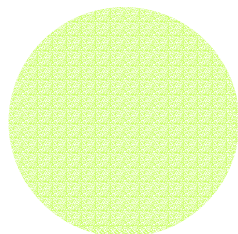


Improving long-term conditions across North East London

North East London managing long-term conditions collaborative

January 2005



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New model for health and social care

The new NHS and social care model for long-term conditions was launched by Health Secretary John Reid on 5 January. 'Supporting people with long-term conditions' has been designed to support local innovation and integration between the NHS and social care. It aims to embed in local health and social care communities an effective, systematic approach to the care and management of patients with a long-term condition.

The key aspects of the model for health communities are:

- identifying all long-term conditions patients
- matching care to the needs of patients
- focus on the high users of secondary care through case management
- appointment of community matrons
- develop a system to identify prospective high users
- multi-professional teams based in primary or community care supported by specialists
- strategy to support self-care
- implement EPP/other self management programmes
- systematic approach linking health, social care, patients and carers
- make use of existing tools and techniques.

John Reid said: "We expect the new long-term conditions model to be fully incorporated into the way the NHS and social care deliver care to people with long-term conditions."

A key part will be the introduction of community matrons assigned to the most vulnerable patients.

NHS and social care organisations will be expected to start implementing the model straight away, adapting it where necessary. The new NSF for long-term conditions is expected later this year.

Chief Executive across North East London have signed up the Improving Chronic Illness Care (ICIC) model. This model embraces all of the areas covered in this new document.

Reminder of local milestones to reach by 2008:

- 5% reduction in emergency bed days
- Expert Patient Programme rolled out across North East London
- Community Matrons for patients with long-term conditions.

The document can be found at http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4100252&chk=f7nOXn

1st learning event - December 2004

The first learning event was a success with over 70 people in multi-disciplinary teams from each of the seven PCT areas coming together at West Ham. Focusing on the two priority areas of case and self management, the event was built around six locally identified learning streams. Invited speakers included Caroline Ward from

the National Primary Care Development Team, Ann Smart from the Strategic Health Authority and Keith Hawley, an independent advisor to the national Expert Patient Programme. With the support of their informative presentations, participants were able to focus minds on mutual learning and group working. cont page 2 ►►►

We're on the web - see us at <http://www.nelondon.nhs.uk/ltc/index.html>



Heather O'Meara, Managing long-term conditions project sponsor and Chief Executive of Redbridge PCT



“There is also so much enthusiasm and commitment being shown towards this (LTC) across the sector.”

*Robert Roots
LTC Project
Manager*

Message from our sponsor

A very happy new year to everyone. It's been a very busy few months. Since the last newsletter we've had two very successful events - the collaborative launch and the 1st learning event. Both were well attended, in fact we were bursting at the seams at the launch.

We were pleased to have Professor John Billings from the Kings Fund at the launch. It really brought home where we are in terms of LTC in North East London. By far the most popular was renal patient Jonathon Hope. We hope to have him back at one of our future events.

The 1st learning event showed just how much work is going on around the sector. We now need to co-ordinate this and start sharing and learning from each other. I'm sorry to have missed the event but the feedback I've received

▶▶▶ 1st learning event continued

Robert Roots, Collaborative Project Manager explains: “The October launch introduced people to the big questions around long-term conditions management. This first learning event gave each of the local teams protected time to think and plan around these big questions.”

On the day, participants broke into three groups in the morning, looking at case management, self management and case identification. In the afternoon, they looked at workforce development, the Expert Patient Programme and case assessment. These workstreams alternated with local planning sessions where the local teams began to define, or move forward, their local strategies.

Robert concludes: “The clock is ticking and there are considerable expectations around the whole long-term conditions agenda, but there is also so much enthusiasm and commitment being shown towards this across the sector. With so much local experience and creativity, every locality has something to offer. With national targets of 5% reduction in emergency bed days to be

has been extremely positive. The date for the second learning event is 23 February so local teams need to be putting that date in their diaries.

An exciting opportunity for us is the Learning Exchange Partnership which is taking place during 2005. This involves members of the North East London LTC collaborative and New York sharing and learning from past and present experiences. Representatives from each locality will be able to take up this great opportunity. Selection will be through the LTC programme board. Keep your ears peeled for how to get involved.

I am really impressed with all the work going on in the sector. Please keep up the good work and don't forget to share your experiences with colleagues across North East London.

Heather

met by 2008, we need to work together to find answers to many of the complex questions that face us.”

Key learning included:

- full involvement of all key partners is essential
- local teams must plan the re-design of their workforce to meet 2008 targets
- more work is needed on establishing viable baselines to measure progress and to identify measurable local outcomes.

Local action plans from the day have been collated and returned to the local leads of the seven teams. Next steps for the teams are to:

- plan around how they will deliver the national model
 - engage with identified individuals and organisations
 - report back to their boards on work being taken forward
 - set annual milestones to show how they will achieve the 2008 targets
 - develop nursing service transition plans
 - sign off local targets at board level.
- Teams have been asked to report back to the next learning event on 23 February.



Collaborative launch October 2004

Around 150 people, from all key disciplines, attended the launch in October. The participants included many decision makers, operational staff and patients from across the North East London health and social care community.

Participants heard keynote speeches from Carolyn Regan, Chief Executive of North East London Strategic Health Authority and Dr David Colin-Thomé, National Clinical Director for Primary Care at the Department of Health. They were also able to choose from a range of breakout sessions covering the breadth of activity within an integrated long-term conditions programme.

Carolyn Regan reminded the audience of the growing evidence base to support the whole system approach adopted in the sector. She also highlighted the need for engagement across primary care, acute trusts, mental health and local authorities in delivering sustainable change.

Commenting on the day, Heather O'Meara, Chief Executive of Redbridge Primary Care Trust and Programme Sponsor, said: "What impressed me most was the energy and enthusiasm shown by individuals and organisations in looking for ways to take forward this change process."

One of the most popular presentations of the day came from Jonathon Hope, a renal patient, who spoke of the 'active' patient concept and the value of enabling individuals with long-term

conditions to take control of their life through self-management.

Sally Bassett, Nurse Advisor from the Modernisation Agency, spoke about the evolving role of the community matron, highlighting the likely high level of physical and psychosocial assessment, the medicines management competency and the need for skilful case management.

Sector clinical lead for long-term conditions, Dr Ken Aswani from Waltham Forest PCT, reminded the audience of the need to fully involve clinicians in this process at both operational and strategic levels. To him the role of the case manager is crucial but there is also a need to work around care plans and have clear agreement on local protocols.

What happens next?

Those involved were invited to identify the top three priorities for long-term conditions management in London. In summary, the following general themes were proposed:

- the need for collaborative working - information sharing/networking/etc
- importance of partnerships - from communities to mental health workers, from COPD services to district nurses
- workforce development alongside service re-design to support the introduction of case management
- consideration of the patient and the importance of self management
- reliable information and analysis to support the change process.

"What impressed me most was the energy and enthusiasm of individuals and organisations."
 Heather O'Meara,
 LTC Project
 Sponsor

Making partnerships work for patients, carers and service users

A new strategic agreement between the Department of Health, the NHS and the Voluntary and Community sector was published in September. It is the first of its kind in health services.

John Reid, Secretary of State for Health, said: "This strategic agreement is the manifestation of the real sense of partnership that has emerged over the last few years within the health and social care sector."

The agreement is based on the work done by a joint working group from the voluntary and community services, health and social care and the Department of Health. It will be used as a framework to promote the increasing role of the VCS in health and social care. Full document link is on page 6.

We're on the web - see us at <http://www.nelondon.nhs.uk/ltc/index.html>



17 million reasons

Twenty organisations have joined forces to lobby political parties to put more emphasis on tackling long-term conditions. The coalition is made up mainly of health charities including the Alzheimer's Society, Rethink and Diabetes UK.

This is the first time that such a diverse group of organisations, patients, managers and professionals, have come together to make the case for a better

deal for people living with long-term conditions.

The group recently launched the '17 million reasons' campaign at the House of Commons. It aims to raise awareness of the 17 million people in the UK who live with chronic conditions.

Find out more about the campaign at www.17millionreasons.org

Newham's Care Navigators

Like many places, long-term conditions is an issue for Newham. Never a place to stand back and watch from the side lines, the PCT and acute Trust pulled together to look at ways to address the issue. The result - a team of community based workers. With funding from the Neighbourhood Renewal Fund (NRF), the Community Care Navigators work closely with local people who have, or are at risk of, long-term illness.

There are currently 10 navigators in three areas and the number will grow when the project goes borough-wide in April. They plan to work with around 100 patients each month, helping them with a range of tailored health and social support. Their aim is to get patients to manage their conditions. They are supported by a full-time nurse, nutritionist, physiotherapy and pharmacist.

Newham Care Navigators have a structured training programme. "They're not necessarily health professionals", explains Angela Single, Project Director, Long-term Conditions, "but local people experienced at working with community groups.

"We plan for the programme to be accredited by April next year. Once it's accredited it can be used towards a diploma. This way the navigators can

build up their skills and feel they're getting something at the end of the training."

Training units include first aid, smoking cessation, benefits advice, IT, alternative therapies, contact assessment, health advocacy, health promotion and the Expert Patient Programme.

Angela added: "The Navigator and patient have to complete an assessment questionnaire to decide on the best course of action. The development of the referral system is ongoing. At the moment the Navigators can refer to a range of services including our Intermediate Care Team, a range of alternative therapies, occupational health, health MOT and nutrition advice. The list is growing by the day."

The Care Navigator team at Newham have already made strong links with a range of professionals including local business and education. Health events have also been very helpful for patients to find out and 'sign up' to the initiative.

For more information contact Scott Fitzgerald, Senior Project Manager, Long-term Conditions on 020 8555 4832 or scott.fitzgerald@nhs.net



There are currently 10 navigators in three areas and the number is expected to grow



Navigators can refer to a number of services including a health MOT and alternative therapies



North East London and New York learning exchange partnership

What have New York and North East London got in common? Macys, Tiffany's, Bloomingdales. Maybe not, but in health terms we have a lot in common. A new learning exchange partnership will be looking at ways where we can share experiences and learn from each other.

The New York City Health and Hospitals Corporation (HHC) and the SHA have seen potential and advantages in communicating with each other on areas around health care delivery and improvement. The partnership will be focussing on implementing improvement in chronic conditions in diverse populations and system level quality improvement.

The partnership has three areas where it wants to learn about and share good practice:

1. designing health care delivery systems that meet the needs of the diverse patient communities
2. implementation of best practice in chronic disease management
3. advancing system level quality improvement.

A series of exchange visits will take place. The aim is to find out about the work that is going on in the sectors covered by the organisations. Regular videoconference calls on specific topics and reviews, and electronic communications will keep the partnership in touch with each other.

Shona Brown, LTC Project Director explains: "Health and Hospitals Corporation has a collaborative like ours which has been running for nearly two years. We have lots in common and it will be a real experience to find out how other countries manage long-term conditions. We expect to host the first exchange in April or May with people from North East London returning the visit in May or June."

Members of the Collaborative will be invited to take part in this exchange very soon.

For more information contact Shona Brown on 020 7655 6642 or shona.brown@nelondon.nhs.uk



Working together in Waltham Forest

The NSF for older people was launched in March 2001. It set out a programme of action and reform to deliver higher quality services for older people. Waltham Forest was one of 20 sites in England that formed the National Falls Collaborative.

In 2004 the programme was mainstreamed in Waltham Forest as the Waltham Forest Falls Collaborative (WFFC). It continues to deliver services and improve the lives of hundreds of older people in the borough.

Local stakeholders are Waltham Forest PCT, London Borough of Waltham Forest social services, Whipps Cross hospital, North East London Mental Health Trust, Waltham Forest Older People's

Voluntary Sector Partnership and Age Concern Waltham Forest. The goal is to reduce falls in the over 65s and the impact of falls on older people, their families and the community.

The WFFC team is multi-disciplinary and has given impetus to the development of a multi-agency falls service. It has achieved a number of service improvements. It also raises awareness amongst front line staff and older people about the causes of falls and the many interventions proven to help prevent falls.

For more information contact Jorge Lagos or Chris Bateson on 020 8558 8716.

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Please share this newsletter with colleagues who may not have access email. We want as many people as possible to learn about the collaborative's work and how national initiatives will affect North East London.

If you've received this newsletter from a colleague and want to be put on our mailing list please email june.morgans@nelondon.nhs.uk with your name, organisation details, job title and email address.

Unique Care

The National Primary Care Development Team has developed an NHS-based case management approach for chronic diseases. Called Unique Care, it is a team based model developed in primary care derived from the socio-medical model developed at Castlefields Health Centre in Runcorn. It takes a primary and social care focused approach to the management of patients with complex needs that incorporates the principles of case management.

The three key elements to Unique Care are:

1. reviewing referrals by a practice-based Unique Care team
2. hospital in reach programme
3. practices identify potentially high need patients.

For more information about Unique Care, contact Jenny Drew on 020 7725 5480, e-mail jenny.drew@londonnpdt.org.uk or visit <http://www.npdt.org/15/Unique%20Care.pdf>

New information leaflets

The Modernisation Agency have just published two leaflets What's in it for GPs and What's in it for Pharmacists.

For GPs uses the Castlefields approach to show how co-ordinated management of people with chronic diseases creates a win-win situation for patients and professionals.
www.natpact.nhs.uk/uploads/2004_Dec/LTC_WhatsinitforGPs.pdf

For pharmacists gives pharmacists opportunities to extend their traditional roles of dispensing prescriptions and selling medicines.
http://www.natpact.nhs.uk/uploads/2004_Nov/Pharmacists_LTC.pdf

New documents for downloading

The Nursing Perspective on Workforce Development (Presentation, Sally Bassett, MA)
http://www.natpact.nhs.uk/uploads/2004_Nov/The%20Nursing%20Perspective%20on%20Chronic%20Disease%20Management.ppt

Long-term Medical Conditions Alliance
<http://www.expertpatients.org.uk/index.htm>

Key Principles of case management - *basis for Community Matron competencies*
<http://www.natpact.nhs.uk/uploads/CHRONIC%20CARE%20MANAGEMENT.pdf>

Organisational self assessment tool (NHS Modernisation Agency)
http://www.natpact.nhs.uk/uploads/2004_Oct/LTC_Self-Assessment_Tool.doc

Making partnership work for patients, carers and service users
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4089515&chk=KvDHnR

Supporting people with long-term conditions - NHS and social care model
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4100252&chk=f7nOXn

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