Long-term conditions in Lancashire

A joint strategic needs assessment

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Produced in partnership with:

Blackpool Council

BLACKBURN *with* **DARWEN** BOROUGH COUNCIL

Lancashire County Council

Foreword

With an ageing population and an increasing number of people with complex needs, one of the major challenges facing Lancashire is to help people with long-term conditions and the inequalities associated with them. Addressing this jointly with all the stakeholders will not only address the current pressures on our services but will also help build healthier and resilient communities in Lancashire.

This joint strategic needs assessment marks an important stage in our journey in Lancashire in making progress towards a better system for promoting the health and wellbeing of our people. Embedding the recommendations of this report in everything we do will also benefit generations to come in living healthier and longer lives.

Our health and wellbeing board is committed to take joint action in improving the lives of people living with long-term conditions and to prevent the onset of them in the first place. I hope you find this report a useful reference point for making commissioning decisions and providing services to the citizens of Lancashire. It is my pleasure to introduce this to you.

County Councillor Azhar Ali

Cabinet Member for Health and Wellbeing

Background

Tackling long-term conditions (LTCs) is recognised as a priority within the NHS Mandate and through the NHS Outcomes Framework. More broadly, the Public Health and Adult Social Care Outcomes Frameworks also play a major role in the prevention of chronic ill health and supporting people with care needs.

An understanding of LTCs across Lancashire is needed in order to support these priorities, assist local health and social care services in meeting their outcomes and inform the future shaping and delivery of care for people with LTCs. The production of a joint strategic needs assessment (JSNA) is a statutory duty for local authorities to ensure that health and wellbeing boards and commissioners have a better understanding of their local populations and the challenges they face in tackling health inequalities. This is the foundation of effective strategic commissioning.

It is therefore timely, given the drivers above, to produce a JSNA for LTCs. The resultant intelligence can underpin a strategic understanding, and guide commissioning decisions that aim to improve the health of the population through sustained high quality experiences of care for those with LTCs that achieve value for money (see fig 1).

Figure 1: Aim of this JSNA for long-term conditions[1]
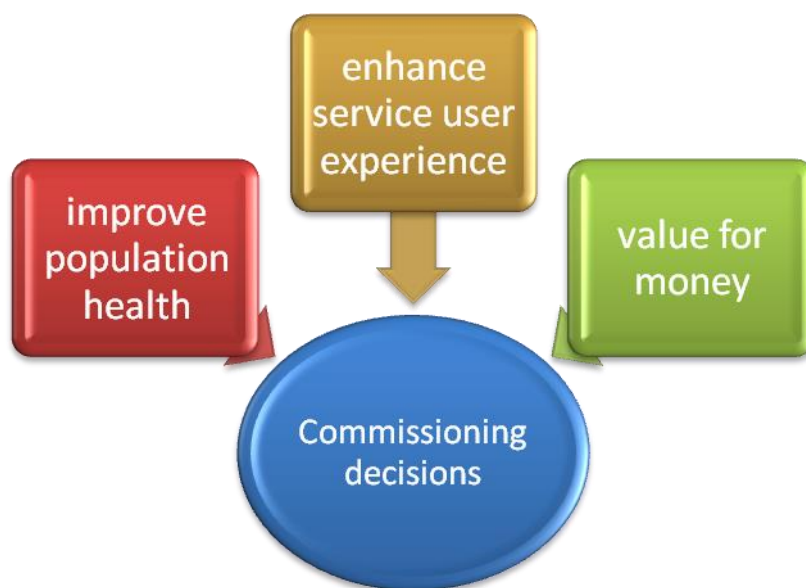
This JSNA provides analysis of the current and future needs for people with LTCs and their carers across the Lancashire sub region. It uses a wide range of data that can be viewed on the long-term conditions section of the JSNA web platform.

Rather than take the form of a single document, the LTC JSNA should be regarded as a repository of health and wellbeing related intelligence available on a website that all partners and the public can access.

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[1] Adapted from the Institute for Health Improvement's 'Triple Aim'

Defining long-term conditions

There are many ways to define LTCs, but it was important to identify one as a reference point for development of this JSNA. Feedback at the scoping event enabled the following definition of a long-term condition to be determined:

A long-term condition is a condition that adversely affects a person's quality of life over a number of years. It can be managed through self-care techniques and other interventions to maintain independence, with the help of assets and support from the community and health, social care and voluntary services and their systems.

Consequently this JSNA recognises the disabling nature of long-term poor health. It is more than just the presence or otherwise of one or more conditions; it acknowledges the social context for people with chronic ill health and the challenges for maintaining independence, having access to services and being able to participate fully as a member of society and requires a 'whole system' response. For example, having a LTC for some people can mean:

- challenges in gaining or sustaining employment and maintaining an adequate level of income;
- regular or frequent contact with health or social care professionals;
- disruption to daily life and its activities either in terms of episodes of poor health and/or coping with disability;
- an impact upon family relationships and reliance on informal care;
- a need for additional support for daily living from social care services and/or the voluntary, community and faith sector (VCFS);
- increasing social isolation and loneliness, particularly for older people; and
- an impact upon self-identity and perceived self-worth with potential for mental health problems.

Furthermore, the experience of long-term poor health does not occur randomly across the population. There are socially constructed patterns of poor long-term health that reflect health inequalities across Lancashire. Rates of poor health from long-term conditions are higher in more disadvantaged groups, where lifestyle behaviours that create particular risks for developing long-term conditions are more prevalent. In addition, once a person has a LTC they will often suffer more from it if they are disadvantaged than if they are more affluent.

Methodology

This JSNA does not consider an analysis of needs associated with LTCs simply as an aggregate of epidemiological intelligence for a series of conditions. It focuses on long-term conditions as a whole and draws on a range of evidence sources that includes epidemiological sources of evidence, service user views and other reputable sources to inform the identification of key priorities and recommendations to support the commissioning process.

In late 2012 a project group of data and intelligence specialists from across Lancashire began the process of data gathering and analysis, underpinned with a broad literature review of international and national evidence on LTCs. The data analysis culminated in a prioritisation workshop in June 2013 with key stakeholders from across Lancashire to consider the evidence and emerging priorities and determine the key actions necessary to address long-term conditions in Lancashire.

The five identified priorities are outlined below along with recommendations for action drawn from the prioritisation event.

1. Intelligence

Priority	Goal
Intelligence for long-term conditions that is fit for purpose	Sharing and integration of data and information that enables an understanding of long-term morbidities in the population and the total burden of need facing the health and social care system for people with LTCs

The 2011 Census highlighted that over 300,000 people in Lancashire reported some degree of limitation as a result of a long-term health problem or disability. However we have only a limited understanding of the extent and burden of their conditions. There are multiple datasets framed around specific diseases or conditions but we know very little about the person-centred experience of LTCs.

People with LTCs frequently experience more than one condition. However, we know very little in Lancashire about who, where and what combination of conditions people have and over what period of time.

But co-morbidity only gives a single perspective of a complex issue. Recognising the disabling social impact of LTCs means that for many people and their carers, additional support or care is required to maintain the emotional and practical resources needed to live independent lives and be resilient to the difficulties of living with one or more LTCs.

Robust commissioning decisions require a fuller understanding of the care needs of individuals with LTCs. This requires linkage of their health and social care information, whether or not they are self-funders.

The future of self-funding and the demand for health and social care services with be affected by the ageing population, the availability of community-based support, rising costs, and low interest rates on savings.

A whole systems approach to data collection and analysis which encompasses sources outside routinely available health and social care is needed to assist commissioners in determining the shape of health and social care services required for meeting the needs of people with LTCs. These could include data on economic activity and welfare benefits or knowledge of local community assets and support.

A few facts

- *In the large Scottish Multi-Morbidity study covering 1.8 million people, the majority of over-65s had 2 or more conditions; over-75s had 3 or more; and more people had 2 or more conditions than only had 1*

- *In a recent small audit across three Lancashire GP Practices of 150 patients at high risk of hospital admission, each had an average of 1.2 conditions (under 50s) to 4.2 conditions (over 90s) on the disease registers*

- *Clients receiving funded social care in Lancashire do so mostly on the basis of physical disability but also on the basis of mental health and learning disability*

Recommendations

Steps need to be taken to re-frame existing sources of data and determine new or alternative approaches that present a person-centred model for data collection and analysis.

Robust systems and processes that meet information governance requirements should be in place to link data and information related to individuals with LTCs.

The extent and nature of community-based assets and support across Lancashire's communities should be determined and understood.

2. Prevention

Priority	Goal
Greater emphasis on reducing the prevalence and impact of LTCs	Achievement of health gains and reduction of the impact of LTCs on future health and social care services with a strategic approach that: a) addresses the wider determinants of health; b) promotes evidence-based interventions at both a population level and targeted for those population groups most in need; and c) identifies those at risk and intervening appropriately with evidence-based interventions.

Upstream, proactive and anticipatory measures to prevent and/or alleviate risks for long-term conditions will lead to improved health outcomes and measurable reductions in LTCs over time.

Across Lancashire there is evidence of the impact of the wider determinants of health on the population and the high rates of health damaging behaviours that have contributed to poor health and health inequalities across the area. For example, relatively lower incomes than nationally, higher rates of fuel poverty, a fragile labour market or areas of poor housing. As a result, mortality rates for common preventable LTCs across Lancashire are significantly high in many districts. Furthermore, population groups such as the black and minority ethnic population; lesbian, gay, bisexual, and transgender people and disabled people can face additional challenges such as stigma, prejudice and stereotype when accessing services.

There is also emerging evidence of the impact of the economic downturn and austerity measures on health and in particular on mental health.

The roots of many lifestyle behaviours lie in the early years e.g. infant feeding and in unhealthy diets, smoking, obesity and poor levels of physical activity in adolescence. All of these are associated with development of chronic diseases later in adulthood.

Making sure that people have access to, and are able to understand and interpret basic health information is referred to as 'health literacy'. Supporting health literacy within primary and secondary prevention can build resilience in individuals and communities and is a key determinant of health and health equality

There is evidence for the effectiveness and cost effectiveness of preventative health interventions. If people with modifiable risk factors (e.g. smokers, those with a body mass index over 30, excessive intake of alcohol, low physical activity) are identified systematically or opportunistically, and given relevant advice and signposting to support that will help address those risk factors, then measurable reductions in LTCs will be observed over time. There is a considerable amount of preventive interventions occurring currently across Lancashire. Local evaluation of outcomes will assist in understanding where and how the greatest gains are being made and

A few facts

- *Lancashire experiences some of the worst life expectancy in the country, with a gap of 5.9 years for males between Blackpool and Fylde and 3.9 years for females between Blackpool and the Ribble Valley*
- *Adult smoking rates continue to be higher than nationally with more than a fifth (22%) smoking. The highest rates are in Blackpool where a third of the population (35%) smoke. Smoking related deaths are significantly higher in Lancashire than the national average as are smoking rates during pregnancy*
- *Physical activity, obesity and healthy eating rates are more in line with national trends however these need to be viewed in context of rising national obesity rates, low rates of physical activity and low rates of uptake of five or more portions of fruit and vegetables daily.*
- *Binge drinking in Lancashire is significantly higher than the national average with 23.5% of adults drinking more than twice the recommended daily intake of alcohol*

how services should adapt in response to increasing pressures for cost savings.

Considerable health gains can be achieved and the impact of LTCs on future health and social care services can be reduced with a strategic approach and by planning a combination of steps that address the wider determinants of health and promote evidence-based interventions at both a population level and targeted for those population groups most in need.

Recommendations

Health literacy should become integral to LTC, and developed throughout the whole population. This will ensure that people have the knowledge and power to make better health choices that could prevent or delay the onset of long-term conditions and prevent existing conditions from worsening or becoming a much larger burden on people's lives.

Policies concerned with wider determinants should be assessed for their impact on the development of LTCs e.g. urban planning and use of space and active transport (walking and cycling); housing renewal programmes; licensing; welfare advice.

Commissioners should focus on developing new models of delivery of effective and cost effective universal and targeted preventive interventions through collaborative approaches with all stakeholders.

Joint commissioning opportunities should be pursued between CCGs, local authorities, health and social care providers and the third sector to deliver value for money effective and cost effective health improvement interventions that are sensitive to the needs of different population groups.

Commissioners should ensure that service users are involved in the design, planning and evaluation of health promotion programmes.

Commissioned public health interventions targeted at children and young people should be recognised as part of a lifecourse approach to preventing the development of LTCs.

The evaluation of existing asset-based community projects associated with reducing risk factors for LTCs should focus on outcomes and identify key messages for future projects.

3. Urgent care

Priority	Goal
Improving the management of urgent care for people with chronic multiple conditions	Development of an integrated system of urgent care for people with multiple conditions that leads to reductions in emergency hospital admissions and emergency bed days for LTCs with people who experience high quality care in the most appropriate setting for their health and wellbeing needs.

Some of the greatest pressures in the health and social care system relate to managing the urgent care needs of (predominantly older) people with multiple conditions. Common mental health problems such as dementia and depression are frequently seen in older age groups. The rising numbers of people with these conditions results in complex presentations that require a response beyond that of the clinical sphere alone.

The understanding and confidence of staff caring for older people in this context is important. This includes having the necessary knowledge and skills for managing common frailty syndromes, such as confusion, falls, polypharmacy and safeguarding. Likewise, attitudes towards older people, a value for old age and ability to be compassionate can have a considerable impact on the quality of care.

The processes, pathways and flows of patients between home, urgent care settings, intermediate care, hospital and care homes are crucial to understanding how to develop an integrated approach to urgent and emergency care. The quality and extent of care and support in the community and the degree of integration across services are major factors in the management of demand upon services and reducing hospitalisation episodes. Most LTCs can be managed well in the community and would not normally require hospitalisation. Integrated systems of care can enable effective management of LTCs.

High quality reablement services including intermediate care and rehabilitation following a hospital episode highlight how the joint work of health and social care services and the third sector can lead to improved outcomes and value for money across the health and social care system.

- *Urgent care has been defined as: 'the range of responses that health and care services provide to people who require–or who perceive the need for–urgent advice, care, treatment or diagnosis. People using services and carers should expect 24/7 consistent and rigorous assessment of the urgency of their care need and an appropriate and prompt response to that need'[2]*
- *Lancashire experiences significantly higher admission rates and significantly longer use of emergency bed days for chronic conditions than nationally*

2. DH definition of urgent care

Recommendations

The high admission rates for chronic conditions and use of emergency bed days across Lancashire require further investigation.

Commissioners should focus on developing integrated approaches to managing urgent care that involve hospital, community, primary and ambulance services through joint service planning and sharing of clinical information through individualised care plans.

Commissioners should determine the patient and carer journey during urgent care episodes that encompass clinical pathways and patient flows in order to identify areas of inefficiency and ineffectiveness.

Healthcare staff in urgent care settings should be knowledgeable and competent in the required skills and attitudes for working with older people. Training should be provided where necessary to meet these requirements.

4. Long-term conditions model of care

Priority	Goal
Development of the LTC model of care	Systematic and coordinated introduction of the LTC model of care that incorporates: a) risk profiling; b) development of integrated neighbourhood teams; and c) self-care.

The landscape for LTC care has become extremely complex given the ageing population and the existence of co-morbidities, particularly in older people in whom physical and mental frailties are common. In response, the experience of care has become increasingly complex and fragmented for service users and their carers.

Evidence suggests that a whole systems approach to managing LTCs in the ageing population and associated co-morbidities should be underpinned with an integrated approach to care. A major focus of concern for the health and social care system is how to develop local, practical, sustainable and affordable systems. This includes the need for a shift in culture that places people with LTCs – and less so their conditions – at the centre of care. It is suggested that whilst a patient with chronic illness may spend 5-6 hours each year with a health professional, they spend over 5,800 hours managing their own problems[2]. A new model of care is therefore required that values the experience and contribution of patients to their own care and includes self-management of their condition(s) with integrated support.

Long-term conditions is one of the priority workstreams within the Quality, Innovation, Productivity and Prevention (QIPP)programme which promotes an evidence based LTC generic care model[3] to support the current financial drive for cost savings within health and social care. This LTC model of care has been shown to reduce hospitalisations and improve care by focusing on identifying need, integrating and co-managing care through:
- systematic risk profiling;
- the development of integrated neighbourhood care teams that reflect a person-centred, psycho-social model of care; and
- self-care/shared decision-making.

The 'Year of Care'[4] approach to funding of LTC care is based on a person's overall needs and not the specific diseases they have. It supports an integrated approach by allowing funding to be moved around as needed for the joined up delivery of a year's worth of care as the most effective and preventive approach for

A few facts

- *Lancashire continues to have significantly high hospital admission rates for both adults and children with LTCs*

- *30-day readmission rates to hospital were significantly higher than nationally across six of the fourteen districts during 2010/11, with only three districts being significantly lower*

- *The potential years of life lost (PYLL) from causes considered amenable to healthcare during 2011/12 were significantly higher for males across all eight CCGs and for females across seven of the eight CCGs, the exception being Chorley & South Ribble CCG*

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[2] Richards, T (2013) Services for patients with long term conditions must be reconfigured, says meeting *BMJ* 346:f2316 doi: 10.1136/bmj.f2316
[3] LTC QIPP Workstream (2012) *A Guide to the Implementation of the Long Term Conditions Model of Care*
[4] DH (2012) *Supporting the local implementation of the Year of Care Funding Model for people with long- term conditions*

a person with LTCs. It focuses providers on moving away from episodic, activity-driven funding flows towards person-centred care irrespective of organisational boundaries.

Admission and discharge rates for Lancashire reflect that, whilst development of the LTC model of care as a sustainable response to the demand for health and social care is underway in parts of Lancashire, development is still in its infancy.

The self-care/shared decision-making approach values service users as co-producers in their care which together with third sector partners and other community assets presents opportunities for commissioning of 'non-traditional' providers through a whole systems approach.

Recommendations

Commissioners, working in partnership with all stakeholders, should seek to develop the LTC model of care locally in a way that builds on lessons learnt from those areas where development is already underway.

This LTC model of care requires providers to develop an integrated care response with the development of integrated neighbourhood teams based on a whole-person centred model of delivery.

Development of the LTC model of care should occur within a whole systems framework that maximises opportunities for 'non–traditional' services to support self-management and shared decision-making.

The LTC model of care should encompass a single point of access underpinned with an individualised care plan that includes an emergency care plan.

Commissioners should take account of national developments surrounding the year of care currencies, and national pricing model and work with providers through the necessary contract processes to develop and implement a funding model that promotes a person-centred, self-care approach.

5. Empowerment

Priority	Goal
Empowerment of service users and carers	To develop systems and services to enable service users and carers to adopt a self-care approach and ensure that resources and support are available to: - improve their quality of life; - reduce episodes of poor health; - reduce unnecessary hospitalisation; and - enable them to maximise their independence.

Capacity, skills and attributes of service users and carers can be seen as central to responding to the increasing demands upon health and social care services. Such an approach views service users and carers positively as active contributors to their own care. Third sector organisations and groups have huge potential for providing support in this area.

However there are huge challenges in Lancashire in the current climate of austerity with community-based resources frequently patchy and with corresponding difficulties with funding and other forms of support for projects. Despite this there are many groups and organisations within the third sector across Lancashire who consider themselves part of a whole system response to LTCs in supporting service users and carers in having greater understanding and control in managing their conditions.

Making sure that people have access to, and are able to understand and interpret basic health information empowers them to look after their own health. It is also important for people to know what services, including those within the third sector, are available to them to help support empowerment and self-care. This health literacy can build resilience in individuals and communities and is a key determinant of health and health equality.

Increasing use of technology in care delivery is associated with better patient satisfaction and reductions in hospitalisation and a wide range of social media is also known to provide both a source of education and support for service users and carers.

Community pharmacies have a key role in supporting self-care and shared decision-making through essential and advanced services and can be viewed as community assets for supporting self-care for LTCs. People with co-morbidities are more likely to be prescribed multiple drugs with consequent poor concordance and are therefore at higher risk of errors. Consequently, educating patients and carers on the optimal use of medicines through medicines use reviews (MUR) is important as part of a systematic approach to self-care.

Any successful LTC programme will have self-care at the centre of the approach. There are examples from the service user inputs to this JSNA of feeling valued when contributing in making decisions about care, and conversely feeling devalued when not being listened to. Whilst there is an educational aspect to self-care to assist service users with LTCs and their

In a review of over 500 sources of research evidence, the Health Foundation concluded that self-care works – and is most likely to do so when it is included as part of wider initiatives to work with patients and improve care. Examples from the review that are considered to be effective include:

- *providing information (written, electronic or tailored)*

- *incentives to learn or develop new skills (e.g. care planning, patient held records, decision support tools, goal setting and follow up)*

- *behaviour change for self-efficacy (e.g. individual or group education, telephone coaching, work based support, self-monitoring/tele-monitoring)*

carers in understanding their conditions it also requires significant shifts in attitudes and beliefs about the nature of the relationship between health and social care professionals and service users and carers to maximise the benefits that can arise from self-care approaches.

Recommendations

Health literacy should become integral to LTC, and developed throughout the whole population. This will ensure that people with long-term conditions have the knowledge, health choices and power to better manage their own health and that of the people they care for. It will enable those who don't have long-term conditions to increase their resilience and to understand how their health behaviours can protect them from developing long-term conditions.

Commissioners should determine how self-management and shared decision-making link in with wider primary and secondary prevention structures and activities so that the 'whole system of prevention' sits within a broad strategic framework.

Working in partnership with stakeholders, commissioners should critically examine the balance of self-care delivery across traditional and other, non-traditional providers in order to determine the most optimal form of self-care provision.

Self-care should therefore be systematically coordinated through clearly determined pathways that can be delivered sensitively and appropriately, across and between a range of different organisations and groups.

Building on existing networks and partnerships with third sector bodies, local communities and other stakeholders commissioners should map available community assets for supporting self-care, particularly with vulnerable population groups.

Opportunities for service users and carers to use acceptable and accessible forms of technology and social media for education, condition management and/or support should be developed and their subsequent use evaluated.

The availability of MUR should be increased through community pharmacies particularly in those areas with a high prevalence of LTCs.

Any introduction of self-care should incorporate the necessary preparation and training for both health and social care professionals and service users.