

## **10. LONG TERM CONDITIONS PLANNING FRAMEWORK**

### **10.1 Analysis of Local Position**

- 10.1.1 In Renfrewshire, responsibility for local planning of services relating to long term conditions is led by the Professional Executive Group (PEG) underpinned by the work of our GP Forum, Rehabilitation and Enablement Managed Care Network and Renfrewshire Diabetes Group. Our local plans are developed within the context of NHSGGC Long Term Conditions, Community Rehabilitation & Enablement and Primary Care Frameworks and the associated steering groups and Managed Care Networks (MCNs). In addition our work is supported by the Long Term Conditions Collaborative and our local joint planning group for Single Shared Assessment and Care Management.
- 10.1.2 The PEG is chaired by the Clinical Director with the aim of promoting a multi agency and cross system approach. Our aim is to work in partnership between the CHP, Acute Division, Renfrewshire Council, Voluntary Sector and service users and carers to plan to meet the priorities and service models required to deliver improvements in outcomes for people living with long term conditions. This is undertaken with a focus on general practice, pharmacy, optometry and dentistry.
- 10.1.3 Establishment of an extended Professional Executive Group (ePEG) with associated terms of reference and implementation plan was delivered in 2009. Specific responsibilities include:
- Ensuring improvements in health and wellbeing of people with long term conditions with an emphasis on addressing inequalities supported self care, disease specific care management and care management. The agreed priority diseases are Diabetes, Coronary Heart Disease, Chronic Obstructive Pulmonary Disease (COPD) and Asthma.
  - Optimising the role of community pharmacists in medicines management particularly through the development of the chronic disease management service.
  - Ensuring coordination with our main stream services including district nursing, AHP and adult mental health services.
  - Ensuring comprehensive monitoring and reporting arrangements in respect of change progress and outcomes.
  - Continuing to develop our infrastructure in relation to learning and education, premises and information technology.
- 10.1.4 The Renfrewshire Diabetes Group was established in June 2007. This is a joint primary and secondary care group, working to a comprehensive work plan which has delivered a community based diabetes team, a detailed service specification and performance indicators, an agreed patient pathway across primary and secondary care and a targeted learning and education programme. Our district nursing service plays a significant role in supporting people with diabetes at home. Over the last 2 years we have undertaken a significant programme of improvement work with our GP practices, undertaking an initial audit, subsequently providing targeted specialist nurse and learning and education support then re audited practice. There has been significant improvement across the key clinical indicators however there is a recognition that we can continue to improve outcomes for people with diabetes.
- 10.1.5 During 2010/11 we will, in partnership with the respective MCNs, seek to establish

local groups for respiratory and coronary heart disease.

- 10.1.6 Our Community Respiratory Nurse Specialist works closely with both community and hospital services to improve patient pathways and outcomes. Spirometry services are provided by some of our GP practices and at also at the RAH. People with asthma are managed, in the main, by practice nurses and GP's involving specialist input as required for chronic asthma and COPD. Any hospital admission for asthma is reviewed by the acute Respiratory Nurse Specialist and if required the Respiratory Consultant. Subsequently a patient centred management plan supported by education and self care is agreed with the patient prior to discharge. Currently there are two Respiratory Consultants within the RAH with a planned increase to three as of August 20 10. A 'Breath Easy' patient run support group is provided in the RAH with input from the Respiratory Nurse Specialists. The pulmonary rehabilitation service is now available across NHS GG&C with easy referral routes into the service. The Respiratory Nurse Specialists work closely with our local hospices to support palliative and end of life care.

## 10.2 Numeric Analysis

- 10.2.1 HEAT (Health Improvement, Efficiency, Access and Treatment) Target 2009/10

One of the HEAT targets under the treatment category, is to achieve agreed reductions in the rates of hospital admissions and bed days of patients with a primary diagnosis of COPD, Asthma, Diabetes or CHD, from 2006/7 to 2010/11.

- 10.2.2 Table 1 below shows Renfrewshire's performance for the period October 2008 to September 2009.

**Table 1: Discharge Rates & Bed Days October 2008-September 2009**

Disease	Discharge Rate and Bed Days			
	Discharge Rate Renfrewshire	Discharge Rate GGC	Bed Days Renfrewshire	Bed Days GGC
COPD	457.0	662.8	6.6	5.3
Asthma	140.2	193.7	2.1	2.1
Diabetes	173.1	151.8	5.6	6.0
CHD	1076.0	1183.7	4.0	3.9
Long Term Conditions: COPD, Asthma, Diabetes, CHD	1846.3	2192.0	4.6	4.3

*Discharge rates are shown per 100,000 population*

- 10.2.3 While the Long Term Conditions discharge rate has decreased from 2007/08 (2,053.0 per 100,000 population), the average number of bed days has slightly increased from 2007/08 (4.5). Within Renfrewshire we have two Intensive Care Managers who work with GP practices using SPARRA data to identify those patients at greatest risk of admission and readmission to hospital and to agree how their care might best be augmented to reduce the requirement for hospital admission and/or their length of hospital stay.
- 10.2.4 Table 2 shows current prevalence rates for (COPD), Asthma, Diabetes and Coronary Heart Disease in Renfrewshire and in comparison to NHSGGC and Scotland.

**Table 2: Current Prevalence Rates (from the Quality Outcomes Framework**

	<b>Renfrewshire</b>	<b>Greater Glasgow &amp; Clyde</b>	<b>Scotland</b>
<b>COPD</b>	1.7%	2.3%	1.9%
<b>Asthma</b>	5.3%	5.3%	5.5%
<b>Diabetes</b>	3.7%	3.6%	3.7%
<b>Coronary Heart Disease</b>	4.8%	4.5%	4.5%

- 10.2.5 Renfrewshire figures for CHD deaths in the under 75 year olds living within the 15% most deprived data zones have fluctuated over the last 6 years. In 2002 the figure was 104 per 100,000 population. This increased to 155 in 2004, fell to 91 in 2006 and increased again in 2008 to 130 per 100,000 population. Renfrewshire figures are at variance with the overall Greater Glasgow and Clyde trend, which is showing a gradual reduction from 163 per 100,000 in 2002; 151 in 2004; 127 in 2006 and 113 per 100,000 in 2008.
- 10.2.6 Community care services are provided to 11,500 people in Renfrewshire who need a degree of care and support to lead safe, independent and healthy lives. Over 1,000 older people and adults are in long term care, 2,300 adults receive Care at Home services and 2,000 people receive day care. Renfrewshire's demographic profile will show a significant increase in the population of older people in the next 9 years.
- 10.2.7 Renfrewshire GP Practices perform well in relation to the QOF results for CHD – 99.8% which is slightly above the Scottish results. It is important to note that we are the only CHP without the Local Enhanced Scheme for CHD.
- 10.2.8 The NHSGGC Long Term Conditions Strategic Framework is underpinned by a set of proxy measures for; Care Management, COPD, Asthma, CHD, Diabetes. These measures are being used to determine our current performance and measure progress within Renfrewshire.

### **10.3 Health Gap and Key Issues**

- 10.3.1 The health gap and issues for Renfrewshire are
- There is a significant number of people in Renfrewshire who report living with a long term condition / or disability (21%; n = 36,272). For many this will be life limiting and impact on their employment opportunities and quality of life. In addition this burden of disease place significant demands on health and social work services.
  - The prevalence of long term conditions increases with age. Given the projected increase in the numbers of older people and very old people in Renfrewshire there is a need to increase our efforts on prevention, effective management of complications and promotion of self care.
  - The prevalence long term conditions in Renfrewshire in 07/08 was as follows:
 

Asthma	9433	0.1%	increase on previous year
CHD	8520	0.4%	increase on previous year
Diabetes	6612	6.4%	increase on previous year

COPD      2966    1.5% increase on previous year

- The above data shows an increased prevalence in all 4 diseases with a significant increase in the prevalence of type 2 diabetes well above Scottish increase of 5%. In relation to CHD deaths in people under 75 years in the 15% most deprived data zones the trend in Renfrewshire is upward and well above the NHSGGC rate / 100,000.
- We will continue to improve the provision of smoking cessation programmes, promote increased levels of physical activity and reduce obesity should assist in this. There is a need to build capacity within communities through improved community development work and partnerships with voluntary organisations.
- Significant cultural change is required to fully deliver community rehabilitation and enablement approach with both service users/carers and staff. We will have an explicit focus on cultural change as part of our approach to wider service redesign.
- There is a need to continue to work to reduce bed days in line with HEAT target.
- Renfrewshire is the only CHP which does not benefit from the CHD Local Enhanced Scheme.
- Currently early supported discharge for respiratory disease is not available in Renfrewshire. This has been identified as a priority by the respiratory MCN.

#### 4. Outcomes Table

#### Long Term Conditions

Outcomes	Actions/Activity Required 2010/11	Change/Progress/Performance Indicator
<p>Patients have an improved experience of care and are empowered to be full partners in their care.</p> <p>(LTC Action Plan CEL23(2009)) High Impact Change 1.</p>	<ul style="list-style-type: none"> <li>- Adopt and implement an outcomes-focused approach to assessment, care planning and review for community care, such as Talking Points: Personal Outcomes Approach.</li> <li>- Regularly review outcomes and data generated from individual assessments, care plans and reviews to inform service redesign.</li> <li>- Use the Community Pharmacy Chronic Medication Service to support people to be more involved in managing their own medicines, whether in the community or in hospital.</li> <li>- Develop multi-agency anticipatory care plans for people with Long term conditions that are shared between in hours and out-of-hours services and functionally useful for clinicians.</li> </ul>	<p>Cross Reference to older peoples and disability frameworks. Pilot in Paisley Area Team and in DN Services. Incorporate into DN Caseload Profiling Activity.</p> <p>Monitor implementation and uptake of CMS</p> <p>Develop approach via ePEG</p>
<p>Individuals have a clearer understanding about their condition and their role in managing it which improves patient's capacity to look after themselves.</p> <p>Improve the experience of care by empowering people with Long term conditions to be full partners.</p>	<ul style="list-style-type: none"> <li>- Provide staff with access to the training that ensures that they have the right knowledge, skills and approach to long term conditions care.</li> <li>- Raise awareness of self management amongst NHS managers, practitioners and people living with Long term conditions.</li> <li>- Facilitate integration of health, social care and voluntary sector support for self management to</li> </ul>	<ul style="list-style-type: none"> <li>- Learning and Education Plan</li> <li>- Key component of ePEG work plan</li> <li>- Considered on disease basis work underway re Diabetes, CHD, Asthma and</li> </ul>

### Long Term Conditions

Outcomes	Actions/Activity Required 2010/11	Change/Progress/Performance Indicator
<p>Increase capacity to self manage (LTC Action Plan CEL23(2009)) High Impact Change 2</p> <p>Capacity to support self management is enhanced for COPD, Asthma, diabetes and CHD</p> <p>(LTC Action Plan CEL23(2009)) High Impact Change 3</p>	<p>develop and share best practice.</p> <ul style="list-style-type: none"> <li>- Provide a means for people with Long term conditions to support each other by easily accessing, contributing to and sharing local information.</li> <li>- Disseminate the document supporting people with Long term conditions to Self Manage: Essential guide to multiagency knowledge and skills and support the development of education and resources which enable healthcare workers to develop the awareness, knowledge, skills and values which support self management.</li> </ul>	<p>COPD</p> <ul style="list-style-type: none"> <li>- Monitor through Renfrewshire LTC implementation plan and reporting mechanism to PEG.</li> </ul>
<p>Staff are trained to ensure that they have the right knowledge, skills and approach to Long term conditions care.</p> <p>(LTC Action Plan CEL23(2009)) High Impact Change 4</p>	<ul style="list-style-type: none"> <li>- Identify Core Competencies required for each LTC tier of care together with Identification of individual training needs and delivery of appropriate training.</li> <li>- Review core competencies for staff delivering Self Management and contextualise them in relation to inequality by linking to NES.</li> <li>- Promote the Equality website <a href="http://www.equality.scot.nhs.uk">www.equality.scot.nhs.uk</a> and E-learning modules to staff.</li> <li>- Ensure a workforce culture and values in place which reflects and is aligned with the LTC model.</li> <li>- Appropriately skilled staff deployed in the right mix according to need.</li> <li>- Staff are trained in agreed care management systems, processes and protocols and ensure that each CH(C)P has a documented MDT process for identifying patients appropriate for care management</li> </ul>	<ul style="list-style-type: none"> <li>- A % increase in the number of relevant staff trained in assessment in care management - current baseline to be established in each CHCP area as at October 2009 (aiming for 100% completion by March 2011).</li> <li>- Regular sampling indicates high and appropriate use of documented process against agreed standards.</li> <li>- Evidence from the CHCP that there has been a dialogue with Health Improvement around self management.</li> </ul>
<p>A systematic and integrated multi-agency approach to LTC care is in place across CH(C)Ps.</p>	<ul style="list-style-type: none"> <li>- Agree and implement plans to roll out proactive integrated care management through the CH(C)P areas.</li> </ul>	<ul style="list-style-type: none"> <li>- A 10% Increase in No of integrated care plans in place - current baseline to be established in each CHCP area.</li> </ul>

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Outcomes	Actions/Activity Required 2010/11	Change/Progress/Performance Indicator
<p>(LTC Action Plan CEL23(2009)) High Impact Change 5</p>	<ul style="list-style-type: none"> <li>- Establish a system of early identification of needs and response to problems or deteriorations and identify those at risk of moving up to level 3 to allow an anticipatory approach to disease management.</li> <li>- Provide systematic primary care and specialist healthcare services for people in care homes, including the use of advanced / anticipatory care plans to guide decisions around end of life care.</li> <li>- Evaluate use telehealth and telecare supports, with an emphasis on helping people to self manage their conditions at home.</li> <li>- Establish Renfrewshire CHD and Respiratory Groups in early 2010/11 in liaison with RAH and respective MCNs.</li> <li>- Work with GMS Steering Group to secure CHD LES in Renfrewshire.</li> </ul>	<ul style="list-style-type: none"> <li>- A 10% increase in the number of patients with a care manager identified in each disease area.</li> <li>- Increase no of people receiving ongoing support from community pharmacy (medicines advice, adherence, basic disease management/self care information) - current baseline to be established.</li> <li>- Discharge information- GP satisfaction on the quality, timeliness and amount of information given on discharge (by random sample) to inform discussions on care management of patient and to assist prevention of further admissions.</li> <li>- Increase in the uptake of prescribing change/advice (random sampling including pharmacists).</li> </ul>
<p>Information systems support registration, recall and review for people with multiple conditions,  Data is effectively shared across agencies  (LTC Action Plan CEL23(2009)) High Impact Change 7</p>	<ul style="list-style-type: none"> <li>- Have in place a numeric approach to identify those at risk of unscheduled admissions.</li> </ul>	<ul style="list-style-type: none"> <li>- Intensive Care Managers targeted use of SPARRA with GP practices.</li> </ul>
<p>Deliver efficient and economic services.  Reduction in hospital admissions and bed days of patients with primary diagnosis of COPD, Asthma, Diabetes and</p>	<ul style="list-style-type: none"> <li>- Develop and deliver a comprehensive programme to focus on hospital admission, discharge and usage and identify action to reduce bed days.</li> <li>- Implement rehabilitation and enablement model.</li> <li>- Clear patient pathways are available that are integrated between health and social care.</li> <li>- Ensure services are in place to allow rapid response</li> </ul>	<ul style="list-style-type: none"> <li>- Target 2% reduction each year of Framework.</li> <li>- Continued use of Direct Access Spirometry Service with the management suggestions given in Spirometry reports (COPD).</li> <li>- Continued referral to pulmonary rehabilitation with record of completion</li> </ul>

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Outcomes	Actions/Activity Required 2010/11	Change/Progress/Performance Indicator
<p>CHD.</p> <p>Deliver care in the right setting</p>	<p>to the call for help.</p> <ul style="list-style-type: none"> <li>- We will further develop palliative care for people with respiratory disease and their families.</li> </ul>	<ul style="list-style-type: none"> <li>- rates for the programme - Referrals, availability, location (COPD).</li> <li>- Increase recording of COPD patients within the GSF (Gold Standard Framework) 'as trigger for advanced care planning.</li> <li>- Proportion of COPD admissions followed up by the Early Supported Discharge Service.</li> <li>- Increase in Provision of Inhaler Technique advice/information (Asthma).</li> <li>- Increase in Number of Patients who were evaluated for the frequency (numeric) of daytime and nocturnal asthma symptoms (Asthma).</li> <li>- Cardiac Rehab - Reduction in the percentage of patients referred for but decline or fail to complete the full cardiac rehab program.</li> <li>- Increase the number of patients taking up the alternative home CR programs such as the "Road to Recovery" program. Community Heart Failure Clinical Nurse Specialist service - A rise in the percentage of newly diagnosed stable heart failure patients signing up for and completing the new community based structured education program</li> <li>- Cardiology Outpatients - A reduction in the return to new patient ratio in Cardiology outpatients clinics</li> <li>- Increase in attendance of patients from the BME community</li> <li>- No of people with HF who have a medication review (by dep/age)</li> </ul>

### Long Term Conditions

Outcomes	Actions/Activity Required 2010/11	Change/Progress/Performance Indicator
		<ul style="list-style-type: none"> <li>- Measure admissions with Ketoacidosis and Hypoglycaemia e.g. acute diabetic emergencies (Diabetes)</li> <li>-</li> <li>- Establish Foot Screening and risk stratification in a minimum of 75% of patients with diabetes</li> <li>- Aim for a target of 90% active foot ulcers to be reviewed at multi-disciplinary clinics (Diabetes)</li> <li>-</li> <li>- Problems related to poor control - with defined outcome measurements reached for:               <ul style="list-style-type: none"> <li>- Blood Pressure 140/80</li> <li>- Cholesterol &lt; 5</li> <li>- HbA1C &lt; 7</li> </ul> </li> <li>- Establish baseline and define % increase in attendance at structured patient education in each CHCP area (Diabetes)</li> </ul>
<p>Deliver better care through early intervention</p>	<ul style="list-style-type: none"> <li>- Develop comprehensive range of early intervention services.</li> <li>- Routinely identify at risk population and intervene with care management approach.</li> <li>- Implementation of the tiered model of care.</li> <li>- Improve management of co-morbidities and co-ordination of care for those with more than one condition.</li> </ul>	<ul style="list-style-type: none"> <li>- People with &gt;6 medicines having completed medication reviews and reconciliation of polypharmacy.</li> </ul> <p>Intensive Care Managers.</p> <p>SPARRA and pilot re DN Services.</p>

## **10.5 Finance and Workforce**

- 10.5.1 There is a need to continue to build the capability and capacity of our workforce to deliver assessment and care management through enhanced band and skill mix in Community Nursing, AHP and Social Work Services. This will be supported by the development of our Community Rehabilitation and Enablement Service and redesign of our District Nursing and AHP Services. In addition targeted learning and education to deliver evidence based management of long term conditions and promote self care and supported self management will be required.

The role of GPs and Community Pharmacists working with our extended community teams (health and social work) will be critical to the delivery of the outcome measures in the framework. This is cross referenced to the Primary Care Planning Framework.

- 10.5.2 All services will be required to operate within existing resources.