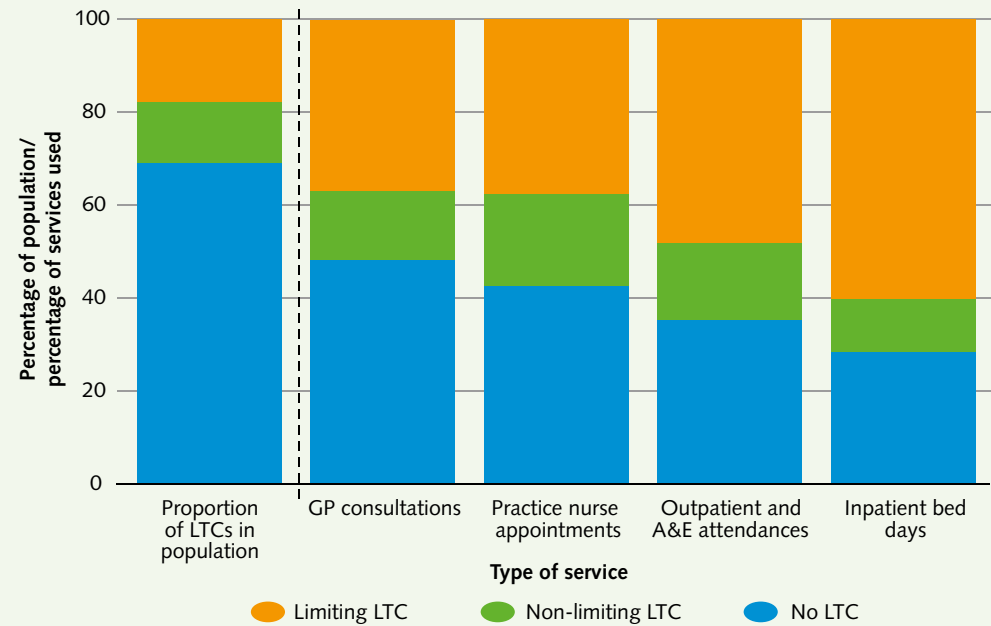
People with limiting LTCs are the most intensive users of the most expensive services

People with LTCs use disproportionately more primary and secondary care services, and this pattern will increase over time with an ageing population.

Over 30% of all people say that they suffer from a LTC. This group accounts for 52% of all GP appointments, 65% of all outpatient appointments and 72% of all inpatient bed days.

Better LTC management, including improvements in clinical care and support for self care, should lead to reductions in the proportion of services used.

Use of primary and secondary services by people with LTCs



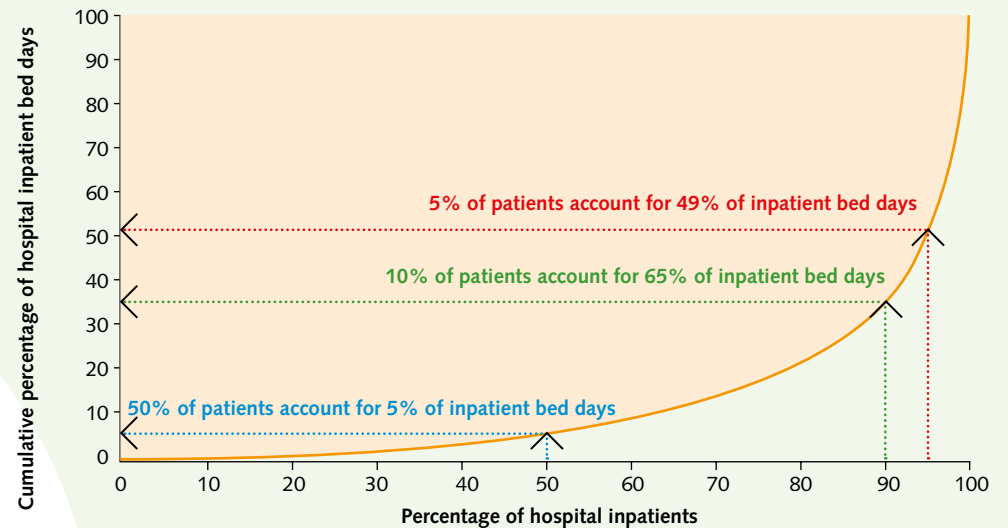
Source: General Household Survey 2005 for England.

A small number of people account for a very high proportion of healthcare resources

With better management of LTCs, including support for those with the most complex needs, unplanned hospital admissions can be reduced and length of stay shortened.

Only 5% of inpatients account for 49% of all inpatient bed day usage.

Percentage of those admitted as inpatients by cumulative days spent as inpatients



Source: Hospital Episode Statistics 2005/06 for England.

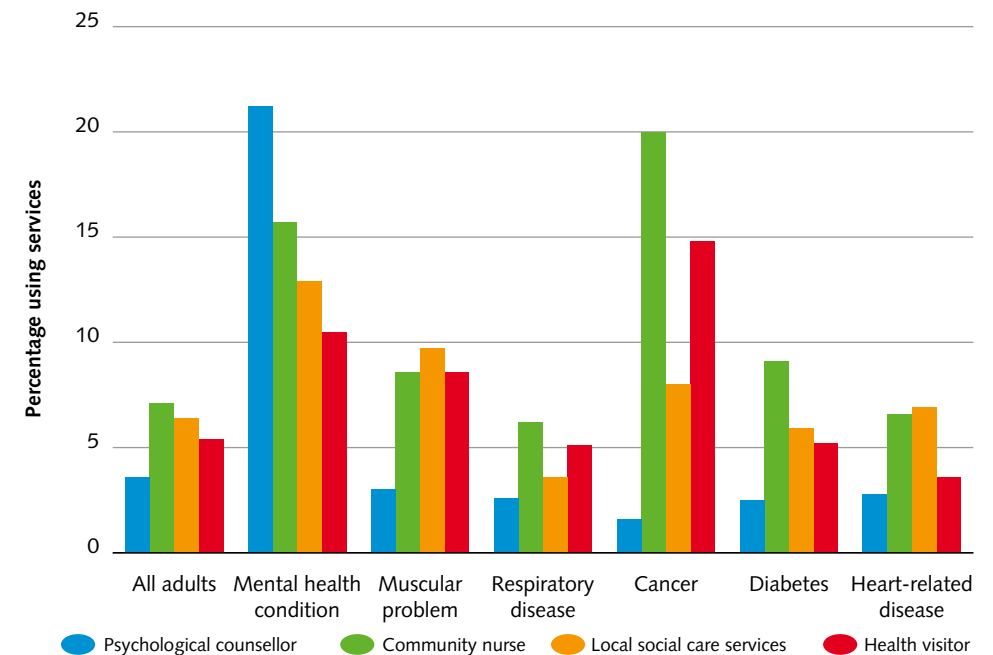
And people with LTCs are high users of social care and community services

People with LTCs are high users not just of primary and specific acute services, but also of social care and community services.

- People with mental health conditions are particularly high users of these services, being twice as likely to have used local social care services in the last six months and almost three times as likely to have used community nurse services.
- Those with other LTCs are also more intensive users of services; for example, those with cancer, muscular problems and diabetes are all more likely to have used community nurse services.

Assessing current and future predicted needs is crucial for providing responsive and proactive services. For example, people with mental health needs should have access to appropriate interventions such as assertive outreach or crisis resolution teams.

Use of specific social care and community services by those with LTCs



Source: Usage and Attitudes Survey 2005/06 for England.

People with LTCs account for a significant and growing amount of health and social care resources

The Department of Health's best estimate is that the treatment and care of those with LTCs account for 69% of the total health and social care spend in England, or almost £7 in every £10 spent.



Looking at social care expenditure, this too is focused on those with LTCs and will be put under pressure by the ageing population. By 2022:

- The proportion of those aged 65 and over will increase by 37% to 10.8 million.
- The number of people aged 65 and over with some disability will increase by 40% to 3.3 million.
- The number of disabled older people with informal care (in households) will rise by 39% to 2.4 million.
- The number of people in residential care homes will increase by 40% to 280,000.
- The number of people in nursing homes will increase by 42% to 170,000.

This need for social care will mean that by 2022:

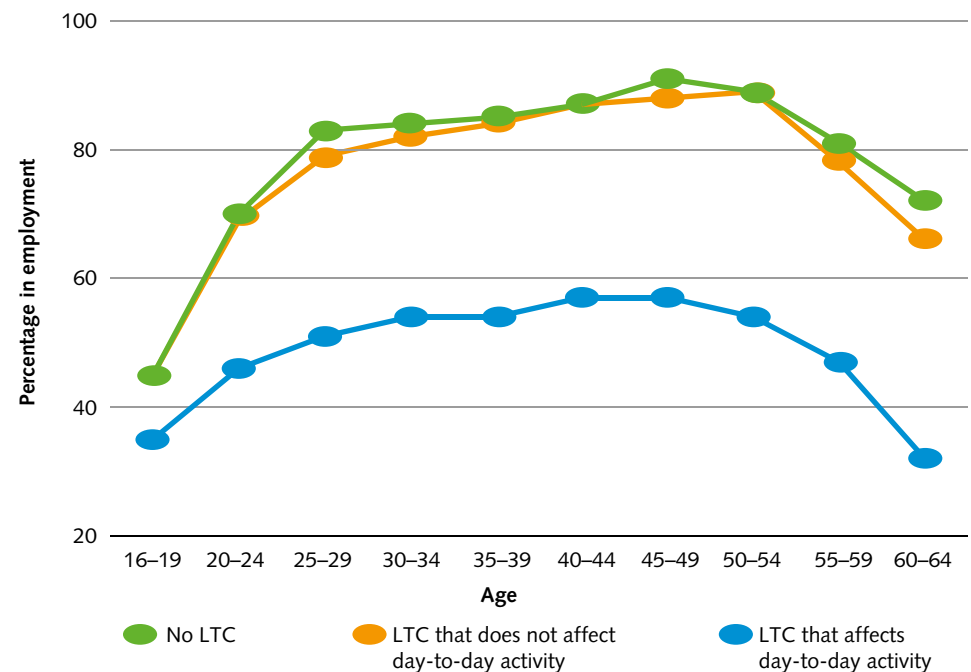
- Public expenditure on long term care will rise by 94% to £15.9 billion.
- Total long term care expenditure is forecast to rise by 103% to £26.4 billion. This is equivalent to a rise from 1.4% to 1.8% of GDP.⁸

People with a limiting LTC are less likely to be in work

The graph to the right shows the potential limits of those with LTCs to gaining employment. Over all ages, people with a LTC that affects their day-to-day activity are over twice as likely to be out of employment compared with those without LTCs.

Being out of work is detrimental to people's health, and can lead to poor mental health and increased psychological distress. People who are out of work in the long term are twice as likely to suffer from depression, three times as likely to suffer from anxiety and have an increased likelihood of suicide. Not only does this have a significant impact on the NHS and social care, figures also suggest that LTCs place a significant limit on the potential to gain employment.

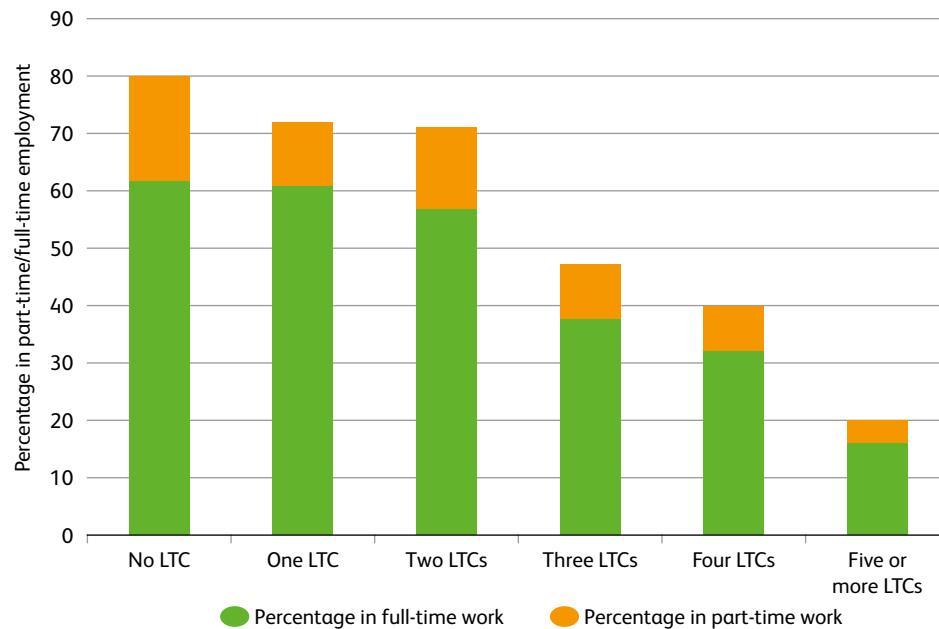
The effect of LTCs on gaining employment



Source: Labour Force Survey 2006 for England.

As the number of LTCs increases so does the likelihood of not working

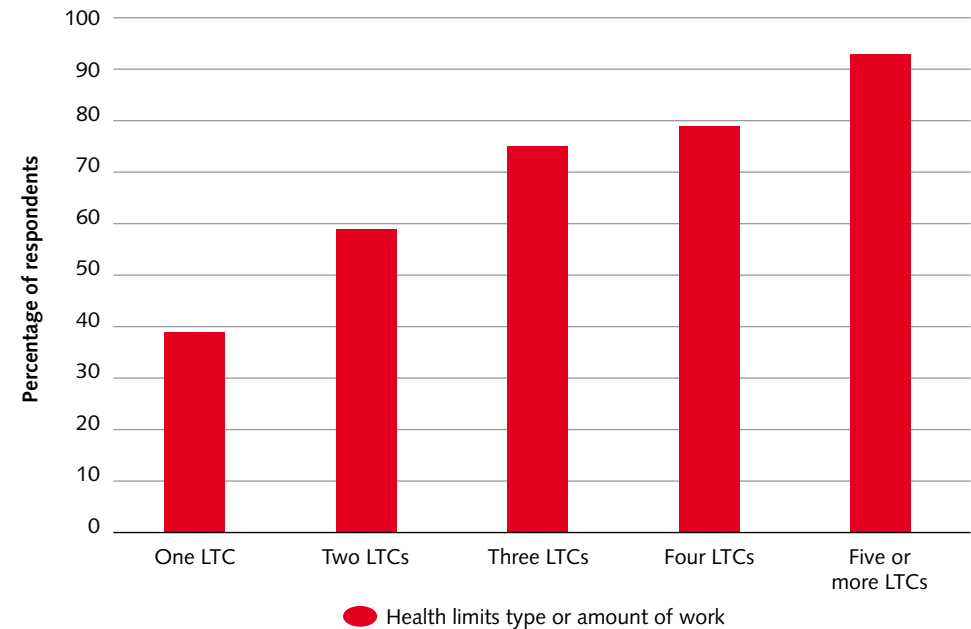
Proportion of working age people in employment by number of LTCs



Source: Labour Force Survey 2006 for England.

- The percentage of people in employment falls significantly as the number of LTCs increases.
- Less than 50% of those with three LTCs are in employment.
- Less than 20% of those with five or more LTCs are in employment.

Percentage of respondents to the Labour Force Survey who cited that their LTC(s) affected the type or amount of work they undertook

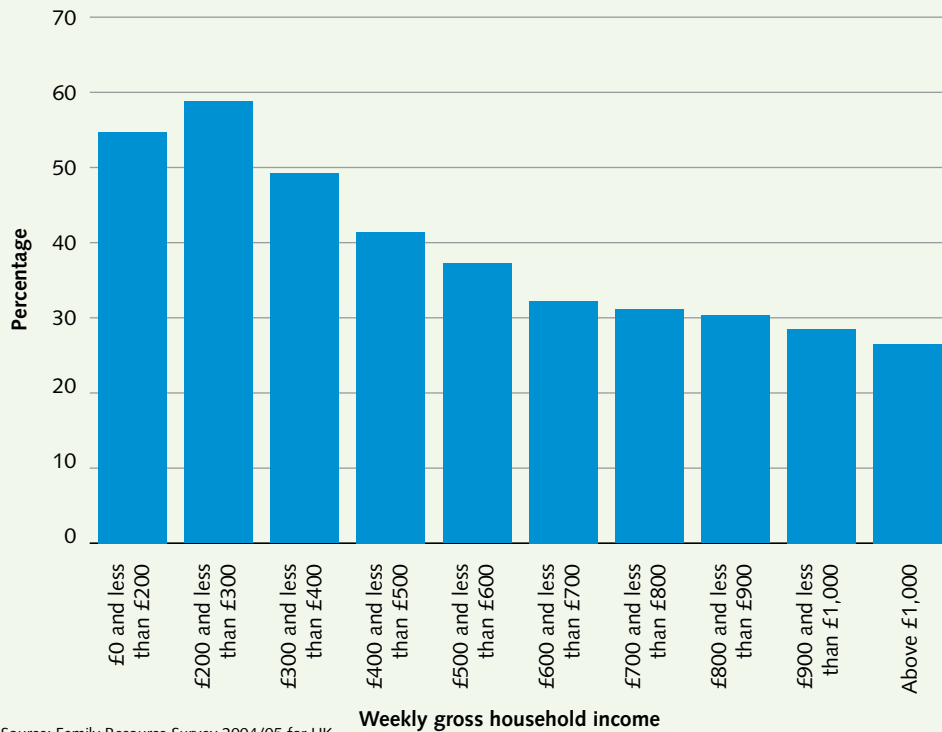


Source: Labour Force Survey 2006 for England.

- Having a LTC limits the amount or type of work that people are capable of.
- The more LTCs a person has, the more limited they become.
- Nearly 40% of those with only one LTC state that their condition affects their work.

Households containing someone with a LTC are more likely to have low incomes

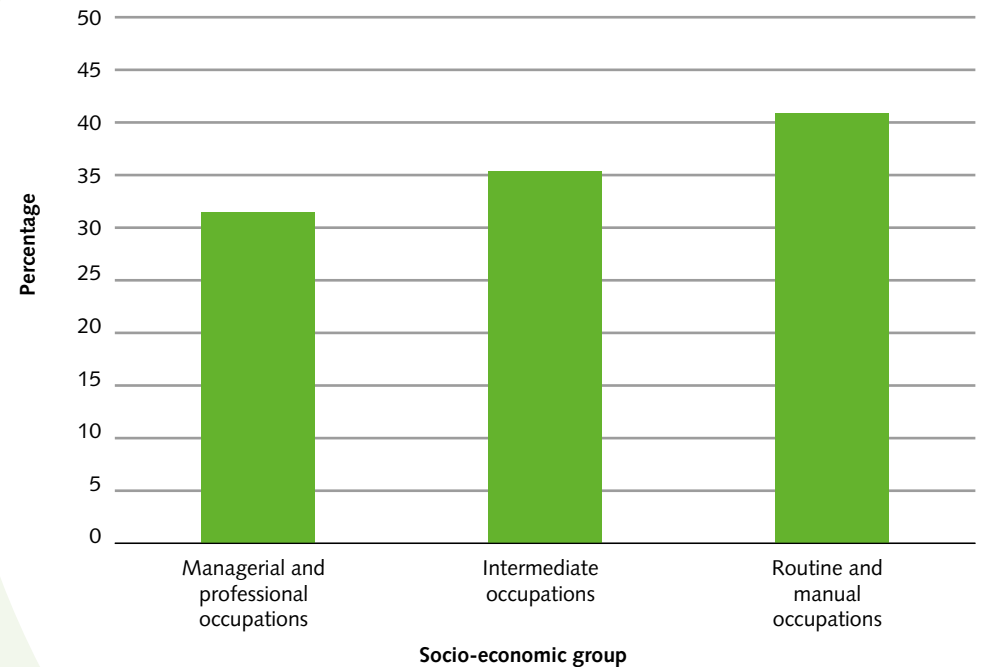
Percentage of households with a member who has a LTC, by income group



Source: Family Resource Survey 2004/05 for UK.

Households with weekly incomes of between £0 and £300 are twice as likely to contain a member with a LTC compared with those with a weekly income of over £1,000.

Percentage of households with a member who has a LTC, by socio-economic group



Source: General Household Survey 2005 for England.

The prevalence of LTCs varies between socio-economic groups. Those who have never worked or are long term unemployed are 10% more likely to have a LTC compared with those with managerial and professional occupations.

Section **Four**

Examples of local achievements

There are some excellent examples of innovative, forward-thinking initiatives across the country as local health and social care communities are adapting the national long term conditions (LTC) model for their local populations and circumstances. In this section are some examples of local achievements that are making a real difference.

Self care

Self care and self management are more than giving people information about their condition. They are about acknowledging their central role in managing their own care and supporting them and their family and carers to manage their condition as effectively as possible. Self care is a well proven and highly effective means of improving LTC care.

Birmingham OwnHealth

Birmingham OwnHealth is a partnership between Birmingham East and North Primary Care Trust (PCT), Pfizer Health Solutions and NHS Direct, to deliver proactive telephone-based healthcare support – ‘care management’ – to individuals with LTCs in Birmingham. The service aims to support people with cardiovascular disease, heart failure and diabetes to take a more active and informed role in managing their own health. There are consistently high levels of satisfaction reported from patients and professionals involved in the service.

A 20-year-old man was in denial about his diabetes. He hadn't told anyone about his condition, drank heavily when out socialising, rarely measured his blood sugars and had not seen his GP in 18 months. Following support and advice from his care manager, he now regularly monitors his blood glucose, is in regular contact with his GP, has moderated his alcohol intake and has explained his condition to his family and friends.

What was achieved in the first six months

Achievements included full demographic, clinical and utilisation history being supplemented by clinical uploads and Hospital Episode Statistics. For the first 506 enrollees, 52% improved their diet, 22% began exercising more within a 49-day period and there were significant reductions in cholesterol levels.

These outcomes have further improved over the course of the first year and will be presented as part of the evaluation of Birmingham OwnHealth. Interim analysis indicates significant improvements in enrolled patients' self efficacy and health behaviours and improvement in some clinical indicators such as cholesterol.

Patients feel the benefits of being weather-wise

An award-winning project to support the forecasting of weather conditions that may exacerbate respiratory disease symptoms reduced hospital admissions of those with chronic obstructive pulmonary disease (COPD) by 82%. The project, which ran from 2004 to 2006 at Chilcote Surgery in Torquay, was supported by the Met Office, Torbay Care Trust and the Improvement Foundation.

COPD patients were presented with special information packs, including room thermometers and a guide to action they could take to avoid their symptoms worsening and requiring professional intervention. The practice developed a COPD register to identify those most at risk and appointed a specialist nurse co-ordinator to make it easier and quicker to communicate with patients. For information, contact the Improvement Foundation Assistant Director, Alison Stephens, on 01803 861886 or email alisonstephens@nhs.net

Disease management

Proactive disease management can make a real difference to people with a single condition or a range of problems that impact on their health and well-being. Implementation of the National Service Frameworks is already demonstrating that this approach can have a radical impact on outcomes for individuals. Good disease management involves identifying needs early and responding promptly with the right care and support. Personalised care planning actively supports this approach.

Improving disease management for diabetes – care planning case report

Care planning is changing the way diabetes care is being delivered in North Tyneside and Northumberland to enable people with diabetes to be more involved in decisions about their care.

Clinics have been reorganised so that patients have their tests performed and are informed of their results before the care planning consultation. This gives the patient a chance to think about what the results mean to them and they are encouraged to make a note of any questions or concerns they want to discuss at their appointment. Their concerns may or may not be related to their results – the care planning review is a holistic consultation that focuses on diabetes but also encourages discussion of other health concerns.

Healthcare professionals have been trained to elicit the patient's agenda, agree priorities and set goals and action plans in collaboration with the patient.

The original pilots were performed in Burn Brae, a general practice in Hexham, as well as at a specialist diabetes clinic at North Tyneside General Hospital. An evaluation of 70 patients indicated very high levels of satisfaction with the process (there was a 91% response rate: 98% reported finding it helpful to have the results before the consultation; 98% felt more involved in decision making).

This approach has subsequently been successfully implemented in a number of local diabetes clinics across both primary and specialist care.

One patient said: "I have found it very helpful. I think the main benefit is getting all the facts gathered beforehand. You can then go into the consultation and know what you're talking about. Everything's up to date and you can decide which points to discuss and what you can do to improve things."

Dr Simon Eaton, Consultant Diabetologist, led the pilots and said: "The process is certainly valued by patients, but also by the professionals in the clinics as a better way of doing diabetes care. Everyone who has tried it has carried on doing it. It's fantastic."

For further details of these service developments and care planning in diabetes, please contact Dr Simon Eaton at simon.eaton@nhct.nhs.uk

Disease management and end of life care

In 2002, Bradford City, South West and North PCTs each appointed a heart failure nurse specialist (HFNS). The nurses formed a team whose aim was to support people at home following a hospital admission for heart failure. None of the nurses appointed had specialist palliative care experience, but they made early links with the local specialist palliative care services. One of the palliative care consultants has been involved with the HFNS team from its outset. In 2003, the team established a support group for people with heart failure and their carers, which has received excellent feedback from participants. It has become clear that the HFNS team is itself capable of co-ordinating excellent end of life care for the majority of people. Additional support often just takes the form of telephone advice from a palliative care consultant or a Macmillan nurse.

Bradford's experience demonstrates that high-quality palliative care can be provided by HFNSs with support from the existing specialist palliative care services. This support can be provided at a modest cost in terms of time and resources. For further details, contact Anne Williams at anne.williams@bradford.nhs.uk

Case management

Some people have an intricate mix of health and social care needs and simple problems can cause their condition to deteriorate rapidly, putting them at risk of unplanned hospital admission. Evidence has shown that intensive, ongoing, personalised case management can improve quality of life and outcomes for such people.

Case management, led by a community matron or a case manager, has been rolled out as part of the LTC strategy. PCTs have been encouraged to undertake local evaluation of this service – below are a couple of examples.

Luton PCT

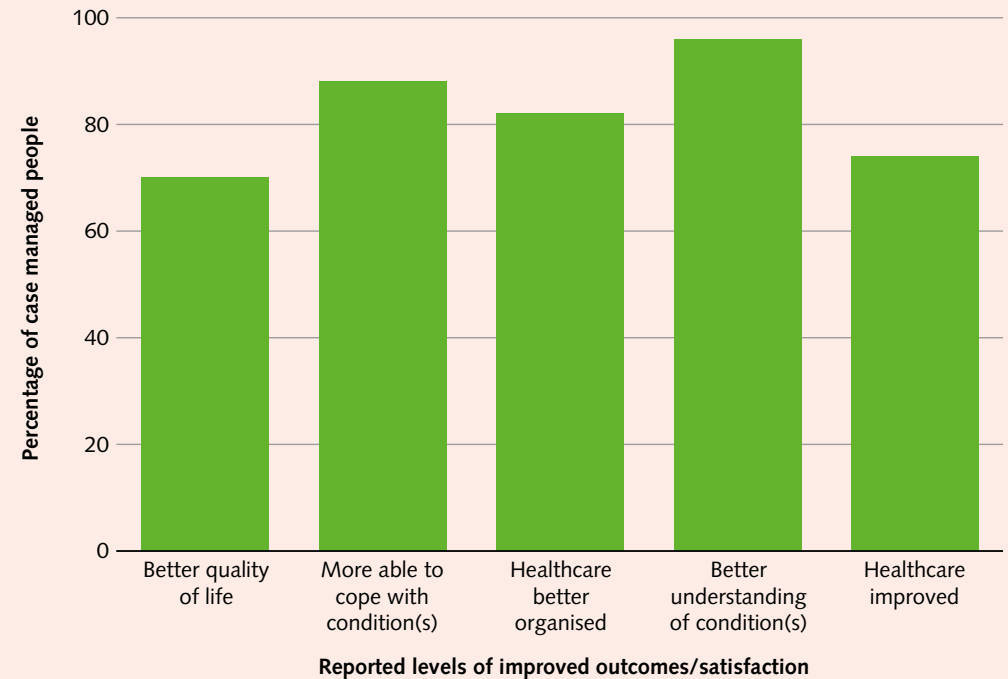
Luton undertook an evaluation of its case management service, looking at levels of improved patient outcomes and satisfaction and efficiency savings from reductions in emergency bed days. The PCT had 12.8 full-time equivalent community matrons who had an average caseload of 50 to 70 people. The PCT used a combination of the Patients at Risk of Re-hospitalisation (PARR) tool and their own threshold referrals for identifying those considered at risk of repeated admission to hospital. Those identified were offered the case management service.

The PCT's local evaluation of the service found:

- a net cost saving of £81,000 per community matron (cost per matron = £74,000 (which includes administration, IT and management costs); saving from reduced inpatient admissions = £154,000 per community matron)
- a fall in the average length of stay in hospital from 14 days to 6 days
- high levels of improved outcomes and patient satisfaction (see chart).

For further details, contact Ian Winstanley at ian.winstanley@luton-pct.nhs.uk

Luton PCT: Levels of improved outcomes and patient satisfaction for case managed patients



Note: The graph shows a reflection of the percentage of people who responded positively to issues such as improved quality of life and understanding of their condition.

Patient and carer views on their community matrons⁹

"She got onto the services and got the hand rails. We bought the stair lift – they said we can have assistance with costs but it would take 12 months. So we bought it because I wasn't prepared to wait. The community matron sorted out the chair in the shower and hand rails at the top of the stairs, and it was very helpful. She did get a lot organised for us."

Female patient and carer, Walsall

"She is in a special position because she comes round and knows my case in detail, to find out what I am capable of doing and what I like doing."

Male patient, Leeds

"All the anxiety has gone. I don't feel trapped in a pit, a helpless bottomless pit."

Male patient, Walsall

"I don't worry so much about Mum as I did when she first came because I've learned the signs from [the matron] showing me."

Female patient and carer, South Birmingham

Multidisciplinary teams

People with LTCs, in particular those with a range of complex needs, often require care or support from a range of different professionals and agencies. Bringing these together into multidisciplinary teams is therefore critical as it underpins a co-ordinated, seamless approach to delivery of care and support, avoiding fragmentation, confusion and duplication of effort. The case study below illustrates this.

Professional identity in multidisciplinary teams

The Tremeduna Team in Sedgefield, County Durham has worked for the past three years as an integrated, multidisciplinary locality team. This evolved from collaboration between social services in Durham County Council, Sedgefield PCT and Sedgefield Borough Council. A system was envisaged in which natural communities across the area were each served by an integrated locality team. A design team was set up, a project manager appointed and a number of work streams established. After 18 months of planning, the Tremeduna Team came into existence, followed by the four other teams that now serve the district.

Implementation

When the Tremeduna Team went live, it consisted of 9.3 full-time equivalent (FTE) nursing staff, two FTE qualified social workers and one FTE social work assistant, one housing support officer, one community partnership manager and three business support officers. Staff were in a single location, they used a single assessment process and a single client recording system, took referrals via a single point of contact and were to be assessed on a single set of performance measures.

The points below summarise some of the views of the Tremeduna Team:

- All staff are more understanding and knowledgeable about each other's roles.
- The single assessment process has been a steep learning curve for all, but now everyone is contributing and it is adding to the richness of the assessment.
- A flexible joint approach is taken to all referrals (social care, health or housing) – this leads to a far superior service to the patient/client.
- We have been able to encourage innovation.
- There is a shared ownership of what we do.
- We create work for each other but that actually means that we are doing some pretty brilliant preventative work – in spite of the tension between a universal health service and eligibility moderated by fair access to care.

For further information, please contact Ann Workman, Community Partnership Manager, Tremeduna Integrated Partnership Team, at ann.workman@cdpct.nhs.uk, or Jeremy Pickard, Project Officer, North East Strategic Health Authority, at jeremy.pickard@northeast.nhs.uk

Self directed care

Individual budgets and direct payments can improve people's lives, giving them more choice and control over services. They can also give people more purchasing power by bringing different sources of funding and support together in one place. There are currently individual budget pilots in 13 local authorities.

Barnsley – Every Adult Matters

Barnsley PCT and adult social services are taking forward their vision for adult health, independence and well-being through their strategy 'Every Adult Matters'. This aims to shift the balance of power, responsibility and control to the individual through self directed support. It moves away from traditional, often paternalistic and professional controlled care to services that support the individual. Health and social care support for individuals will be based on a model of maximum self assessment, self managed care and use of individual budgets.

Evidence shows that this type of model results in true client-focused services with improved outcomes for health and well-being. Individuals own their care record, determine who (if anyone) will help them and what services they want. This fully supports outcome-based commissioning led by individuals.

The Barnsley model is part of a whole system approach that includes education, employment, housing, community well-being and public health. Underpinning this are strong health and social care partnerships, for example integrated adult and children's services, joint appointment of directors of adult social services, a joint public health department and pooled budgets.

Individual budgets in Barnsley

The Self Directed Support Team in Barnsley has captured some of the experiences of people who are using individual budgets to direct their own support in order to learn more about the programme and ultimately improve people's lives. Below is one of the individual stories that they have captured.

Amy has found that directing her own support has made a big difference to her ability to continue to live as active a life as possible.

I am a 91-year-old lady. I am very independent and intellectual. I worked full time as a lecturer until I retired. My health took a downward slide after having a series of falls and I started to need more extensive care. I went to a residential home to have some rehabilitation – I felt like a fish out of water, my health started to get really poor and I felt sad and lonely.

A social worker mentioned direct payments to me and she arranged for someone from the Direct Payments Support Service to come and talk to me. I decided it was a good idea and went ahead to get it organised so I could get on with my busy life. I employ two carers: one who lives in, and my direct payment pays for an agency. Having a direct payment has really made a difference to my life – it has enabled me to keep my independence. Because of the direct payment and the care I purchase privately, I feel alive and look forward to the future. I teach my classes and remain in my own home. In 2006, I got the Queen's Award for voluntary work I have done in Huddersfield.

For further details on Every Adult Matters and individual budgets in Barnsley, contact Martin Farran at martinfarran@barnsley.gov.uk

Health, work and well-being

The Welfare Reform Green Paper – *Pathways to Work: Helping people into employment* – sets out a strategy for enabling people with health conditions to move into and remain in work. Pathways to Work, launched in April 2003, provides an opportunity for a groundbreaking partnership between the Department of Health, the Department for Work and Pensions (DWP), Jobcentre Plus, the NHS and the private and voluntary sectors to work together to deliver a range of choices, one of which is the Condition Management Programme (CMP).

The programme was initially delivered in seven pilot sites across the UK: Bridgend Rhondda Cynan Taff; Derby; East Lancashire; Essex; Gateshead; Renfrew; Inverclyde, Argyll and Bute; and Somerset, although there are now a further 21 sites using this mode of delivery. From April 2008 Pathways to Work and CMP will be available across the whole of the UK, delivered by the private and voluntary sectors.

The Lancashire CMP

The CMP in Lancashire, established in 2003, was one of the seven initial national pilot sites for Pathways to Work. CMP uses a number of mental and physical health interventions, delivered by healthcare professionals working within Jobcentre Plus offices. The aim of the programme is to provide support in managing mild to moderate long-term health conditions, in order to facilitate a return to work. The programme is voluntary, evidence-based and has a clear outcome focus in the management of mental health, musculoskeletal and cardiorespiratory conditions.

Based on a bio-psychosocial model of assessment, CMP is a 13-week, self help-based programme. Participants work with a case manager to identify deep-seated barriers to work, such as anxiety and lack of confidence, resulting in an agreed and personalised action plan to help them achieve their goals.

Findings 2005–07 (primary diagnosis)

The primary diagnosis is recorded as either mental health, musculoskeletal, cardiorespiratory or other. However, many participants have a dual diagnosis of two or more of the above. Presenting symptoms as described by the participants, usually with a long history of unsuccessful NHS treatment, include: chronic depression (29%); chronic pain (20%); anxiety (16%); brain injury/epilepsy (2.5%); and chronic fatigue syndrome/fibromyalgia (2%).

Results

Initial assessments and outcome well-being measures (SF-12, the standardised health measure) show statistically significant improvements in perceptions of general health, mental health, pain, vitality, and physical and social functioning.

Benefits of CMP include:

- It demonstrates the effectiveness of the bio-psycho-social approach.
- It strengthens self care and partnership approaches in health and other services.
- It provides a platform for returning to work.
- It provides a learning environment for students and healthcare professionals.

For further information on the CMP in Lancashire, please visit www.lancscmp.nhs.uk or contact the team on 01254 226426.

For further information on welfare reforms and updates, visit www.dwp.gov.uk

Section **Five**

The national strategic direction

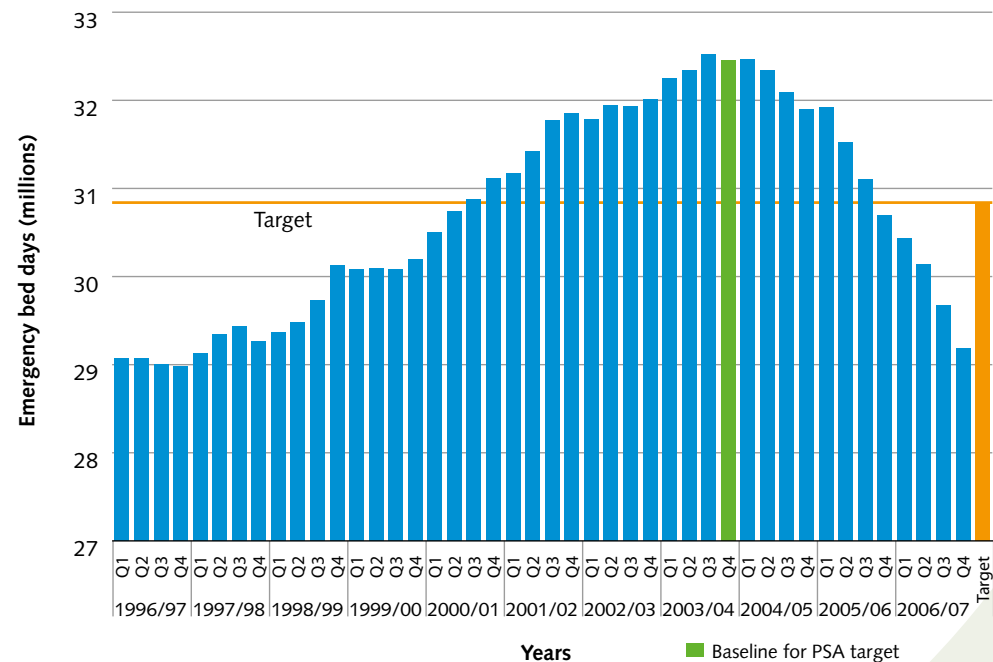
Achievements in reducing emergency bed days

The LTC strategy has been driven by a PSA target:

To improve health outcomes by offering a personalised care plan for vulnerable people most at risk, and to reduce emergency bed days by 5% by 2008 through improved care in primary care and community settings.

NHS and social care organisations have made a major impact in reducing emergency bed days by 10.1% in 2006/07 over the baseline year 2003/04, meaning that the target reduction of 5% has been significantly over-achieved. The data tells us that reductions in mental health and circulatory bed days have driven this, which suggests that the National Service Frameworks are having a positive impact across the country. Continued efforts and reform are crucial to maintain these improvements in care across all parts of the country and to sustain the bed day reductions in the future.

Annual emergency bed days



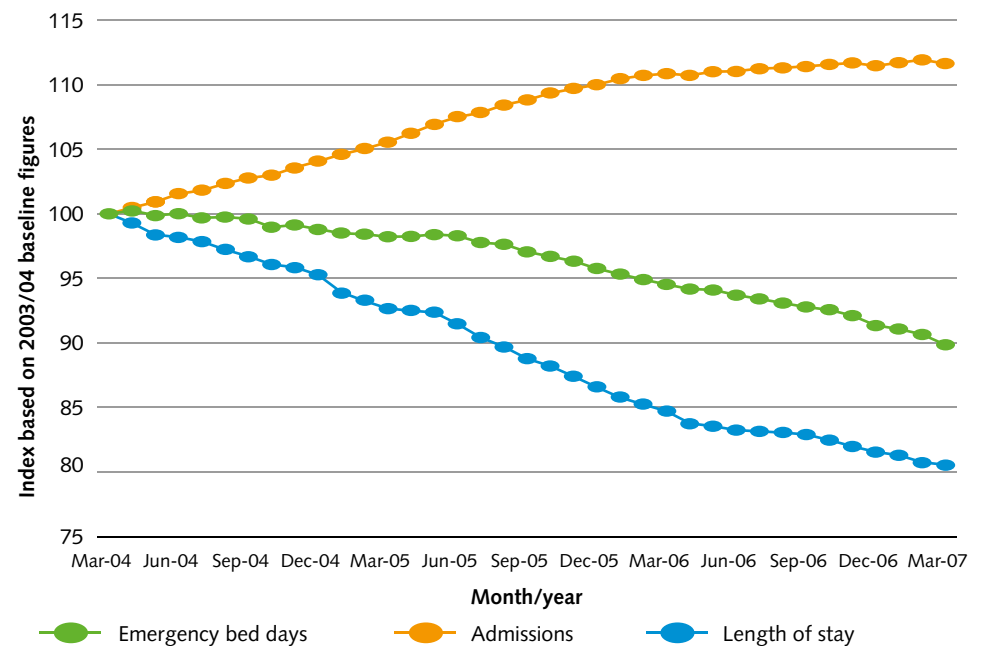
What is the future direction?

The information in this compendium strongly reinforces the need for a continued emphasis on improving care for people with LTCs which goes far beyond the 2008 PSA target. The foundations for transformational change that are being embedded now must continue, if health, social care and third sector partners are to meet the demands on resources in the future.

Departmental Strategic Objectives and LTCs

The 2007 Comprehensive Spending Review sets the Department of Health's vision and strategic objectives for health and adult social care services for the period 2008/11. It combines national strategic direction setting and accountability framework through Departmental Strategic Objectives (DSOs) and a small number of PSAs.

Trends in emergency bed days, admissions and average length of stay



Reductions in emergency bed days have been driven by falling lengths of stay. Emergency admissions are continuing to rise; however, the rate at which they are rising has been steadily declining and this has continued over 2006/07.

DSOs 2008/11

- **Better health and well-being for all** – helping people to stay healthy and well, empowering people to live independently and tackle health inequalities.
- **Better care for all** – the best possible health and social care, offering safe and effective services, when and where people need help, and empowering people to make choices.
- **Better value for all** – delivering affordable, efficient and sustainable services, contributing to the wider economy and the nation.

Improving care for people with LTCs can help deliver all three of these objectives; however, it sits predominantly under the objective 'Better care for all'.

The following indicator has been set to measure improvements as part of the National Outcomes Framework:

For people with LTCs, improving their satisfaction with the support they are given to be independent and in control of their condition and reducing the number of emergency bed days.

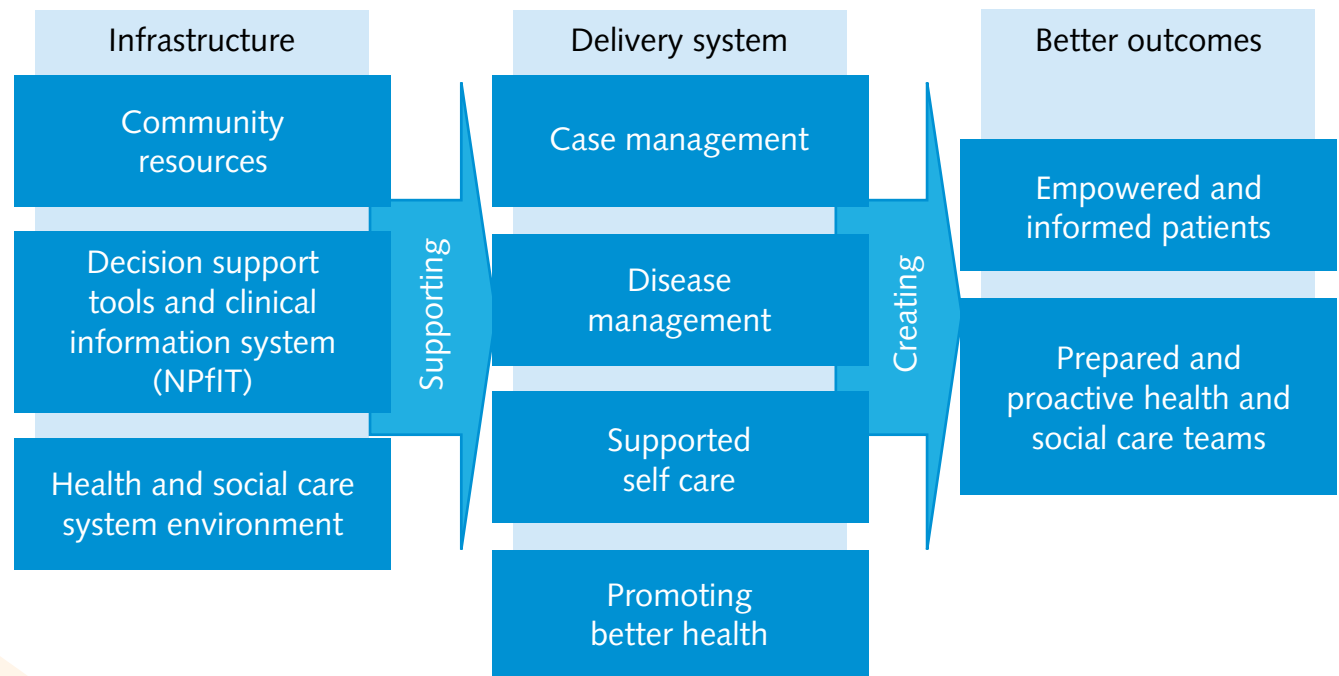
In addition, the Department of Health is considering how health and social care organisations might measure the impact their LTC management programmes are having in achieving all of the outcomes described in section 2.

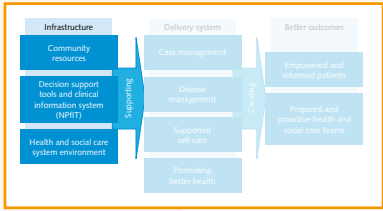
Section Six

Taking it further forward – how to deliver the outcomes for people with long term conditions

Delivering the outcomes for people with long term conditions (LTCs) described in section 2 requires wholesale change in the way health and social care services deliver care and support, particularly given the predicted increase in the number of people with LTCs.

This section summarises what health and social care communities can do and the underpinning systems and levers that they can use to deliver these outcomes.





What can health and social care communities do?

Service re-design – primary care, secondary care and community care services providing more services in the community.

Develop IT systems that can support information sharing – build on the evidence-based guidelines for the treatment of LTCs and incorporate them into IT systems.

Primary care trusts and local authorities joining at strategic level – forming Local Strategic Partnerships and developing joint commissioning posts, pooled budgets and joint public health departments. Undertaking joint strategic needs assessment and joint commissioning – not forgetting to engage across the board, e.g. including the third sector, employment and housing. Use of Local Involvement Networks.

Partnership working and collaboration at all levels – PCTs, GP practices, primary and secondary care and the acute sector. Integrated working between health and social care, which includes multidisciplinary teams to create a more holistic approach for providing services around the needs of individuals.

Infrastructure

Community resources

Decision support tools and clinical information system (NPfIT)

Health and social care system environment

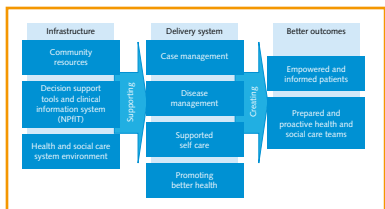
Remember the three Rs: registration, recall and review. The NHS is well placed on registration but could do more to improve recall and review. The use of good quality information can support strategic needs assessment and better commissioning, including risk stratification, prevention and targeting interventions earlier and more appropriately. IT should support integrated care records and care planning and the monitoring of the quality of care.

Use of the Quality and Outcomes Framework to incentivise and drive improvements.

National Strategic Frameworks and National Institute for Health and Clinical Excellence guidance help create the framework for decision support.

Supporting

Taking it further forward – how to deliver the outcomes for people with long term conditions



Use of risk prediction tools such as PARR⁺⁺ and the Combined Model to stratify risk – providing case management to high risk individuals identified. Evaluate case management and adapt locally.

Personalised care planning is important for good disease management – providing information and self care/self management support to prevent deterioration and complications in later life.

Self care and self management always being an integral part of care planning for everyone.

To promote healthy lifestyles by ensuring that the self care support is in place for people to make healthier choices about diet, physical activity and lifestyle, for example reducing alcohol intake and smoking cessation.



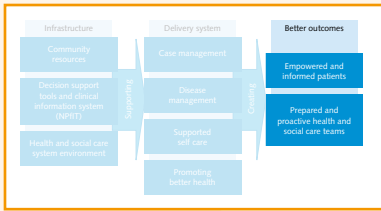
A whole-system approach to support case management – such as fast access to diagnostics, good out-of-hours cover, good partnerships between primary, secondary and social care and multidisciplinary team working.

Person centred and integrated assessment and care planning will benefit those with complex needs who require more intense levels of planning and co-ordination of services – with crisis planning for exacerbations.

Use of specialist nurses or other specialist teams – proactive, timely interventions.

Access to self care tools, monitoring equipment and assistive technology – as well as information and support for their use. Access to self care skills training programmes and courses and self care support networks.





1. **People have improved quality of life, health and well-being** and are enabled to be more independent.
2. **People are supported and enabled to self care** and have active involvement in decisions about their care and support.
3. **People have choice and control over their care and support** so that services are built around the needs of individuals and carers.
4. **People can design their care around health and social care services** which are integrated, flexible, proactive and responsive to individual needs.
5. **People are offered health and social care services** which are high quality, efficient and sustainable.

Better outcomes

Empowered and informed patients

Prepared and proactive health and social care teams

There is join-up at strategic level – e.g. Joint Strategic Partnerships, Joint Commissioning Boards, Joint Strategic Needs Assessments and Local Area Agreements.

There is joint planning and shared goals based on outcomes.

Multidisciplinary team working is common practice.

Some of the system levers that health and social care communities can use to support people with LTCs



What about the workforce?

How can the workforce contribute to delivering the outcomes for people with LTCs?

Service transformation and use of the right systems, levers and incentives are needed to make a difference, but the NHS and social care workforce is **crucial** to delivery of better LTC care and supporting people to achieve the outcomes they want.

By having:

- the right skills, knowledge and competencies to
 - communicate effectively
 - identify people's strengths and abilities
 - advise on access to support networks
 - promote choice and independence
 - enable people to manage identified risks
 - provide relevant and evidence-based information
- the right approaches, systems/structures and processes to support
 - partnership working across all agencies – health, social care, community and third sectors

By having:

- the right attitudes and behaviours, which are
 - encouraging
 - supportive
 - professional
 - advisory
 - respectful
- provision of care/services that deliver person-centred outcomes.

And finally...

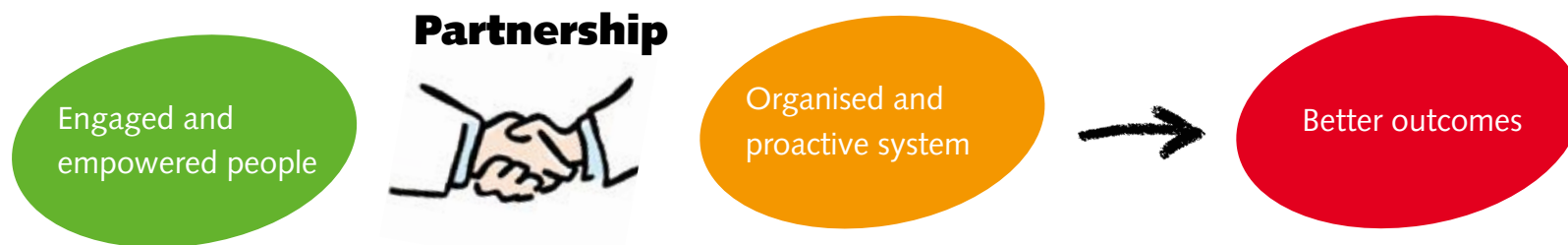
The evidence tells us that the prevalence of LTCs is not going to decrease – **it is estimated that by 2025 there will be 18 million** people whose lives will be affected by long-standing illness.

It is therefore crucial to think longer term, to plan accordingly to meet needs both now and in the future and to ensure efficient use of health and social care resources.

This is not about applying short term solutions – investing now will reap benefits later...for example:

Investing in self care will reduce GP visits by between 24% and 69% and hospitalisation by 50%.

Successful outcomes for people with LTCs require a partnership between engaged, empowered individuals and a proactive responsive and integrated system.



Long Term Conditions Programme
"adding life to years and years to life"
www.dh.gov.uk/longtermconditions



Annex A – Supporting tools/publications

The following publications and tools are available to help local health and social care communities deliver improved care for people with LTCs:

Self care:

- *Supporting People with Long Term Conditions to... Self Care. A guide to developing local strategies and good practice* published in February 2006 sets out the philosophy behind supporting self care together with key actions for health and social care economies.
- *Questions to Ask* is a series of prompts and tips to ensure patients get the best out of their appointments with professionals. This supports the principles of self care and shared decision making, and helps overcome communication barriers. Copies available from dh@prolog.uk.com reference no: 279234.
- The White Paper *Our health, our care, our say: a new direction for community services* published in January 2006 focuses very strongly on the role of self care support for people with longer term needs.

Disease management:

- There are National Service Frameworks (NSFs) covering coronary heart disease, cancer, mental health, older people, diabetes, long term neurological conditions, renal services, children and paediatric intensive care and chronic obstructive pulmonary disease (in development). Available at www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/DH_4070951
- The Disease Management Information Toolkit (DMIT) – a free web-based tool, designed to help organisations strengthen their approach to disease management. Available at www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Longtermconditions/DH_074772
- The White Paper *Our health our care our say* includes commitments to provide integrated care plans for those with complex needs by 2008 and for everyone else with a LTC by 2010. Care planning guidance is planned for 2007.

Case management:

- Case management competences framework for the care of people with long term conditions is available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4118101
- Caring for people with long term conditions: an education framework for community matrons and case managers www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4133997
- How a community matron can help you with your long term condition www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4133998
- Supporting people with long term conditions: Liberating the talents of nurses who care for people with long term conditions www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4102469

Risk prediction tools:

- The **Patients at Risk of Re-hospitalisation** (PARR+) software algorithm uses hospital inpatient data and is free for use by NHS organisations to systematically identify patients who are at risk of repeated admission to hospital. A further developed tool, PARR++ will be released at the end of 2007.
- The **Combined Predictive Model** uses both hospital and community data to predict not only those at risk of repeated re-admission, but also those at risk who have never had an admission. The model stratifies risk across the whole population, allowing more timely and appropriate interventions.
- PARR+ is available at www.kingsfund.org.uk. Information about how to implement the Combined Predictive Model can also be found on the King's Fund website.

References

- 1 *Chronic disease management: A compendium of information*, DH, May 2004.
- 2 *Supporting People with Long Term Conditions – An NHS and Social Care Model to support local innovation and integration*, January 2005.
- 3 *Our health, our care, our say: A new direction for community services*, DH, January 2006; *Building on the best: Choice, responsiveness and equity in the NHS*, DH, December 2003; *Independence, well-being and choice: Our vision for the future of social care for adults in England*, DH, March 2005; *The NHS Plan*, DH, July 2000.
- 4 *Your health, your care, your say: Research report*, Opinion Leader Research for DH, January 2006.
- 5 DH MORI Survey: Public Attitudes to Self Care Baseline Survey, February 2005.
- 6 General Household Survey, 2005.
- 7 Quality and Outcomes Framework (QOF) 2006/07. More information on QOF prevalence counts can be found at www.ic.nhs.uk
- 8 Personal Social Services Research Unit, *Future Demand for Long-Term Care, 2002 to 2041: Projections of Demand for Long-Term Care for Older People in England*, March 2006.
- 9 Department of Health qualitative services evaluation pilot on the case management of LTCs, April 2007.



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