

Improving Long-term Conditions across North East London

Issue 1 October 2004

Special Interest Articles:

- Long-term conditions - programme board
- Improving Chronic Illness Care model
- Projects across the sector

Individual Highlights:

National priorities	2
ICIC model	3
New website	4
Programme Board	5
LTC leads	6
Good practice	7

Welcome

Welcome to the first edition of our newsletter which is dedicated to news and information about managing long-term conditions in North East London. This newsletter will be just one of the ways we will be communicating with you.

One thing you'll notice straight away is our re-naming of chronic disease management (CDM) to managing long-term conditions (LTC). This follows suggested guidance from the Department of Health. I'm sure you'll agree it reflects much better the nature of these conditions.

We know that a lot of resource is put into services for people with long-term conditions. We also know that we can do a lot to improve those services. The new collaborative across North East London has been set up to do just that. By building on current successes, and sharing the knowledge and experience from these, we can make changes that will benefit our patients and the NHS.

In this edition you'll get information about some of the projects already going on around the patch. From the REDS (respiratory early discharge team) project in Newham, to primary care teams supporting practices in Barking and Dagenham.



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

We'll let you know about others in future editions. You can also visit our new website and find out about what we're doing in North East London. Visit www.nelondon.nhs.uk/ltc for the most up to date information.

The approach to managing long-term conditions being taken by us is through the Improving Chronic Illness Care (ICIC) model. A project team has been set up to take this forward. We will also be getting more involved in the Expert Patient programme, case management and working to develop advanced primary nurses in the patch.

We'd like to hear from you about what you're doing so that we can help you share your experiences - good and bad. You can contact us using the details below.

Heather

We'd like to hear your news. Tell us what's going on in your area and share your experiences. Contact June Morgans at june.morgans@nelondon.nhs.uk or phone 020 7655 6788



Shona Brown, Director of Education and Workforce Strategy at North East London SHA and Managing long-term conditions Project Director

Launch of the North East London collaborative

Monday, 4 October is a significant day for North East London as it celebrates the launch of the new collaborative for managing long-term conditions. More than 130 delegates from across the patch will be gathered at West Ham football ground to hear keynote speakers from the Department of Health, Kings Fund and Chief Executives from North East London.

David Colin-Thome, National Clinical Director for primary care and Sally Bassett, Nurse Advisor will present the national perspective. Professor John Billings from the Kings Fund will be flying in from the USA to present findings from the work they have been doing with three PCTs across the sector. Carolyn Regan and Heather O'Meara will be presenting the North East London perspective.

The launch will be an opportunity for delegates to hear accounts from across England of how other primary, acute and mental health trusts, as well as social care are managing long-term conditions.

Shona Brown, Project Director explains: "The launch is about getting people involved. We are planning to share experiences from across the sector as well as nationally. We have nine breakout sessions where delegates can find out about the improving chronic illness care model, what it's like to be an advanced primary nurse and perspectives from mental health, primary and acute care and the community, amongst others."

A full report of the launch will be included in the next edition.

Managing long-term conditions across North East London

A significant proportion of health and social care resource is taken up providing services for people who have a chronic disease. As a result it is now a national priority for the NHS. People with long-term conditions are more likely to see their GP, be admitted to and spend more time in hospital, than those who do not suffer these diseases.

Lots can be done to improve the way services are delivered for people with chronic diseases. This will lead to improved quality and efficiency. Heather O'Meara says: "Many people

have more than one chronic condition and they face particular challenges medically and socially. Generally they deal with the psychological, physical and social demands themselves. For some, a simple problem can lead to rapid deterioration. By intervening sooner we can stop this happening.

For more information about the managing long-term conditions project contact Shona Brown, Project Director on 020 7655 6642 or shona.brown@nelondon.nhs.uk.

"The NHS needs to provide a much better service for patients with these conditions and provide high-quality personalised care to meet their needs. It needs to enable people to take greater control of their own treatment, and to spend more time at home and in the community with their families and friends."

Department of Health

National priorities for long-term conditions

The Department of Health has set targets for the management of long-term conditions. The North East London collaborative will be guided by these targets which are:

- 5% reduction in emergency bed days by 2008 (from the expected 2003/4 baseline)
- Expert Patient Programme rolled out nationally by 2008
- Community matrons for patients with complex long-term conditions in every PCT by 2008
- Rapid implementation of NICE guidelines relevant to management of long-term conditions.





Improving chronic illness care (ICIC) model

“Effective management of long term conditions requires a fundamental shift in the way we organise and deliver health and social care” says Shona Brown, LTC Project Director. “We need to move from the current NHS approach where care is organised predominantly around the concept of infectious disease and perform best when addressing patients’ episodic and urgent concerns.

“We need to build a health system that supports appropriate extended care and regular health care contact for the increasing number of people living with long term conditions. The Improving Chronic Illness Care Model offers us a framework for action.”

The ICIC model was developed by Dr Ed Wagner and colleagues at the MacColl Institute for Healthcare Innovation. It has been adopted by the World Health Organisation.

The aim of the North East London improving long-term conditions programme is to implement a locally adapted version of the Improving Chronic Illness Care (ICIC) model to transform the way that long-term conditions are managed.

Shona added: “There are six fundamental areas identified by the ICIC model making up a system that encourages high-quality management of long term conditions.

“Organisations must focus on these six areas, as well as develop productive interactions between patients taking an active part in their care and health care teams backed up resources and expertise.”

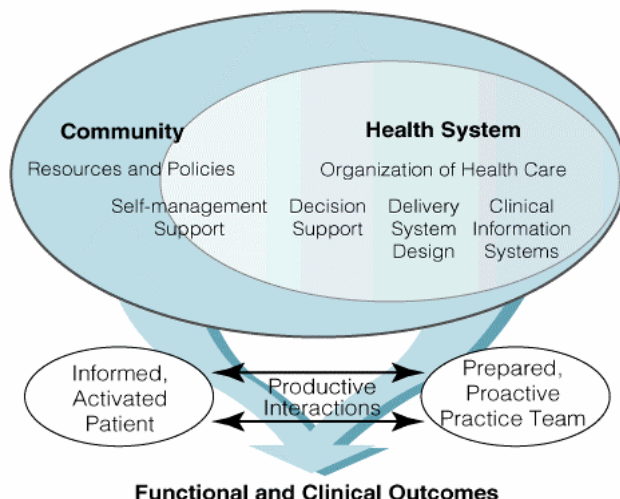
To find out more about the model and how its use has proven to be successful in delivering real improvements in the care of people living with long term conditions, can visit the ICIC web site at <http://www.improvingchroniccare.org/change/model/components.html>

An Assessment of Chronic Illness Care survey tool has also been developed to assist healthcare organisations in assessing current levels of care based on the six components of the model. This tool enables organisations to:

- identify areas for improvement in chronic illness care before beginning quality improvement work and,
- periodically evaluate the impact of the changes made.

The tool can be found at www.IHI.org/IHI/Topics/ChronicConditions

“Health care systems world wide are faced with the challenge of responding to the needs of people with chronic medical conditions such as diabetes, heart failure and mental illness.”
World Health Organisation



Chronic Care Model

Wagner EH. Chronic disease management: What will it take to improve care for chronic illness? *Effective Clinical Practice*. 1998;1:2-4.



Long-term conditions project team

The project team consists of senior managers and clinicians who have the responsibility of making sure that the management of long-term conditions is adopted throughout north east London. They are working with health and social care organisations.

Project team

- Heather O'Meara, Project Sponsor, Chief Executive of Redbridge Primary Care Trust
- Shona Brown, Project Director, North East London Strategic Health Authority
- Ken Aswani, Clinical Lead
- Sheila Adam, Director of Public Health, North East London Strategic Health Authority
- Robert Roots, Collaborative Manager, North East London Strategic Health Authority.

"With the right support many people can learn to be active participants in their own care, living with and managing their conditions."
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Programme Board members

(as at 1 October 2004)

- Heather O'Meara, Chair
- Shona Brown, Vice Chair
- Ken Aswani, Clinical Lead
- Robert Roots, Collaborative Manager
- representatives from across the sector in:
 - ICT
 - Director of Finance
 - Director of Public Health
 - Acute Clinician
 - Allied Health Professional
 - Dr Ian Bassnet, North East London Strategic Health Authority
 - Trish Morris-Thompson, North East London Strategic Health Authority
 - Monica McSharry, North East London Strategic Health Authority

Long-term conditions website - your chance to share your good work and find out what's going on in North East London

Another way of keeping you up to date will be through the new website which is being launched in mid-October. You can check out the latest projects, see what's happening in the sector as well as nationally.

There are details of the projects currently operating to help patients with chronic conditions as well as information about the different types of models being used across the country.

The website is split into four sections:

- the public - with general information about chronic illnesses and how things are changing in the NHS for patients
- practitioners - fact and figures, management models
- project team - project plans, executive notes
- communications - sharing projects across the sector, communications strategy.

Let us know what you think about the website. What would you like to see? Share your projects with others. Contact June Morgans at june.morgans@nelondon.nhs.uk or 020 7655 6788



North East London Programme Board



Chief Executives across North East London are committed to working together on a programme which will improve the management of long-term conditions (LTC). The collaborative programme is being championed by Redbridge PCT Chief Executive, Heather O'Meara. As lead for LTC in North East London she has drawn together a project board and supporting team who will be responsible for looking at the way LTC is managed across the sector. The Programme Board is accountable to the North East London Chief Executives group.

Terms of reference

The aim of the chronic disease programme is to effect whole system redesign that results in provision of a proactive service to ensure patients health and wellness are maintained in primary care. Key objectives include:

- increase in numbers of people with chronic diseases being managed through case management approach
- reduction in rates of unplanned admissions and unnecessary follow up for people with chronic disease
- increased numbers of patients on self-management programmes under pinned by health living strategy
- reduce the incidence of chronic disease

The North East London Chronic Disease Management Programme Board will set the overall direction for the work of the programme through the assessment and ratification of the proposed approaches for implementation of the Chronic Care Model across health and social care providers in North East London.

Roles and responsibilities

The programme board will:

- ensure that appropriate planning and support is in place within the programme to ensure achievement of key targets and outcomes, including:
 - strategies to influence leaders across North East London sector
 - implementation of the Chronic Disease Collaborative to fast-track best practice
 - a communications plan to support effective collaboration between providers and service users
 - a benchmarking process to guide the development and implementation of the Chronic Care Model
 - an objective evaluation that will measure expected outcomes

- keep oversight of progress towards achievement of programme targets
- act as a hub for the management of interdependencies between other workstreams (e.g. National Service Framework Managed Care Networks, Service Commissioning models, financial flows and capacity planning), ensuring that improved chronic disease management is supported by these workstreams and, in turn, contributes to other service outcomes
- act as a hub for members to update the board on developments in national and local policy areas which have implications for the chronic disease management programme
- champion the Chronic Care Model in discussion within the service and the community and among service providers and users
- act as a hub for key linkages with local and national initiatives and community resources.

Ways of working

The Board will meet at least four times in the year. The Chair is responsible for reporting actions, decisions and concerns to the Chief Executives Group and may invite guests appropriate for the agenda. Any decisions made by the Board will be by consensus. Recorded minutes of the meeting will be distributed to all Committee Members.

The Board will be meeting on 25 October 2004.

“Improving people’s care will have an impact across all health and social care services. Waiting lists will be shortened, unnecessary inpatient visits will drop and GPs will have more time to spend with patients. For social services it will mean patients are less dependent on support services such as community equipment, housing adaptations and personal care.”

Heather O'Meara, long-term conditions project sponsor



“Chronic disease has a huge impact on people’s quality of life and on their families, and it consumes a large proportion of health and social care resources. There is a lot happening already, both nationally and locally to introduce better chronic disease management.”
John Reid, Secretary of State for Health

North East London leads

Each NHS organisation in North East London now has a dedicated lead responsible for long-term conditions. These senior managers will be responsible for taking the long-term conditions agenda forward in their own areas. They will report back to the project board.

- Barking and Dagenham PCT, Rebecca Scott, Director of Modernisation, 020 8532 6334, Rebecca.scott@bdpct.nhs.uk
- Barking, Havering and Redbridge Hospitals NHS Trust, Elaine Maxwell, Director of Nursing, 01708 708205, Elaine.maxwell@bhrhospitals.nhs.uk
- Barts and the London NHS Trust, Brian James, Project Manager, Transformation Unit, 020 7377 7000, brian.james@bartsandthelondon.nhs.uk
- City and Hackney PCT, Richard Clements, Project Director, 020 7683 4244, Richard.clements@chpct.nhs.uk
- East London and City Mental Health Trust, TO BE ADVISED
- Havering PCT, Gill Gale, Director of Modernisation, 01708 465057, Gillian.gale@haverinpct.nhs.uk
- Homerton University Hospital NHS Trust, Tracey Fletcher, Director of Planning and Service Development, 020 8510 7298, tracey.fletcher@homerton.nhs.uk
- Newham Healthcare NHS Trust, Penelope Haile, Director, Emergency and Elective Care, 020 7363 8449, Penelope.haile@newhamhealth.nhs.uk
- Newham PCT, Roger Harris, Director of Commissioning and Service Improvement, 020 8271 1372, Roger.harris@newhampct.nhs.uk
- North East London Mental Health Trust, Dr Annie Lau, Medical Director, 020 8970 4052, Annie.lau@nelmht.nhs.uk
- North East London Strategic Health Authority, Shona Brown, Director of Education and Workforce Strategy, 020 7655 6642, shona.brown@nelondon.nhs.uk
- Redbridge PCT, Kay Matthews, Assistant Director, Primary Care, 020 8926 5069, Kay.matthews@redbridge-pct.nhs.uk
- Tower Hamlets PCT, George Leahy, Director of Public Health, 020 8223 8956, George.leahy@thpct.nhs.uk
- Waltham Forest PCT, Liz Rahim, 020 9828 2336, Elizabeth.rahim@wf-pct.nhs.uk
- Whipps Cross University Hospital NHS Trust, David Cheesman, Director of Emergency Care, 020 8535 6912, David.cheesman@whippsx.nhs.uk
- City University, Sue Procter, 020 7040 5964, s.procter@city.ac.uk
- London South Bank University, David Sines, 020 7815 8091, sinesdt@lsbu.ac.uk



The next meetings of the project leads are 6 October and 1 December. If you would like to know more or get involved please contact Shona Brown on 020 7655 6642 or shona.brown@nelondon.nhs.uk

Sharing good practice across the sector

In each edition of this newsletter we will bring you a taster of the good work that's currently going on across North East London. It will be an opportunity to share the projects successes and learn from some of the things that should be avoided. Here are some examples.

The REDs (respiratory early discharge) team project is helping patients in Newham with COPD (coronary obstructive pulmonary disease) to stay at home. The team work with COPD patients when they are admitted to hospital. Their aim is to provide early discharge for patients and develop links with A&E, district and practice nurses. They are also being proactive with patients in the community and have outpatient clinics offering telephone and email advice.

Contact Angela Single on 01480 811225 or email angela@ajsingle.co.uk



The primary care chronic disease management (CDM) team in Barking and Dagenham supports practices with all aspects of CDM including; education and training, setting up nurse led clinics, annual review programmes, diagnostics, disease registers, IT support and audit. The team is multi-skilled and consists of a diabetes link nurse, respiratory link nurse, primary care facilitator and CDM facilitator. They have so far successfully implemented an expert patient programme, have ongoing spirometry training and respiratory and diabetes audits.

Contact Lorraine Brown, Primary Care Development Manager, on 020 8532 6226 or email lorraine.brown@bdpct.nhs.uk

A range of new services, including diabetes clinics, GPs with special interests based in A&E and the establishment of a clinical assessment centre, are all part of the **primary care**

contracting collaborative at Newham PCT. This project is primary care led giving a focus on redesigning commissioning and contracting arrangements. Each of the four localities has a chronic disease facilitator and there are GP clinical leads in specialist areas such as cancer, child protection, diabetes and mental health.

Contact Sampana Banga, Director of Primary Care, on tele no, email sam.banga@newhampct.nhs.uk



There are now 60 expert patients in Barking and Dagenham under the **expert patient programme**. As part of the national pilot, the PCT ran four courses for patients who wanted to be able to manage their own care. Four of the participants have also trained as volunteer tutors for future expert patients.

Contact Lorraine Brown, Primary Care Development Manager, on 020 8532 6226 or email lorraine.brown@bdpct.nhs.uk or Steve Wedgwood, Director of Organisational Development and Corporate Support, on 020 8532 6220, steve.wedgwood@bdpct.nhs.uk

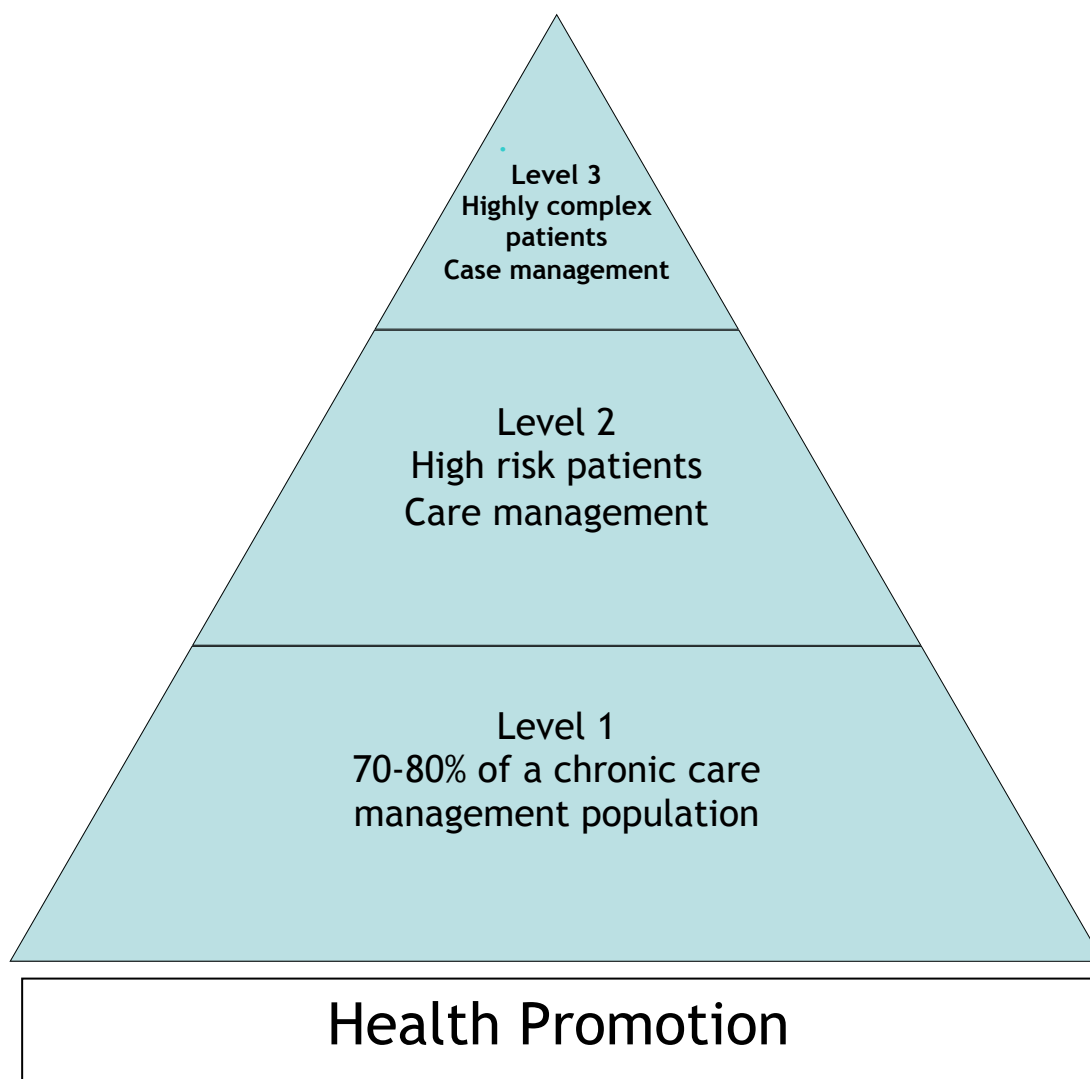


"With the right support many people can learn to be active participants in their own care, living with and managing their conditions."
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You'll find other examples on the website at www.nelondon.nhs.uk/ltc (launched mid-October). Please let us know what you're doing so we can include them in the website and future editions of the newsletter.

Chronic Disease Management: Population Management



Deciding the right approach

It is important to have the information and knowledge to be able to carry out a risk-stratification on local populations to identify those who are most at risk

● Level 3

As people develop more than one condition (co-morbidities), their care becomes disproportionately more complex and difficult for them, or the health and social care, system to manage. This calls for case management - with a key worker (often a nurse) actively managing and joining up care for these people.

● Level 2

Disease/care management, in which multidisciplinary teams provide high quality evidence-based care to patients, is appropriate for the majority of people at this level. This means proactive management of care, following agreed protocols and pathways for managing specific diseases. It is underpinned by good information systems - patient registries, care planning, shared electronic health records.

● Level 1

With the right support many people can learn to be active participants in their own care, living with and managing their own conditions. This can help them to prevent complications and avoid getting further conditions. The majority of people with chronic conditions fall into this category - so even small improvements can have a huge impact.