Opportunities and Challenges of Managing Long-Term Conditions (LTC) in Integrated Care Systems (ICSs)

UCLPartners
September 2020
# Opportunities and Challenges of Managing Long-Term Conditions (LTC) in Integrated Care Systems (ICSs)

## Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
<th>Presenter</th>
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<tbody>
<tr>
<td>18.00</td>
<td>Welcome and introductions Overview of UCLPartners Long Term Conditions Frameworks</td>
<td>Dr Matt Kearney (Programme Director at UCLPartners)</td>
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<tr>
<td>18:10</td>
<td>Vision and priorities of managing Long Term Conditions in NCL, in partnership with UCLP</td>
<td>Tendai Wileman - (Director of Programme Delivery North London Partners in Health and Care)</td>
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<tr>
<td>18:25</td>
<td>Opportunities and challenges for pharmacists in managing long term conditions from a secondary care perspective</td>
<td>Stuart Semple - (Chief Pharmacist at Moorfields, who has agreed to act as ‘interim’ pharmacy lead for NCL)</td>
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<tr>
<td>18:30</td>
<td>Vision and priorities of managing Long Term Conditions in NEL, in partnership with UCLP</td>
<td>Dr Ken Aswani (Waltham Forest CCG Chair &amp; Chair of ELHCP Medicines Optimisation Steering Group)</td>
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<td>18:45</td>
<td>Opportunities and challenges for pharmacists in managing long term conditions from a primary care perspective</td>
<td>Moira Coughlan (Programme Director for Medicines Optimisation &amp; Pharmacy Transformation, ELHCP)</td>
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<td>18:50</td>
<td>Group discussions (Breakout rooms)</td>
<td>All</td>
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<tr>
<td>19.10</td>
<td>Q&amp;A</td>
<td>All</td>
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<td></td>
<td>Survey poll</td>
<td>All</td>
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<td>19.15</td>
<td>Close</td>
<td>Dr Matt Kearney</td>
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<td>Next event: is 29th October 2020 - 18:00 –19:15</td>
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Vision and priorities for managing LTCs in NCL

Tendai Wileman, Director of Programme Delivery, North London Partners in Health & Care

24 September 2020
Our ambition and purpose is to improve lives in NCL

We are working to deliver improvements in outcomes for local people – through changes in the way we plan and deliver health and care services

Our purpose is: To improve outcomes and wellbeing, through delivering equality in health and care services for local people. Supporting them to Start Well, Live Well and Age Well. We also want to support the many local people who are employed by health and social care to Work Well.

We will be guided by a shared outcomes framework setting out the difference we will make for the population in NCL and how we will be monitoring that we are achieving our strategic aims.

Our future success depends on the health and wellbeing of local people. We have made good progress in recent years but there are still too many health disparities and inequities within and between North Central London communities that prevent our residents getting the same opportunities to start well, live well and age well.

We know that, in particular, we have the need and the opportunity to improve children and young people’s health. Focusing on public health and the quality of health and care services for children and young people means we can help make a real difference to key determinants of good health such as reducing childhood obesity and increasing immunisation rates.

We know that the economic climate impacts health. Poor health and care, in turn, affects individuals, their quality of life and their ability to contribute to the local economy. Health and care services and the staff and carers that work in them can impact and help break this cycle. This will help reduce urgent or long-term care for problems that could have been identified earlier, managed better, or prevented altogether. This upholds our whole purpose to support residents, communities and the economy.
The way we organise ourselves in NCL

To deliver on these outcomes, North London Partners is organising itself within our health and care system across five key components:

<table>
<thead>
<tr>
<th>Transformation and change through ICS leadership</th>
<th>Strategic Commissioning (NCL CCG)</th>
<th>Integrated Care Partnerships</th>
<th>Networks</th>
<th>Providers working collaboratively</th>
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<td><strong>Aims:</strong> <strong>Leadership across NCL to transform ways of working across organisations</strong> to improve the health and wellbeing of residents in North Central London. This will be through networks, programmes of work, and organisational development.</td>
<td><strong>Aims:</strong> Assessment of population needs and setting plans to prioritise resources to address these needs in line with our priorities for local people.</td>
<td><strong>Aims:</strong> Local <strong>borough-based Partnerships</strong> that bring together local authorities, health and care services including primary care, local community care, and the voluntary sector to deliver person-centred, community focused care.</td>
<td><strong>Aims:</strong> Working in new ways to enable greater provision of proactive, personalised, coordinated and more integrated <strong>health and care</strong> for our communities across social care, primary care and hospitals. e.g. Primary Care Networks</td>
<td><strong>Aims:</strong> Health and care providers, organising themselves through provider alliances to ensure that high quality services are being provided for all.</td>
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Proposed structure of our Outcomes Framework

There are many different forms of an outcomes framework, but we recommend that our structure is one that is made up of seven components – as this will allow us to meet the different purposes for an OF outlined on the previous slide:
Our proposed Strategic Aims aligned to our outcome domains

Bringing together the key factors around population health, the London vision and key enablers for success, our proposed Strategic Aims aligned to the Outcome Domains for the Integrated Care System are:

**Strategic Aim 1:**
Working collaboratively with schools and communities our children and young people will have:
- Tools to manage their own health
- Access to high quality specialist care
- Safe and supported transitions to adult services

**Strategic Aim 2:**
Our residents will have early support for health issues including:
- Equitable access to high quality 24/7 emergency mental and physical health
- World-class planned and specialist care services
We will drive true parity of esteem between physical and mental health

**Strategic Aim 3:**
Our residents will:
- Be supported to manage their long term conditions and maintain independence in their community
- Receive seamless care between organisations
- Experience high quality and safe hospital care that ensures they can get in and out of hospital as fast as they can

**Strategic Aim 4:**
Our workforce will:
- have equal access to rewarding jobs, work in a positive culture, with opportunities to develop their skills
- have support to manage the complex and often stressful nature of delivering health and social care
- strengthen and support good, compassionate and diverse leadership at all levels

**Strategic Aim 5:**
We will provide key enablers for success, including:
- Digital technologies to connect our health and care providers with our residents and each other
- A fit for purpose estate in each locality
- Being a financially balanced health economy driving value for money for the taxpayer
Our shared priorities and how we work together focused on local care recovery and restoration were discussed at a GOLD meeting that took place in June. At that meeting, there was acknowledgement that we needed to work as a system to:

- manage interfaces between each of our areas of work so that these don’t adversely impact health outcomes
- identify what we could do to deliver the maximum benefit for our population recognising the current challenges with delivering care
- Deliver integrated care recognising that this was an ambition and priority for primary, mental health, community and social care sectors.

Integration opportunities by each sector, as set out below, emphasises the importance of integrated care models by each of the sectors.

<table>
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<tr>
<th>Integration opportunities</th>
<th>What?</th>
<th>Mental Health</th>
<th>Primary Care</th>
<th>Community / Social Care / LA</th>
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<tbody>
<tr>
<td>Community staff working with primary care to support care homes</td>
<td>• Community services teams working with Care Home Clinical Leads and GPs to provide wrap around support for people with complex needs in care home settings</td>
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<td>Community staff working with primary care to support “temporarily housebound” patients</td>
<td>• Community services teams working in collaboration with primary care to manage this group ensuring that every contact counts and remote monitoring technology is used where possible</td>
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| Multi-agency approach to vulnerable and shielded patients (Inc. voluntary sector)        | • Primary care, community services, MH services and LA services to share information on vulnerable/shielding patients to ensure appropriate support is being deployed to prevent deterioration
  • Ensure mental health needs addressed
  • Increased role of voluntary sector                                                                                                                   |               |              |                             |
| Community staff working with primary care, reablement & homecare staff & MH staff to manage the post Covid19 admission cohort | • Development of a single team response to people who need support in their own homes after discharge                                                                                               |               |              |                             |
| Joint MH and community priorities                                                        | • Identification of shared priorities to develop models of support that do not separate meeting physical health needs with mental health needs
  • Shared inpatient facilities for CAMHs and Adults                                                                                                     |               |              |                             |
| Continued alignment of the SPA models                                                    | • Continued delivery of the community in-reach model that has been established, relying on maintaining the strong integrated approach with the acute and council brokerage teams                                                                 |               |              |                             |
| Integrated Mental Health and community health offer                                       | • A integrated care offer that addresses the mental and physical health of two priority groups identified. (Patients with serious mental illness and older people with dementia)
  • Shared MDT workforce                                                                                                                                  |               |              |                             |
| Further progress integrated VCS Offer                                                     | • Integrated, responsive and personalised offer across traditional service boundaries, in line with principles of new Community Framework for Mental Health                                                                                     |               |              |                             |
| SPA Discharge Model for MH patients                                                      | • A discharge model that includes integrated acute, community social care and housing teams expediting discharge pathways.                                                                                     |               |              |                             |
LTC – case for change

• **People with long-term conditions are disproportionately affected by covid-19.** Clinical evidence shows that patients with certain LTCs (e.g. chronic kidney disease, COPD, diabetes, heart failure) are at increased risk from severe complications of covid-19.

• **Prevalence of LTCs** – modelled prevalence shows that NCL Boroughs are in the top ten for undiagnosed hypertension, heart failure and COPD.

• **Inequalities** - We know that people more at risk of covid-19 are more likely to live in deprived areas, BAME communities are more likely to be in the shielding population, as are older people. We also know that levels of deprivation, prevalence of LTCs, and the % borough populations who are older or BAME varies by borough.

• **There is inequality across NCL in terms of funding and provision of LTC services** - we need to consider how we reduce unwarranted variation in the funding and provision of primary and community services equitably across the five boroughs, whilst continuing to support adaptation of provision to local need.

• **As we accelerate the restart of routine care** - we need to ensure that primary care and community services, working together, reach out proactively to these clinically vulnerable patients, particularly those whose routine care has been delayed or disrupted.

• **Taking a consistent approach to how we work on LTCS** – We need to work through how we pull together the various strands of work happening across NCL and the resourcing implications to ensure we provide maximum value to our population in a way that supports the reduction in health inequalities.
As a developing ICS we are setting ambitious priorities to:

**Increase our secondary prevention programmes with the aim of supporting people to stay well and when people become unwell, to recover quickly** – our LTC population is some of the most vulnerable in society, if we get the in-reach offer right for them we’ll improve their outcomes and reduce pressure on the wider system.

**Provide local care so people only go to hospital when it is clinically necessary** – by accelerating and developing prevention programme for people with LTCs as well as other community services such as rapid response we can manage patients in their home, leading to better outcomes and avoiding unnecessary ambulance conveyance and admission to acute services.

**Provide a consistent standard of care available to everyone and reduce variation** – there is huge unwarranted variation and inequality in the service offer and price paid for LCS’ and community services across NCL. If we are truly committed to acting as a single CCG as part of an ICS we need to have a consistent standard of care.

As a system we need to think about how we work with partners to deliver on our priorities in a sustainable way in order to deliver the best outcomes for our population.
Opportunities and challenges for pharmacists in managing long term conditions from a secondary care perspective

Stuart Semple, Chief Pharmacist, Moorfields Eye Hospital NHS Foundation Trust and Interim Chief Pharmacist, North-Central London Integrated Care System

24 September 2019
Role of Pharmacy – ‘Profession’ and ‘System’

• Understanding the ‘Value Added’ of Pharmacy’s contribution
  • Delivering SMRs.
  • ‘Generalist’ versus ‘specialist’.
  • Looking at the whole drug regimen.
  • Specifically identifying drug/drug, drug/disease, drug/patient interactions.
  • Experts in formulation and product utilisation.
  • Promoting medicines optimisation, especially principle 1 – aim to understand the patient experience; the purpose and benefits of drug therapy.
Developing Skills

• To deliver effective SMR usually involves a period of development of around 18 months.
• Delivering across all aspects of ‘Foundation’ level practice takes 2-3 years.
• The elements required to support development are:
  • Working to a competency framework.
  • Working to a curriculum relevant to the role.
  • Maintaining a portfolio of evidence.
  • Appropriate supervision and assessment.
  • Developing a professional network.
• These models of development almost exclusively sit within secondary care – this is an issue for the profession.
The Professional Network / System

• As a profession, Pharmacy has been poor at developing network-style working across ‘sectors’.
• There is a real risk that cohorts of PCN Pharmacist will evolve into a new sector that is not integrated into a professional network.
• Role and professional development, availability of resources (such as clinical guidelines) and clinical expertise are disproportionately located within secondary care.
• The challenge for system leadership is to integrate PCN Pharmacists into a sector-based network to support development, access to guidelines and expert opinion.
• Overall aim is to promote effective networked Pharmacy care.
Long Term Conditions and Pharmacy

Dr Ken Aswani, SRO for Medicines Optimisation, East London Health and Care Partnership

24th September 2020
Overview

• Challenge of Long-Term Conditions
• Current Approaches
• UCLP /North East London approach
• Implications
• Outcomes
North East London population overview

What local people have told us:

- **94%** of people said their health and well-being is important or very important to them.
- **50%** of people would like to improve their physical health.
- **32%** of people would like to improve their mental health.
- **40%** would like to eat more healthily.
- **31%** mentioned money as a barrier.
- **36%** mentioned time as a barrier.
- **24%** mentioned struggling to get motivated.
- **30%** mentioned having too many things going on.
- **28%** mentioned having a health condition which prevents it.
Long term conditions: In north east London

129,000 people living with diabetes

337 people were diagnosed with HIV in 2018

CVD is responsible for one in four premature deaths

Type 1

Havering has the highest Type 1 diabetes rates in London

Type 2

Newham has the highest Type 2 diabetes rates in London

Respiratory disease affects one in five people and is the third biggest cause of death

Barking and Dagenham has the highest rate of emergency admissions for amputations in diabetes patients in London

Up to 70% of strokes could be prevented

One in four stroke survivors are working age adults
Long Term Conditions

• Cardiovascular disease (CVD)
• Stroke
• Respiratory disease
• HIV
• Diabetes
• Mental Health
Population Health Management approach

- Population health management is an approach that aims to improve physical and mental health outcomes, promote wellbeing and reduce health inequalities across an entire population.

- Our health and care needs are changing; we are living longer and have an increased incidence of multiple long term conditions. Population health management can help us better understand and predict future health and care needs. We are using population health data to inform our strategy and priorities across all of North East London. This will allow improved targeted support, making better use of resources and reducing health inequalities.
Challenges

• Patients with multiple risk factors
• High morbidity and mortality
• Diabetes alone 129,000 patients in NE London
• Limitations to historical programmes. Now need to focus further on prevention and supporting high risk population.
• Learning from Covid 19
• Workforce; recruitment, retention and effective deployment.
• How to monitor and demonstrate improvement in clinical outcomes
New Opportunities

• Integrated Care partnerships and Integrated Care Systems
• NHS Long Term Plan
• Data – Clinical Effectiveness Group and UCLP
• Risk Stratification
• Ability to focus on outcomes
• PCN – working at scale, diverse workforce
• Remote working
The approach

• Tools for Risk Stratification – low, medium and high risk
• Use of data for prioritisation
• Workforce training – team approach and skill mix
• Patient centred care
• Measuring outcomes
• Changing systems within the practice /local setting
• Improving at scale
The approach in WEL (Tower Hamlets, Newham and Waltham Forest CCGs)

- Collaborative working between Primary Care, Commissioning, IT and Training Hubs.
- Webinars with over 100 people attending
- Rolling out risk stratification packages
- Localisation of frameworks
Summary

• A structured approach using a new workforce and remote working is a significant leap forward

• Pharmacists are a major asset

• The Integrated Care System gives us a significant opportunity to drive forward, allowing all sectors to work together
Opportunities and challenges for pharmacists in managing long term conditions from a primary care perspective

Moira Coughlan Programme Director for Medicines Optimisation and Pharmacy Transformation East London Health and Care Partnership (ELHCP)

24 September 2020
Opportunities

• Contractual arrangements
• Integrating the pharmacy workforce within professional networks
• Embedding all pharmacists in integrated care partnerships
• Optimising digital technology to support managing long term conditions
Contractual Arrangements to support managing patients with long term conditions

- Quality and Outcomes Framework
- Direct Enhanced Services
- Local Enhanced Services
- Community Pharmacy contract
- Public Health commissioned services
- Immunisation programmes - Flu
Working with all healthcare professionals

- Care Homes
- Community Pharmacy
- Hospices
- Other PCN Pharmacists
- Acute Trusts
- Community Health Services
- Mental Health
Digital developments

• Using digital tools to manage risk for example; PINCER
• Using technology to support patients being discharged from hospital for example; TCAM (Transfer of Care Around Medicines)
• Virtual consultations
Challenges

• Continuing professional development and personal development plans
• Understanding and promoting the role of the pharmacist both within and outside your organisation
• Understanding the local processes for managing patients with long term conditions.
Next steps for consideration

• Is the role and remit of the pharmacist clear in the management of patients with long term conditions locally?

• What support do pharmacists need in the immediate future?
  ➢ Training needs
  ➢ Understanding local pathways
  ➢ Understanding internal work plans

• What opportunities exist or can you create to expand your professional network?
Q&As
Breakout room - Group discussions
Close and next steps

Primary Care Support package

- Available via UCLPartners’ website (https://uclpartners.com/long-term-condition-support/)
- Your feedback continues to shape the training and education package that is offered

Next Community of Practice: 29th October 6pm-7:15pm
(last Thursday of every month excluding December 2020)
Thank you

For more information please contact

Primary Care enquiries Primarycare@uclpartners.com

www.uclpartners.com
@uclpartners