



Long-term Conditions Newsletter

Welcome to a packed issue of NHS North East Essex PCTs up-to-date news on our continued inspiring work around Long-term Conditions.

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Information for Carers

Have you seen our new carers microsite and Carers Information Leaflets?

<http://www.northeastessex.nhs.uk/carers>

The Government's national strategy for Carers 'Recognised, Valued & Supported: Next Steps for the Carers Strategy (2010)', sets out plans for supporting carers. One of the priority areas in the Strategy is to support those with caring responsibilities to identify themselves as carers at an early stage and to provide them with information about local support services. A consultation representing the views of 4000 carers by the Department of Health last year found that carers need better and timely access to information - on the illness or condition of the person they care for; on appropriate caring, on accessing benefits and other support, on financial and employment issues. Our new information leaflets and related website are an attempt to gather together the various sources of information and support available to carers locally. Comments on both the leaflets and the website would be welcome in order to improve them in the future, and should be made to:-



Sharon Withnell, Carer Project Lead, Clinical Quality Directorate

NHS North East Essex PCT

Tel 01206 286837 sharon.withnell@northeastessex.nhs.uk



Successfully Increasing COPD Diagnosis in NE Essex

Over 1,000 Patients Newly Diagnosed with COPD

Early identification and treatment of COPD can reduce the severity of COPD later in life. In its 2009/10 Strategy, NHS NE Essex therefore set a target to increase the COPD diagnosis rate in NE Essex. *Over 1,000 new COPD diagnoses have been made since the target was set.*

The total number of people with diagnosed COPD in NE Essex is now just over 6,000, an increase of over 16% since the target was set. Based on published evidence, this is unlikely to have avoided 36 hospital admissions in 2010/11 alone, and should result in a net saving of over £350,000 by 2013/14 if this performance is maintained.

This has been achieved through spirometry and diagnosis by General Practices and the ACE COPD team.

A huge thank you goes to all those who have contributed to this fantastic result which will have a direct impact on respiratory health in NE Essex. The General Practice Local Enhanced Service supporting COPD diagnosis will continue during 2011/12. We will also look at other schemes to identify people with COPD e.g. screening through smoking cessation services.

Dr. Jo Broadbent, Consultant in Public Health, NHS North East Essex Tel 01206 286876

For further information about any of the information provided in this newsletter please contact:

Jennifer Speller, Head of Community Commissioning, NHS NEE PCT jennifer.speller@northeastessex.nhs.uk tel: 01206 286889

Dr. Jo Broadbent, Consultant in Public Health, NHS NEE PCT jo.broadbent@northeastessex.nhs.uk tel: 01206 286876

Self-care Work Continues



Work continues in NEE to support people to have the skills, knowledge and confidence to manage their long-term condition and work in partnership with their healthcare team:-

✧ Promoting Self-care

The principles and importance of self-care are being promoted to clinical teams through presentations and face-to-face meetings. It includes an explanation of what pieces of work make up the project and the range of materials available to support this, such as NHS Choices, The Well-being Star™ and Information Prescriptions. Work is also underway to identify training needed to embed this work.

✧ Its effectiveness

Our evidence review of the effectiveness of self-care support for people with different long-term conditions has progressed, with completion of two further conditions (inflammatory bowel disease and glaucoma). This will help to understand how best to provide support to these groups to maximise results and value for money.

✧ NEW Pilot Service to Support Self-Care

A competitive quote process is underway for a year long pilot service - *the Empowerment and Self-Care Service (ESC)*. This service would have a role as local lead in promoting, co-ordinating and developing the self-care programme in the area, including delivery of self-care for those people who have been identified as benefitting most from such support, but for whom services do not currently exist.

✧ Well-being Star Packs on offer

Well-being Star™ packs have been produced which will be offered to people with a long-term condition who are seen by our community provider (ACE). The packs include instructions on how to use the tool, the Well-being Star™ tool itself, action plan and sign-posting sheets.

✧ NHS Choices & Information Prescriptions

A section has been added to our new community services contract to promote the use of NHS Choices and Information Prescriptions. For example, the onus will now be on the provider to ensure they list their service on the directory section of the website and take account of patient feedback. This is being backed up by a PCT policy on using NHS Choices in NEE (this is currently in draft format— - please contact Alison Connolly below if you would like to comment on the draft version).

✧ The Self-care Menu

Our community provider has also been tasked with offering people with a LTC, who go through their services, an intervention from a 'Self-care Menu'. This menu lists a range of services and organisations which provide the principles of supported self-care which patients might find useful. It is expected that this menu will grow as more services carrying out this type of role are identified. We hope that this approach ensures people are given choice of ways to get help to self-care.

✧ Personal Health Planning Network

A regional Personal Health Planning network has been running for the last 18 months or so, where PCTs have come together to share ideas and best practice. This is now going to be expanded to look at more of the personalisation initiatives, such as personal health budgets, shared decision making and information provided at point of diagnosis.

For further information of any of the self-care matters raised in this newsletter

please contact Alison Connolly

on 01206 286732 or alison.connolly@northeastessex.nhs.uk



Diabetes News

Personal Diabetes Handbook

NHS North East Essex launched the Personal Diabetes Handbook late 2009 which has been distributed to people with diabetes via Practices, clinics and Structured Education programmes. It has now been updated and the updated pages (eight in total, packed in small bundles) are now available and will be sent out to all Practices and diabetes clinics. The people with diabetes who already have Handbooks can then update them and simply remove the obsolete pages. The updated bundles will also be available at the Primary Care Centre Reception for anyone attending services here. Any newly diagnosed patients presenting during 2011 who do not have the old version of the Personal Diabetes Handbook will now received new handbooks which are already updated. The updates include information about medication changes, the new HbA1c measurements, diet portions and a Patient Evaluation Questionnaire which the PCT will use to take feedback from people using the handbook.

Children & Young People's Service Re-design

An initial meeting with the PCT and CHUFT has taken place. The PCT have provided CHUFT with a draft service specification for their review. Another meeting to agree the specification and the new national Children & Young Person's tariff (means of payment for the level of diabetes care provided by the Paediatric Diabetes Team) was set for 13th May 2011.



Teenagers' Website Link for Diabetes

NHS North East Essex Health & Wellbeing Team have commissioned the development of a website for Teenagers as improving health and wellbeing in Young People is a priority area for the PCT. This has been extended to include diabetes links for the Teenagers with diabetes in the area. A focus group is being set up to work with the PCT to ensure that this group of people can have access to quality information relevant to them about living well with diabetes. The link for this website is

<http://www.essexhealth.co.uk/healthy-lifestyle/diabetes/>

Diabetes Adult Pathway Redesign

The Diabetes Steering Group is leading the work on this. Developments in the last quarter include

Foot care Workshops

As part of the redesign of the diabetes pathway the commissioners have had two workshops with current providers of the local foot care service and a draft foot care strategy has been developed. There has also been a meeting between the hospital diabetes team and the foot care/podiatry service to identify all the current issues and the possible solutions. Once any immediate actions are agreed a full workshop with all interested stakeholders will be arranged to look at the medium to longer term planning.



Continued

Diabetes Adult Pathway Redesign continued

Diabetes Local Enhanced Services (LES) for Practices

Diabetes Local Enhanced Service is being continued as part of the Public Health Local Enhanced Service. It will continue to stretch Practices to go beyond the Quality and Outcomes core work and deliver care enhanced care, enabling more patients to receive care closer to home. Practices are sending General Practitioners and Practice Nurses on advanced diabetes training up skilling the workforce. This will continue to be part of our model of care of North East Essex.

Diabetes Patient Forum



The forum meets monthly and at the last meeting there were presentations on Weight Management/ Health Trainers and Health Checks, the THINK GLUCOSE programme at CHUFT and an update from the GP Consortium. The Strategic Health Authority (SHA) are also arranging a Quality Innovation, Productivity and Prevention (QIPP) day for Service Users to participate and help Commissioners and Providers to understand that 'personalisation—no decision about me without me' is a vital component for improving services.

Diabetes Retinal Screening

Health Intelligence has been successful in its bid to provide a Diabetes Retinal Screening Service to six Primary Care Trusts across East Anglia, which includes North East Essex. This quality service will offer more accessible diabetic retinal screening and a new screening schedule with all the new sites will be available in the Summer. Diabetes UK have been involved with the procurement of the new service and Sharon Tillbrook the Regional Officer is confident that the views of the service users will be heard.



THINK GLUCOSE Hospital Programme

This national scheme has been piloted at CHUFT on two different wards, a medical diabetes ward and an orthopaedic ward. The results from the diabetes ward have been very promising, demonstrating the same results as the National Pilot sites which include:

- Improving identification of people with diabetes on admission and coding
- Reducing insulin errors through greater awareness
- Reducing inappropriate referrals to the Diabetes Specialist Team
- Reducing length of stay for people with diabetes by a minimum of two days
- Improving foot care for people with diabetes

This will now be introduced across most wards in CHUFT and Community Hospitals.



Structure Education for People with Diabetes

NEE has developed a Structured Education Strategy which will ensure more options for people with diabetes and aims to address the patients' different learning needs. As part of the pathway redesign it is vital that courses are commissioned on outcomes. NICE approved courses are cost effective, robust on internal and external quality performance review and audit and demonstrate very good patient outcomes. These will be commissioned as part of the new integrated pathway along with other options for people who enjoy learning online, or prefer 1:1 and shorter sessions.



For further information about Diabetes or any of the Diabetes items featured in this newsletter
please contact:

Linda Jewsbury, Public Health Diabetes Nurse, NHS NEE PCT

Linda.jewsbury@northeastessex.nhs.uk Tel: 01206 286911

Stroke Pathway Improvement

‘To provide an early, seamless transition from hospital to home, through a multidisciplinary, co-ordinated specialist stroke rehabilitation team’.



Procurement of a Stroke Early Supported Discharge Team



NEE PCT have procured the Stroke Early Supported Discharge Service and congratulations goes to ACE for winning the contract

The PCT have met with ACE to commence development and are aiming for service commencement in July - August 2011.

NHS North East Essex would like to take the opportunity to thank all the bidders for their time, members of stroke steering group and procurement project group for their help and collaboration in developing the service design and ensure the process continues on target, with extra thanks to our patient representatives and voluntary services for giving up their time to ensure the service meets local needs.

The project team held a Final Lessons Learned Workshop on the 3rd May 2011 to ensure the organisation captured all aspects of the journey and can inform commissioners of best practice for future procurement processes.

ACE will now be establishing robust links with all the stakeholders within the pathway, including Acute teams (CHUFT), social care and our third sector organisations.

We are confident that with the growth of ESD, along with existing services, the vision for the NEE stroke pathway will be realised thus providing high quality, seamless transition of care and rehabilitation across the stroke pathway,

Essex Cardiac & Stroke Network Local Peer Review

The PCT are pleased to report that since the peer review last year, action plans were developed with current providers of stroke services and all have made excellent progress to date.

We are keen to invite the network back to acknowledge the developments that have been made.

Questions or comments should be sent to:

Morag Kirkpatrick, Commissioning Manager

NHS North East Essex PCT

Tel 01206 286726

morag.kirkpatrick@northeastessex.nhs.co.uk

Primary & Secondary Prevention

In March a joint event by NHS North East Essex and the Essex Cardiac and Stroke Network was held for local GPs. The event covered TIA and Stroke, including awareness of local processes.

NEXT STEPS

As the Early Supported Discharge Service develops, the PCT will review the impact this has on peripheral and key linked services such as post stroke specific and generic community rehab services. To also review the voluntary sector organisations.

Virtual Ward - the story so far

The virtual ward concept is currently being tested by nine practices, three community matrons and one dedicated social worker, who are collectively focusing on improving the health of patients who have multiple, or complex, long-term conditions in the south Tendring area.

There are two key stages of the establishment of the project:

- setting up the structures and facilitating communication between the organisations and staff involved with providing the virtual ward.
- identifying which patients could most benefit from preventative care to reduce risk of exacerbation of their condition, and therefore benefiting most from admission to the virtual ward. This is achieved using a risk stratification tool known as the combined predictive model (CPM).

Both elements of the project demonstrate efficiencies and effectiveness for patient care individually, but when combined, as they will be within the virtual ward, provide an opportunity to make best use of the resources available.

Element 1 – facilitating structures and communication between services and staff

During the first stage patients are being admitted into the ward from a group who are already known to GPs and Community Matrons, and who are considered to benefit from the care of the virtual ward.

When on the virtual ward LTC patients are managed in their own homes by a Multi Disciplinary Team comprising of a GP, Community Matron, Social Worker and other health professionals when required, co-ordinating patient care with the support of Voluntary and Council services.

Ultimately the service is designed to reduce hospital admissions, readmissions and length of stay by:

- Improving health outcomes for patients
- Improving the quality of life for patients

Element 2 – identifying which patients will most benefit from being on the virtual ward

The second element of the project involves a risk stratification tool known as the Combined Predictive Model (CPM) that generates a list of all patients at the practices who are most at risk of exacerbation of their condition. This list will then be used to identify patients who could most benefit from being cared for within the virtual ward, to prevent their condition exacerbating.

Eventually up to 75% of patients will be identified using the CPM, and 25% will be referred from other sources across the health, social and voluntary sectors.

The CPM part of the project is about to be delivered, when the CPM tool is up and running, the full virtual ward model will be in place and data and patient and staff experiences can be collected and assessed. It is envisaged that the experiences and findings, of the wards during the establishment and development phase between February and the end of 2011, will be used to inform and refine the model and to assist with introducing the model to other parts of North East Essex, over the course of the next year.

For further information about Virtual Ward please contact:

Lizzy Warrington

Ignition Project Co-ordinator & Contracts Manager Acute Commissioning, NEE PCT

lizzy.warrington@northeastessex.nhs.uk Tel 01206 286905

LES for Life Report

The LES was offered in August 2010 to practices in NEE. Out of the total 44 practices, 35 (80%) signed up to offer the local enhanced service. Some practices did not sign up because of limited capacity to offer the services. The sign up increased gradually throughout the year. The LES has three major components in the beginning:

▪Senior Health Checks ▪QOF Stretched Targets ▪COPD Diagnosis

An additional addendum was sent to the practices in February 2011 to start:

- Statin Prescription to hypertensive patients aged 40—74 years
- Bone sparing agents (Biphosphantes) prescription to female patients aged 75+ year with a history of fragility fractures plus referral to falls prevention service

Senior Health Checks

The health checks were aimed for patients aged 75—84 years. In NEE we estimate that approx 6470 patients would have been eligible for these checks at the rate of 29% (based on data from 10 sample practices). GP practices offered 1633 Senior Health Checks throughout the nine months from August 2010 - March 2011. Great Clacton Medical Partnership offered the highest number of Senior Health Checks for the year at 405 whilst Mersea Road Surgery offered the highest, 61 checks in low LE wards.

QOF Stretched Targets

Three QOF targets were selected and practices were offered incentives to maintain or achieve the stretched targets while additional payments were offered to target patients in low performing practices to achieve these targets.

1. BP5: The QOF target requires practices to keep percentage of patients with hypertension in whom the last blood pressure (measured in the previous nine months) is 150/90 or less, below 70%. Under this LES practices were required to stretch the target to 80% while 12 practices achieved 75% of the target. At the end of the year 16 practices achieved the target of 80% while 12 practices achieved 75%. Practices controlled blood pressure in 2399 additional patients in order to reach this target. If this control is maintained, based on published evidence, this is likely to prevent around 100 cardiovascular events over the next five years, at a net saving of £75,000.
2. CHD 6: The QOF target requires practices to keep percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the previous 15 months) is 150/90 or less, below 70%. Under this LES practices were required to stretch to 90% without exception reporting. At the end of the year 17 practices achieved the target of 90% while 16 practices achieved 85%. Practices controlled blood pressure in 291 additional patients which is likely to prevent 12 cardiovascular events over the next five years, at a net saving of £9,000.
3. CHD 8: The QOF target requires practices to keep percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the previous 15 months) is 5mmol/l or less, below 70%. Under this LES practices were required to stretch to 80% without exception reporting. At the end of the year 5 practices achieved the target of 80% whilst 19 practices achieved 75%. This controlled levels in 322 additional patients which is likely to prevent around 10 cardiovascular events over the next 5 years, saving £5,000.

The LES achieved very good results in the identified indicators and COPD screening targets. Therefore we should continue to incentivise practices to reach the patients at the bottom end of the long-term conditions registers. The COPD activity really increased when support services, including training, was commissioned from ACE in the last quarter of 2010-11, therefore, we should re-commission the services during 2011-12.

telehealth

Colchester Borough Council will continue to provide telehealth support to patients with Long-term conditions in North East Essex during 2011/12. Patients with COPD and Heart Failure under the care of ACE specialist teams are benefiting from this support. NEE PCT are working with both teams to increase the use of telehealth during 2011/12. We are also working with other Essex PCTs, Essex County Council and Central Essex Community Services to develop an Essex-wide telehealth business case for expanding the use of assistive technology in health care across Essex in the future. This is in line with the Department of Health's Operating Framework for 2011/12, which states that plans for 2011/12 should include

- *use of digital technology in key areas to support delivery of the QIPP agenda, including:*
- *use of telehealth and telecare to help people stay in their own homes*
- *introduction of digital or online services to deliver greater convenience for patients and to free up face-to-face clinical time for those who really need it*

Essex Wide Assistive Technology Market Place Event

This event was organised in partnership with all five Essex Primary Care Trusts, Essex County Council and Central Essex Community Services and was held on 11th May 2011, 10.30am - 9pm, at The Waterfront in Chelmsford. The aim of the event was to bring together providers of technology, clinicians and service commissioners to raise awareness of the benefits it could provide within health and social care, and explore how it can be used to provide value for money and to support vulnerable people closer to home. A large number of technology providers attended the event, which was an ideal opportunity to consider the potential technological interventions that could support patients with long-term conditions in their homes, and facilitate remote monitoring for patients.

The trial of telehealth, including support for COPD, Heart Failure and Diabetes patients, is expected to report in June/ July this year. It is expected to demonstrate efficiencies and savings from using Assistive Technology in LTC pathways. Further guidance on the use of AT is expected from the Department of Health after publication of the trial. For further information, please contact:

Claire.aldridge@nhs.net

2011 Diary Dates

NEE PCT Long Term Conditions Workstream Group Meetings

Wednesday 18th May 2011, 2pm - 5pm, room 12a & 14a, NEE PCT

Wednesday 17th August 2011, 2pm - 4pm, room 12a & 14a, NEE PCT

Wednesday 16th November 2011, 2pm - 4pm, 12a & 14a, NEE PCT

If you are interested to find out more about the on-going work surrounding Long-term conditions at NEE PCT, please feel free to attend any of the above group meeting dates and advise Claire Cornell at NEE PCT on 01206 286722 or at claire.cornell@northeastessex.nhs.uk

For further information about any of the information provided in this newsletter please contact:

Jennifer Speller, Head of Community Commissioning , NHS NEE PCT	jennifer.speller@northeastessex.nhs.uk	tel: 01206 286889
Dr. Jo Broadbent, Consultant in Public Health, NHS NEE PCT	jo.broadbent@northeastessex.nhs.uk	tel: 01206 286876
Newsletter compiled by Claire Cornell, NHS NEE PCT	claire.cornell@northeastessex.nhs.uk	tel: 01206 286722