

# Board Assurance Prompt – managing long-term conditions

July 2011

## What is this guide? Who is it for?

This briefing is targeted at Clinical Commissioning Groups (CCGs), NHS and Health and Wellbeing Board members and others planning healthcare improvement. It is intended to support debate around service quality, operations and planning in a precise and informed manner. The contents are drawn from the Good Governance Institute report on quality and safety issues for managing long term conditions out of hospital<sup>1</sup>.

## Long Term Conditions and future resource needs

Long-term conditions (LTCs) are associated with damage and deterioration of a major vital function over many years. They include conditions such as:

- Congestive heart disease (CHD)
- Chronic obstructive pulmonary disease (COPD)
- Diabetes
- Alzheimer's disease and other dementias
- Depression
- Hypertension

This increases the pressures for providing services. LTCs account for over two-thirds of NHS hospital care currently. Advances in medicine has led to the reduction of deaths and increasing life expectancy with LTCs. Combined with what is known about funding needs for up and coming treatments, and the effect of an ageing population with greater numbers of vulnerable older people needing care, the additional funding needed by the NHS in England is estimated to be around £20bn by 2014. Funding this is often described as the 'cuts' that are being sought as part of the current healthcare reforms. In actual fact, the flat funding of the NHS in line with retail inflation means that an additional £20bn needs to be found in order to pay for new treatments as they become available and crucially manage the demand from long-term conditions and an ageing population. The only way the system can cope is by creative thinking, integrated services and coordinated locality approaches, which harness the resources of both Health and Social Care.

## To deliver this, those planning healthcare services need to turn to the following options:

- 1 Improving the health of the population – a longer-term solution where actions now achieve payback over decades rather than years
- 2 Improve the effectiveness of current services and drive out waste. This will without doubt deliver some new resources, but in no setting have savings of the kind needed been taken out of such a large, complex system as a national healthcare service through efficiency savings alone
- 3 Changing the referral patterns of clinicians, within the envelope of existing service provision. This includes approaches such as service substitution, care pathway redesign and introducing new structures. Research suggests that significant change can be achieved over a five year timescale and significant new capacity found<sup>2</sup>
- 4 Changing the way patients are able to use services. Patients have the most vested interest in their care being safe, effective, high-quality and within budget. Empowered patients in control of their lives and able to remain active are those who have a high-level of understanding about their conditions, are aware of service options and understand how and when to seek help. Where patients are included as a key part of the care team dramatic improvements to both outcomes and the use of resources have been achieved

The above reasons point to interventions that support both clinicians and patients change the pattern of care as the most certain way in which a sustainable healthcare system for the 21st century can be built and better outcomes achieved. Healthcare planners (including clinical commissioners), those developing provider services, patients' advocate groups and the National Commissioning Board need to be sure that service developments and investment are being directed towards solutions that support re-thinking and re-shaping care pathways in a way that supports people with long-term conditions remaining healthy and not defaulting to hospital care. The QIPP (Quality, Innovation, Productivity and Prevention) programme aims to achieve this service transformation.

<sup>1</sup>Corbett-Nolan A, Bullivant J, Green M and Parker M, "Better care for people with long-term conditions: the quality and good governance of telehealth services", GGI June 2011

<sup>2</sup>Corbett-Nolan A, Hazan J and Bullivant J, 'Cost savings in healthcare organisations: the contribution of patient safety', GGI November 2010

## The rest of this guide

Overleaf are a series of assurance questions that board members and others developing services might ask to ensure that the local service development is progressing along sustainable lines to meeting the known needs of patients in the future and is focussed on better population outcomes. These assurance questions are examples only, and are intended to provoke thought in those holding service planners and commissioners to account. We also provide our view about what

an adequate and thoughtful answer to these questions would look like, and also what an unsatisfactory response would be. Often the adequate answer indicates something has happened or will happen, that it will be possible to monitor its implementation/effectiveness/ and there is accountability. The inadequate answer often suggests either buck-passing or ongoing activities that cannot be monitored/evaluated.

## Healthcare in a modern society

Healthcare is a universal right initially enshrined in the Universal Declaration of Human Rights 1948. The challenge of meeting this aspiration grows year on year, as medical knowledge improves to provide patients with enhanced opportunities and the demography of the population changes. Care models are changing as the disease patterns within populations change. In the early 20th century with the domination of infectious disease and prior to antibiotic treatments, patients depended on good nursing care provided in high-bedded hospitals. Over the last 70 years this pattern changed to the hospital catering for patients with acute needs, supported by an increasing primary care sector. In an older, sicker and fatter world providing healthcare within the current care paradigm is set to become economically unsustainable. Healthcare services need to find ways of supporting large numbers of people living with long-term conditions to enjoy an active and healthy life, and to have power and determination over their daily home lives. The key tools to achieving this will be predictive risk management at the level of the individual patient, personalisation of services and patient empowerment.

### Key facts from the Department of Health:

- Due to the aging population the number of people in England with a long-term condition is set to rise by 23% over the next 25 years
- 5% of the patients, the majority of whom have one or more long-term condition account for 49% of all in-patient hospital bed days
- 6.4 million people have clinically identified hypertension. It is estimated that the same number again have unidentified hypertension, meaning that an estimated one in five of the population suffers from the condition
- Common mental health problems affect about one in seven of the adult population with severe mental health problems affecting one in a hundred
- It is estimated that 85% of deaths in the UK are from chronic diseases. Within this, 36% of all deaths will be from cardiovascular disease and 7% from chronic respiratory disease

### Key issues for patients living with a long-term condition:

- Patients receive information support including: facts about the condition; information about all available local health, social care and support services; decision support with regard to treatments; medications – their purpose, risks, how to take them, what to do in case of uncertainty or lack of efficacy
- Patients have access to education for self-management
- Patients are entitled to a comprehensive, annually reviewed care plan
- Patients have access to a care co-ordinator with the power to deliver agreed packages of care
- Preventive services are available (eg dietary advice/support, falls prevention, health coaching, telehealth)
- Patients have access to electronic records

	Example assurance question
1	Is there a common understanding in this healthcare economy amongst service planners of the scale of need around LTCs in the coming years, and a forum to discuss how we are going to change the way we work to address this?
2	Where we feel service changes hold the potential to address LTC capacity issues in the coming years, are we now investing to build this capacity?
3	Are we engaging all our clinical teams in identifying improvement opportunities as part of their everyday work?
4	Do we reward those who institute adapted solutions identified from elsewhere, rather than simply value local innovation?
5	Where we are using technological solutions to support patient care, are we making the required changes in clinical behaviour and care pathways to get the best?
6	Are we incentivising providers, through means such as sharing benefits and creating investment strategies, to dramatically change their use of services?

## Key facts about long-term conditions

There are 15.4 million people in England with at least one long-term condition, and it is thought many more are not yet diagnosed.

Three out of every five people aged over 60 in England suffer from a long-term condition, with actual numbers set to double by 2021.

The UK economy stands to lose £16 billion over the next 10 years through premature deaths due to heart disease, stroke and diabetes.

People with long-term conditions are very intensive users of services. They make up 31% of the population but account for 52% of GP appointments and 65% of outpatient appointments.

Plausible answer	Insufficient answer
<p>Our Joint Strategic Needs Assessment (JSNA) has identified the scale of current challenges, and we have a local joint planning forum at which we are working through the implications of managing LTCs in future years. GPs, local providers, the local authority and the PCT are all active participants. We have agreed a holistic outcomes framework</p>	<p>We have appointed an LTC lead in the PCT who is developing plans to address this issue. Our contracts require local providers to reduce admissions for people with LTCs.</p>
<p>We have set our cost improvement programme (CIP) at a level that will allow real investment in new services, as well as achieving the savings needed today. We are working up local programmes for providing better home care for people with LTCs at scale now. LTCs appear on our board assurance framework (BAF), with identified risks, controls and assurances</p>	<p>We understand there are a number of pilot programmes going on currently and when these report we will make decisions then.</p>
<p>We understand we have to be proactive in not tolerating any barriers that deter GPs and hospital-based clinicians from actively engaging in transforming local services. We are supporting and investing in clinically-led care pathway redesign work around LTCs.</p>	<p>This is a matter for the new pathfinder CCGs and clinical senates, who will manage clinical leadership locally.</p>
<p>We support clinicians and service planners network nationally with their peers, and learn from programmes that work elsewhere and could be useful here. As part of this we benchmark ourselves with others in order to learn where we need to improve our service performance.</p>	<p>We have a robust QIPP programme locally. Our healthcare economy is unique and so we like to pilot ideas ourselves first. It is too risky to just adopt ideas from elsewhere. We have made useful savings from reducing trips to external conferences and that sort of thing.</p>
<p>The large scale adaptors of technological solutions supporting change in patient care advise us that we need to re-think the entire care pathway to successfully introduce change. For this reason we have involved clinicians from the start of our service transformation, and have put resources into supporting sustainable change in how patients are cared for.</p>	<p>Our procurement team deal with buying in new technology. This ensures we achieve best value for money.</p>
<p>We recognise the tariff provides short-term incentives for local providers to fill capacity, and little reward for creating long term change. For this reason we are working up joint risk and benefits sharing strategies so that savings made can be channelled into new ways of working without destabilising our current providers.</p>	<p>This is a matter for providers within QIPP. The tariff provides them with adequate incentive for change. Where a provider is unable to change we will tender out the service and obtain best value.</p>

**Long term conditions take up 75% of NHS spend.** To meet care needs for the UK population using current care approaches would require an increase in healthcare funding from 9% of GDP in 2010 to 20% of GDP by 2025.

**1 in 3 people over 65 will die with dementia.** 700,000 people in the UK have a form of dementia. In less than 20 years nearly a million people will be living with dementia. 1 in 6 people over 80 have dementia.

**COPD is the sixth most common cause of death in England and Wales, causing over 30,000 deaths a year.** By 2020 it will be the third biggest killer in the world. It is the only major cause of death that has increased significantly in recent years.

**Since 1996 the number of people diagnosed with diabetes in the UK has increased from 1.4 million to 2.6 million.** By 2025 it is estimated that over four million people will have diabetes.

# Transforming care for people with long-term conditions: A maturity matrix to support development and improvement

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To use the matrix: identify with a circle the level you believe your organisation has reached and then draw an arrow to the level you intend to reach in the next 12 months.



Progress levels	0	1	2	3	4	5
Key elements	0	1	2	3	4	5
<b>Building local understanding and support</b>	No	<b>Basic level</b> Principle accepted and commitment to action  Our JSNA is up to date, and we have been ensuring that local Pathfinder CCGs and any nascent HWBB properly understands the JSNA and any local LTCs services. LTCs have been considered for inclusion on our board assurance framework	<b>Early progress</b> Early progress in development  We have mapped out expectations of future local morbidity and service needs for the main LTCs and have shared this with partner organisations. Our plans dovetail with the commissioning of independent care services has been considered	<b>Results</b> Initial achievements evident  Local plans for all main partners in the area address the future needs of people with LTCs. We have common service trajectories and demand projections	<b>Maturity</b> Comprehensive assurance in place  Year on year, partner organisations are checking actual service demands against predictions and triangulating future expectations with peers	<b>Exemplar</b> Others learning from our consistent achievements  As new partner organisations emerge, they routinely are accepting local predictions and plans for LTC services
<b>Clinical engagement</b>		We have mapped out those local clinicians who need to be involved and have discussed this with all relevant local organisations. LTCs are on the agenda of our local clinical senate/similar clinical advisory groups	Joint planning groups with significant clinical input from across the entire care pathway and membership have developed or endorsed strategies for change. Clinicians shape identifying what success means	We can identify service changes that have resulted from ideas generated or supported by local clinicians. Plans have been supported by the local clinical senate/similar clinical advisory group	Contract specification and monitoring routinely involves clinicians, as does the QIPP programme	Local clinicians are active in pushing forward national thinking, and our local service developments are being adopted and adapted by others
<b>Engaging service users and patient experience</b>		We know the relevant local patient groups interested in LTCs and there is a forum by which we can engage with them. We are working with patients on their perceptions of service success	We know of all local patient registers and have other systematic means of communicating with patients with LTCs. New patients with an LTC receive thorough information about their condition and care	Our planning approach has involved local patient groups, and is informed by sound social science methods of gaining wider patient views. Patients are uniformly involved in their own care and we seek feedback on their experience	We have an active patient advocate system in place, with patients acting as peers support as part of formal local schemes. Our patients with LTCs are knowledgeable about their own individual vital signs and report positive experience of the service	Our understanding of our local patients is helping shape regional and national thinking on services for people with LTCs. Our patients report sustained achievement of their own health and wellbeing goals
<b>Care pathway transformation</b>		We understand and have mapped out the current pathway of care – both planned and actual. We are working on a sustainable and genuine QIPP programme	We have engaged clinicians, planners and patients in critiquing the current pathway of care. Our QIPP programme is supporting this work. We have identified the outcomes we feel we can improve	We have recast at least two pathways of care for people with LTCs and are measuring adherence and outcomes. We track variations	We are confident that changes to pathways have changed outcomes, patient experience and resource use beneficially	We promote our pathways of care, and have attracted interest in these from elsewhere. Commissioners are funding future pathway development. Our outcomes benchmark in the upper quartile
<b>Introducing change at scale</b>		We know what small scale pilots programmes for LTCs are going on locally, and have modelled the implications of scaling these up	We have live plans for investing in up-scaling at least one transformation pilot (either local or other) to cater for all our suitable patients in that category	We have introduced at least one at scale service transformation for people with LTCs, and understand the benefits this has accrued	Providers are incentivised through formal risk and benefits sharing schemes to invest effort into at scale service transformation for LTCs	All local partners have gained from service transformation at scale, and for whole categories of patients with LTCs we have improved outcome and patient experience