Long Term Conditions Strategy and Vision, 2012-2017

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Executive Summary

This document sets out the strategic intent and vision for the commissioning of long term conditions for the people of all ages of Northamptonshire.

The definition of long term conditions has been defined as:

‘those chronic health conditions that cannot, at present, be cured’.

It is recognised that the spectrum of severity for a long term condition will vary from individual to individual and can have a significant impact on life-from well managed asthma to a paralyzed child on a long term ventilator because of a congenital condition. This document does not exclude any one of these but does take a broad approach to encompass them all. Whilst the focus of this document is upon services delivered to the adult population the vision to develop localised, personalised, integrated care delivered to meet individual needs applies equally to children.

Below are the vision statements that capture the essence of the document. The remainder of the document includes the justification of these positions. The strategy is a five year plan that will underpin the work developed by Nene CCG, in conjunction with other partner organisations.

The overall vision for managing long term conditions across Northamptonshire is for a model of shared care that promotes health & wellbeing, and is driven centrally by the individual. It aims to deliver a whole systems approach to care, and through transformational workforce change, deliver care that is liberating and places people at the heart of their care. As the experts they know what works best, and through the development of effective partnership working will influence local professionals to enable it.

- The model of care developed for people with long term conditions, will be based on promoting health and wellbeing, and the prevention of ill health in either body or mind. Services will be developed that encourage people to build social capital, communities, and the move away from people needing high cost specialist services. Services will work together as simply as possible, and people will be supported in order to help people to help themselves. This will be through information, coaching programmes, and becoming informed to know how and where to access services. Access to specialist knowledge and skills when they are needed is recognised as being important, and it is recognised that people want easier access to local support with just one place to go for help and better sharing of information to avoid multiple assessments. Services will concentrate on those likely to escalate into specialist services. The Government priorities of localism and co-production are at the heart of this strategy, and through joint working with a wide range of partners and building on their expertise will bring opportunities and benefits not available to one organisation in isolation.

- People living with complex long term conditions in Northamptonshire will have access to a community neighbourhood team. These will be made up of core members and have access to specialists. Neighbourhood teams set up and operation may vary across localities, according to the population needs, but each will work within the same core long term condition principles, and be designed to support people in managing their long term conditions, staying healthy, and working towards self care/management.

- People in Northamptonshire and living with long term conditions will be offered support by neighbourhood teams through the use of local risk profiling tools. These will be used through safe and secure IT systems, and have shared Governance arrangements put in place across stakeholders if patient records are to be accessed across health and social care, and for the benefit of shared care.
People with long term conditions will be supported to write (or a representative on their behalf) to hold a personal wellbeing plan. The plan will encompass all their health and social care needs and they will be supported and designed around their defined needs and across services, accessible only with their consent. The key worker and neighbourhood team will support them to develop this, and through discussion, enable other services such as OOH care, and emergency services (such as ambulance and A & E) to access it in critical times of need.

People across Northamptonshire will have access to The NHS Health Check programme. The programme aims to help prevent heart disease, stroke, diabetes and kidney disease. Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions, will be invited (once every five years) to have a check to assess their risk of heart disease, stroke, kidney disease and diabetes and will be given support and advice to help them reduce or manage that risk. By extending the availability of ‘predict and prevent’ checks to give people information about their health, support lifestyle changes and, in some cases, offer earlier interventions.

People across Northamptonshire will experience significant quality improvement in primary care. Rising the Bar in Primary Care (Health Inequalities National Support Team 2010) highlighted that every General Practice can saves lives & reduce morbidity by identifying patients with risk & managing them effectively on disease registers. Finding patients who already have, or who are at risk of developing, disease & successful management of their condition/s are crucial to efforts to reduce premature mortality, morbidity & inequalities in health. This improvement will be achieved through the current Quality Outcomes Framework (QoF) practice use to deliver care for their patients, and where countywide, every practice will achieve at least 90% across all of the indicators.

People across Northamptonshire will be seen as 'our customers', and in managing long term conditions we will enable them to prioritise their needs at their own pace, such that appropriate scales of time to response, and contact are adhered to.

Those caring for people with long term conditions will be included at every level, and be invited to have their health needs met, recognising the important and value they contribute to the health economy locally.

A guide on the definitions used in the document
In order to help guide people through this paper the following definitions have been agreed and used:

**A neighbourhood team** = as defined by a localities and those members working in it. A suggested model can be found at appendix B.

**Care** = The prevention, treatment, and management of illness and the preservation of mental and physical well-being through the services offered by the medical and allied health professions.

**Community** = as defined by a group of people with a shared interest. Often based on shared experiences/memories and not by a geographical neighbourhood.

**Complex Long Term Conditions** - an individual with three or more diagnosed chronic conditions that cannot be cured.

**Person/people** = anyone who may access health or social care services living in Northamptonshire

**Personalization** = thinking about public services and social care in a different way – starting with the person and their individual circumstances rather than the service and based on the principles of independent living, enabling choice, and control, outcomes, and co-production (active input by those who use services, as well as those who provide services-empower or collaborate.

**Services** = Any local service that provides a health or social care element to an individual

**Wellbeing plan** = a plan developed by an individual, or a representative on their behalf through support by professionals and that identifies their own needs at that time.
1.0 Introduction

This document has been developed jointly with other partner organizations and is therefore intended as a joint strategy for managing long term conditions countywide across Northamptonshire. In 2012 shared priorities are to provide health and social care that improves health, reduces inequalities in health, promote health and well being, and enable independence across Northamptonshire. Managing long term conditions encompasses the frail elderly, a countywide leaders priority, and those complex people that are known to multiple services, yet still receive poorly co-ordinated care.

The drivers for change have been twofold: recognitions that current health and social care systems are fragmented, and that care is not always person-centred in a way that allows individuals to become involved in their care. Through the enablement of shared decision making, and self management, this strategy aims to enable and support people to take control of their health and wellbeing, learn to manage their long term conditions, and as a result live healthier, longer lives.

This strategy document aims to set out the vision and guiding principles for managing people with long term conditions in Northamptonshire, against which options for provision can be assessed. At the heart of this strategy is the need to ensure that every person living in Northamptonshire with long term conditions, has access to appropriate high quality clinical care, at the right time and in the right place, and that inequalities are eliminated.
2.0 Scope of document

This document will be of primary use to those involved in commissioning or providing parts of the management of people with long term conditions across Northamptonshire. This includes locality based commissioners, contracting, finance, public health, quality/public engagement, providers as well as current and potential out of hours general practice providers, voluntary sector, charities, acute emergency service providers, and ambulance service providers.

It will also be of interest to members of the public who might wish to view or comment on the strategic direction taken by Nene CCG in helping to support people with long term conditions countywide.

The aim of the strategy is to improve the value of managing long term conditions, and thus, by definition, there will be improvements on the quality of care commissioned for people. These will be measured under the framework of Quality, Productivity, Innovation, and Prevention.

Limitations of strategy - specialist and high level mental health services, those services that are defined as planned care, those people with new diagnoses and requiring immediate health care interventions, including cancer. Many long term conditions arise in childhood and remain life long such as disability and mental health needs. The strategies to meet these children and young people’s needs are being developed separately. Implementation of this strategy will be done in collaboration with child care colleagues to ensure that the vision and principles of care are consistent and the transition to adulthood is seamless.
3.0 Context

3.1 National context

3.1.1 Policy environment
During 2010/11, the publication of the Coalition Government’s White Paper “Equity and Excellence: Liberating the NHS” created a new roadmap for the NHS, and has changed the commissioning responsibility as we transition to full GP commissioning in 2013. This paper also highlighted the fundamental need for health professionals in the NHS to provide care in a holistic manner ensuring at all times that “no decision made about me, without me” became embedded in everyday practice. This philosophy has set the platform for managing people with long term conditions.

There is predicted to be a 252% rise in over 65 year olds by 2050 and a 60% increase in the number of people with multiple long term conditions by 2016. Around 170,000 people die prematurely in England each year in total, with the main causes being cancers, circulatory diseases and respiratory conditions. We currently spend £19 billion on people with 3+ long term conditions. This is projected to rise to £26 billion by 2016. Many 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. Costs to the health care system are also significant – by interacting with and exacerbating physical illness, co-morbid mental health problems raise total health care costs by at least 45 per cent for each person with a long-term condition and co-morbid mental health problem. This suggests that between 12 per cent and 18 per cent of all NHS expenditure on long-term conditions is linked to poor mental health and wellbeing – between £8 billion and £13 billion in England each year. The more conservative of these figures equates to around £1 in every £8 spent on long-term conditions (Kings Fund 2012). Technological developments have also allowed many children and adults with complex needs to survive placing an increasing burden on the health economy, and in an increasing difficult financial climate. Across Northamptonshire we are facing increasing demands for services, at a time when financial resources are reducing. Locally all health and social care services are required to make significant savings in the next five years, and these will only be achieved by working together with the local population, and finding more ways of people being able to manage health themselves, and becoming less reliant on specialist services.

The NHS Future Forum, Kings Fund and Nuffield Trust recently highlighted that whilst patient centred care may be evident in some areas, the system as a whole is not, and people are expected to fit their lives around the services locally available to them. Such inflexibility has called for the case of integration, both in the literal sense, of shared services providing care that are centred around the patient, not the system, and a significant reform of the current workforce in primary and community care in order to develop capacity, and deliver care closer to home. Such reform includes prioritizing the contributions agencies such as social care, and third sector can make in developing new models of care. The important message that came from patients and services users was that integration is not that of a formalised system, but one that demonstrates co-ordination, and that receiving care, is more important than where it comes from.

The NHS Operating Framework for 2012/13 made clear the agenda for integrated care:

“It will be equally important that, as more decision making is taken locally to reflect the needs of patients and the clinicians who support them, the NHS does more to integrate service delivery, not only across primary and secondary care between mental and physical health but also with social care organisations. Each sector needs to look at where it can work better with partners, including voluntary organisations, so that services are organised around the interests of patients and service users rather than institutions”

but the evidence to date for integration gives mixed results (Chitnis2012), so further research, and system reforms that are more far reaching may be required, and the current care and financial system needs to evolve to meet these demands.
• The national health agenda for long term conditions is led by Sir John Oldham, National Clinical Lead, QIPP, Long term conditions and Urgent Care, Department of Health, and has a care model that is based on three key principles:

  • Risk profiling
  • Neighbourhood care teams
  • Self care/shared decision making

Underpinning this is the aim of reducing emergency unscheduled hospital admissions by 20% by 2014.

The evidence based best practice care model for people with LTC requires risk stratification, the development of integrated health and social care teams, and the role of a key worker, or navigator supporting an individual, and through effective partnership working enabling people with LTC to co-manage or self care for their conditions.

The Department of Health is currently developing a across- government long term conditions strategy for England only—expected to be out in the autumn of 2012. Their intention is to set out a vision for how services such as health, social care, education, housing and others can work together to improve life chances and outcomes for people living with long term conditions.

This joint strategy for Northamptonshire takes a proactive approach for the population of Northamptonshire, and in doing so aims to help to prevent or delay the onset of conditions, prevent the deterioration of conditions, and develop joined up services to support people living with long term conditions. The strategy won’t cover specific detail of how services are to be delivered since this is the responsibility of individual organisations, but through joint working will be regularly reviewed, in order to ensure it represents new and emerging best available evidence.

At the same time, the Department are also implementing a national “Year of Care Funding Model”, across the country through the QIPP LTC work stream.

This strategy adopts those core principles, and sets out a vision upon which Nene CCG will develop best practice models for the people of Northamptonshire.

4.0 Defining long term conditions in Northamptonshire

4.1 Nomenclature
Defining long term conditions helps to provide clarity, and guidance for others working in health. It is important also as the definition may mean many things to many people. The most universal national definition is by the World Health Organisation, and says that long term conditions are:

*Health problems that require ongoing management over a period of years or decades.*

When debating this, commissioners locally have recognised the need to keep the definition broad, thus avoiding being disease specific, and yet also not excluding those people who may not have a medical diagnosis. Care therefore can remain at an individual level, and ensure equality.

Nene CCG have thus chosen locally to adopt the following definition:

*Long term conditions are those chronic conditions that cannot, at present, be cured.*

Other terms frequently used to describe people with long term conditions may include complex needs, high needs, or frequent attendees, and all reflect one key aspect:

needs that may be currently unmet despite regular contact with health services.

### 4.2 Demographics

Northamptonshire is one of the fastest growing areas in the United Kingdom. Its population is getting older, increasingly diverse and more people are benefiting from longer life expectancy. There are still significant differences in health and life expectancy across the county.

The county’s population is around 685,000 people, with over 85% living in towns and urban areas. The county age profile is slightly younger than the UK average with only 14% of people aged 65 or over and with a greater proportion of young children than the UK average. However the population of Northamptonshire will increasingly become older over future years. The over 85 age segment will experience the largest growth in the period to 2012.

Black and minority ethnic groups constitute less than 10% of the population of Northamptonshire and there has been a significant increase in the number of people from eastern European communities over recent years.

As a county, Northamptonshire has relatively low deprivation, rating 116th out of 152 PCTs in England and only 10% of Northamptonshire’s population fall within the most deprived quintile nationally. However, these figures hide pockets of high deprivation – and relatively low life expectancy – which tend to concentrate predominantly in urban areas.

The population’s health is improving but not equally across the county, meanwhile people are living longer and developing disease later in life. The number of people with conditions such as diabetes, Coronary Heart Disease (CHD), Chronic Obstructive Pulmonary Disease (COPD) or dementia is predicted to increase over the next 5 to 10 years.

The geographical area that is covered by Nene CCG has an average deprivation score of 17.5 which is lower than the England average.

The two key components of the IMD score: the income deprivation affecting children 16.2 and income deprivation affecting older people 16.9 are also lower than the England average.
Average life expectancy is 78 years for men and 82.3 years for women which are both higher than the England average.

Across Northamptonshire there is significant variation in life expectancy, the life expectancy gap between the most and least deprived areas in the county are 9.4 years for men and 4.8 for women.

Evidence taken from the JSNA 2010/11.

4.3 What do the People of Northamptonshire currently use to manage their Long Term Conditions?

- Emergency care:
  NHS Nene CCG
  includes NHS Coby CCG

- Primary care

- Community services

- Social care

Social care do not measure people by health condition, so it is not possible to differentiate between the adult customer they support as to which have long term conditions. This means actual activity could not be established as a baseline.

For the purposes of providing some background to the services however, and that may be accessed by people with long term conditions the broad categories are:

Young Adults (YA) 18-64)
Learning Disability
YA Physical Disability
YA Mental Health
Older People (65+)

For people with long term conditions the range of support social care might provide in the community, includes:

Reablement
domiciliary care via START or Serve
residential reablement via Specialist Care Centre
emergency response via crisis Response Team

Ongoing care
personal budget which allows flexible approach as long as defined outcomes are met
domiciliary care via agency
domiciliary care via personal assistant (PA)
daycare
respite care (if the person with a LTC has a carer)
Meals-on-Wheels

There is also a range of support services in the community some of which are wholly or partially funded by NCC including:
Telecare (including emergency call button)
Equipment and adaptations
Sensory Impairment Services
Community transport
Carers Support Services
Advocacy

Most of these services are chargeable following a financial assessment to determine how much the customer will be required to pay.

- End of life care

Please note this activity only relates to patients within the last eight weeks of life who have been registered with the provider. It shows activity related to the different components of the service and runs from Dec 2010 to Sept 2011 and one from Oct 2011 to April 2012 due to internal reporting changes by the provider.

5.0 Local commissioning strategy

Nene CCG has made “managing long term conditions” a strategic commissioning priority, recognizing that the system in place locally is not providing optimal cost effectiveness. Improving the quality of cross team working across local stakeholders is particularly important, and developing shared decision making/self care since significant overspend in secondary care usage is adversely impacting ability to invest in other clinical areas. Nene CCG is also clear that improved efficiency should not decrease the quality of care received, but significantly improve it.

Partner organizations also have similar objectives, and by working together care can be better co-ordinated and effective.

Northants Health and Wellbeing Board established in shadow form in May 2011. The Board is chaired by the Health Portfolio Holder and the Vice Chair is from Nene CCG, Corby CCG is a member. The NH&WB is developing a revised health strategy to which it will expect the CCG to respond. Nene commissioning is establishing a Health & Wellbeing Fora in partnership with each District and Borough Council and other local stakeholders in each locality.

Public health transferred to Northamptonshire County Council in December 2011. Public health commissioning has transferred for some services with other commissioning support being provided by the commissioning support organisations.
There is a joint declaration of partnership working in place.

A comprehensive transition plan has been drafted (DH Guidance awaited). This includes details of future commissioning arrangements, risk identification and mitigation, governance arrangements, workforce, communication and engagement. It also identifies future provider contracting arrangements.

Nene has agreed in principle the support that Public Health will provide to support commissioning. This broadly reflects the national specification, but reflects the needs of our localities. We are keen to develop those elements of public health advice, such as health economic advice, that will help us to make better value based commissioning decision.

The relationship between public health and long term conditions management across Northamptonshire will be a key component to successful delivery, and this strategy sets out a way of working that will build upon this new platform.

Our joint ambition is to develop a community where health and social care is improved and high quality services are provided because local people, local clinicians and our partner organizations work together to make all the significant decisions about the planning and delivery of local health services. Our first Strategic Plan is our first step towards making this vision a reality and the plan is built around a focus on key areas. Developing a wholes systems approach to care underpins this strategy, and our overall aim of ensuring quality as our guiding principle, will be at the heart of everything that is delivered.

5.1 The Move to Personalization

A recent paper by the Kings Fund *From vision to action* (2012) brought together ten leading health and social care charities and through working with the Kings Fund on how high quality, patient-centred care could be delivered, identified five key themes all of which align with this strategy:

1. Co-ordinated care
2. Patient/parent/carer engaged in decisions about their care
3. Supported self management
4. Prevention, early diagnosis and intervention
5. Emotional, psychological and practical support.

This strategy supports these, terming them as personalization, and provision of care that is both holistic and encouraging in people living longer, healthier lives. Personalization can be seen as putting people first, and yet more often, in health care terms has to date, been seen as a social care agenda, or in mental health care provision. This is also echoed in the *Children’s and Young People’s Health Outcomes Forum-Report of the Long Term Conditions, disability and palliative care Sub Group* (2012) who make key recommendations of an integrated approach to care, and that getting a quality service should contribute towards positive physical and mental health and well being in the family, including having access to a key worker approach. CIPFA (2010) describe personalization as the tailoring of public services more closely to their users. Social Care Institute for Excellence describe it as finding new ways to give people more choices, and making sure the right help gets to the right people. In an era of unprecedented financial challenge, commissioners will need to make the money spent go further, and it is suggested to improve current systems, a set of principles that demonstrate transparency and rigor is applied (Rumbold & Smith 2012).

An estimated 30 per cent of people with a long term condition also have a mental health problem, and investing in emotional and psychological wellbeing for those people, including those with medically unexplained symptoms will form part of this work (Mental Health Network NHS Confederation 2012).
Further evidence from a recent public engagement event held by Nene CCG also supported this, with many of those present calling for more transparency, and to have closer involvement in decision making. Nene CCG believe personalisation is about putting individuals firmly in the driving seat of building a system of care and support that is designed with their full involvement, and tailored to meet their own unique needs. Such an approach is completely different to the current system of ‘one size fits all’, and a system that expect people to fit around it rather than offering flexibility, and responsiveness. People should be able to do different things, and have more control over their lives. Since 2010 Nene CCG has been a pilot site for developing personal health budgets for both adults and children. This work has primarily focused on people with mental health needs, and the evidence to date collated has been highly positive, with a full review planned nationally of all pilot sites in the autumn of 2012. Already there is evidence that developing robust shared services would prevent people escalating into more significant mood disorder, and that alternative to previous clinical procedures, and more user involvement, could have benefits. The potential opportunity to develop this personalised model of care on a wider scale across Northamptonshire is exciting, and will help towards developing personalization by enabling people more choice, and control over managing their health.

5.2 Organization & Workforce transformation

A position paper by the Sainsbury Centre for Mental Health (2012) summarized 10 key organisational challenges faced when implementing organisational change. These were developed through a series of workshops and through the publication of Making Recovery a Reality (2008). Recovery is based on ideas of self determination and self management, and which have alignment with the principles of managing long term conditions. Self management is perhaps not a new concept, and with around 18 million people living in the UK with a long term condition, on average they will spend up to 3 hours each year with a healthcare professional (DH 2012). The rest of the time they will be looking after themselves, managing their conditions. With numbers however likely to double by 2030, more needs to be done to support them, and with an increasing older population in Northamptonshire this only emphasises the importance, and the need for a supportive framework that can deliver meeting those needs. The NHS Midlands & East- East Midlands Region Workforce and Education Investment Plan 2012/2013 outline the current workforce profile and an overarching aim of workforce transformation reshaping the workforce to meet patient need. The ambitions that are particularly pertinent to long term conditions management are:

- Fully understanding the changing patterns of healthcare need, prevention and care so as to have a clear transparent strategy for developing the appropriate capacity and capability in the healthcare workforce.
- Developing increased staff flexibility to work in different health care settings and to achieve greater integration between health and social care.
- Developing the educational model to ensure the workforce can support the shift of care from hospital to community – based service and work within an ever evolving multidisciplinary multiagency team.
- Developing the workforce by enabling them access to education and training.

Supporting people to manage their healthcare requires changes in the way healthcare is delivered, and placing a greater emphasis on understanding the motivations and challenges people face in adopting health-promoting behaviours (The Health Foundation 2012). Nesta’s paper Right Here, Right Now (2010) says that people’s needs are better met when they are involved in an equal and reciprocal relationship with professionals and others, working together to get things done. This is the underlying principle of co-production – a transformational approach to delivering services – Whose time has now come? Such transformation requires as they put it:

- Changing the way services are managed and delivered.
- Changing the way services are commissioned.
• Opening up new opportunities

Managing transition between adolescence and adulthood is highlighted as a particular area where current services need to improve and in particular for those young people with a long term condition or disability. Transition needs to promote the aspirations, independence and autonomy of the young person as they move to become a young adult. Outcomes of educational attainment and employment are key-delivered through effective transition planning.

In the UK creating a culture of innovation has been developed in Scotland social services, using a programme that has an aim of improving the lives of those who receive support. Three of the key internal factors used to facilitate innovation are referred to as ABC or:

- Attitudes
- Behaviours
- Capabilities

The final report on the work by IRSS (2012) Creating a culture of innovation highlighted that whilst innovated thinking is important, it is unlikely to change culture, attitudes and behaviours, and that connecting with those individuals that has an interest in organisational change is more likely to create the right environment for change. It requires a ‘thinking differently’ approach, and work that has individual outcomes as an end point in mind. For managing long term conditions this is an important point, for if the workforce is to promote health, and wellbeing, they much consider what health means to them, and how their values and behaviours may influence those that they are working with. Those who are responsible for providing health and social care need to recognize and support the autonomy people exercise in managing their own condition, and develop ways in which public services can support people to care for themselves on a day to day basis. This evidence to date on achieving this in practice has already been found to be challenging, but with 70% of the current NHS spend taken up by 30% of the population with long term conditions it’s a more intelligent and effective way of working and will require a phased approach that includes evaluation of achievements. To support this large scale change, a workforce plan will therefore be developed following on from the strategy and set out the key requirements of planning and evaluating these changes over the five year period.

5.3 Defining health

Health is often defined using the WHO constitution of 1948, or another well known definition by Acheson (1998). Both definitions use the word disease, suggesting that health is disease specific. If this is the case, then clearly society plays no part in health, and Marmot’s statement can be discarded. To understand this further though, we need to refer back to the Ottawa Charter of health promotion (1986). This is where the first international conference was held on health promotion, and the international group identified eight fundamental conditions and resources for health, seeing them as the basic foundation prerequisites for improvements to health. The Charter was seen as the growing public health movement for actions at a global level, and taking practice to 2000, and beyond. The formation of the Faculty of Public Health was established in 1972 and defines itself as a charity to develop public health through three main aims. The first of these encompasses the role of health promotion for public benefit. Such definitions suggest that health is everyone’s business, and that it should be a collective approach. Yet public health practice also states that health is both an art and a science combined (Jones & Douglas 2012) and this supports Acheson, so how it is that health can also be defined by lay people as simply ‘feeling good’, or an ‘ability to cope with daily life?’ (Scotland BASA & Coventry –health initiatives 2011). This dynamic interaction of embedding health into every day life, suggests that health should be seen in a wider context also, and not just merely the absence of disease. It also suggests that health is multi factorial, or influenced by many different factors. These are best viewed through Dahlgren & White head’s social model of health (1991) seen below:
The model depicts the core determinants of health such as age and sex at the centre, with the factors that can influence health in the surrounding layers and Seedhouse (1988) definition of health links the positive and social models definition: :

A person’s optimum state of health is equivalent to the state of the set of conditions which fulfil or enable a person to work to fulfill his or her realistic chosen and biological potentials. Some of these conditions are of the highest importance for all people. Others are variable dependent upon individual abilities and circumstances.

Disease management and prevention clearly requires health interventions and the promotion of health through basic fundamentals suggests that health status is universal but that there may be many different approaches towards it. These can be seen termed as models of health, and are most commonly known as medical or social models.

6.0 A joint approach to developing models of care for managing long term conditions

The concerns of an aging population create a ‘perfect storm’ (Oliver 2012), and our current systems are overloaded and failing. As the Rt Hon Stephen Dorrell said in 2011:

“Systems designed to treat occasional episodes of care for normally healthy people are being used to deliver care for people who have complex and long term conditions. The result is often that they are passed from silo to silo without the system having ability to co-ordinate different providers”

This strategy supports the view that only by working together, can organizations prioritize, and that by integrating mental and physical health care more closely as a key part of their strategies, there is opportunity to improve quality and productivity in health care.

The role of promoting health and wellbeing, and prevention management is key to the success of securing healthy outcomes for the future, and will only be achieved through the development of effective partnership working, the provision of proactive care, integration and care closer to home. Securing health improvements will be through constructive solutions and taking small steps that are relevant, effective,
multifaceted and multi-agency. There is no ‘magic bullet’. Instead it requires a clear vision, and a focus of understanding what the world could look like, with commitment and engagement from those at the heart of delivering care.

The model of care can best be seen in the diagram below

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**Model of care for managing long term conditions**

The service model outlines the high level aims – prevention, support to stay in the community and care in a crisis - with the identification states of an individual's health and social well-being along with the high level outcome.

This strategy identifies the need for a stepped approach to developing this, and within a supporting framework of workforce transformation. These models of care are defined in terms of working towards as medium term model, and a long term model. There may also be referred to in terms of a community based model, and a community developed model.

Both can be seen visually at appendix A.

It is recognised that these models will develop differently across the localities, and take time to effective and sustaining health outcomes. Shared learning will therefore be a crucial outcome marker, and taken directly from the professionals and public’s own experiences. The experiences will be used for making local improvements through ‘action in learning’, and with a view to gradually enabling the community to begin to drive the agenda.

The strategy will also work within the national framework of Making Every Contact Count (MECC). MECC is about utilising the vast human resources of the NHS in the Midlands and East as ambassadors to inform and enable people to make positive changes to their lifestyle. This can be achieved through the systematic delivery of health improvement, using consistent and simple healthy lifestyles advice combined with
appropriate signposting to lifestyle services. To summarise MECC is focussed on health improvement and the prevention of poor health in patients, and thus aligned with the overall strategy of workforce transformation across Northamptonshire.

Along side this, and recently, the Acute Service Review has been widened to include the patient journey from primary through community into a secondary care setting. An appointed Senior Responsible Officer will cover two clusters and the programme governance arrangements are now in place with a Programme Board, a Clinical Senate, Clinical Working Groups and a Patient and Public Advisory Group. The 12 organisations affected by what is now known as ‘Healthier Together’ meet on a regular basis and the aim is to embark upon the public consultation between June and September 2012. The Commissioner led review will concentrate on the specialist end of the spectrum. The purpose of the review is driven by a desire to either sustain or improve quality and the clinical working groups will measure effectiveness against safety, sustainability, accessibility, population growth and changing demographics. The resultant impact from the above work will not materialise in 2012/13, and, subject to the outcome from the public consultation, service changes will be brought into effect over a three year period. This strategy will ensure any outcomes from this are included in long term conditions localities plans to maximise patient benefits and efficiencies.

This strategy is focused on improving quality and delivering care across communities. Communities are often understood differently by different groups of people (ref), and it is important that those working in localities, and responsible for supporting people with long term conditions share and agree upon a common understanding. For the purposes of this strategy and bearing in mind the development of a community development model, a community is seen as

‘A group of people who, regardless of the diversity of their backgrounds, have been able to accept and transcend their differences, enabling them to communicate effectively and openly and to work together toward goals identified as being for their common good’.

( FCE 2012)

Such a definition also calls for the need to work in partnership, and can also be perceived as a collaborative or joint working approach. WHO (2009) defines it as ‘the creation of something new and a long term approach requiring flexibility and openness’. Partnership working requires participation, and community participation is a proven approach to addressing health care issues and has been long utilized in HIV prevention in the United States and in development internationally, in projects varying from sanitation to child survival, clean water, and health infrastructure (Cheetham 2002). SEPICH( 2007) says that:

“Participation occurs when consumers, carers and community members are meaningfully involved in decision making about health policy and planning, care and treatment, and the wellbeing of themselves and the community. It is about having your say, thinking about why you believe in your views, and listening to the views and ideas of others. In working together, decisions may include a range of perspectives.”

The key prerequisite to delivering a culture of participation is trust, and Involve (2005) advocate that this needs to be a key priority in policy. National evidence on partnership working suggests it requires trust, understanding, commitment, and a clear focus on the issues. It is though often complex, and clear benefits need to be understood, based on transparency, and include an evaluation of its success.

Carers are seen as an important part of this work as they make a significant contribution to supporting people with LTCs, and they are integral to developing a model of care that offers effective partnerships. It is estimated that there are 6.4 million people currently caring for a child, friend, neighbour, partner, parent or a combination of these Carers UK 2011). One of the key recommendations from a report Valuing Carers (Carers UK 2011) was that the Government should take a social contract approach to carer support and work with employers, the third sector and community groups alongside public services to ensure that carers are identified recognised and supported throughout society. This strategy embodies the same approach, and over the 5 years of implementation will develop effective partnership working, coaching, and skills that will gradually see wide scale change of care and directly improve levels of involvement and support available for carers.
Quality in care underpins this strategy and starts in primary care. Since 2004 the General Medical Services Contract has included the Quality and Outcome Framework (QoF). The QOF rewards practices for the provision of ‘quality care’ and helps to fund further improvements in the delivery of clinical care. Practice participation is voluntary but most practices take part, and the process is an annual part of the commissioning and contracting cycle. Recent local evidence completed by the public health team, and based on national modelling, has identified that brief interventions from GPs is one of the top cost-effective lifestyle interventions for the population of Northampton after taxation and mass media campaigns. This strategy aims to support that evidence by supporting localities to develop such interventions at a local level, and engages the population in taking control of their health needs.

6.1 Working with ‘Big Brands’

The public do not usually understand how to self-diagnose and triage themselves into appropriate categories as defined by the services provided in a clinical commissioning group area, in which they live. For example, “how do I know if I have a long term condition?” Furthermore, information on the range of services provided tends to arrive at times when it is not needed for the majority of the population and is forgotten by the time they eventually do need it. In the 21st century the internet provides a prolific amount of information people can and will access on health, some good, and some not, and we know from social market campaigns that conversations with families and friends are very often the biggest influencers in accessing health care. We also know that the public can remember, understand and use the ‘big brands’ (see Figure 1.1) and that re-direction or attempts to encourage use of other services have been mixed. For long term conditions management it is therefore important that service development and improvement recognises that familiarity and use it rather than attempt (and fail) to compete with it. People with long term conditions will at some point in their care need to access acute care, and the more they know about managing their health, the more likely they are to know exactly when that moment is required. As commissioners we need to encourage or hang our developments on those familiar brands, work with them, and ensure people have access the full range of services, in a flexible and manageable model.

Established big brands include:

- **A&E**: the aim should be for them to “see, treat and transfer” and we need to incentivise this
- **999/ambulance**: the aim should be to develop a single point of contact (SPOC) so that we ask a healthcare professional to decide the best place for the patient to go, not the patient to self-triage – they will often over-estimate the severity of their condition
- **GPs**: the aim should be for them to work with community services to support self-care and patient empowerment
- **NHS Direct**: despite government investment and widespread publicity, the service is not familiar to many people
- **111**: this will take over from NHS Direct *in 2013* with some CCGs
7.0 Current work to date

7.1 Governance

Current work is developed through a multi agency team that meets monthly. This chaired by a clinical lead, with central management support. The group report directly to the NICP board, and are responsible for the delivery of progress and working together for the benefits of the population.

7.2 Key national principles

Work has already begun on the three core principles, and is detailed below:

7.3 Risk Profiling

7.3.1 Kettering Locality:

Practices in Kettering will continue to have access to the existing risk profiling tool, currently used by practices and PAC teams, to identify potential patients who may benefit from referral to the Multi Disciplinary Team (MDT). The existing tool, PARR++, uses secondary uses service data (SUS) detailing hospital attendances which is available 4-8 weeks following the attendance or discharge date to assess the likelihood of the individual requiring hospital admission during the coming 12 months.

The team will have access to existing voice conferencing technology to support working across the team. Once operational any requirement for visual conferencing, desk top sharing or other unified communications will be established and considered as part of the pilot. A number of suitably secure solutions have been identified to enable a rapid deployment on identification of the requirement.

7.3.2 Daventry Locality:

The MDT in Daventry will be piloting a new tool which provides enhanced risk profiling and a new case management facility.

The new tool, Health Analytics (using the LinkWell platform), uses the Kings Fund Combined Model which combines secondary care (A&E, Outpatient, Inpatient) and primary care data from multiple sources to develop a predictive model to target interventions for current high users as well predicted future high/medium users of health care. The output of this tool is a practice-specific list of patients with their risk scores and is used to help practices and commissioners to improve patient care and commission effective services. The data will allow Practices to refer patients to the MDT who will be able to access the referred patient record in the Health Analytics (HA) system, alternatively the MDT case finder will be able to view anonymised patient level data and recommend to practices patients to be considered for referral to the MDT.

The Health Analytics tool provides further functionality for correlation of disease severity to medications and similar analysis, a timeline of contact at individual level across all data sources (in the initial phase this will be primary and SUS data, mental health data will follow soon, and work is underway to source both
prescribing and social care data) which will enrich the information available for both care and intervention planning.

The tool will be used in a twofold approach: risk stratification and care planning. All practices in the locality will have the tool for practice use and are now uploading practice data and populating the HA tool. The Train the Trainers programme is being rolled out for super users, and the Daventry Senior Locality Manager is included in this.

This will enable Daventry to:

1. Start using the tool from July & begin to identify people with LTCs for referral into the MDT or for practice intervention.
2. Begin to develop care plans in the shared access model from August. This will include information from social care once available (technical testing complete, information governance to be concluded and data feeds constructed).
3. Work with social care from a shared plan

Work against these is progressing, and includes progressing signed off agreements between partners on information governance.

A paper has been requested by the locality board to consider deployment of the Health Analytics tool across Nene.

The team will have access to existing voice conferencing technology to support working across the team. Once operational any requirement for visual conferencing, desktop sharing or other unified communications will be established and considered as part of the pilot. A number of suitably secure solutions have been identified to enable a rapid deployment on identification of the requirement.

7.3.3 Northampton central & Northampton West localities

Practices across these localities have developed self management programmes for COPD management and heart failure, pro-actively inviting the patient to attend the practice to assess both the mental and physical condition of the patient and enabling them to better understand their long term condition.

These commenced in July and will be evaluated in the autumn of 2012.

7.4 Neighbourhood teams

Early work here started as the strategy has been developing, and is twofold in approach:

Opportunities to develop things

A three month pilot ran between Jan-March 2012 of a multi-disciplinary team supporting people with COPD in the north of the county. This has been evaluated (Riddaway 2012) and the learning taken forward to be used within the locality. The key outcomes established there are benefits from professionals working together focused on people with complex needs, and that a whole systems approach in the community setting will enable maximum benefit.

Locality based developments

One locality has commenced building a prototype neighbourhood team, through the formation of a team, and is intending to go live in testing in July 2012. The team recognise that they are on a journey of learning, and that the learning and evaluation of the work will be critical to successful outcomes.
At this point it is very much a test bed for other localities that are developing work against specific diseases, or just beginning the journey.

This strategy supports the different approaches, and recognises that a core part of the work developed – seen as action in learning, will be evaluation through the main multi agency group. This group will need to ensure professionals working together can offer both supportive challenge, and commitment to seeing the work through. Leadership and board level support for such working practice will be a critical component.

7.5 Self care/shared decision making

The Northamptonshire Integrated Care Partnership Board are piloting plans to mainstream personal health budgets within their LTC delivery model in two localities, it is anticipated that, depending on evaluation of the pilots, this will form part of the QIPP plans during the latter half of 2012/13. The intention is to increase LTC self management and move care into the community and closer to home and reduce the need for visits and admissions to hospital.

Personalisation and the care/support plan are seen as an integral part of this new approach, with personal health budgets being offered as an option. By allowing everyone to assume some degree of self-management, and supporting them, the expectation is that people will become increasingly confident to take on more control. Therefore they would expect the take-up of personal health budgets, and then direct payments, to grow steadily as people become more comfortable with the role and available support.

It is anticipated that in the future patients will be able to self-refer but GPs will start by targeting patients and approaching them. This is not expected to be condition-specific but based on need as identified through:

- GP risk profiling of their most vulnerable patients;
- emergency admissions/A&E attendance linked to the person’s LTC; or
- referral from other clinicians/professionals i.e. community nurse, community psychiatric nurse, physiotherapist, OT, social worker

The person will then choose their key worker from multidisciplinary neighbourhood teams, who will help the care/support planning process, help coordinate any specialist input needed in the community, and review that the care/support plan is achieving the expected outcomes.

(Audit Commission 2012)

Along side this work, the development of risk profiling, and neighbourhood teams, and care planning will enable clinicians to begin to work with people and through effective partnership working offer them coaching programmes to develop self management skills. Nationally the Health Foundation is working with the Department of Health and organizations to develop tools and skills for taking this forward. Northamptonshire will be using this to support the strategy and local deliverables.

This will also be reflected in the local workforce plan as a training programme available

7.6 Specific projects

A number of specific preventative projects have been identified as those that will benefit people with long term conditions. Each of these has quality and experience of care efficiencies, as well as costs reduction opportunities.

They are:

- Diabetes MDT
- Cardiac Rehabilitation
- Frequent attendees
8.0 Vision for long term conditions from 2012 and beyond

The vision for long term conditions management must be for a system and the workforce working around an individual’s needs, and in a manner that is simple and straightforward as possible. Care will focus on prevention, and developing effective partnership working that supports people towards self management of their conditions. The health & wellbeing board’s philosophy of ‘Delivering meaningful healthier, longer lives for the people of Northamptonshire’ will be a key message that the workforce will adopt. Active health promotion through lifestyle and behaviour interventions, screening, and education will enable health inequalities to be reduced, and will ensure the people of Northamptonshire live life for longer. As a result the outcomes mean those people with long term conditions in Northamptonshire will be able to choose appropriate high quality care and support at the right time, and in the right place, such that inequalities in access to this care are eliminated.

8.1 Risk profiling

8.1.1 Vision – the desired outcomes

- People in Northamptonshire and living with long term conditions will be offered support by neighbourhood teams through the use of local risk profiling tools. These will be used through safe and secure IT systems, and have shared Governance arrangements put in place across stakeholders if patient records are to be accessed across health and social care, and for the benefit of shared care.
- The option of shared care and case management will be offered only by individual consent, and through people’s own choice. Those people, who do not wish to take the offer up, will not be disadvantaged in their access to health services.
- All health, social care, and third sector services across Northamptonshire will use opportunistic screening to identify new people with long term conditions, and alert primary care in order that they can register these people, and help support them in the future.
- Risk profiling will enable early prevention approaches to be offered to people across Northamptonshire thus reducing health risks.

8.2 Neighbourhood teams

8.2.1 Vision – the desired outcomes

- People across Northamptonshire will have a single point of access to a community neighbourhood team. These will be made up of core members and have access to specialists. Neighbourhood teams set up and operation may vary across localities, according to the population needs, but each will work within the same core long term condition principles, and be designed to support people in managing their long term conditions, staying healthy, and working towards self care/management.
- Neighbourhood teams will define their functions, and commitment to the deliverables through a shared philosophy, which will be publically available and shared with the individual at the time of contact. Practice may include multi disciplinary team working, case management, and/or access into interventions for help over a specified period of time. Outcomes will be visible, shared and evidenced based. A key worker role, or navigator will help to support
people and ensure they have choices, and control over their lives in order to manage their health.

- Those people requiring access into specialist services will be seen and assessed in an assessment clinic (discrete from a ward) by a senior clinician at the earliest possible point, with strong links to primary care, social care, and community services ensuring that only those that need prolonged specialist clinical care are admitted to hospital.

8.3 Shared decision making/self care

8.3.1 Vision – the desired outcomes

- People across Northamptonshire will be seen as ‘our customers’, and in managing long term conditions we will enable them to drive their requirements at their own pace, and own priorities such that appropriate scales of time to response, and contact are adhered to.
- People in Northamptonshire will be able to receive appropriate advice about their condition in a way that they choose. This may be face to face, by telephone, e-mail, text or post.
- People with long term conditions will be offered a key worker who will support them in navigating services they may choose to use. The key worker role will be a support interface that helps them navigate through services, and provides support at times of need.
- People with long term conditions will be encouraged and supported to write and hold a wellbeing plan to manage their long term conditions. The plan will encompass and prioritise all their health and social care needs and be designed around their individual defined needs and across services, accessible only with their consent. The key worker and neighbourhood team will help them to develop this, and through discussion, enable other services such as OOH care and emergency services (such as ambulance and A & E) to access it in critical times of need.
- Increasingly, people search for advice on managing their long term conditions healthcare matters from the internet. The NHS locally will educate and direct people to reliable and accurate sources of information on the web, and to where they can find creditable sources of information about their condition, and how best to manage it.
- All aspects of primary care (i.e. general practice, community pharmacy, optometry and dentistry) will take the opportunity of the patient encounter to promote prevention (including screening and brief interventions) as well as cure.

8.4. Vulnerable groups

8.4.1 Vision – the desired outcomes

- There will be fast access to appropriate commissioned interpreter services for people whose first language is not English. Information on these services will be made available across all organisations, and by their workforce.
- People with acute mental illness will be cared for in appropriate commissioned facilities and by appropriately trained staff
- Working practices in managing long term conditions will support effective safeguarding of vulnerable adults and children and contribute to a reduced risk of abuse for people who use services.
• Those people living in care homes will have full access to health and social care services, without prejudice.
• It is recognised that people living with long term conditions will eventually require end of life care. This care must be readily accessed locally, of a high quality, and evidenced based, with priorities of enabling individual choice, dignity and respect, managing pain, and in preparing for their death with the involvement of close family and/or friends. Teams caring for people with long term conditions will be knowledgeable in the local end of lives services available, and able to provide information in an appropriate format, and timeliness.

For some people, their management of longer term conditions will require health professionals to work harder to ensure the same high quality effective health care can be provided to them, perhaps because of language differences, different expectations coming from different cultures, or because the person’s own health problems intervene. Yet, these are often the people who stand to benefit most from access to high quality effective health care, and therefore the additional investment and efforts required to deliver this health care must be made. The development of neighbourhood teams aims to help people further in these situations and will require a workforce who are committed to towards a personalization agenda, and to working across multiple sectors to maximise benefits.

This principle is at the heart of the NHS constitution: “The NHS provides a comprehensive service, available to all irrespective of gender, race, disability, age, religion or sexual orientation. It has a duty to each and every individual that it serves. At the same time, it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population.”

This same principle must be at the heart of care for people in Northamptonshire with long term conditions.

8.5 Whole systems

This strategy supports the principles of delivering care through integration. Integrated care is best described as a strategy for improving patient care. The individual is the organising principle of integrated care, and one size of integrated care does not fit all (Nuffield Trust 2011). The management of long term conditions across Northamptonshire will only be successful if organisations work together, and have a shared aim of ensuring people receive high quality clinical care at every level and stage of their journey. The interface between primary and secondary care will be crucial, and should enable the individual to receive a smooth handover and remain in control.

Partners will include GP practices; SPA; acute hospitals, social work teams, public health, mental health services; residential + nursing homes; independent sector care providers; community housing and other local authority services; voluntary and third sector; police, East Midlands Ambulance Trust.

This list is not exhaustive and there may be others that are determined locally.

9.0 Creating the Vision: Next Steps

National Health Service constitution consultation paper. Available at: (last accessed May 11, 2012)
The vision statements as set out in this document should be used as the criteria against which to assess options for provision of urgent care services in the next 5 years.

In the first instance, the Long Term Conditions Sub Group will remain the route through which suggestions for development and improvements in pathways for managing long term conditions are proposed. If agreed by the group to be in line with the vision, then further work to develop the pathway can be undertaken, to include estimations of resource implications and, if appropriate, submission to the NICP board for requisite funding. The strategy does not intend to be viewed as a punitive vehicle recognising that localities will be keen to develop innovation to the work, and instead aims to be seen as a framework upon which their ideas and creation can be hung, and the multi agency group acting as a central source of resources, support and expertise. A key part of this early development phase will be the shared learning. Learning principles and practice will be encouraged both at locality level, and through discussions at the monthly Sub Group Meetings, helping to develop and drive best practice models that can be adopted countywide.

9.1 Year 1: 2012/13

The three key principles of managing long term conditions will be given as a key message, along with a shared adoption of the Health & Wellbeing Strategy, and Board principles.

A number of pilots will run across identified localities, developing the community based model, and using the core principles of long term conditions. These pilots will include risk profiling using IT tools, development of neighbourhood teams through multi disciplinary working, and case management.

Evaluation of these will be critical, and through learning in action, and accessing available national support, the localities will begin to define their neighbourhood, and engage people locally in what the area needs.

Personal health budgets will continue to be rolled out, and evaluated through the capture of patient stories. These will be shared via webpage access, and DVDs. A full national review of pilot sites is due out in the autumn of 2012.

The model of community diabetes MDT will go out to tender for a new enhanced service to commence April 2013.

After agreement was secured for pulmonary rehabilitation service re-design countywide, an options appraisal is being developed to define commissioning options, and the possibility of merging parts of cardiac and pulmonary rehabilitation services. The business case will subsequently follow with a possible work up by providers of a pilot in order to secure cost efficiencies, and quality.

The countywide community alcohol & drugs pathway will continue to be rolled out across localities, alongside the development of a community clinic by each locality.

A communications plan will be developed to support this work and will underpin this strategy in the next five years. The fundamental principals of this will be taken from Nene’s Communication and Engagement Strategy of which the important elements are detailed below.

The communications and engagement strategy has been designed to support the CCG through authorisation which places patients, communities, carers and patient groups at the centre of the new commissioner’s role and function. The following principles will underpin all future patient and public engagement. They are:

- Be targeted - Ensure local input into local decisions
- Be meaningful - Ensure all views of our diverse population are represented when and where appropriate
• Avoid duplication - Embody the ‘no decision about me, without me’ ethos

A summary of the six communications and engagement objectives are to:

1. Identify and deliver the key communications and engagement evidence requirements for CCG authorisation that ensure integrated communications and engagement activities are firmly embedded in Nene CCG.

2. Launch Nene CCGs vision, aims and culture to key partners, stakeholders, patients and the public by positioning the CCG as a high performing, credible clinically led organisation.

3. Establish a highly effective patient, public and community engagement network to support the CCG in delivering it’s commissioning intentions.

4. Deliver effective communications that encourage patients to better understand and take advantage of CCG led developments:
   - Primary and community care
   - Urgent (unplanned) care
   - Planned care
   - Care for long term conditions
   - Mental health
   - Children and maternity
   - Management of medicines

5. Establish effective communication channels that encourage leadership and engagement across the 71 GP practices.

6. Proactively safeguard the reputation of both the CCG and the NHS by managing patient and public expectations.
9.2 Years 2 and 3: 2013-14

Further pilots will be implemented in localities, and using the learning outcomes from the evaluation of the early adopters.

The diabetes MDT will be embedded and extend to secure benefits for patient care.

Cardiac rehabilitation services will be commissioned with a clearly defined set of outcome measures and links to neighbourhood teams.

All eight localities will have scoped the community clinic concept for managing people with alcohol dependency, and those localities identified as having a higher need will have a local clinic fully operational and that can demonstrate value, and is accessible to people with long term conditions.

Personal health budgets will continue to be rolled out and be offered according to agreed criteria. Those people that choose not to take one up through personal choice will continue to access and receive full care without prejudice.

Joint budgets between health and social care will be explored, with the intension of securing future integrated commissioning arrangements from year 2 onwards.

9.3 Years 4 and 5: 2015-16

Long Term Conditions Strategy 2012-2017

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October 2012
Those localities working on long term condition pilot models will begin to move to developing a community
developed model, through the creation of a culture of participation.

A full evaluation of all the localities against the key principles will commence in 2015, and be available for
reporting in 2016.

Progress towards the vision should be monitored against the following set of indicators:

(a) A set of defined outcome measures drawn up by a locality. These will be of a mixed
methodology approach and include capture of user experience.

(b) Capture of patient stories, through either: face to face interviews, focus groups, interviews, or
observations.

(c) Cost of long term conditions per 100,000 people in Northamptonshire (using programme budget
data)

(d) Comparison data of identified top 100 peoples’ episodes of emergency care with the baseline
collected in year 1.

10.0 Equality Impact Assessment

Measuring the impact of any service change will be a key part of the work carried out from this strategy and
commissioners will ensure that robust assessment and subsequent decision making will refer to local
policy.

11.0 Quality Standards

This strategy will ensure that standards of care across services commissioned for people with long term
conditions are compliant with the Essential Standards of Quality & Safety laid out by CQC in 2010.

2.0 Implementation and dissemination of document

The most recent versions of this document will be held on

It will be shared directly with current providers and services of long term conditions management and as
part of any future tendering exercises that occur during the lifetime of the strategy.
13.0 Overall responsibility for the document

The strategic document is the responsibility primarily of the central management function of Nene CCG, but shared closely with the public health team, at Northamptonshire County Council.

Advice on its content will be provided by Nene CCG Long Term Conditions Group.

Appendix A
Medium term model

Community based model
Care is developed through a locality, based on population needs, locality plans, and developing integrated care. Target largely individuals within either geographic area or specific subgroup in geographic area defined by sponsoring body. The community is based on geographic areas, and defined through interventions delivered in the community. Activities are largely health-orientated.

Long term

Community developed model
Problems, targets and action defined by community. Community itself the target of intervention in respect to capacity building and empowerment. The community setting is recognised as being complex, changing and subject to power imbalances and conflict. Activities may be quite broad-based, targeting wider factors, with an impact on health, but with indirect health outcomes empowerment, social capital).

Models of care developed over the five year period.

Appendix B
Appendix: Index of abbreviations

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<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
</tr>
<tr>
<td>IT</td>
<td>Information Technology</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service</td>
</tr>
<tr>
<td>QIPP</td>
<td>Quality Innovation, Productivity &amp; Prevention</td>
</tr>
<tr>
<td>JSNA</td>
<td>Joint Services Needs Assessment</td>
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