HEALTH AND WELLBEING BOARD				
Report Title	Reducing Emergency Admissions for people with Long Term Conditions – Lewisham CCG Progress Report			
Author	Lewisham Clinical Commissioning Group		Item No.	5b
Class		Date:	25 November 2014	
Strategic Context	Priority 9: Reducing Emergency Admissions for people with Long Term Conditions.			

1. Purpose

1.1 The purpose of this report is to provide an update on the progress against the objectives for key priority area 9 in the Health and Wellbeing Strategy; Reducing Emergency Admissions for people with Long Term Conditions. The focus of the report will be on the objectives and actions identified in the delivery plan of the Health and Wellbeing Strategy delivered by Lewisham Clinical Commissioning Group. This work on long term conditions is now encompassed within the Adult Integrated Care Programme.

2. Recommendation/s

Members of the Health and Wellbeing Board are recommended to note Lewisham Clinical Commissioning Groups progress against the delivery plan.

3. Policy Context

3.1 The Health and Social Care Act 2012 establishes health and wellbeing boards as a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities. Health and wellbeing board members will collaborate to understand their local community's needs, agree priorities and encourage commissioners to work in a more joined-up way. As a result, patients and the public should experience more joined-up services from the NHS and local councils in the future.

3.2 In line with Lewisham's Sustainable Community Strategy priority to create a 'Healthy, active and enjoyable borough where people can actively participate in maintaining and improving their health and wellbeing', the Health & Wellbeing Board has developed a ten year Health & Wellbeing strategy. The strategy sets out the improvements and changes that the Board, in partnership with others, will focus on to achieve our vision of;

Achieving a healthier and happier future for all

The strategy outlines the key health and wellbeing challenges that people in Lewisham face, as well as the assets, skills and services that are available locally to support people to stay healthy and be happier.

In taking forward action to achieve our vision we have three overarching aims;

I. ***To improve health*** – by providing a wide range of support and opportunities to help adults and children to keep fit and healthy and reduce preventable ill health.
II. ***To improve care*** – by ensuring that services and support are of high quality and accessible to all those who need them so that they can

regain their best health and wellbeing and maintain their independence for as long as possible.

III. ***To improve efficiency*** **–** by improving the way services are delivered; streamlining pathways; integrating services so ensuring that services provide good quality and value for money.

4. Long Term Conditions Programme

4.1 Lewisham Clinical Commissioning Groups 5 year (2013 – 2018) Commissioning Strategy: *A Local Plan for Lewisham* and subsequent priorities are aligned to the Health and Wellbeing Strategy. More so this is particularly apparent for long term conditions;

> *Strategic Aim: To develop integrated care pathways, building on COPD, Heart Failure and Diabetes service redesign work.*
>
> - To provide personalised care, using risk stratification tools to systematically identify people earlier with health issues.
> - To provide comprehensive integrated services for people with dementia.
> - To improve the patient's and carer's experience by changing culture and behaviours so that the patient is at the centre.
> - To enable patients to be better supported to take greater responsibilities, with the opportunity for a healthcare personalised budget.

4.2 The long-term conditions work stream is delivered through the CCGs Quality Innovation, Productivity and Prevention (QIPP) programme. The QIPP programme is the national initiative that aims to make the NHS work more efficiently so that there are more funds available for treating patients. Delivering a successful QIPP programme will be crucial to ensuring that the CCG is using its resources in the most efficient way to enabling it to meet its vision for better health and best care.

4.3 In 2014/15 the number of emergency admissions across all acute providers in Lewisham continues to show a downward trend in comparison to 2013/14. More over for specific long-term conditions; Heart Failure, Chronic Obstructive Pulmonary Disease (COPD) and Diabetes there has been a reduction in the number of emergency admissions by 6.9% for Q1 2014/15 in comparison to the same period in 2013/14. Emergency Admissions for COPD saw the largest fall for the same period in Q1 2014/15 by 8.5%.

4.4 This report provides an update on the actions against each of the 4 deliverables underpinning *Priority 9* attributed to Lewisham CCG;

(i) *Implementing the key principles for treatment and care for all people with long term conditions; Risk Stratification, Integrated Care Teams and Self-Care. the key principles for treatment and care for all people with long term*

(ii) *Encouraging GPs to identify undiagnosed COPD, Diabetes and CVD (hypertension, atrial fibulation, arrythmia, heart failure, CHD) among their patients*

(iii) *Providing support, training and development to primary care in the management of long term conditions*

(iv) *Redesign of all key LTC pathways*

4.3 Implementing the key principles for treatment and care for all people with long term conditions; Risk Stratification, Integrated Care Teams and Self-Care. the key principles for treatment and care for all people with long term

4.3.1 Neighbourhood Community Team (NCT)

4.3.2 The Neighbourhood Community Teams (NCT) are forming the basis of integrated health and social care and the CCG are working collaboratively with partners to deliver this programme. The team consists of health, primary care and adult social care professionals based in four neighbourhood locations in order to enable comprehensive and co-ordinated proactive care to be delivered to at-risk patients. These patients are being referred to their NCT in order to;

(i) have their health and social care needs stabilised to slow down, reduce or prevent any deterioration that could lead to an otherwise avoidable hospital admission
(ii) be intensively supported following discharge from hospital in order to prevent relapse and subsequent re-admission

4.3.3 Locations with adequate capacity for these and mental health teams have been proposed and are being discussed with relevant estates representatives.

4.3.4 Referral to the teams will be via a ‘Single Point of Access’, where appropriate triage and workflow mapping will be carried out to ensure that the patient’s most urgent needs are prioritised but with all other needs being met before “discharge” back to the GP.

4.3.5 The NCTs are a pillar of the Better Care Fund approach to integrated care and exist on a continuum with risk stratification and care planning: identification cannot be divorced from proactive care that stabilises the patient’s risk status. The overarching ethos of the NCT approach is that patients only tell their story once in order that seamless support will be delivered to them by the appropriate team of health, primary and social care professionals working closely together to deliver the same agreed goals with the patient.

4.3.6 For additional detail on progress on delivering and embedding the NCT please refer to the Adult Integration Programme update.

4.3.7 Risk Stratification and Care Plans

4.3.8 LCCG has supported GP practices to deliver the National Unplanned Admissions Enhanced Services (ES). More so 40 of the 41 GP practices have used the Risk Stratification Tool to identify 2% of the cohort and agreed in excess of 5000 care plans for those patients identified as being most at risk of an avoidable hospital admission. A significant proportion of these patients will be referred for proactive support from health and social care professionals in Neighbourhood Community Teams (NCT) – with GPs coordinating the delivery of the care for the patient.

4.3.9 The CCG is currently conducting a review of the care plans to determine the following;

(i) The types of patients selected by the practices for proactive care e.g. long- term condition, age and history of falls etc.
(ii) How selection of at risk patients using clinical experience differs from the risk score assigned to patients using the Risk Stratification Tool.

(iii) The extent to which those selected by GP practices as being most at risk differs from Adult Social Care caseloads.

4.3.10 The planned outcomes from these analyses are as follows;

(i) The standardisation of clear pathways for different types of patients to reduce variation across the borough in the proactive care offered to them.
(ii) The identification of patients not naturally assumed by GPs and nurses to be at high risk of an avoidable hospital admission i.e. those outside of age and long term condition risk, in order to enhance practice learning.
(iii) The commissioning opportunities which arise from the comparative analysis.

4.3.11 The longer term risk stratification strategy, now a component of the integrated care programme – seeks to identify common approaches to the stratification of risk across the whole system and to develop successively more sophisticated patient segmentation initiatives and the subsequent care pathways.

4.3.12 **Collaborative Care Plans**

4.3.13 The CCG implemented a successful pilot with a small number of practices. Consequently, GP practices are being supported to deliver Collaborative Care Planning through the Lewisham Neighbourhood Primary Care Improvement Scheme.

4.3.14 By the end of 2014/15, in excess of 80 GPs and Nurses will have undertaken the training for the Year of Care approach to Collaborative Care Planning. This approach incorporates;

(i) Motivational interviewing technique, which seeks to support the patient to become an equal partner in discussions and decisions about their care: the patient as expert about themselves, the clinician as expert about conditions.
(ii) An 'informed' patient ethos, with the patient being educated about tests and results prior to their consultation to encourage two way discussion and the promotion of self-care and self-management.

4.3.15 The CCG is working closely with the NHS Year of Care Team to expand this approach from its initial focus on Diabetes to be applicable to all long term conditions.

4.4 Encouraging GPs to identify undiagnosed COPD, Diabetes and CVD (hypertension, atrial fibulation, arrythmia, heart failure, CHD) among their patients

4.4.1 Health Checks

4.4.2 As part of a collaborative programme commissioned by Public Health and delivered by the CCG, a structured programme to support practices to increase the numbers of health checks, increased smoking cessation and improving immunisations was delivered in 2013/14. This involved developing toolkits and supporting aids and information for GP practices. All GP practices were visited by the CCG facilitator team; using a standardised toolkit, there were structured discussions around improving delivery of the Health Checks programme. Best practice was shared and recommendations were fed back to Public Health; commissioners for NHS Heath Checks.

4.4.3 The collaborative programme between the CCG and Public Health has been extended into 2014/15 with a continued focus on NHS Health Checks. CCG facilitators will be undertaking follow up practice visits between November and December 2014 to consider progress since the first round of visits and feedback any new recommendations to improve the uptake and impact of the Health Checks programme.

4.4.4 Lewisham Neighbourhood Primary Care Improvement Scheme (LNPCIS)

4.4.5 Aligned to the Lewisham CCG Primary Care Strategy and building on previous schemes designed and managed by the CCG, the LNPCIS has been structured to support a reduction in emergency admissions with a specific focus on long term conditions. It also directly supports practices to work collaborative together to deliver the elements of the scheme.

4.4.6 The scheme supports GP practices in 'neighbourhoods' to work together to improve the quality and reduce variation in the delivery of services and care to patients with diabetes, COPD, hypertension and cancer. There is also a focus on driving up seasonal flu and pneumococcal vaccination coverage rates across neighbourhoods to directly impact on reducing emergency admissions in these areas.

4.4.7 The CCG intends to extend the scheme into 2015/16 carrying forward the same themes and with a continued focus on directly supporting reductions in emergency admissions.

4.5 Providing support, training and development to primary care in the management of long term conditions

4.5.1 Protected Learning Time Events (PLTs)

4.5.2 Lewisham CCG is committed to providing protected learning time for GP practices to support continual two way dialogue between the CCG and its constituent members. The annual programme of PLTs supports delivery of the CCGs commissioning intentions and priorities. The CCG funds medical cover to enable all staff from GP practices to attend the monthly sessions. PLTs encourage clinicians, GPs, nurses, practice staff and other key stakeholders to be briefed on current intervention, pathways and exchange ideas and examples of best practice.

4.5.3 Previous PLTs in 2014/15 have included sessions on Falls and Mental Health. In October 2014, the PLT session examined alternative care settings and pathways to acute emergency admissions. The PLT session explored what other interventions could be implemented by individual GP practices, at neighbourhood level and borough-wide initiatives, which would further support patients and reduce admissions. Consequently, the CCG is developing action plans and will be updating members via its dedicated GP Interactive Portal (GPi).

4.5.4 Health Education South London (HESL)

4.5.5 The CCG submitted a number of bids to Health Education South London (HESL) and received a total of £630,700 for the following schemes for primary care;

- Medicines Optimisations Education and Training Scheme (MOETS)
- Mutually Agreed Outcomes
- Primary Care Customer Service
- Workforce Development for Integrated Adult Care

- Lay educators for Type 2 diabetes
- Practice Nurse development
- Telephone consultation and triage skills

4.5.6 The schemes began implementation in March/April 2014 and are due to run until March 2015. The MOETS scheme began in December 2013. All the projects are on track to deliver their objectives.

4.5.7 The Practice Nurse Development project has undertaken an audit of practice nurses in Lewisham, asking nurses to complete a self-assessment form and then following up with an observational visit. A total of 63 practice nurses took part in the observations and the report is currently being drafted. The report will make recommendations on improving the quality and profile of general practice nursing. As a part of this project, the CCG also purchased a web-based toolkit called HeART. The toolkit enables practice nurses to log all of training and education, undertake appraisals and personal development plans as well as producing their portfolio – this will support Nursing Medical Council (NMC) revalidation requirements, which comes into effect in 2015.

4.6 Redesign of all key LTC pathways

4.6.1 Diabetes

4.6.2 The Lewisham Diabetes Clinical Network Group supported by the CCG, (which has with representation from patients, providers, commissioners and public health) continued work to build on the objectives outlined in the Lewisham CCG Diabetes Strategy, which was first launched in 2012. Core work streams for 2014/15 include;

4.7.1 *Improving access to structured education programmes*
DESMOND is the acronym for Diabetes Education and Self-Management for On-going and Newly Diagnosed. It is part of a school of patient education for people with diabetes, developed by a number of NHS Organisations. The CCG commissions DESMOND via its integrated community contract with Lewisham & Greenwich Trust. Enabling patients to 'self-refer' to DESMOND is currently being rolled out across Lewisham after a successful pilot in 2013/14. Marketing of the initiative will include pharmacies, leisure centres and leisure centres.

4.7.2 The CCG funded a dedicated administrator post to the DESMOND team to support proactive patient contact and follow-up, reducing the numbers of patients that do not attend and improving the quality of audit data. These benefits are already being realised within the team.

4.7.3 Taster sessions of the DESMOND course have been delivered to community pharmacists and others to promote understanding of the course. It has also invited health care professionals to join patients on the course and this has been very well received by the first GP registrars to sign up.

4.7.4 *Redefining Diabetes Community Services*
Lewisham CCG commissions Diabetes services as a part of the integrated community contract with Lewisham & Greenwich Trust and the service Is delivered by the Community Diabetes Team. The service redesign and improvements are supported by a CCG Diabetes Patient Focus Group.

4.7.5 The Community Diabetes Team conducted an audit of patient feedback from 2012/13 courses, which was very well received as a poster and was presented at the Diabetes UK Professional Conference 2014. The findings

were used to inform changes in the programmes approach and a re-audit is planned for the end of 2014/15. This is positive example of how patient feedback used to inform service design.

4.7.6 The CCG are redefining the specifications for the diabetes community services team, which includes delivery of Collaborative Care Plans for all patients in 2014/15.

4.7.7 The CCG Diabetes Patient Focus Group has joined their opposite groups in Lambeth and Southwark to discuss their experiences of insulin prescribing and management. This will inform the work of South London Health Improvement Network aimed at improving insulin prescribing and management.

4.7.8 In response to issues raised around insulin prescribing habits, an audit was conducted by the CCG Prescribing Team that resulted in the development of a local Insulin and Devices visual aid assist clinicians in prescribing choices. This has been very positively received by clinicians.

4.7.9 The referral pathway for Foot Services has been revised to reflect national guidance. Training events for primary care clinicians have been delivered and presentations were made to services users at a recent Diabetes UK event.

4.7.10 The CCG with joint commissioning colleagues has commenced work on scoping models for providing psychological support for people with diabetes and other LTCs whose complex needs are currently outside the scope of currently commissioned models.

4.7.11 Chronic Obstructive Pulmonary Disease (COPD)

4.7.12 In 2013/14 Lewisham CCG delivered a successful Diabetes Community Champion programme in partnership with Diabetes UK and it is this experience and learning that is being utilised to develop a similar programme with the British Lung Foundation for COPD. This year the CCG will be emulating the success of this programme by commissioning a 12 month pilot to increase awareness of COPD and its risk factors to those who are directly at high risk and its complications. The volunteers recruited will work at grassroots level to deliver pertinent messages and signposting to the community and increase the uptake of self-management for people with COPD via the structured education programme; LEEP (Lung Exercise and Education Programme).

4.7.13 From December 2014 Lewisham CCG, in partnership with Healthwatch Lewisham, will be delivering the Community Champion pilot for people with COPD.

4.7.14 Asthma

4.7.15 Lewisham CCG ran an event for people living with asthma, which involved patients, carers and their family members. The event provided local people with an opportunity to share experiences and make suggestions that could help improve how adults with asthma are cared for and supported. Clinical teams involved in caring for people with asthma discussed ways people can manage asthma and the support available to improve their health. Patients' advised about their expectations from practice nurses, the importance of clear information to support with managing their condition and the need for an Asthma Support Group.

4.7.16 The learning from this event supported the CCGs workshop for Practice Nurses; where new prescribing guidelines and skills development were

provided. At the Practice Nurse Forum, the CCG provided practice nurses with up to date equipment (including Spirometers) to support with the management and diagnosis of Asthma.

4.7.17 As a part of the Protected Learning Time (PLT) sessions the CCG will be running a Respiratory event for GP practices in November 2014. The session will support with consolidating the pathway.

4.7.18 The CCG has signed up for the National Review of Asthma Deaths, which goes live in April 2016 and the Asthma Standards Framework.

4.7.19 **Proactive Primary Care (PPC)**

4.7.20 PPC aims to instigate a shift from acute to chronic care using a suite of activities that build on current primary and community care practices, extending it in an evidence-based way through implementation of the following;

- Telephone calls by *Motivational Callers* to identified patients at risk of future use of A&E and subsequent admissions.
- Interventions through ready access to appropriate healthcare professionals and local organisations.
- Support and training for patients in self-care and decision-management to promote a "continuous healing relationship". Patients develop skills to become active, informed participants in their healthcare.
- Development of communication pathways between primary, community, secondary and voluntary care agencies.
- Befriending by local voluntary agencies.

4.7.21 The CCG successfully applied for NHS London Innovation funding to support a Proactive Primary Care pilot for a GP practice based model. The work and evaluation is being shared with NHS England, which has replaced NHS London Innovation.

4.7.22 The project is supported by 'Motivational Callers' who are non-clinical practice staff. The callers received training in empathetic and considered listening skills and are provided with a software programme that supports the calls and enables them to appropriately advise and sign post patients.

4.7.23 The expectation is to evaluate the health and wellbeing outcomes of the patients contacted by telephone on 3 separate occasions, using a structured calling script, accompanied by a set of evaluation questions. Practices representing all four Neighbourhoods took part in this pilot project.

4.7.24 The CCG has teamed up with the London School of Economics who have evaluated the pilot. The outcomes from the pilot will inform future commissioning intentions.

5. Financial implications

There are no implications arising from this report. The long-term conditions programme supporting the reduction in acute emergency admissions is a part of the CCG QIPP 2014/15 programme.

6. Legal implications

There are no specific legal implications. Members of the Board are reminded that under Section 195 Health and Social Care Act 2012, health and wellbeing boards are under a duty to encourage integrated working between the persons who arrange for health and social care services in the area.

7. Crime and Disorder Implications

There are no specific crime and disorder implications arising from this report.

8. Equalities Implications

Lewisham CCG conducted Equalities Impact Assessments on core programmes including Risk Stratification and Collaborative Care Plans.

9. Environmental Implications

There are no specific environmental implications arising from this report.

10. Conclusion

The report provides an update on the progress towards the objectives and outcomes to date on reducing emergency admission for people with long term conditions. However, it is important to note that for the CCG in delivering its Commissioning Intentions and QIPP for 2014/15 reducing emergency admissions is and will continue to be a key priority. The focus of the report is on the objectives and actions within the delivery plan of the Health and Wellbeing Strategy, it also covers the ongoing work of the varied strategies and plans that support this priority.

11. Contacts

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