NHS
Newcastle Gateshead
Clinical Commissioning Group

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Strategy for the
care of patients with

Long Term Conditions

2016 to 2021

Transforming lives together

Contents

Foreword

Long Term Conditions represent a challenge for us all, those who are affected by a Long Term Condition and their carers as well as commissioners and providers of health and social care.

We have ever increasing numbers of people affected by a LTC and new approaches are needed. 130 000 people in Newcastle and Gateshead have a LTC. LTC account for a significant amount of the activity in the health service with about 70% of bed days in hospital and about half of all General Practice consultations relating to LTC.

Our local NHS and Social care work together to support those with LTCs to be as healthy as possible. In the last few years we have changed the emphasis of care for those with LTC from a single disease model to a more holistic personalised person-centered approach. We know that people with LTC want a greater say in their care and their ideal would be "*I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me."* (1)

This strategy details our vision for Long Term Conditions over the next five years. We aim to transform how services are managed to a partnership approach both in planning and providing care. We will integrate services further, move care closer to the patient's community, increase the information and support people can access making use of all the resources available in communities to fully develop the more than medicine approach.

Dr Steve Kirk

1. Introduction

1.1 CCG Strategic Vision

This Long Term Conditions strategy is part of a collection of strategies that make up Newcastle Gateshead CCG 'Strategy Framework'. The framework will provide an anchor and 'golden thread' for all key strategic plans and is aligned to the CCG's Vision, Mission and Purpose as set out in our 5year strategic plan. In brief we will do this through:

- **Involvement** of people in our communities and providers to get the best understanding of issues & opportunities
- **Experience** - people centered services that are some of the best in the country
- Our **Outcomes** are focused on preventing illness and reducing inequalities

The following diagram summarises our vision, which is underpinned by the core NHS values.

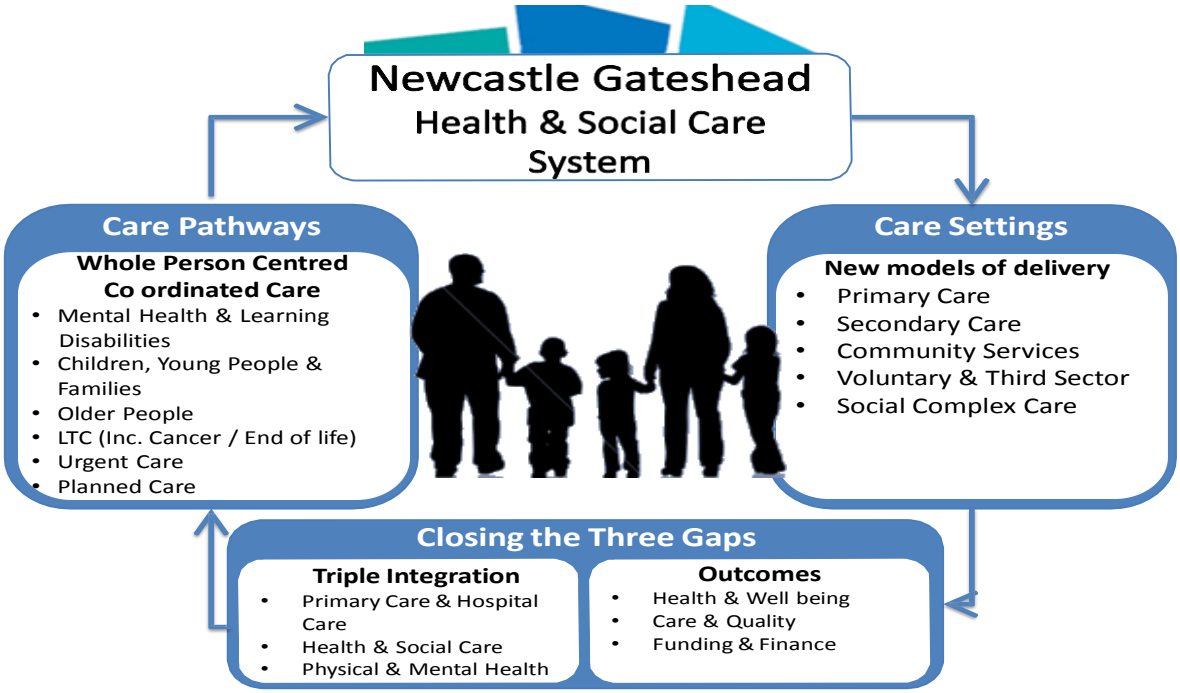
The diagram below represents Newcastle Gateshead CCG strategic approach to deliver our vision. We are focusing on **Care Settings** to enable integration within and between settings as we develop *new models of delivery*. This works with the national

'triple integration' agenda. It also includes the key **3 gaps that we want to close** i.e.:

- variation in health and wellbeing,
- the quality improvements needed
- The challenge of managing the NHS's income and expenditure.

Our **Care pathways** coordinate physical health, mental health and social care through an individual's life journey from Fitness to Frailty. Our Clinical Work Programmes group together many of the CCGs projects to ensure they are coordinated.

Our aim is that through all this we will work with the people of Newcastle and Gateshead to improve the quality and experience of services so that they live *happier, healthier lives, transforming lives together*



The CCG is currently working to develop a single Sustainability and Transformation plan for the Northumberland Tyne & Wear region which will be made up of three local footprints, namely Newcastle Gateshead, North Tyneside Northumberland & Sunderland South Tyneside.

This plan will describe our shared local vision for 2021 regarding care both inside and outside our hospitals underpinned by better integration with local authority services in respect of prevention and social care. It describes how we will close the “3 gaps” identified in the Five Year Forward View.

In Newcastle Gateshead we are committed to the delivery of our STP plan, however we are also aware of the fact that this will require significant changes. We have identified the following three priority areas:

1. Optimal Use of the Acute Sector combined with
2. The complementary redesign of a Collaborative Out-of-Hospital model that promotes care closer to home based on individual and population need, while investing in
3. Prevention, Health and Wellbeing to increase personal and community resilience and reduce future demand on health and care services.

1.2 Background

1.2.1 What are Long Term Conditions?

Newcastle & Gateshead Clinical Commissioning Group (CCG) uses the following definition of a long term condition:

> Long Term Conditions (LTCs) are diseases that cannot currently be cured, but are controlled by medication and/or other treatment. They are health problems that require ongoing management over a period of years or decades and are often characterised by acute exacerbations of ill health resulting in repeated admissions to hospital.

The Kings Fund report on long-term conditions and multi-morbidity states;
long-term conditions are more prevalent in older people (58 per cent of people over 60 compared to 14 per cent under 40) and in more deprived groups (people in the poorest social class have a 60 per cent higher prevalence than those in the richest social class and 30 per cent more severity of disease) (1).

People with long-term conditions now account for about 50 per cent of all GP appointments, 64 per cent of all outpatient appointments and over 70 per cent of all inpatient bed days.

Treatment and care for people with long-term conditions is estimated to take up around £7 in every £10 of total health and social care expenditure (2).

Projections for the future of long-term conditions are not straightforward. The Department of Health (based on self-reported health) estimates that the overall number of people with at least one long-term condition may remain relatively stable until 2018. However, analysis of individual conditions suggests that the numbers are growing, and the number of people with multiple long-term conditions appears to be rising (2).

The 2009 General Lifestyle Survey identified 14% of those aged under forty report having an LTC, and 58% of those aged 60 and over report having an LTC, with 25% of over 60s having two or more. Coupled with a projected national increase in the numbers of people aged 85 and over by 2034 to be 2.5 times larger than in 2009, reaching 3.5 million and accounting for 5% of the population; plans need to be put in place now to address the growing needs of these people. It is clear that the NHS, as currently configured for long term condition care, is not sustainable in the face of this projected future increase in co-morbidity and the level of need predicted (2).

Most individual long-term conditions are more common in people from lower socio-economic groups, and are usually more severe in this group, even in conditions where

prevalence is lower – for example, stroke. General Household Survey data (2006), analysed by the Department of Health, shows those from unskilled occupations (52%) suffer from long-term conditions more than groups from professional occupations (33%

1.2.2 Multi-morbidity and deprived populations

The number of people with three or more long-term conditions is predicted to rise from 1.9 million in 2008 to 2.9 million in 2018 (2).

The ageing population and increased prevalence of long-term conditions have a significant impact on health and social care and may require £5 billion additional expenditure by 2018 (2).

Multi-morbidity is more common among deprived populations – especially those that includes a mental health problem (3) – and there is evidence that the number of conditions can be a greater determinant of a patient's use of health service resources than the specific diseases (4).

There will be rising demand for the prevention and management of multi-morbidity rather than of single diseases (3).

1.3 Interdependent Strategies

This strategy is linked to and supports:

- The Newcastle Gateshead CCG Five Year Plan
- Newcastle and Gateshead Better Care Fund and Care Homes Vanguard
- The Newcastle Gateshead CCG Mental Health Transformation Programme
- The Newcastle Gateshead CCG Urgent Care Strategy
- Newcastle Gateshead CCG Primary Care Strategy
- The Gateshead Community Services Strategy
- The Sustainability Transformation Plan

It will be the role of the LTC Programme Board to ensure there are clear linkages between the above strategies and the LTC Strategy and to assure integrated delivery across these plans in order to improve outcomes for people with LTCs.

1.4 Scope of the Strategy:

The Long Term Conditions Strategy takes a generic approach rather than condition specific. It identifies the framework needed to manage long term physical health conditions based around the individual's life journey that focus on five strategic work programmes for delivery i.e. prevention, identification, support for self management, proactive management and end of life care.

The Kings Fund (2012) states that at least a third of people with long-term physical health conditions also have mental health problems. These can lead to significantly poorer health outcomes and reduced quality of life. The LTC Strategy recognises that care for large numbers of people with long-term conditions can be improved by better integrating mental health support with primary care and chronic disease management programmes, and closer working between mental health specialists and other professionals.

The risk of developing dementia increases with age; as the population ages the numbers of people developing physical LTCs also increases therefore the numbers of patients diagnosed with dementia who are also diagnosed with other LTCs will increase with age. Although dementia is not within the scope of this strategy, the fact that people with dementia are highly likely to have more than one physical LTC means that this strategy will work to ensure that patients suffering from dementia and with other LTCs are in receipt of integrated high quality care that meets all of their health needs.

The work carried out under the scope of the LTC Strategy will therefore work to ensure that an integrated approach is taken to address the health needs of patients diagnosed with dementia, severe mental health issues or other LTCs not specifically identified within this strategy. It is hoped that these patient groups will benefit from the generic, patient centred approach detailed within the five strategic programmes of work detailed later in this strategy.

We will aim to ensure improved management of LTCs in vulnerable groups for example carers and people with learning disabilities living in Newcastle and Gateshead.

LTC Programme Board will ensure clear linkages to the Newcastle and Gateshead Mental Health Programme Board to ensure areas common to both are addressed jointly in order to improve outcomes for all patients living with LTCs.

2. Case for Change

2.1 National Policy Context

The Challenge facing health care systems across the world is how to deliver better quality, safe services at a reduced cost. Fillingham and Weir identified the need to rethink the way care is delivered and coordinated across organisations. In order to achieve this "improving coordination around the needs of the individual will be part of the solution" (10)

The Five Year Forward View published by NHS England in 2014, recognised that Long term health conditions -rather than illnesses susceptible to a one-off cure -now take 70% of the health service budget. At the same time many people wish to be more informed and involved with their own care, challenging the traditional divide between patients and professionals, and offering opportunities for better health through increased prevention and supported self-care.

It talked about closing 3 widening gaps:

1. *The health and wellbeing gap:* if the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness.

2. *The care and quality gap*: unless we reshape care delivery, harness technology, and drive down variations in quality and safety of care, then patients' changing needs will go unmet, people will be harmed who should have been cured, and unacceptable variations in outcomes will persist.

3. *The funding and efficiency gap*: if we fail to match reasonable funding levels with wide-ranging and sometimes controversial system efficiencies, the result will be some combination of worse services, fewer staff, deficits, and restrictions on new treatments.

The Five Year Forward View envisaged a future that empowers patients to take much more control over their own care and treatment; a future that dissolves the divide between family doctors and hospitals, between physical and mental health, between health and social care, between prevention and treatment. One that no longer sees expertise locked into often outdated buildings, with services fragmented, patients having to visit multiple professionals for multiple appointments, endlessly repeating their details because they use separate paper records. One organised to support people with multiple health conditions, not just single diseases. A future that sees far more care delivered locally but with some services in specialist centers where that clearly produces better results. One that recognises that we cannot deliver the necessary change without investing in our current and future workforce

It emphasised that the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health. To support this, the NHS will back hard-hitting national action on obesity, smoking, alcohol and other major health risks; and will advocate for stronger public health-related powers for local government.

It advocated for patients to gain far greater control for their health and that the NHS will become a better partner with voluntary organisations and local communities to support this.

It stated that the NHS will take decisive steps to break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health, between health and social care. The future will see far more care delivered locally but with some services in specialist centres, organised to support people with multiple health conditions, not just single diseases.

2.2 Local Context

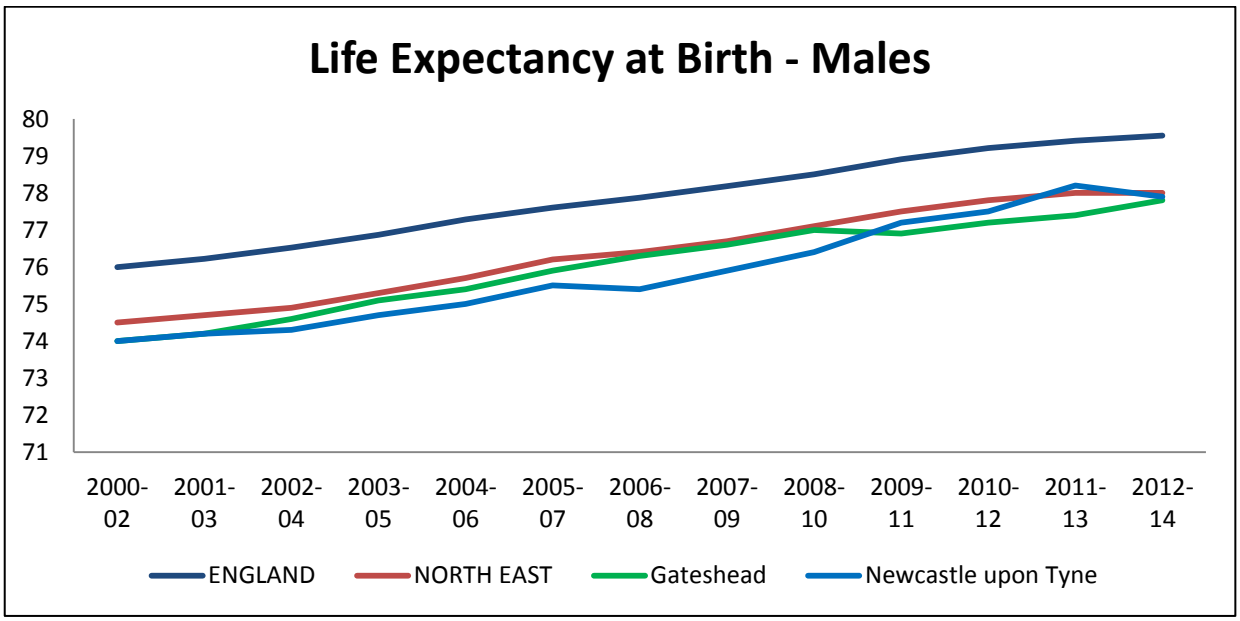
The health of people in Newcastle and Gateshead is generally worse than the England average, with life expectancy for both men and women lower than the England average.

2.2.1 Life Expectancy

In Gateshead life expectancy is 9.2 years lower for men and 7.3 years lower for women in the most deprived areas than in the least deprived areas.

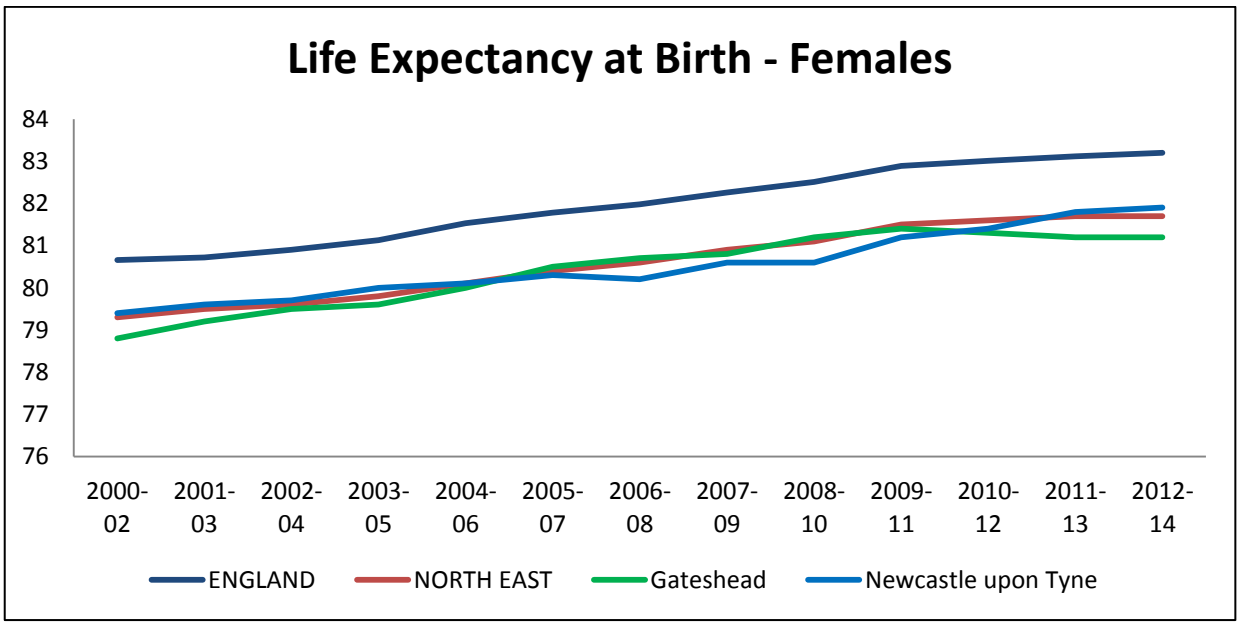
In Newcastle upon Tyne life expectancy is 12.1 years lower for men and 10.1 years lower for women in the most deprived areas than in the least deprived areas.

(Source: Public Health England)



(Source: Health & Social Care Information Centre Indicator Portal)

Male life expectancy in Newcastle upon Tyne has reduced for the first time in 12 years as it has dropped just below the North East average. Previously this was consistently increasing but has now stopped.



(Source: Health & Social Care Information Centre Indicator Portal)

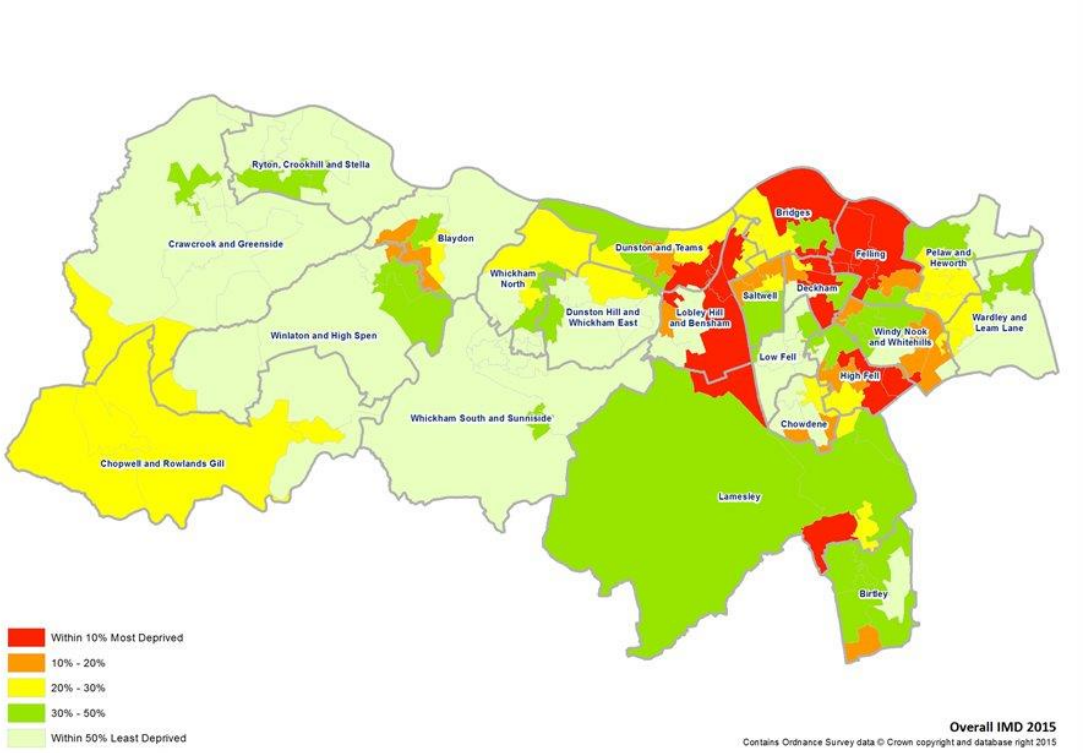
Female life expectancy in Gateshead has been declining since 2009 and is below the North East average. The Gateshead area had previously been hovering around the North East average for female life expectancy but more recently it is under, whereas the life expectancy for females living in Newcastle upon Tyne is just above the North East average.

2.2.2 Deprivation

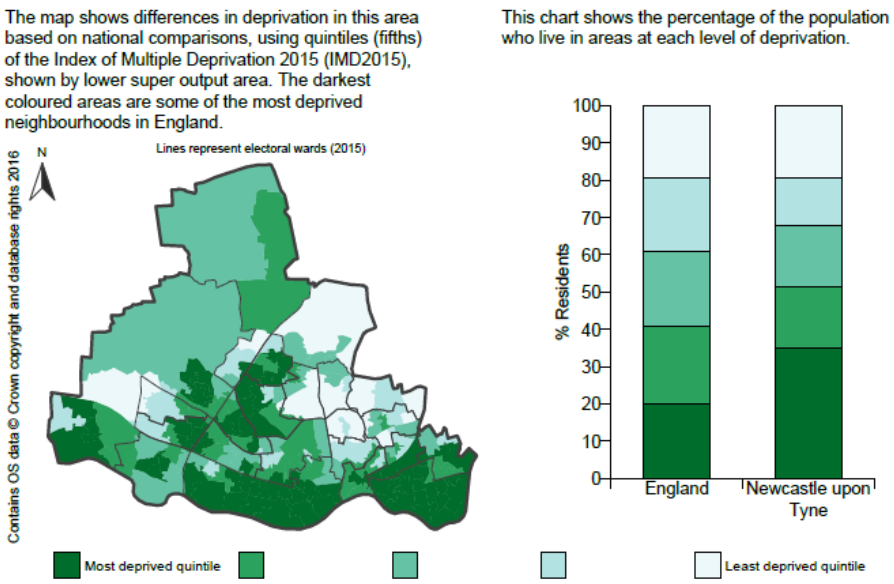
The following maps show differences in deprivation for Gateshead and Newcastle upon Tyne based on national comparisons, using quintiles (fifths) of the Index Multiple Deprivation 2015, shown by lower super output area. The darkest coloured areas are some of the most deprived neighbourhoods in England.

-Public Health England

Gateshead



Newcastle



2.2.3 Lifestyles

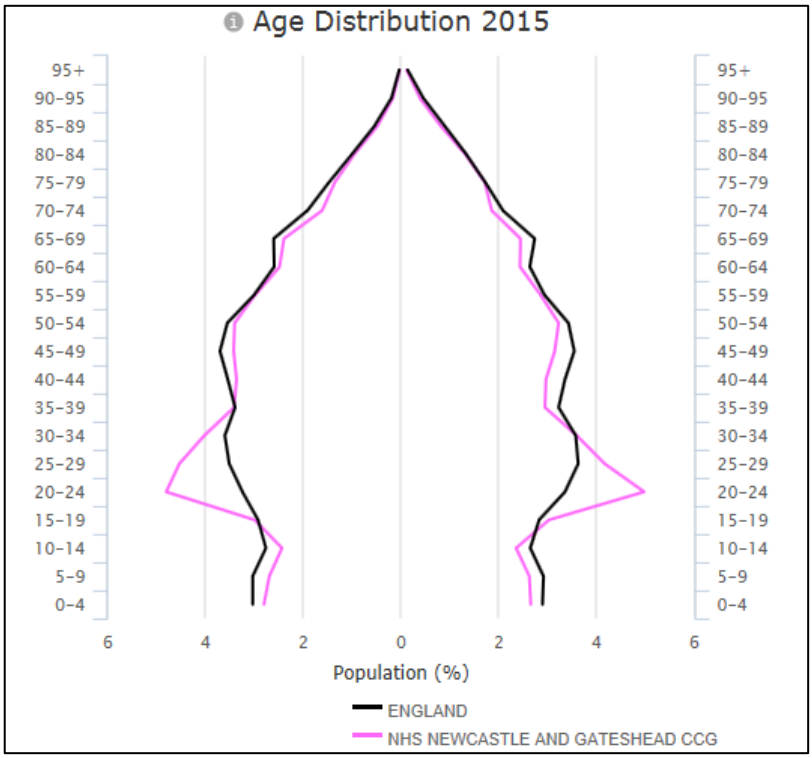
Lifestyle factors can have a significant impact on the prevalence of long-term conditions. In both Newcastle and Gateshead smoking prevalence is slightly higher, but statistically similar to the national rate. In Gateshead, significantly fewer adults are physically active and significantly more adults are overweight or obese than the national average. In Newcastle the rate of physical activity and proportion of adults with excess weight are similar to the national average. In both areas there are significantly more hospital stays for alcohol-related harm than the national average. .

	England	North East	Newcastle	Gateshead
Smoking prevalence	16.9	18.7	18.6	18.3
Percentage of population who are physically active	57.0	52.7	55.7	46.3
Percentage of population who are overweight or obese	64.6	68.6	61.3	68.9
Hospital stays for alcohol-related harm (per 100,000 population)	641	830	927	831

Compared with England:

better	similar	worse

2.2.4 Population



The age distribution chart above illustrates that for Newcastle and Gateshead CCG the elderly population is lower than the national England population.

There is a spike in the 18 to 30 age range for both males (left side of the chart) and females (right side) presumably because of the high student population in Newcastle.

The population is ageing in both Newcastle and Gateshead:

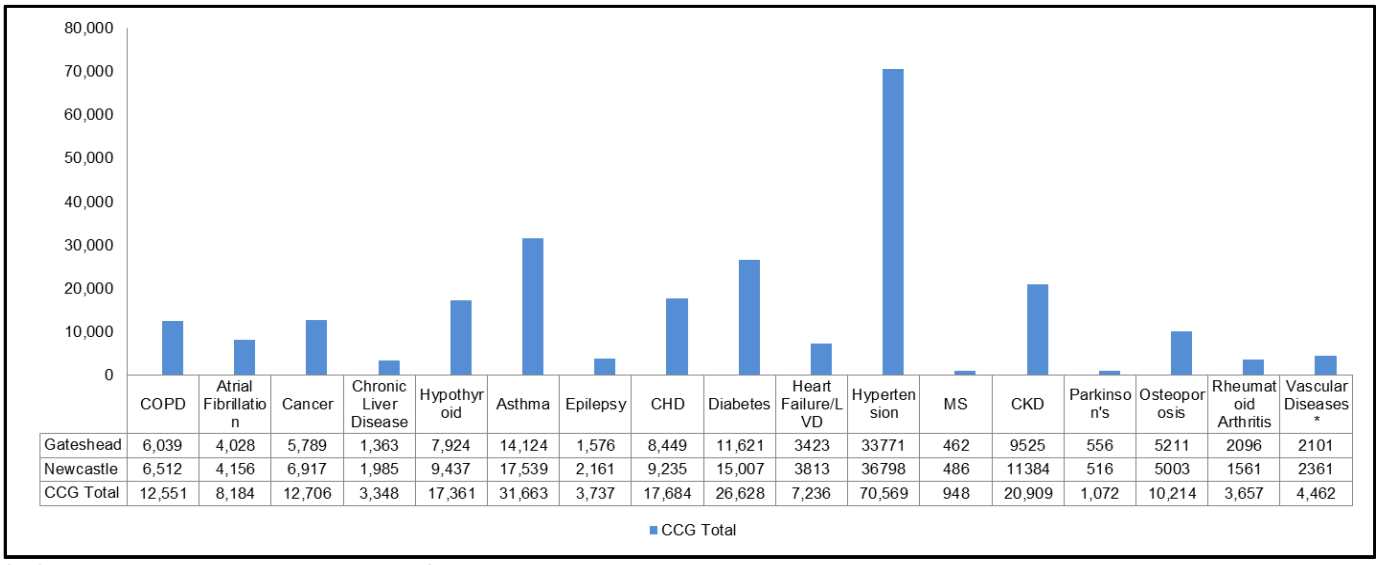
- In Gateshead it is projected that by 2039 there will be an additional 14,400 people aged 65 or older, an increase of 38% from 37,800 in 2014 to 52,200 in 2039, 9,700 of these people will be aged over 85+.

- In Newcastle it is predict there will be a significant increase in people aged over 65 or older, by almost 50% (20,000 people) from 40,700 in 2013 to 60,600 in 2037. A third of these - 6,200 people - are aged over 85+. (Source: ONS)

The older the population the more LTCs they tend to have and the greater the complications arising from these.

2.2.5 Current Numbers of People with Long Term Conditions

The following chart shows the number of Long Term Conditions for the Newcastle Gateshead area as a total, with individual figures for each area:



	COPD	Atrial Fibrillation	Cancer	Chronic Liver Disease	Hypothyroid	Asthma	Epilepsy	CHD	Diabetes	Heart Failure/LVD	Hypertension	MS	CKD	Parkinson's	Osteoporosis	Rheumatoid Arthritis	Vascular Diseases *
Gateshead	6,039	4,028	5,789	1,363	7,924	14,124	1,576	8,449	11,621	3423	33771	462	9525	556	5211	2096	2101
Newcastle	6,512	4,156	6,917	1,985	9,437	17,539	2,161	9,235	15,007	3813	36798	486	11384	516	5003	1561	2361
CCG Total	12,551	8,184	12,706	3,348	17,361	31,663	3,737	17,684	26,628	7,236	70,569	948	20,909	1,072	10,214	3,657	4,462

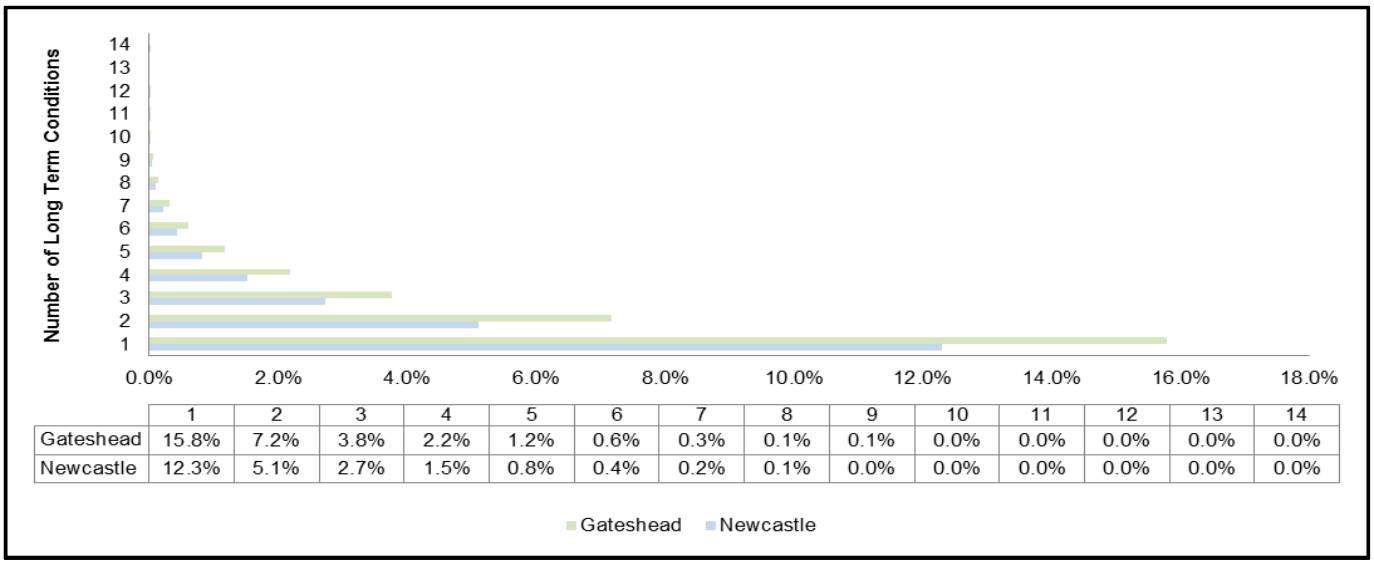
(Primary Care Data as at June 2016)

There are more than 60,000 people in Gateshead currently on disease registers in scope of the LTC strategy.

There are more than 70,000 people in Newcastle upon Tyne currently on disease registers in scope of the LTC strategy.

2.2.6 Co-Morbidities

The following chart highlights the number of patients who have more than one LTC as a percentage of the population of each area:



	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Gateshead	15.8%	7.2%	3.8%	2.2%	1.2%	0.6%	0.3%	0.1%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%
Newcastle	12.3%	5.1%	2.7%	1.5%	0.8%	0.4%	0.2%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

As at 30th June 2016 the Primary Care Data for the whole Gateshead population 7.2% of patients have two or more LTCs and 3.8% of patients have three or more LTCs.

For the same time period, out of the whole Newcastle upon Tyne population 5.1% of patients have two or more LTCs and 2.7% of patients have three or more LTCs.

2.2.7 Frailty

As people age and develop more LTCs their reserves and resilience reduce so that they become increasingly frail. Tools such as the electronic Frailty Index (eFI) have been developed to risk stratify the population for frailty and it is estimated that in our population 23% have mild frailty, 2% have moderate frailty and 0.2% have severe frailty.

Levels of frailty can be defined as follows:

Fit (eFI score 0 - 0.12) – People who have no or few long-term conditions that are usually well controlled. This group would mainly be independent in day-to-day living activities.

Mild frailty (eFI score 0.13 – 0.24) – People who are slowing up in older age and may need help with personal activities of daily living such as finances, shopping, transportation.

Moderate Frailty (eFI score 0.25 – 0.36) – People who have difficulties with outdoor activities and may have mobility problems or require help with activities such as washing and dressing.

Severe Frailty (eFI score > 0.36) – People who are often dependent for personal cares and have a range of long-term conditions/multi-morbidity. Some of this group may be medically stable but others can be unstable and at risk of dying within 6 - 12 months.

2.3 Demographic and Operational Challenges

We know the NHS is facing a period of unprecedented challenges which are not unique to NHS Newcastle Gateshead CCG. These challenges are driven by the following:

An ageing population	• Anticipated significant growth in over 85 year olds • Currently more than 40% of people admitted to hospital are over 65 years • Unplanned admissions for people over 65 years account for more than 70% of hospital emergency bed days • When they are admitted to hospital, older people generally stay longer and are more likely to be re-admitted • Increased complexity as an aging population is associated with increased multi-morbidity,
Lifestyle factors	• 80% of deaths in England are from major diseases (e.g. Cardiovascular Diseases and Cancer) many of which are attributable to lifestyle risk factors e.g. excess alcohol, smoking, poor diet • 46% of men and 40% of women will be obese by 2035
Budgetary constraints	• Although NHS budgets are protected in real terms, current forecasts point to a £30bn gap in funding by 2020/21. • Local Authority budgets are being cut in real terms
Increasing long term conditions	• It is predicted that there will be 550,000 additional cases of diabetes and 400,000 additional cases of stroke and heart disease nationally • 25% of the 15 million people in England with a long term condition currently utilise 50% of GP appointments and 70% of the total health and care spend in England.
Public expectations	• Patients and the public rightly have the high expectations for the standards of care they receive. There are increasing demands for access to latest therapies, greater information requirements and more involvement in decisions about their care.
Increasing pressure on existing health services	• General Practice is at saturation point and unable to take on additional work without major changes to primary care infrastructure and workforce • Reduced provision of services by Local Authorities resulting in pressure on health services and health budgets

In response to the challenges set out in the previous table, our collective ambition is to maintain high quality and sustainable health and care services for our public and patients which we will achieve through:

- Ensuring our citizens are fully engaged
- Wider primary care provided at scale
- A modern model of integrated care
- Access to highest quality urgent and emergency care
- A step change in the productivity of elective care
- Specialised services concentrated in centres of excellence.

2.4 Workforce:

There are a number of challenges facing the local workforce that have the potential to impact upon the provision of LTC care:

- There is an ageing workforce in Primary care – in both GPs and Practice Nurses which necessitates the need for succession planning. This is addressed in the CCG's Primary Care Strategy.
- Skills in primary care workforce for LCT disease management – we will aim to ensure consistency of standards and skills across all practices in the provision of care to patients with LTCs. In addition we will support the development of new skills that support the move to multi-morbidity such as coaching for behavior change, shared decision making and motivational interviewing techniques.
- We will work closely with the Primary Care Transformation teams to support the development of new roles in primary care such as health care navigators; and explore the expansion of existing roles to support delivery of LTC care e.g. practice pharmacists.
- In the community there is a need to ensure closer integration of these staff into general practice to support delivery of LTC care for example optimising the role district and community nursing teams have to play in the care of housebound patients with LTCs.
- The over 65s are the biggest consumers of health and social care and their needs can be hugely challenging to address. While traditionally the most experienced workforce would have sat in specialist secondary care services there has been a move to develop more creative and innovative posts in community and primary care services in recent times e.g. practice based frailty nurses. However much more needs to be done if we are to have a workforce able to respond to the needs of those most frail and complex. As long as we continue to consider long term conditions as single system diseases we will never have the workforce ready and able to proactively manage older people living with multiple conditions or frailty.

2.5 Patient Experience

To inform the Long Term Condition Strategy, the CCG wanted to find out about individual patient experiences of being diagnosed with an LTC, the impact of living with one or more conditions and discover what would help patients manage their conditions as effectively as possible.

This was undertaken by carrying out a review of recent consultations; holding focus groups and one to one discussion with patients (which resulted in the development of a number of case studies); an online survey promoted widely across Newcastle and Gateshead resulted in 245 responses and discussions with the Gateshead LTC Patient Reference Group.

A comprehensive report detailing all responses and findings has been developed as a supporting document to this Strategy. The main points raised are summarised in the following sections together with implications that should be considered in the implementation of this strategy:

2.5.1 Receiving a diagnosis

For many people, being diagnosed with an LTC is a shock, even if it has been a progressive illness. If the onset is sudden, the impact can be greater than recognised by health care professionals and patients are left floundering. If the condition evolves more slowly, people often still require time to accommodate their new circumstances and talk through the implications. Some people have indicated that they did not share their worries with practice staff or with their family because of concern about being a burden.

There is evidence from the case studies that when people are able to come to terms with the diagnosis and learn more about their condition, they are able to make choices to improve their health.

Implications for strategy

- Emotional support offered at time of diagnosis
- A need to ensure people are supported to understand and learn about their condition

2.5.2 Relationship with GP Surgery staff

This relationship is vital for patients with a long term condition. When there is a reliable and trusting relationship with their practice things go well but often patients do not have confidence in the care that they will receive.

Implications for strategy

- Continuity of care for patients with LTCs
- Consultation skills of practice staff to take a holistic approach to the needs of LTC patients during consultation (i.e. to unearth and address MH issues and identify needs for support beyond traditional medical model of care – Social Prescribing)

2.5.3 Understanding and agreeing future plan of care

One key issue that emerged from patients was uncertainty about future appointments and follow up by General Practice. Often patients were unsure if they had to continue taking medication, if they would get called for follow up or if they had to request an appointment. In addition, people were unsure if some new symptoms or a change in

their condition required an urgent appointment. Clarity about long term management is essential for patients.

Implications for strategy

- Ensure systematic approach to LTCs undertaken in general practice and communicated clearly to patients so they know what to expect
- Care plans developed and agreed with patients, where appropriate to cover all LTCs a patient has.
- Ensure patients have a clear understanding of their medication and treatment.
- Patients understand what to do in an emergency or if their condition worsens.

2.5.4 Support to remain in employment

The Gateshead Patient Reference Group raised several problems associated with working. These issues were explored further in the LTC survey. Patients were asked if staff understand and are supportive and helpful about work issues. Similar results were obtained for primary and hospital care and showed that more can be done to assist patients in or looking for employment.

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2.5.5 Finding out about information, services and support that might help patients

For patients, information is the key to be able to manage their condition well and needs to come from a variety of sources. The survey asked 'Do you know where to go for the information you need, such as finding out about how to manage your conditions or what treatments might be right for you?' Although 48% of responders (108 people) knew where to access information, a further 38% know where to go for some things but not others and 14% are confused about where to start to get the information. Discussion with patients raised the following points.

- Information needs to be tailored to the needs of the particular patient and his/her family
- Leaflets and written information are not enough for most people. Word of mouth and personal recommendation is how people engage with activities that can inform and support them.
- People learn about good ways to manage their conditions from others in a similar position.
- Few patients are signposted to the main health charities' advice lines, websites and local peer support
- Most people are not offered courses about their condition. However those that have attended courses to learn more about their condition found them valuable.

Implications for strategy:

- Development of support for self-care needs to ensure information in provided in ways that meet individuals preferred methods of communication – link to care and support planning
- Ensure where required there is personalized support for people to engage in activities that can support them to improve their health outcomes e.g. the role of health care navigators to connect people, use of practice champions to engage patients in activities
- Consider the role of peer support when developing services that support self-care

- Consider how the CCG and partners can work better with the Charity sector to deliver support for self-care
- Commissioning of structured education for patients with LTCs – ensure systematic referral to these courses for patients with LTCs; and consider how to improve uptake of these amongst people with LTCs.

2.5.6 Learning from others in a similar position

Community group classes for those with cardiac, pulmonary or reduced mobility are popular and attendees are very clear about the positive benefits to help them manage their long term condition. They work so well because patients feel safe and are able to work at their own pace but also encouraged to progress. They offer the opportunity to talk to and learn from others in a similar position and offer the camaraderie that helps people to cope. This model seems particular effective at helping patients cope with quite major ill health. The demand outstrips supply and people find out about them in a haphazard way.

Implications for strategy:

- Recognise the importance of community based programmes for patients with LTCs and ensure strategies in place to ensure ongoing commissioning of these.
- Ensure systematic awareness and referral to these courses by general practice
- Ensure services are commissioned at appropriate level to meet demand

2.5.7 Multiple long term conditions

Patients who have several long term conditions face increased problems. Most of these center around getting advice that takes account of all of their conditions, this is particularly important for people who see many different specialists. In addition increased medication increases the complexity for the patient.

Implications for strategy:

- Ensure holistic (as opposed to disease specific) approach to care of patients with multiple LTCs – ensure this happens in both primary and specialist services
- Consider how care and support planning to deliver patient focused care can be used across the health economy.
- Establish an approach that includes comprehensive assessment, problem identification and care planning
- Consider how care and support planning to deliver patient focused care can be used across the health economy, including identified key workers and case managers that interface with secondary care and out of hours services especially
- Look beyond the medical model so support patients to live with their LTCs
- Support a change in the patient professional relationship to empower patients to care for themselves and promote shared decision making

2.5.8 Taking medicines

Patients report that it is getting easier for them to take control of their medication as simpler ways to order repeat prescriptions and advice from their local pharmacist really do help.

In the survey 68 % of patients (n=207) wished that they did not take as many medicines that they do. On the whole respondents felt that they understood their medication (68%) and could work out what to take and when (89%). 36% of respondents find it confusing when they are given a different brand of the same drug

and 33% felt that they had significant side effects of the medication. Managing side effects can be problematic as judgements need to be made. Are the side effects sufficiently serious to seek medical attention or do they just stop taking them? If so will this matter? Who can they get advice from?

Implications for strategy:

- Improve medicines management advice for patients with multiple LTCs

2.5.9 Worry about the future

Every patient is unique and this is reflected in how they cope with thoughts about the future. Some are sanguine, some worry, and others do not want to consider or plan for the future.

2.5.10 Conclusions

Patients living with long term conditions have to make frequent decisions about their health. Informed and supported patients have greater confidence to make effective choices to stay well and seek medical attention when required. This can be maximised by effective relationships with health care professionals, encouraging peer support and health education delivered in a variety of formats to enable people to select the most suitable programme for them.

3. Local Vision and Strategic Priorities

3.1 Models of Care

The Kings Fund paper "Delivering better services for people with long-term conditions Building the house of care" (5) advocated that "the management of care for people with long-term conditions should be proactive, holistic, preventive and patient-centred" The report describes a co-ordinated service delivery model – the 'House of Care' – that incorporates learning from a number of sites in England that have been working to achieve these goals. This forms the basis for Newcastle and Gateshead CCG's approach to care for patients with LTCs.

The house of care model differs from others in two important ways:

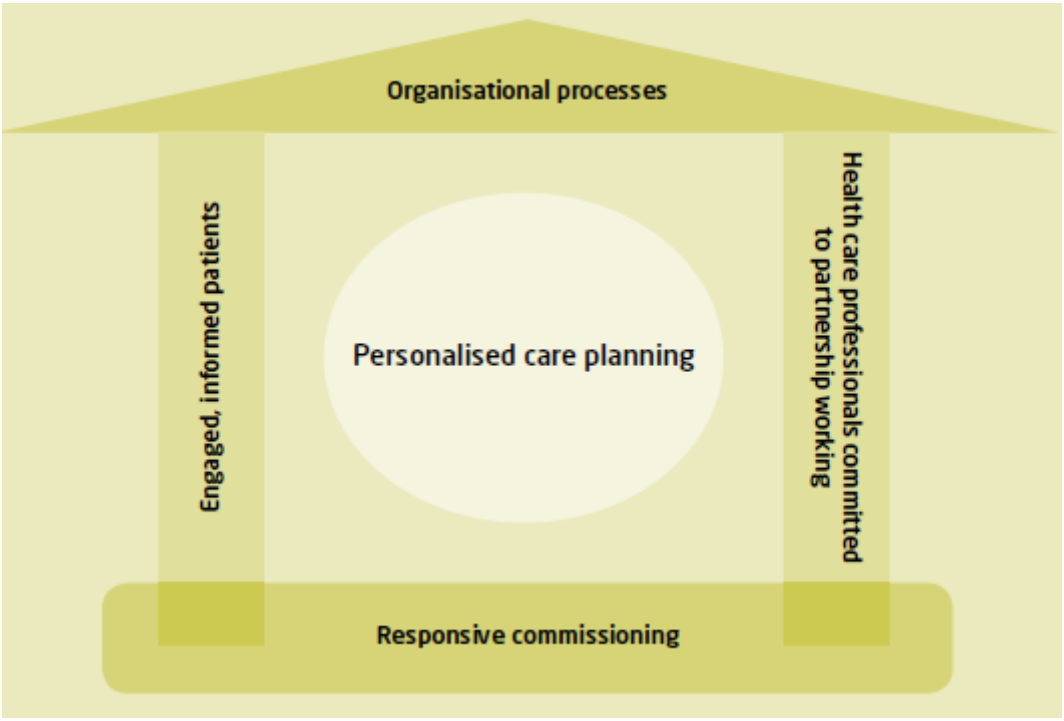
- it encompasses all people with long-term conditions, not just those with a single disease or in high-risk groups;
- it assumes an active role for patients, with collaborative personalised care planning at its heart.

Implementing the model requires health care professionals to abandon traditional ways of thinking and behaving, where they see themselves as the primary decision-makers, and instead shifting to a partnership model in which patients play an active part in determining their own care and support needs.

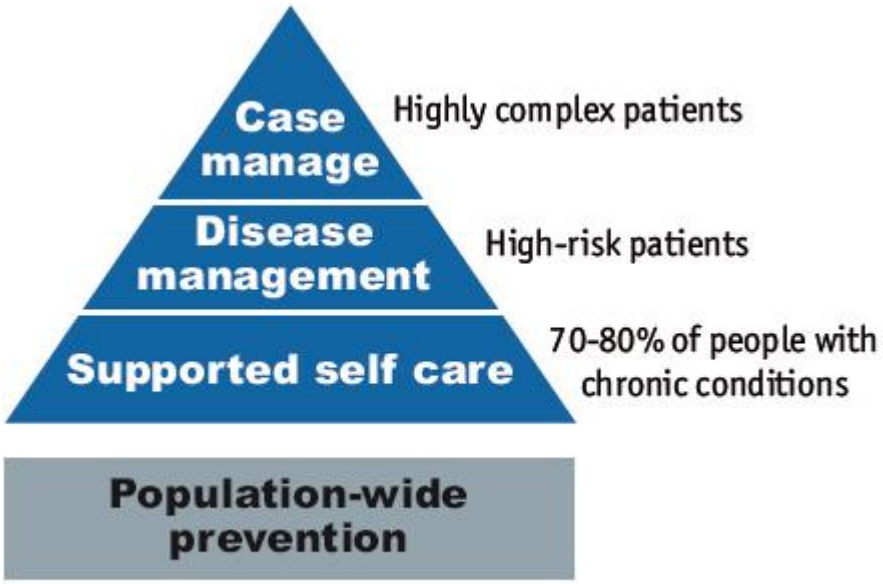
In personalised care planning, clinicians and patients work together using a collaborative process of shared decision-making to agree goals, identify support needs, develop and implement action plans, and monitor progress. This is a continuous process, not a one-off event.

An important feature of the approach is the link between care planning for individuals and commissioning for local populations; it aims to make best use of local authority services (including social care and public health) and community resources, alongside more traditional health services.

The house of care metaphor is used to illustrate the whole-system approach, emphasising the interdependency of each part and the various components that need to be in place to hold it together. Care and support planning is at the centre of the house; the left wall represents the engaged and informed patient, the right wall represents the health care professional committed to partnership working, the roof represents organisational systems and processes, and the base represents the local commissioning plan.



A number of models have been developed to identify the most effective ways to deliver services for people with Long Term Conditions. One model that is useful in illustrating the approach Newcastle and Gateshead CCG has to LTC care is the "Kaiser Triangle" as described by Chris Ham (6). This model focuses on integrating services and removing distinctions between primary and secondary care and represents the differing levels of need for people with LTCs as illustrated below:



Source: NHS and University of Birmingham.

This shows that most - 70-80 per cent - of people with long term conditions can care for themselves, and need minimal input from health and social services. They represent the bottom layer of the pyramid.

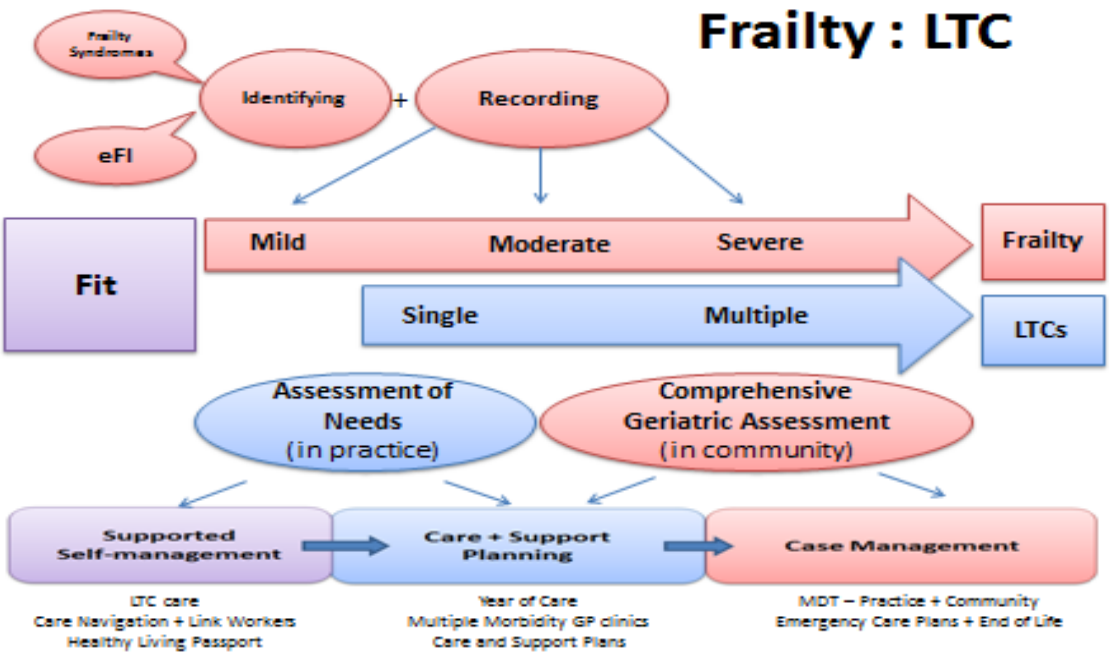
In the middle layer are ‘high risk patients’ – people who need more active disease and care management from professionals.

Finally, in the top level, are the patients with highly complex needs. These patients represent a small proportion of the population, but account for a large number of emergency admissions.

The model assumes with the right information, advice and support, most people are able to manage their own conditions the majority of the time. However, the intensity of co-ordination and support required will vary according to the morbidity, dependency and complexity of the conditions involved.

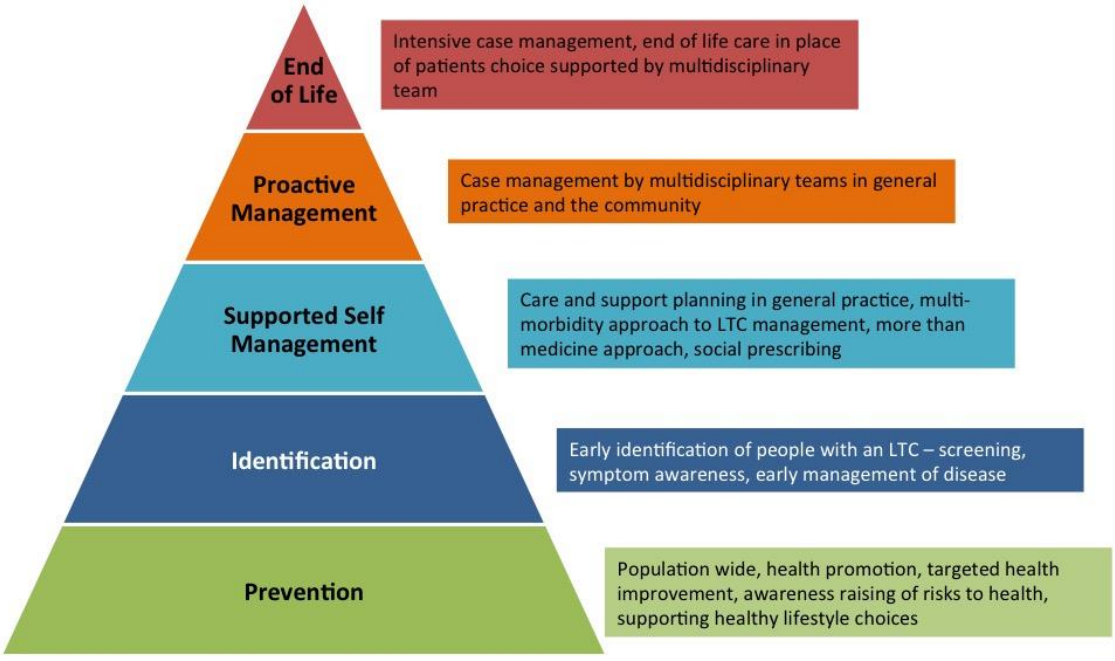
The model is based on a foundation of population-wide prevention, health promotion and targeted health improvement activity, through action to prevent disease, raise awareness of risks to health and support healthy lifestyle choices. This is essential given the high prevalence of long term conditions which are preventable, and the health inequalities associated with living with long term conditions. Supported self-management is where people with long term conditions are given the information and other practical support they require to manage their own conditions in a way that helps them use this information to their own benefit. Disease management is provided when a greater level of professional support is required to help avoid complications or slow the progression of disease; and care management is provided for those with particularly complex needs who require a more intensive level of care - a coordinated and proactive approach to improve health and help them avoid being admitted unnecessarily to hospital.

This strategy recognises the emerging evidence for managing frailty as a long term condition. The following model illustrates how frailty fits within the above model for it’s management as a long term condition:



Newcastle Gateshead CCG

Model for Long Term Conditions



System Enablers- Workforce, IT, Social Prescribing, New Contracting Frameworks, Estates and Medicines Support

3.2 Our Vision, Principles and Strategic Goals

3.2.1 Our Vision - *what we want achieve*

N&GCCG is committed to improving the health of our population over the next 5 years by systematically tackling the effective management of LTCs. Newcastle and Gateshead CCG will work to ensure that all partners are engaged and working in an integrated manner to achieve this vision. This strategy will complement the wider CCG's vision of seamless care, improved quality and patient and carer involvement.

The CCG's vision for LTCs is to reduce the numbers of people developing LTCs and for those who do develop LTCs ensure that they lead a healthier, happier life.

3.2.2 Principles - *the rules within which we will work to achieve our vision*

- We will promote health, wellbeing and prevention
- Ensure the provision of patient centered personalised care.
- Recognise patients and carers as active participants in their care; who are informed and fully involved in decision making about their care
- We will foster a culture of support for self-management.
- Organisations will work in partnership to ensure a system wide approach to the provision of care to achieve the best outcomes for our local population
- As a health care system we will recognise the assets that already exist in our local communities in order to enhance care we provide and improve outcomes for individuals
- We will take a holistic approach to care in order to manage patients' conditions as a whole person rather than looking at individual diseases

3.2.3 Strategic Goals – *how we are going to deliver it in the long-run*

- We will work with our local authorities and other partners to ensure that prevention remains a priority across the health economy
- Patients will be informed about their condition and have access to specialist advice when appropriate.
- Services will be provided locally by multidisciplinary teams who will use clear pathways of care.
- We will work to reduce variation in care
- We will ensure the provision of proactive and structured care based on clear evidence of effectiveness;
- We will ensure clinical pathways and services deliver best value within the funding available
- Care will be provided closer to patient's homes
- We will support people to manage and understand their own conditions with a focus on support for self-management and care and support planning, involving advocates and family carers when necessary

3.3 The Role of the CCG

The CCG will work with Primary Care, local FTs, the Local Authorities, the voluntary sector and general public to agree and support the development of integrated models of care that will deliver sustainable patient centered services. We will support transformation in Primary and Secondary Care and seek to commission new pathways of care that deliver the aims of this strategy.

The CCG will focus on delivering better value to the public. This will mean tackling unwarranted variation in clinical care, reducing waste and ensuring that quality and safety are at a key priority for all providers involved in the provision of LTC care.

4. Strategic Approach

Our Strategic Approach to ensure delivery of the LTC Strategy is made up of five programmes of work based around the individual's life journey (fitness to frailty); each of which identify key strategic actions necessary to ensure delivery of the overall strategy. These are detailed in the following section.

4.1 Prevention

4.1.1 How will this look for the patient?

"*I will be supported to make appropriate life choices for my health and wellbeing by all health care professionals and the choices made available to me in the wider community which I live in"*

4.1.2 Local Context

N&GCCG has a high numbers people who have unhealthy lifestyle behaviors increasing their risk of developing LTCs. There are currently gaps in provision and uptake of secondary prevention services

Key factors that increase the risk people developing an LTC include smoking, diet, alcohol consumption and weight.

Smoking

- As at June 2016, 23.3% of the non- LTC Gateshead patients aged 15+ were smokers.
- As at June 2016, 21.8% of the non- LTC Newcastle upon Tyne patients aged 15+ were smokers.

The following smoking age heat table is for patients **with** a Long Term Condition:

Smokers With A LTC	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85+
Gateshead CCG	0.9%	2.3%	2.6%	3.7%	4.7%	6.2%	9.4%	12.5%	12.7%	12.9%	12.1%	8.5%	6.4%	3.3%	2.0%
Newcastle CCG	0.9%	2.8%	3.4%	3.8%	4.7%	6.5%	9.6%	12.9%	13.1%	12.7%	11.7%	7.5%	5.7%	2.8%	1.8%
CCG Total	0.9%	2.6%	3.0%	3.8%	4.7%	6.4%	9.5%	12.7%	12.9%	12.8%	11.9%	7.9%	6.0%	3.0%	1.9%

The following smoking age heat table is for patients **without** a Long Term Condition:

Smokers With No LTC	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-69	80-84	85+
Gateshead CCG	2.8%	10.2%	14.2%	14.2%	12.8%	11.0%	11.1%	9.5%	6.3%	3.6%	2.3%	1.1%	0.4%	0.2%	0.1%
Newcastle CCG	3.4%	15.6%	17.1%	14.8%	11.8%	9.8%	8.9%	7.7%	5.2%	2.8%	1.6%	0.7%	0.3%	0.1%	0.1%
CCG Total	3.2%	13.5%	16.0%	14.6%	12.2%	10.3%	9.8%	8.4%	5.6%	3.1%	1.9%	0.9%	0.3%	0.2%	0.1%

It can be seen from the two previous tables, the majority of smokers with a LTC are in the age range 50-69. For both Gateshead and Newcastle the % of smokers in these age ranges is above 10% and therefore represents the largest age group of smokers with LTCs. In contrast the majority of smokers without a LTC are in the age range 20-49.

The greatest scope for prevention of long term conditions is in this younger age group

Obesity

- As at June 2016, 25.1% of the non-LTC Gateshead patients aged 16+ were classed as obese or morbidly obese
- As at June 2016, 19.8% of the non-LTC Newcastle upon Tyne patients aged 16+ were classed as obese or morbidly obese.

The following BMI age heat table is for patients **with** a Long Term Condition:

Obese / Morbidly Obese Patients With A LTC	16-20	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	71-75	76-80	81-85	85+
Gateshead CCG	0.7%	1.1%	1.6%	2.2%	2.9%	5.4%	8.0%	11.1%	12.0%	13.5%	14.9%	10.8%	8.7%	4.9%	2.1%
Newcastle CCG	0.7%	1.3%	2.1%	2.6%	3.2%	5.7%	7.9%	11.6%	13.4%	13.1%	14.1%	9.7%	7.7%	4.8%	2.1%
CCG Total	0.7%	1.2%	1.9%	2.4%	3.1%	5.5%	8.0%	11.4%	12.7%	13.3%	14.5%	10.2%	8.2%	4.8%	2.1%

The following BMI age heat table is for patients **without** a Long Term Condition:

Obese / Morbidly Obese Patients With No LTC	16-20	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	71-75	76-80	81-85	85+
Gateshead CCG	4.4%	9.3%	12.3%	12.6%	10.2%	12.8%	12.1%	9.8%	6.8%	4.1%	3.3%	1.5%	0.6%	0.2%	0.1%
Newcastle CCG	6.3%	13.2%	15.2%	14.9%	11.0%	10.6%	9.2%	7.7%	5.0%	3.4%	2.2%	0.8%	0.4%	0.1%	0.1%
CCG Total	5.4%	11.4%	13.9%	13.8%	10.7%	11.6%	10.5%	8.6%	5.9%	3.7%	2.7%	1.1%	0.5%	0.1%	0.1%

From the BMI LTC age heat table you can see that the majority of patients who are classed as obese or morbidly obese are in the age range 51-75. In contrast, for patients who do **not** currently have a LTC patients are at risk of developing a LTC because obesity is prevalent in a younger age group (21 onwards).

If advice in regards to lifestyle, exercise and healthy eating is offered to the younger patients who do not currently have a LTC there is a chance that they can avoid developing a LTC in future.

Alcohol

- As at June 2016, 13.2% of the non-LTC Gateshead patients aged 18+ drink a hazardous amount of alcohol and 3.5% of non-LTC patients aged 18+ drink a harmful amount of alcohol.

- As at June 2016, 9.7% of the non-LTC Newcastle patients aged 18+ drink a hazardous amount of alcohol and 2.6% of non-LTC patients aged 18+ drink a harmful amount of alcohol.

The following alcohol age heat tables are for patients **with** a Long Term Condition:

Gateshead CCG LTC	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85+
Hazardous	0.1%	0.4%	0.6%	0.8%	2.0%	4.1%	7.2%	11.1%	13.8%	14.9%	17.6%	13.2%	8.7%	4.1%	1.6%
Harmful	0.2%	0.2%	1.1%	2.7%	3.4%	7.3%	9.7%	14.8%	17.2%	15.1%	13.0%	9.0%	4.1%	1.5%	0.7%

Newcastle CCG LTC	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85+
Hazardous	0.2%	1.3%	0.7%	1.1%	1.9%	3.6%	6.5%	10.7%	13.6%	16.1%	17.4%	12.4%	7.5%	4.5%	2.5%
Harmful	0.2%	0.6%	0.9%	1.6%	3.0%	6.2%	10.8%	13.7%	14.6%	17.7%	14.2%	9.9%	4.0%	1.8%	0.8%

Total CCG LTC	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85+
Hazardous	0.1%	0.9%	0.7%	1.0%	2.0%	3.8%	6.8%	10.9%	13.7%	15.5%	17.5%	12.8%	8.1%	4.3%	2.1%
Harmful	0.2%	0.4%	1.0%	2.1%	3.2%	6.7%	10.3%	14.2%	15.8%	16.5%	13.6%	9.5%	4.0%	1.7%	0.7%

The following alcohol age heat tables are for patients **without** a Long Term Condition:

Gateshead CCG Non-LTC	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-69	80-84	85+
Hazardous	0.6%	3.9%	5.4%	6.5%	6.6%	13.3%	15.6%	15.8%	12.3%	8.6%	6.9%	3.3%	0.9%	0.2%	0.0%
Harmful	0.2%	3.7%	5.7%	8.9%	12.1%	13.5%	17.4%	14.5%	11.5%	5.9%	4.1%	1.5%	0.7%	0.2%	0.0%

Newcastle CCG Non-LTC	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-69	80-84	85+
Hazardous	2.9%	17.4%	6.3%	6.8%	5.5%	9.0%	12.0%	13.0%	10.8%	7.5%	5.6%	2.2%	0.8%	0.2%	0.1%
Harmful	1.8%	9.3%	7.2%	9.2%	10.9%	10.1%	13.8%	16.2%	10.1%	6.1%	3.4%	1.5%	0.6%	0.0%	0.0%

CCG Total Non-LTC	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-69	80-84	85+
Hazardous	1.7%	10.7%	5.8%	6.6%	6.0%	11.1%	13.8%	14.4%	11.6%	8.0%	6.2%	2.7%	0.9%	0.2%	0.1%
Harmful	1.0%	6.5%	6.5%	9.0%	11.5%	11.8%	15.6%	15.3%	10.8%	6.0%	3.8%	1.5%	0.6%	0.1%	0.0%

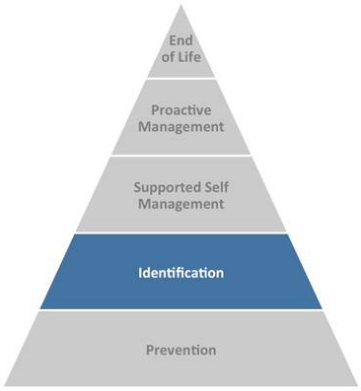
For the non-LTC patients, the hazardous and harmful drinkers vary depending on the area. This is because Newcastle has a student population, evident from the 17.4% of patients who are drinking a hazardous amount of alcohol on a weekly basis. Whereas in Gateshead from age 40 to 59 is the target group for hazardous drinkers and from age 40 to 59 is the target group for harmful drinkers. Contrast this with those that already have a Long Term Condition and for both areas the age range is 50-74 for both drinking groups.

4.1.3 Intention

The CCG will work with interested parties including our Local Authorities and Public Health to minimise the number of people who develop a LTC and reduce the impact for those that do. Identifying patients who are at higher risk of developing a LTC will be followed up with a clear explanation for the patient about this risk and discussion about possible options to reduce risk. It is recognised that health care professionals need to listen to, understand and respond to all the factors that influence a person's health and wellbeing and together with the individual make a shared plan to address them.

4.1.4 Strategic Actions

- We will work with our Local Authorities, to enable people to access support to improve health
- We will work with our Local Authorities, in particular Public Health, to make sure that services meet the needs of individuals and enable them to take steps to improve their health e.g. Stop Smoking Services
- We will support people with LTCs to help them reduce the risk of deterioration in their LTC e.g. reducing the risk of developing complications in people with type 2 diabetes by providing advice and support on a healthy diet
- Support our local populations to address the wider determinants of health by ensuring a more than medicine approach is taken when planning developing health services.
- Develop services for those at highest risk of developing Diabetes to help them reduce their risk.
- Work with Practices to ensure that patients at high risk of stroke because of other medical problems are offered treatments to reduce their risk
- Work with Providers to identify other opportunities for prevention at scale



4.2. Identification

4.2.1 How will this look for the patient?

"If I do develop a long term condition, it will be identified early and I will be supported through diagnosis"

4.2.2 Local Context

The number of people diagnosed with an LTC in Newcastle and Gateshead is lower than expected when compared to estimated numbers, suggesting that we have not identified the whole population. Unknown patients imply unmet need, increased use of local health services and increased chance of people suffering unnecessarily and dying early, compared to England averages

The following table highlights for the disease groups Hypertension, CHD, Stroke, COPD and Diabetes what the prevalence is and also what the expected rate is for each area:

	CCG List Size	Gateshead 208,050	Newcastle 324,714
Hypertension	No. With	33,771	36,798
	Prevalence	16.2%	11.3%
	Expected	32.3%	27.3%
CHD	No. With	8,449	9,235
	Prevalence	4.1%	2.8%
	Expected	6.7%	5.3%
Stroke	No. With	3,048	3,709
	Prevalence	1.5%	1.1%
	Expected	2.8%	2.2%
COPD	No. With	6,039	6,512
	Prevalence	2.9%	2.0%
	Expected	5.2%	4.4%
Diabetes	No. With	11,621	15,007
	Prevalence	5.6%	4.6%
	Expected	7.5%	7.0%

4.2.3 Intention

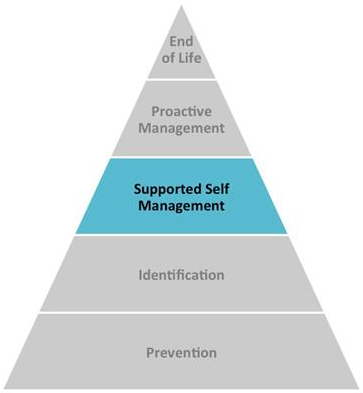
The CCG will work with our partners to increase uptake of screening and awareness of symptoms that need investigation and as a result of this improve the early identification of patients with Long Term Conditions.

4.2.4 Strategic Actions

We will begin to address this by:

- Maximising the uptake of the NHS Health Checks Programmes through participation in local and national campaigns
- Improving the identification of people with COPD through maximising opportunities to note smoking status and standardising the use of risk assessment tools.
- Implementing the NICE suspected cancer guidelines to ensure earlier diagnosis of cancer
- Working with General Practice to ensure systematic approaches to idenitifying those who have developed conditions such as Diabetes or Hypertension.
- Working with General Practices to identify people at risk of osteoporosis

- Improve identification of heart failure through improving the Heart Failure Pathway.
- Maximse uptake of cancer screening programmes



4.3. Support for Self-Management

4.3.1 How will this look for the patient?

"I will be able to understand and manage my own condition, with support from health care professionals when I need it."

4.3.2 Local Context

NGCCG, has an ageing population, high levels of deprivation and an increasing prevalence of patients with LTCs who have a high use of secondary care services. A recent frailty census undertaken in one of our hospitals identified that over 70% of inpatients [excluding children's and maternity services] were frail with 30% of those people found to be severely or very severely frail using the Rockwood frailty tool.

Most people with LTCs spend just a few hours per year with healthcare professionals and more than 99% of their lives managing their conditions themselves. As such, they need to become experts in their own health and will make all the day-to-day decisions which affect their own health. In terms of healthcare this means that the system needs to support individuals to develop the knowledge, skills and confidence to manage their own care. Additionally, healthcare professionals may also need support to develop new knowledge and skills from time to time and this can include learning from expert patients and their families.

Support for self-management recognises that people with long term conditions (LTCs) are in charge of their own lives and are the primary decision makers in relation to the management of their condition. This means the role of the clinician moves from doing things 'to' the person, to supporting people's confidence and competence to manage the challenges of living with their condition. This also includes supporting family carers to lead on self-management when necessary, given that such people are often the reason those with LTC are able to remain living in their community rather than being admitted to hospital in a crisis or live in an institutional setting in the longer term.

There is an extensive evidence base for the effectiveness of interventions which support self-management and their cost effectiveness. The Chronic Care Model (11) describes how better outcomes for people with LTCs can be achieved when there is partnership working between an 'engaged', 'empowered' or 'activated patient' and an organised proactive healthcare system. It has been suggested that the most important element of this complex intervention is support for self-management.

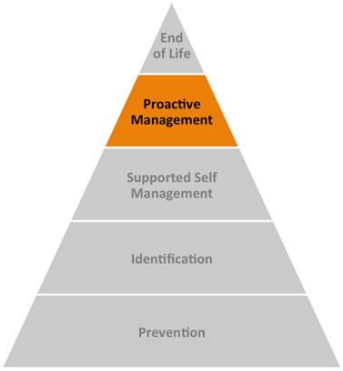
4.3.3 Intention

Our aim is to make sure patients are aware of what is available to them, to help them to manage their own conditions effectively, using services which support individuals and their carers. This can include a range of services and groups, with peer and emotional support, (such as social prescribing, peer support groups and referral to community psychological therapies)

4.3.4 Strategic Actions

We will achieve this by:

- Working with General Practices and the wider health care system to ensure delivery of the Year of Care approach for LTCs – a way services can provide personalised, coordinated care for all LTCs through care and support planning.
- Work in partnership to enable the development of services to support patients to live with and understand their condition e.g. developing patient support groups such as Breathe Easy Groups (British Lung Foundation), providing training to help patients better understand and manage their condition; ensuring effective rehabilitation services are in place; developing service to support patients who have survived cancer
- Contributing to the development of the social prescribing system to ensure it addresses the needs of people living with LTCs or at risk of developing them.
- Using technology to help people to live with and manage the impact of their LTC
- Making sure patients and health care professionals are aware of the services available locally to support them.
- Offer support for carers of those with LTC ensuring carers are able to access the full range of support available to them



4.4. Proactive Management

4.4.1 How will this look for the patient?

"I will be supported by an identified team to manage the impact of my conditions on my wellbeing and make sure there are plans in place for when I need them."

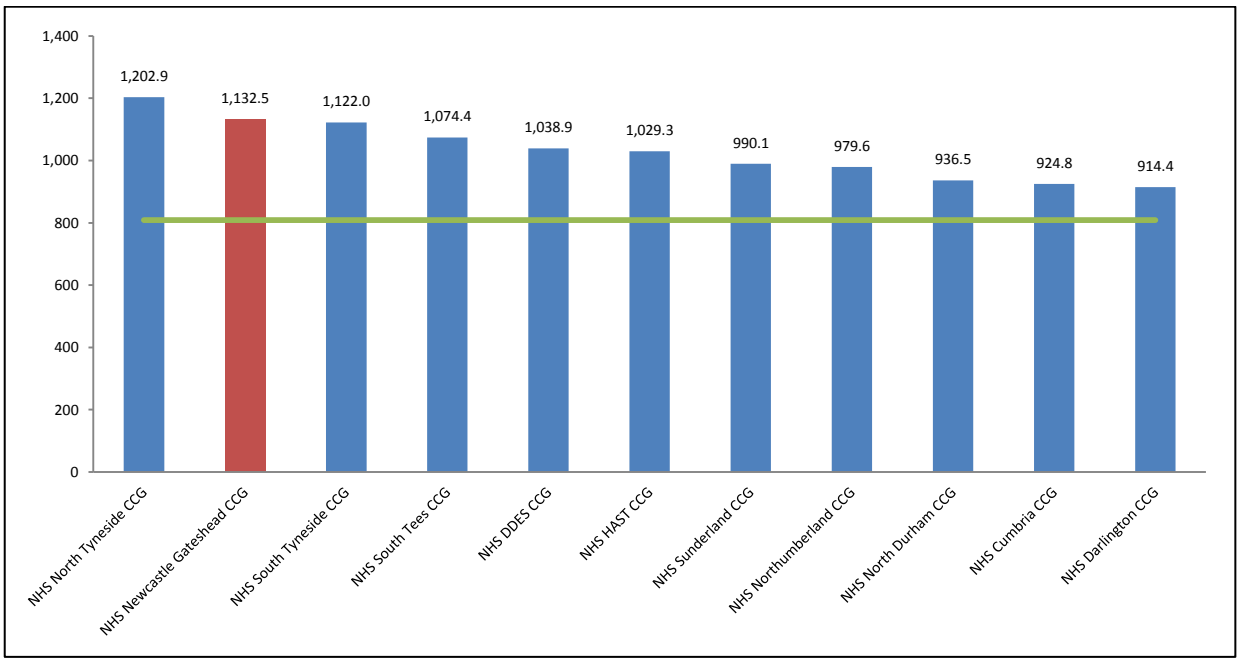
4.4.2 Local Context

Each year more people with one or more LTC are identified and the population of frail elderly people with multiple LTCs is increasing.

The population is ageing and life expectancy is increasing each year. This is a success for society brought about by improvements in public health, welfare and increasingly effective management of patients with long-term conditions. However, not everyone remains healthy and active as they age. Most older people live with at least two long term conditions that affect their health and wellbeing. The National Institute for Health and Care Excellence (NICE) (2015) suggested that, on average, a man of 65 will live a further 17.6 years but will face 7.7 years of ill health and 7.4 years with a disability towards the end of life. On average, a woman of 65 will live a further 20 years but will have 8.7 years of ill health and nine years with disability. This time spent in ill health and disability can be attributed in some cases to frailty (8).

Frailty is a distinctive late-life health state in which apparently minor stressor events are associated with adverse health outcomes. Frailty shares the key features of a long-term condition but is not currently conceptualised as such. Individuals living with frailty could benefit from frailty being managed as a long-term condition as this would allow for the development of primary care-based registers, the application of chronic disease models and a more coordinated team based approach to management (9).

Newcastle Gateshead CCG has the second highest rate in the North East for unplanned hospitalisation for chronic ambulatory care for all ages. Overall in England, Newcastle Gateshead CCG is above the England average and is also in the significantly higher group, giving a high rate of unplanned admissions for Chronic Ambulatory Care conditions.



Clinical experience and medical research suggests that older people have better health outcomes when their care is comprehensive, co-ordinated, multidisciplinary and expert. Approaches to assessment and care based on single or episodic illnesses, or single diseases, are not suitable for many older people who are living with multiple conditions. Their requirement is for holistic, person-centred care and in practice the wellbeing of many older people is compromised by gaps in assessment and by failures in the diagnosis, treatment and management of conditions such as frailty, dementia, arthritis, foot health, chronic pain, mobility problems, visual and hearing impairment, incontinence, malnutrition and oral health. These people need an approach to care ensuring comprehensive assessment, personalised care plans and long-term follow-up(12). Hence the need for multi-morbidity clinics in primary care that are integrated with community teams providing accompanying case management when necessary.

4.4.3 Intention

Each year more people with one or more LTC are identified and the population of frail elderly people with multiple LTCs is increasing. Providing good quality, proactive care is a priority to guide patients and their carers in the right direction. We are working to change services to improve joined up care to benefit those living with LTCs and their carers.

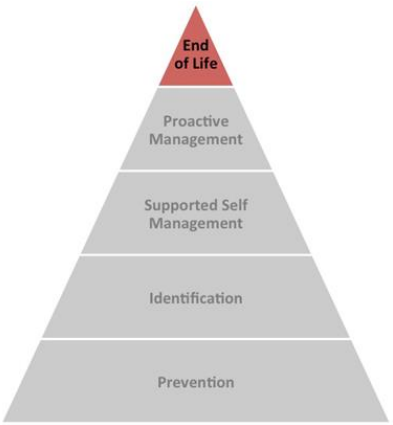
4.4.4 Strategic Actions

We will achieve this by:

- Working with hospital teams to support the development of frailty services that recogise the long relationship patients and their families have with primary care and community services so that liaison and co-working starts early in the inpatient journey
- Working with general practices to enhance the services they provide for people with specific LTCs
- Working with local health services to identify those patients with LTCs who need

more complex care plans developed to support them.

- Working with general practices to ensure care for people with LTCs is based on the person and not the condition
- Linking to work in the wider CCG, to develop a model for risk profiling the population both at a CCG level to inform allocation of resources; and at a practice level to inform identification of patients suitable for Case Management
- Ensuring that intermediate care services, commissioned by NGCCG, recognise and meet the needs of those patients with LTCs.
- Working with providers to reduce follow up in secondary care, and move to a system that allows patients to be seen on the basis of need.
- Increasing support for General Practices to manage people with LTCs, including support from specialist secondary care teams.
- Analysing General Practice data, and ensuring the use of guidelines, best practice and the use of data to identify variation in practice, to help General Practices address this and implement best practice.
- The integration of care pathways to join up in and out of hours care, especially in terms of shared care plans
- The development of multidisciplinary teams that work closely with primary care teams making transition of care and case management seamless
- The identification of frailty, using standard tools to promote active management and care delivery that seeks to delay progression through the spectrum
- Building on new models of care such as the Enhanced Health Care for Care Homes [EHCH] given it's success in shifting from a reactive to a proactive model
- Working with partners in the local health economy to meet the goals in the National Cancer Strategy on faster diagnosis, faster access to treatments and improved cancer survival rates



4.5. End of Life Care

4.5.1 How will this look for the patient?

"As I approach the end of my life, care and support will be planned so that I can die where I choose, in comfort and with dignity."

4.5.2 Local Context

Nationally we know that on average approximately 1% of a given population will be expected to die in an average year. The CCG wants to ensure that this part of our population can be identified to ensure that they receive coordinated, high quality, appropriate care during this period in their life. Currently across Newcastle and Gateshead we know that only 0.33%% of our population are identified as being on General Practice's Palliative care registers.

For this population we want to ensure that they have had an active role in developing clear plans together with the people involved in providing their care that reflects how they would like to be cared for at this point in their life which will be written in an Advance Care Plan. Currently only 27% of patients in Gateshead and 42% of patients in Newcastle have an Advance Care Plan in place.

It is understood that older people living with frailty, especially those over 85 years old, are less likely to access palliative care than younger adults (13). We want to be mindful of this and seek to ensure that a targeted approach is taken e.g. all those living in care homes will have end of life discussions and be considered for inclusion on the practice palliative care register.

When people are approaching the end of their life we want to ensure that services are able to work together closely to coordinate the person's care to ensure the last stage of their life is as good as possible. In Newcastle and Gateshead we need to work with all services to ensure consistency of care and sharing of information to enable this to happen.

4.5.3 Intention

To Develop systematic ways of improving care for people approaching the end of their life with LTCs. To improve coordination of care and ensuring sharing of information, enabling patients and their cares to have a voice in the care they wish to receive.

4.5.4 Strategic Actions

We will achieve this by:

- Promoting the use of palliative care standards in general practice with a focus on developing palliative care registers and increasing the use of Advance Care Plans.
- Developing an electronic palliative care record
- Implementing guidelines for prescribing in palliative care
- Reviewing hospice and palliative care services primarily in Gateshead but followed by Newcastle
- Ensuring services are in place to enable facilitated discharge both in and out of hours and sees coordination between health and social care teams
- Ensuring professionals involved in end of life care are confident and skilled to have difficult conversations with patients and their cares by the provision of relevant training

5. System Enablers

5.1 Workforce Development

A significant amount of long term conditions care in General Practice is carried out by the practice nursing team and it is recognized that there is a pool of skilled and experienced nurses in the CCG practices.

It is essential that all members of the team have the opportunity to access education and training to support them to deliver patient focused care that is effective, evidence based and facilitates self-care. The CCG will link with other local, regional and national work to ensure that education is appropriate to the needs of learners, their employers and patients.

The CCG recognises the need to develop the nursing workforce for the future who will provide care as part of multi-disciplinary teams and will work with providers to minimize variation and maximize interdisciplinary working.

The emerging roles of Primary care navigators and Community Link Workers are increasingly involved in helping and supporting patients with LTCs. We need to ensure that staff in these and other new roles are involved in delivering the aims of this strategy and that their work is effectively evaluated and developed in line with national policy.

Innovative roles such as the recently introduced practice based frailty nurse posts will be robustly evaluated and explored further for widening to all practices.

Patients have told us that some of their key concerns involve medication; understanding what they are for, how to use them and understanding what side effects they should watch out for. Pharmacists have a key role in supporting those with long term conditions and the CCG will support the new roles being developed for pharmacists in practices.

We recognise the needs of our future workforce and will work with partners to promote the principles outlined in this strategy so that the Health Care Professionals of the future are equipped to adopt a patient-centered approach in managing Long Term Conditions

5.2 IT

Our digital vision is to deliver the best seamless care by ensuring:

- Secure real time access to agreed relevant health and social data is available to the practitioner wherever and whenever they are legitimately involved with the service user
- Rapid, efficient and effective transfer of relevant information relating to service users across organisations
- Easy electronic access to organisational support materials/resources for professionals (including resources to be able to signpost service users)
- Patients, their families and / or their carers or other patient proxy have access, where appropriate, to their records

Plans to deliver a paperless NHS system and ensure delivery of the above vision

have been documented in the Newcastle Gateshead Local Digital Roadmap. This includes plans for developing:

IT infrastructure so systems are able to work together seamlessly, with an increased use of mobile technology

- Information sharing solutions so information can be safely shared across organisations
- Digital solutions to enable patients to self care, including use of telehealth and Apps

The Great North Care Record is an initiative which is developing a regional approach and solution to information sharing, this will deliver a system where:

The ***population*** (the patients, customers and citizens we serve) will be safer, more in control, and more involved in decision-making. They will have a well-founded confidence that the professionals who are listening to their story have the whole picture, in so far as they have chosen to share it. Health outcomes and measures of wellbeing will improve. The Great North Care Record will accelerate the diffusion and implementation of solutions, particularly those which enable people to interact with their own records and manage their own care.

The ***staff*** (the health and social care practitioners employed in health and care organisations) will have more efficient and enjoyable working lives. They will be able to make decisions with more certainty and less risk. Because record keeping will be more productive, they will spend less time on administration and paper-work, and more time offering care. Job satisfaction will increase and frustration will decrease. Time will be better spent. The people who lead and organise services (managers) will see value for money improve and waste reduce. This will happen because process costs will fall, in the same way as they have in other industries. It will be easier to launch new services, because the information needed to operate safely will already be available.

Commissioners (the people who plan and fund services) will be able to target services with more precision at the people who need them. Because information moves safely and securely across organisational boundaries, transfers of care are safer and more seamless. Because interoperability is built in from the start, reconfiguration of services is quicker, cheaper and safer. Use of expensive, disruptive, stressful and risky unplanned care will decrease. Over time, commissioners will develop an increasingly rich understanding of the way in which their populations access and interact with services. And because The Great North Care Record offers a holistic picture of services, it is a tool for understanding how changes and interventions interact and combine to alter outcomes.

5.3 Using new models of contracting to change the provision of LTC Care

The emerging contractual models for General Practice offer opportunities for practices to work together to pool skills and expand the skills available in primary care to manage those with LTCs and Multi-Morbidity.

Outcome based contracts also provide new ways of delivering care that is delivers the outcomes needed by those with LTC.

The CCG will work together with providers to ensure that these contracting models provide maximum benefit for those with LTCs

5.4 Prescribing support and medicines optimisation

Medicines are the most frequent healthcare intervention. The NHS spends £13.8 billion per year. The number of prescribed items is growing by 5.3% annually, but:

- 30-50% of medicines prescribed for long term conditions are not taken as intended
- 4-5% of hospital admissions are due to preventable adverse effects of medicines
- In primary care it is estimated that £300 million per year of medicines are wasted, £3 million per year in Newcastle Gateshead CCG, of which half is avoidable.

Our aims are to ensure people with long-term conditions get the most out of medicines and the best outcomes; that they get the right medicine at the right time; that these medicines are taken correctly and safely; that unnecessary medicines aren't being taken; and medicines are not wasted.

We will do this by:

- Ensuring evidence based, cost effective prescribing by having robust local decision making processes for medicines in line with the NHS Constitution and effective systems for implementation of NICE guidance.
- Ensuring all medication is used safely. This includes reporting medicines errors and embedding learning into policies, training and practice; appropriate antibiotic prescribing.
- Understanding the patient's experience and supporting patients and clinicians to reach shared decisions on the use of medication
- Supporting patients to manage their condition and medicines and to make choices about prevention of illness and disease and healthy living
- Supporting medicines reviews for patients with long term conditions e.g. GP/nurse/pharmacist medicines reviews, and working with community pharmacy colleagues to maximise benefits from new medicines reviews and medicines use reviews
- Including medicines optimisation within all commissioning and service re-design, and support new models of delivery to embed safe, high quality and cost-effective use of medicines across providers and seamless care across care settings
- Delivering medicines optimisation QIPP initiatives each year promoting quality and innovation as well as productivity and prevention in pathways of care involving medicines
- Working with all stakeholders/ commissioned providers e.g. patients, primary care based contractors, community providers, secondary care, care homes, local authority to ensure medicines optimisation is part of routine practice
- Supporting the use of new technology e.g. telehealth and telemedicine where this will help to improve patient care.

5.5 Social Prescribing

An increasing body of evidence supports the greater use of a ‘more than medicine approach’ to health care. Working within 4 specific activation areas we will increase the current social prescriptions being offered, and build a sustainable approach via:

- Practice Activation: Supporting the currently workforce and development of the future workforce to offer social prescriptions to patients.
- Person Activation: Supporting patients to support themselves via self care or support their communities via asset based community development approaches.
- System Activation: Supporting NHS settings to work across system on the social prescribing agenda, engaging with all partners to develop robust models of health and wellbeing across communities.
- Community Activation: supporting communities to engage in health and wellbeing activities via the above.

5.6 Estates

The CCG estates strategy provides opportunities for practices and community services to work together in new ways to integrate services for those with long term conditions

6 Ensuring Delivery

6.1 Governance

Implementation of the LTC Strategy will be assured by the Newcastle and Gateshead Long Term Conditions Programme Board.

The Programme Board will be underpinned by clinical working groups delivering programmes of work in the following areas:

- Diabetes
- Respiratory care
- Cardiovascular disease
- Cancer
- End of life care
- Liver disease
- The Year of Care
- Frailty

It will be the responsibility of these working groups to ensure implementation of the LTC Strategy. The working groups are accountable to the LTC Programme Board and will provide quarterly updates on delivery of their work plans to the LTC Programme Board.

The LTC Programme Board is accountable to Newcastle and Gateshead CCG Executive Committee. This is illustrated in the following diagram:

6.2 Monitoring Implementation

An implementation plan will be developed for the strategy which will be underpinned by detailed work plans produced by all of the supporting clinical work streams.

An LTC Outcomes Framework will be developed in conjunction with our stakeholders to include the use of “I statements”, together with supporting metrics, will be used monitor ongoing implementation of the Strategy.

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