Coventry City Council

Briefing note

To Health and Social Care Scrutiny Board (5) **Date 4th February 2015**

Subject "Clinical Management of Large Scale Chronic Diseases: To review how pathways are being managed in primary care for a range of challenges"

1 Purpose of the Note

1.1 To describe services being delivered in primary care and designed to prevent onset or progression of long-term conditions which are currently being commissioned by Coventry City Council Public Health (CCC PH)

1.2 To describe existing pathways designed to prevent progression of and manage specific long-term conditions (focussing on parts of these pathways which are undertaken in primary care)

1.3 To describe plans to transform existing long-term conditions pathways, focusing on areas were a move towards delivery of care in primary care setting is planned

1.4 To describe plans to provide more integrated, holistic care for patients with multiple long term conditions or frailty, rather than focussing on individual conditions

2 Recommendations

2.1 To note services commissioned by both Coventry City Council Public Health (CCC PH) and Coventry and Rugby Clinical Commissioning Group (CR CCG) and delivered in primary care settings designed to prevent onset or progression of a number of different long term health conditions; especially noting planned changes to treatment pathways

2.2 To make recommendations to relevant commissioning organisations, especially where significant changes to pathways are being suggested

2.3 To note and make recommendations on plans to provide more holistic, integrated care to those with multiple conditions and frailty.

3 Information/Background

3.1 *Introduction*

3.1.1 Long term conditions are defined as diseases which cannot be cured and therefore the treatment focus is on management. Treatment may be aimed at stopping or slowing down disease progression. For some long term conditions focus of treatment is on preventing complications associated with the condition, for example preventing blindness in people

who have diabetes. The overall aim of treating long term conditions is to minimise the impact the condition has and enable the patients to lead a fulfilling life, despite their illness. In England 15 million people are diagnosed with one or more long term conditions and care of people with long term conditions accounts for 70% of the money spent on health and social care in England. Common long term conditions include diabetes, chronic obstructive pulmonary disease (COPD) and cardio-vascular diseases (for example heart disease, heart failure and stroke). Degenerative conditions like dementia are also considered to be long term conditions.

3.1.2 The last number of years has seen significant improvement in prognosis for some long-term conditions, for example early deaths from heart disease have reduced by 40% in the last fifteen years. However, as people are living longer, their risk of developing one or more long term conditions increases. Living longer also increases the likelihood that serious disease complications will develop. Development of long term conditions is also linked to deprivation. People living in deprived areas are more likely to develop long term conditions, more likely to develop them earlier in life and less likely to have well managed conditions. Any strategy to reduce burden of long term conditions needs to consider the wider challenge of reducing inequalities. Finally new technology to diagnose and treat conditions is always developing, while this will increase numbers of people living well with these conditions, it will also increase the costs associated with these conditions.

3.1.3. The way people wish to be treated is changing with many people wanting greater involvement in their own care. This challenges the traditional patient-professional divide and creates an opportunity for people to care for and manage their own conditions.

3.1.4 The NHS Five-Year Forward Plan, describes a number of ways to deal with the increasing prevalence and associated increasing cost of managing long-term conditions, including:

- Greater investment in prevention and public health to curb the sharp increase in the burden of avoidable illnesses; including national action to decrease smoking, obesity and alcohol use
- Sharing of health and social care budgets to reduce existing inefficiencies and increase patient satisfaction
- Breaking down barriers between different parts of the care system, so that a whole-person, patient centred approach can be given to those with multiple conditions and complex needs.
- Support GP practices to provide high-quality long term care and facilitate a shift in investment from hospital to primary and community care, where appropriate.

This report will outline how services are being commissioned to reflect these principles in Coventry. It includes cross-cutting prevention strategies and a range of disease-specific pathways, as well as some innovative work to create holistic care pathways for people with multiple needs. The report has been produced in consultation with Public Health, Clinical Commissioning Group and Acute Care colleagues.

3.2 *Cross-cutting, prevention strategies*

3.2.1 A number of services to prevent conditions developing, to increase early diagnosis, and to prevent disease progression and complications are commissioned. These include a range of services from those designed to support healthy lifestyle choices and commissioned locally by CCC PH to nationally commissioned vaccination programmes for people with long term conditions. A full list of healthy lifestyle services has been created and CCC PH have developed a Single Point of Contact from which to access these services which will

be live from February 2015. The following section highlights some of the prevention services commissioned by both CCC PH and other organisations.

3.2.2 Physical activity can prevent weight gain and aid weight loss, but evidence also shows that physical activity alone can independently improve outcomes for people with a number of different long-term conditions including diabetes and COPD. CCC PH commission a range of services to help people increase their levels of physical activity. We also engage with GP practices to ensure that they are aware of these services and to sign-post their patients to these services, where appropriate. Last year CCC PH held a consultation event with GPs to try and understand some of the barriers to physical activity for patients and how CCC PH could support GPs to support their patients to increase their physical activity. CCC PH also commission a programme of healthy walks around the city – about 1000 individual walks and around 8000 individual attendances. Some of these are targeted at groups with or at greater risk of developing long term conditions.

3.2.3 Obesity is linked to a number of long-term conditions including diabetes, stroke, and coronary heart disease. Being over-weight or obese is also linked to complications for many long term conditions including heart failure and COPD. CCC PH commission a number of services to help people achieve and maintain a healthy weight including Slimming World on prescription which can currently be access via some GP practices in the city. From April 2015 all PH-commissioned weight management services will be delivered via the Health Trainer Service, this includes Slimming World on Prescription which will no longer be available through GPs. This decision was made as not all GP practices are providing referrals, thus limiting accessing to the service. It is believed that Health Trainers will improve access to weight management services and are in a position to target those most at risk of developing long term conditions. While most of the support Health Trainers deliver is around weight management they also deliver support and advice around other lifestyle behaviours like smoking and alcohol. This means that people can be offered more holistic support to help them change their unhealthy behaviours.

3.2.4 Smoking is linked to both the development and progression of a number of long-term conditions including COPD, heart failure and stroke. CCC PH commissions three providers to deliver a stop smoking service in a wide range of locations. These include pharmacies, GP practices, community health centres and non-health venues in the community venues. Services specifically targeting vulnerable populations and populations with high prevalence of smoking (for example people with mental illness) are also commissioned.

3.2.5 The NHS Health Check programme aims to help prevent heart disease, stroke, diabetes, kidney disease and certain types of dementia. Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions or have certain risk factors, will be invited (once every five years) to have a check to assess their risk of these conditions and will be given support and advice to help them reduce or manage that risk. In Coventry GP practices are the main provider of NHS Health Checks. Additionally, NHS Health Checks are being delivered in outreach locations across Coventry to target people who do not attend their GP. There are also plans to increase uptake among men using innovative approaches like partnering with Coventry Sports Foundations and Trusts. Over 65% of Health Checks have been delivered in GP practices based in the most deprived areas of the city.

3.2.6 Living in a cold home is associated with exacerbation of a number of long term conditions including COPD and cardio-vascular diseases. People how live in cold homes also have an increased likelihood of developing flu or pneumonia-both of which are more serious for people with long term conditions. CCC PH has commissioned Groundwork to deliver the Keeping Coventry Warm programme. The programme aims to support vulnerable groups

including those with long term conditions. This results in reduce demand for health and social care provision. The service includes support to manage energy use, switching utility bill supplier and (where the patient meets eligibility criteria) the provision of home improvements such as loft insulation, cavity wall insulation and boiler replacements and repairs.

3.2.7 NHS England commission an adult vaccination schedule for older adults and adults with specific health conditions. This schedule includes annual 'flu vaccination and pneumococcal vaccination for adults over 65 and those diagnosed with long term conditions. Adults with long-term conditions are offered these vaccinations because they are at increased risk of developing serious complications if they do become infected with influenza or pneumococcal. Both vaccinations are provided by GP practices with the local health protection board (led by CCC PH) responsible engaging with practices to ensure good vaccination uptake.

3.3 *Diabetes*

3.3.1 Diabetes is one of the key priorities for CR CCG as defined in the 2014/15-2018/19 Plan on a Page (Appendix I). The rate of diabetes is rising across the population of Coventry, with prevalence rising from 4.7% in 2005 to over 5.5% in 2015 and is predicted to rise to over 6.5% by 2025. This prevalence relates to diagnosed cases only and it is estimated that the true number of cases is about 35% greater. The diabetes service transformation is designed to ensure that services are fit for the increasing numbers of diabetics.

3.3.2 The programme has been formed to take forward a number of key areas to improve services for patients with diabetes, and ensure that CR CCG are commissioning the right services that are best placed to meet the needs of patients and carers. It will ensure only specialist diabetes patients requiring acute hospital care will be seen in hospital, in line with best practice guidance

3.3.3 CR CCG has considered models of care identified as best practice from across the country, and has decided to that only patients who need very specialist care (for example children diagnosed with diabetes and people at risk of foot amputation) will be seen in hospital. The remaining patients will be seen within the newly developed Community Diabetes Service. The Community Diabetic Team will consist of a multi-skilled, multi-function team whose role will be to support primary care (GP Practices) and will be responsible for:

- Advice and support to primary care (by telephone and email)
- Case management of borderline cases to decide if patients need hospital care
- Patient pathway monitoring
- Consultant-led community clinics
- Audit and education (including educational sessions with CR CCG clinical educators)

The team will be consultant-led and include:

- GP with Specialist Interest in Diabetes
- Diabetes Nurse
- Dietician
- Podiatrist
- Consultant diabetes physician

3.3.4 The transformation programme will be commissioned so that the provider will be paid based on patients' outcomes, rather than a traditional commission model where payment is based on activity. In developing the new community clinics, CR CCG is working with

Diabetes UK to ensure patient engagement and have had 4 patient events with over 300 people attending. The new service provider will also lead on developing a self-care approach in partnership with Diabetes UK. This part of the service will focus on developing local communities' assets to provide peer support for diabetics. Another key element is patient education including a number of initiatives to engage with ethnic minority groups whose uptake of diabetes patient education has traditionally been low.

3.4 *Stroke*

3.4.1 The CR CCG Stroke transformation programme is focussing on primary and secondary prevention, and community neuro-rehabilitation. CR CCG is also involved in a wider Coventry and Warwickshire re-design of the acute care pathway across the patch.

3.4.2 Both Coventry and Rugby and wider Coventry and Warwickshire stroke programmes are taking a whole pathway approach so that acute stroke care, bedded stroke rehabilitation, early supported discharge and community stroke rehabilitation can be considered. Both programmes will aim to achieve shorter lengths of stay in each element of the pathway, achieving improved health outcomes, reduced disability as a consequence of stroke, and a reduction in the number of strokes. The programme will also consider the workforce requirements for the new service model, and ensuring that stroke physicians are suitably available on the pathway according to the regional stroke service specification.

3.4.3 Across Coventry and Rugby there are an estimated 1000 cases of undiagnosed Atrial Fibrillation (AF). Individuals with unmanaged AF who go on to have a stroke have significantly worse recovery time and outcomes. Diagnosis and management of AF is the subject of 2014 NICE guidelines and considered an important part of Stroke prevention. This part of the prevention stream of the stroke programme includes working with primary care to detect AF in patients who may currently be asymptomatic. Part of this will be to make AF detection a mandatory part of NHS Health Checks from April 2016. With enhanced AF detection it will also be necessary to redesigning the current anticoagulation service to cope with the increased impact finding undiagnosed cases will have. This work-stream will be informed by the 2014 NICE guidance for AF.

3.5 *Dementia*

3.5.1 Dementia is a major and growing challenge for the UK society and economy due to increasing life expectancy, chronic morbidity and the aging population. With better understanding of prevention, diagnosis, treatment and care for dementia, and an understanding of the local population, there is more scope to improve the quality of life and wellbeing of people with dementia and their carers in Coventry.

3.5.2 In Coventry, there are thought to be approximately 3,600 people living with dementia. According to the Alzheimer's Society, only around 50% of those people have received a formal diagnosis. The National Dementia Strategy highlights the importance of timely diagnosis, in ensuring that people receive appropriate treatment and support.

3.5.3 Following on from a 2012 Needs Assessment undertaken by CCC PH, Coventry's Living Well with Dementia Strategy 2014-2017 was published in 2014. The vision of this strategy incorporates whole scale change to enable people with dementia and their carers to be as independent as possible, for as long as people, and for people with dementia to 'live well' with the condition. The aim is to fully engage people with dementia and their carers in the design and evaluation of services and support. The needs and wishes of people with

dementia and their carers will be at the heart of action planning and delivery of this strategy. The detailed strategy including plans for implementation are included with this briefing note (Appendix II)

3.6 *Heart Failure*

3.6.1 CR CCC has commissioned an integrated heart failure service the main purpose of which is to provide a consistent and systematic approach to the diagnosis and treatment of chronic heart failure throughout Coventry by strengthening the existing specialist provision in the community and by introducing clear clinical leadership and responsibility across the agreed clinical pathways. The primary aims of this service are:

- To improve the quality of life and clinical outcomes for patients with heart failure
- To reduce admissions, lengths of stay & readmissions to hospital

This aim will be achieved by:

- Prompt diagnosis
- Optimal treatment and management in line with best practice guidance
- Provision of individualised management plans for all newly diagnosed and unstable patients
- Facilitating and supporting management in primary care by improving GP understanding of heart failure management and thus the confidence to treat in a practice setting
- Improving patient access to appropriate treatment and high quality personalised care in the community setting, therefore reducing the over-reliance on hospital care
- Developing a shared care approach across primary, secondary and specialist care services for the patients most at risk
- Supporting self-care

3.6.2 The new service due to commence in April 2015 will:

- Stabilise patients with decompensating heart failure to avoid crisis and hospital admission
- Continue intravenous diuretic therapy for patients stepped down from inpatient treatment to reduce length of stay; or day therapy in secondary care to reduce hospital attendances.
- Reduce admission to hospital for patients with an established diagnosis of heart failure who attend A&E with signs of fluid overload where their condition can be safely managed in the community

3.6.3 Success of the integrated heart failure service will require collaboration with other services, in particular general practice, community services and secondary care. This service will support a shift from reactive care (with a focus on crisis management) to a more proactive preventative approach which promotes partnership and multidisciplinary collaboration. Patient education and the promotion of self-management are integral to the service.

3.7 *Chronic Obstructive Pulmonary Disease (COPD)*

3.7.1. A new COPD pathway was approved as part of CR CCG's transformation programme. The transformation included the implementation of a new community COPD service in April 2012. The overall focus of the transformation was:

- Optimal chronic disease management (including assessment for long term oxygen therapy and optimisation prior to pulmonary rehabilitation)
- Exacerbation assessment and management
- Care for advanced disease
- Self-care and well being

- Support and advice for healthcare professionals

3.7.2 The purpose of the transformation was to make a significant improvement in the care provided for people with COPD and improve access to appropriate treatment and high quality personalised care in the community setting, therefore reducing the over-reliance on hospital care. This will be achieved by supporting the shift from reactive care, with a focus on crisis management, to a more proactive preventative approach which promotes partnership and multidisciplinary collaboration. Patient education and self-care are central pillars of this service transformation. Transformation will require integrated working with other services, in particular general practice, community services and secondary care. The service helped keep admissions to hospital for COPD stable whilst admissions have risen by 25% in other medical areas over the last three years.

3.7.3 An innovative element of the new COPD pathway is the RIPPLE Project (Respiratory Innovation: Promoting a Positive Life Experience) a joint research project between University Hospitals Coventry and Warwickshire, Coventry University and its 3rd sector partners – the British Lung Foundation, Age UK, Grapevine, and People Point Coventry. The project is built upon an asset based community development model that focuses on using community organisations to help bring about better wellbeing when coupled with medical care. The project was conceived following observations by Dr Colin Gelder (respiratory consultant) and Coventry's Community Respiratory Service that their COPD patients were not only experienced ill health from their COPD, but also experiencing social exclusion because of the chronic breathlessness and hyperventilation that is characteristic of this disease. RIPPLE aims to increase patients' wellbeing and resilience by plugging them into community assets, this in turn increases their ability to self-manage and leads to improved clinical outcomes. The RIPPLE project is an important example of asset-based working, use of non-medical interventions to improve clinical outcomes and use of a holistic, person-centred approach to healthcare. The RIPPLE Project is currently being evaluated by Coventry University. If the project is considered cost effective, the model could be transferred to other long-term conditions. The service would need to be funded from the reduction in hospital admissions attributed to it.

3.7.4 Key performance indicators to measure effectiveness of the new COPD pathway include:

- Patient satisfaction as measured by questionnaire
- Number of complaints/compliments received
- Number of adverse events
- Clinical patients outcomes
- Quality of life measures
- Patient admission data

3.8 Holistic care pathways

3.8.1 The traditional divide between primary care, community services, and hospitals is increasingly a barrier to the personalised and coordinated health services patients need. And just as GPs and hospitals tend to be rigidly demarcated, so too are social care and mental health services even though people increasingly need all three. Caring for the needs of patients with long term conditions requires a partnership with patients over the long term rather than providing single, unconnected 'episodes' of care. This partnership is even more important when we are dealing with patients with multiple conditions, or older people who have more complex care needs.

3.8.2 A Kings Fund Inquiry into Managing People with Long Term Conditions states that people with several long-term conditions have markedly poorer quality of life, poorer clinical outcomes and longer hospital stays, and are the most costly group of patients that the NHS has to look after. There is little evidence suggesting what high-quality care looks like for people with multiple long-term conditions and complex needs. However, what evidence does exist suggests that people with multiple long-term conditions tend to get poorer treatment than others. The challenges posed by multi-morbidity underline the importance of general practice, but also the need for it to work more collaboratively with other care providers – and vice versa. Problems in the care of people with multiple needs appear to be system-wide rather than specific to general practice. This suggests a need for a collaborative care model comprising multi-disciplinary case management, systematic follow-up, and working that is better integrated – for example between mental and physical health professionals. While GPs or other professionals in general practice might not necessarily take the lead role, they need to work closely with whoever does provide the case management, as well as maintaining clinical responsibility and remaining a locus of care continuity for the patient.

3.8.3 Locally, services to address the needs of patients with multiple-morbidities and complex care requirements are being developed through The Integrated Neighbourhood Team (INT) pilot which is one programme within the Better Care Fund (BCF). BCF is a local single pooled budget to incentivise the NHS and local government to work more closely together around people, placing their well-being as the focus of health and care services. The INT pilot project is being funded as part of the Coventry Better Care Programme. This is a three-tiered model of care which seeks to ensure that the frail elderly are managed with the most appropriate levels of care from healthcare, social care, community and voluntary sectors. At level 3, a multi-disciplinary team case manages patients with extremely complex needs in order prevent avoidable hospital admissions. The team includes a GP, community matron, social worker, and with other specialists being invited where required. This team puts together a holistic package of care to meet the needs of the individual. At levels 1 and 2 patients with lower need levels will be assessed opportunistically and packages of care developed to help them stay as healthy as possible. This will include support to access both medical and non-medical interventions.

3.8.4 Currently, this new service is being piloted in two GP practices and is focussing mainly on level 3 patients. Plans to reach level 1 and 2 patients and to roll out the service city-wide are being developed. This pilot focusses on older people, but if successfully rolled out in this cohort, could be used as a model to better manage the needs of complex patients of all ages.

VALERIE DE SOUZA,
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APPENDICES

I. **Coventry and Rugby Clinical Commission Group Plan on a Page**

II. **Coventry Living Well with Dementia Strategy**