

Cambridgeshire Long Term Conditions Strategy 2008-2011

and

Action Plans 2008-2009

Final Version
July 2008

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“Adding Years to Life and Life to Years”



By the Long Term Conditions Board
Cambridgeshire PCT

Cambridgeshire Long Term Conditions Strategy 2008-2011 and Action Plans 2008-2009

“Adding Years to Life and Life to Years”

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1. SUMMARY

Over fifteen million people in this country report living with a long term condition. Long term conditions are those conditions that cannot, at present, be cured, but can be controlled by medication and other therapies. This strategy introduces action to implement the Government's priority to improve care for people with long term conditions by moving away from reactive care based in acute systems, towards a systematic, patient-centred approach.

The latest evidence continues to support the clear messages about long term conditions:

- People with long term conditions are the most intensive users of the most expensive services.
- Numbers are increasing due to factors such as an ageing population, health inequalities and certain lifestyle choices that people make.
- People with long term conditions are not just high users of primary and specific acute services but also social care and community services and urgent and emergency care.
- Ill health among the working population places a significant burden on health and social care.
- Long term conditions are by far the leading cause of mortality in the world.
- There are huge benefits to the population and financial savings if health and social care communities invest in effective long term condition management.

The government initiatives promote personalised care. Consultation with patients and practitioners emphasise the importance of educational programmes to help those with long term conditions. Education underpins this strategy.

Membership of the Cambridgeshire PCT Long Term Conditions Board

| | |
|-------------------------|---|
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| Sue Ashwell | Chief Pharmacist & Assistant Director |
| Pauline Brimblecombe | Chair of CATCH (PBC) |
| Jenny Brown | Business Development Partner CATCH |
| Claire Bruin | Director of Adult Support Services, CCC |
| Jill Challener | Medical Director |
| Dennis Cox | PEC Chair |
| Bob Dawson | Head of Children & Young People |
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| Arnold Fertig (Chair) | Turnaround Clinical Lead |
| Penny Fowler | Commissioning & Service Improvement Manager |
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| Gillian Turrell (Chair) | Acting Locality Manager, Community Access Team (EC&F) |
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2. STRATEGIC AND OPERATIONAL OBJECTIVES

2.1 Vision of Future Service Provision

Key facts

National data from primary care, based on chronic disease registers, suggests that 3.7% of the population is living with diabetes, 1.4% has chronic obstructive pulmonary disease and the proportion of people experiencing heart disease and stroke are 3.5% and 1.6% respectively.

18% of children aged 0 to 19 have a long-standing illness or disability, 8 out of 10,000 children aged 0 to 16 have a severe disability.

Circulatory disease (heart disease and stroke) is the leading cause of death. On average 1865 people die annually from circulatory disease in Cambridgeshire. All-age deaths rates from circulatory disease in Cambridgeshire are significantly lower than the national average, except for in Fenland where they are significantly higher.

Prevalence estimates suggest that, in 2006, there were around 6,600 older people with dementia in Cambridgeshire. By 2021 this is forecast to rise by 56% to 10,200.

The estimated number of first new strokes in Cambridgeshire in 2007 was 1,136 of which 872 were in people aged 65 and over.

Smoking killed 44 Cambridgeshire residents on average per week between 2002 and 2004. Among the three top diseases causing death were coronary heart disease and chronic obstructive pulmonary disease.

High level outcomes for people with long term conditions

In recent consultations people have voiced their opinions about what matters most to them in the care and the services they receive. A number of common themes and key messages have emerged.

People want services that will support them to remain independent and healthy and have increased choice. They want far more services to be delivered safely and effectively in the community or at home; and they want seamless, proactive and integrated services tailored to their needs.

These views have been taken into consideration to draw up the following high-level outcomes for people with long term conditions (LTCs):

- People have improved quality of life, health and wellbeing and are enabled to be more independent.
- People are supported and enabled to self care and have active involvement in decisions about their care and support.
- People have choice and control over their care and support so that services are built around the needs of individuals and carers.
- People can design their care around health and social care services which are integrated, flexible, proactive and responsive to individual needs.
- People are offered health and social care services which are high quality, efficient and sustainable.

2.2 Key Objectives

East of England Strategic Health Authority pledges

As a result of its 'Improving Lives; Saving Lives' consultation, the East of England Strategic Health Authority formulated eleven pledges to improve the healthcare and quality of life of people in the East of England. Cambridgeshire Primary Care Trust will lead in implementing the pledges over the next three years, many of which are important in improving the lives of people living with long term conditions.

Pledge 1 – We will deliver year on year improvements in patient experience: Patients with long term conditions are higher than average users of healthcare; joint working with public and patient groups is vital to delivering a long term conditions strategy.

Pledge 2 – We will extend access guarantees to more of our services: Shifting care of patients out of hospital and into the community is a central ethos of commissioning services for long term conditions.

Pledge 3 - We will ensure GP practices improve access and become more responsive to the needs of all patients.

Pledge 4 – We will ensure NHS primary dental services are available locally for all who need them.

Pledge 5 – We will ensure fewer people suffer from, or die prematurely from, heart disease, stroke and cancer: Programmes addressing obesity and smoking, as well as managing risk factors such as hypertension and diabetes can reduce the prevalence of heart disease and stroke. Rapid diagnosis and assessment of patients can reduce premature death, whilst rehabilitation can reduce disability. A long term conditions strategy should consider all levels of prevention.

Pledge 6 – We will make our healthcare system the safest in England: Patient safety is the top priority for the PCT. Making care safer for people with long term conditions may be through managing the implementation of the latest guidance from NICE and the safer management of controlled drugs.

Pledge 7 – We will improve the lives of those with long term conditions: Ultimately this is the aim in commissioning services for people with long term conditions.

Pledge 8 – We will work with our partners to reduce the differences in life expectancy between the poorest 20% of our communities and the average in each PCT:

In implementing measures to improve life expectancy in those with long term conditions, programmes should be targeted at those experiencing the worst health outcomes.

Pledge 9 – We will ensure healthcare is as available to marginalised groups and ‘looked after’ children as it is to the rest of us:

Patients with long term conditions from marginalised groups are more likely to experience worse health outcomes and be less able to access care than those in other groups.

Pledge 10 – We will cut the number of smokers by 140,000:

This is central to the prevention of coronary heart disease and stroke and chronic obstructive pulmonary disease. It is important for diabetic patients, who through the nature of their condition are already at higher risk of coronary heart disease and stroke. There is no upper age limit for which stopping smoking can have benefit.

Pledge 11 – We will halt the rise in obesity in children and then seek to reduce it:

Reducing obesity in children and related to this, reducing adult obesity, has a significant impact on the rates of many long term conditions.

2.3 National and Local Priorities

National policy

The Government’s aim is to promote and spread across the NHS approaches that will lead to improved services and support for people with long term health and social care needs – the specific aims being to produce better health outcomes and quality of life, slow disease progression and reduce disability. This in turn will result in improved quality of life, helping to relieve discomfort and stress and reduce the need for hospital admission.

People with long term conditions have better lives when they are supported to take care of their conditions themselves. If people have a clear understanding of their condition and what they can do, they are more likely to take control themselves. One of the priorities from participants in the 'Your health, your care, your say' consultation was for services based around their needs which help them take control of their health, support their wellbeing; and enable them to lead an independent and fulfilling life.

'Our health, our care, our say: a new direction for community services (January 2006)' sets out a vision and package of proposals designed to address the expectations and outcomes that people want for themselves; maintaining a sense of wellbeing; and leading an independent life. There is solid evidence that care is less effective if people feel they are not in control.

Three themes run throughout the White Paper:

- Enabling and supporting health, independence and wellbeing.
- Rapid and conventional access to high quality, cost effective care.
- Putting people more in control of their own health.

Self care lies at the heart of putting people in control and plays a key role in improving the management of long term conditions. Self care is "led, owned and done by people themselves. NHS and social care organisations cannot do self care to people, but what they can do is create the right environment where people feel supported to self care." This definition is taken from the self care guide for supporting people with long term conditions that was published shortly after the White Paper.

The self care guide for supporting people with long term conditions – 'Supporting people with long term conditions to self care – a guide to developing local strategies and good practice' (published 24th February 2006), complements the proposals set out in the White Paper and both reinforce the existing programme of reform.

The document identifies key areas in which patients need support (skills; training, information, tools; devices and support networks) and gives examples of good practice together with the role of patients, professionals and PCTs/Trusts in supporting these areas.

There are National Service Frameworks (NSFs) covering coronary heart disease, cancer, mental health, older people, diabetes, long term neurological conditions, renal services, children and paediatric intensive care, and chronic obstructive pulmonary disease (in development) available at www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/DH_4070951

The Long Term (Neurological) Conditions National Service Framework (NSF) was launched in March 2005. The NSF aims to transform the way health and social care services support people to live with long term neurological conditions. Key themes are independent living; care planned around the needs and choices of the individual; easier, timely access to services and joint working across all agencies and disciplines involved. The principles of the NSF are also relevant to service development for other long term conditions. This NSF is a key tool for delivering the government's strategy to support people with long term conditions outlined in the White Paper 'Our health, our care, our say' and the NHS Improvement Plan 'Putting People at the Heart of Public Services'. It applies to health and social services working with local agencies involved in supporting people to live independently, such as providers of transport, housing, employment, education, benefits and pensions.

There is much common ground between the Long Term Conditions Strategy and the Long Term (Neurological) Conditions NSF, for example around person-centred care planning, information and support, self care and case management. The strategy will be able to use neurological examples and case studies to illustrate how case management and self care can work. In turn it will rely on the NSF and all other NSF teams (eg renal, diabetes) to lead delivery of disease-specific issues under the broader long term conditions work. However, it is important to ensure that NSF for Long Term (Neurological) Conditions maintains its neurological focus and a discrete identity under this broader umbrella.

Annual Director of Public Health Report

The Director of Public Health Annual Report makes references to long term conditions in the following areas.

Cambridgeshire Primary Care Trust should support GP practices and local communities in more socio-economically deprived areas of the county, to ensure patients are accessing treatment for heart disease risk factors.

Significant increases in the numbers of older people in Cambridgeshire, including those who are physically frail, are forecast over the next fifteen years. Joint planning between Cambridgeshire Primary Care Trust, Cambridgeshire County Council and district councils is required to meet the needs of the growing population in a way that will maintain older people's independence and quality of life. It will also provide appropriate levels of adapted and supported housing, and ensure appropriate models of health and social care services within local communities.

Local authorities, the local NHS and other agencies should work together to improve outcomes for children and young people living in areas of higher socio-economic deprivation, and for specific population groups such as children in care, traveller children and children with disabilities.

Key National Indicators:

NI 55: Obesity among primary school age children in Reception Year.

NI 120: Mortality from all circulatory diseases at ages under 75.

NI 124: People with a long term condition supported to be independent and in control of their condition.

NI 125: Achieving independence for older people through rehabilitation/intermediate care.

NI 128: User reported measure of respect and dignity in their treatment.

NI 129: End of life access to palliative care enabling people to choose to die at home.

NI 131: Delayed transfers from hospitals.

NI 134: The number of emergency bed days per head of weighted population.

NI136: People supported to live independently through social services (all ages).

NI 137: Healthy life expectancy at age 65.

2.4 Links to Commissioning Plans

The developments in this plan are referenced in the Cambridgeshire PCT Commissioning Intentions, the response to the SHA pledges, and the PCT Operational Plan. As this report is being finalised the contracts for 2008/9 with providers are being signed. The contracts follow the Payment by Results Guidance for the PCT and the implications of tariff will be part of the project plan of work for the commissioners. The PCT is still in turnaround and the expenditure is higher than benchmark in many areas. Efficiency savings will therefore be a means for obtaining funding for service changes. However the PCT has invested against the East of England pledges. This is documented in the Cambridgeshire PCT Commissioning Intentions.

Commissioning intentions for both Smoking Cessation and Obesity are also linked with this Strategy.

2.5 Impact/Risk Assessments

Funding has been secured as part of the response to the SHA pledges.

2.6 Engagement with Stakeholders and Public Consultation

The PCT convenes the Cambridgeshire Long Term Conditions Board, which plans to have a wider stakeholder group. In Cambridgeshire some people use Direct Payments, but there is also a new policy on Individualised Budgets. The aim of self directed support or individual budgets is to give recipients of social care and associated services increased opportunities to design a package of services that meets their specific needs. Service users will be given a notional or cash sum of funding to use in developing their care package. This can be provided either as a direct payment or in the form of commissioned services. The principles of choice and control are critical to this policy development.

Individual budgets can, in the longer term, include a variety of existing service and funding streams including local authority provided social care services, Supporting People, Independent Living Fund, Community Equipment Services, Access to Work and Disabled Facilities Grants. Cambridgeshire are currently introducing individual budgets.

Phase two of the Joint Strategic Needs Assessments involves identifying work undertaken on the views of each of the client groups, on health and wellbeing to add to the information. We are collating public/local community views – particularly broad quality of life surveys, along with service user views and the needs of particular groups.

2.7 Local Workforce Issues

The PCT will work with providers towards workforce plans. New posts are funded through the PCT pledge response.

3. NEEDS ASSESSMENT AND COMMUNITY ENGAGEMENT

3.1 Demographic Trends

Patterns of health across the county broadly follow the patterns of deprivation shown by the Index of Multiple Deprivation. As a whole Cambridgeshire has a healthy population. In all districts except Fenland fewer residents perceive their health to be poorer than average for England. Across the county as a whole 15% of residents have a limiting long term illness and 7% perceive their health to have been “not good” in the year prior to the Census.

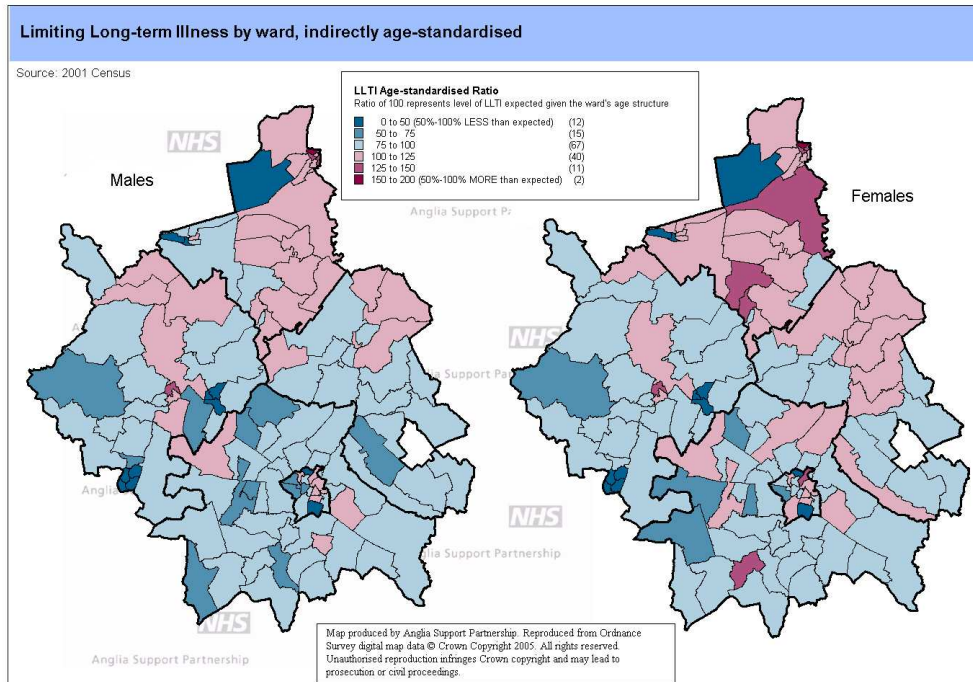
Table 1: % of residents with a limiting long term illness and % with “not good” health (all ages)

| Local authority | % Limiting long term illness | & "not good" health |
|----------------------|------------------------------|---------------------|
| England | 17.9% | 9.0% |
| Cambridgeshire | 14.6% | 6.6% |
| South Cambridgeshire | 13.3% | 5.5% |
| Huntingdonshire | 13.5% | 6.0% |
| Cambridge | 13.7% | 6.8% |
| East Cambridgeshire | 15.2% | 6.8% |
| Fenland | 19.4% | 9.1% |

Source: 2001 Census National Statistics. © Crown Copyright 2003

The map shows the variation in self-reported health status across Cambridgeshire, taking the age and sex structure of the population into consideration. There is a fairly consistent pattern across the county, with residents being more likely to have a limiting long term illness or to perceive their health to be poor in wards to the north of the county particularly in and around Wisbech, Huntingdon North, and in parts of Cambridge City.

Map 1: Limiting long term illness by ward, indirectly age-standardised (all ages)



Source: 2001 Census National Statistics. © Crown Copyright 2003

Figure 1: Age standardised LLTI ratios for people aged 50 and over

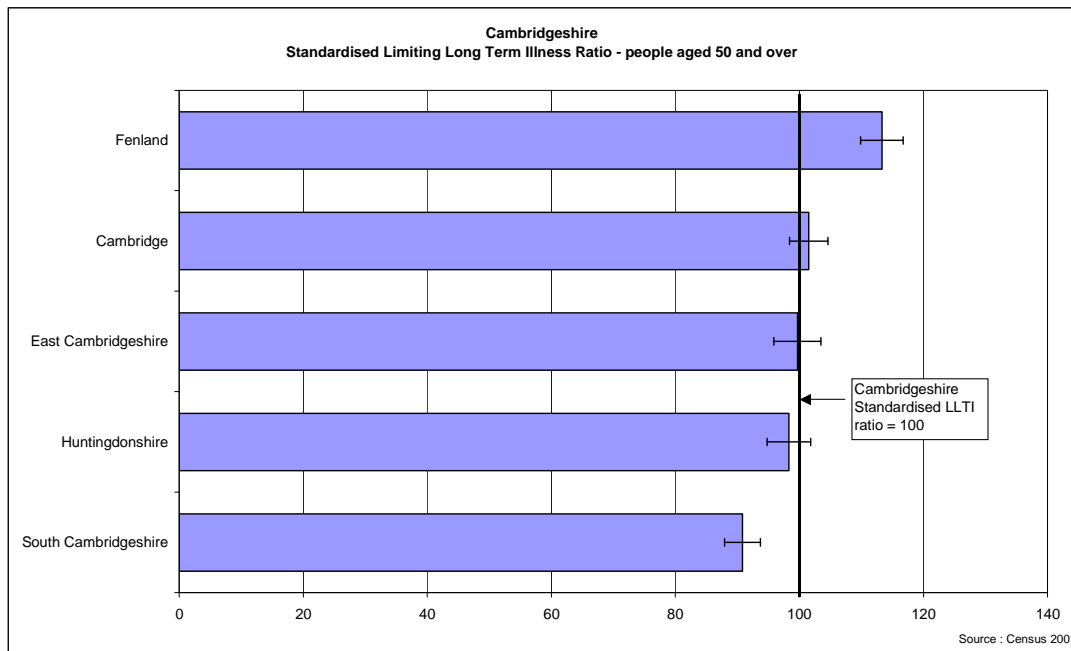


Table 2: Population forecasts 2006 – 2021, Local Authority

| Year | 2006 | 2011 | 2016 | 2021 | % change 2006-2021 | Absolute change 2006-2021 |
|----------------------|---------|---------|---------|---------|--------------------|---------------------------|
| Cambridge | 113,800 | 131,700 | 147,700 | 149,400 | 31.3% | +35,600 |
| East Cambridgeshire | 76,400 | 80,700 | 82,200 | 81,300 | 6.4% | +4,900 |
| Fenland | 89,800 | 91,700 | 95,400 | 99,700 | 11.0% | +9,900 |
| Huntingdonshire | 160,800 | 168,200 | 166,000 | 166,300 | 3.4% | +5,500 |
| South Cambridgeshire | 138,200 | 150,400 | 162,000 | 172,700 | 25.0% | +34,500 |
| Cambridgeshire | 579,000 | 622,700 | 653,300 | 669,400 | 15.6% | +90,400 |

Source: Cambridgeshire County Council Research Group 2005-based population forecasts
 Note: These forecasts are based on a series of assumptions and are indicative only; they do not represent the policy of the County Council or any district council.

The population of Cambridgeshire is projected to increase; population forecasts developed by Cambridgeshire County Council Research Group, taking into account housing plans from the draft Regional Spatial Strategy, forecast an increase in Cambridgeshire’s population of 16% between 2006 and 2021. While new housing will lead to considerable population growth, population ageing will also be an important demographic trend over coming years. In general, people are living longer and there are therefore increasing numbers and proportions of people aged over 75 years and over 85 years. Across Cambridgeshire, the greatest proportional population change will be in the population aged over 75. This age group is forecast to increase by 55% between 2006 and 2021.

Table 3: Population change 65+, 2006-2021, Local Authority

| Local Authority | Forecast | | | | % difference | | | | Actual change |
|----------------------|----------|---------|---------|---------|--------------|-----------|-----------|-----------|---------------|
| | 2006 | 2011 | 2016 | 2021 | 2006-2011 | 2011-2016 | 2016-2021 | 2006-2021 | 2006-2021 |
| Cambridge City | 13,800 | 15,200 | 17,700 | 20,200 | 10.1% | 16.4% | 14.1% | 46.4% | 6,400 |
| East Cambridgeshire | 12,700 | 14,600 | 17,300 | 19,400 | 15.0% | 18.5% | 12.1% | 52.8% | 6,700 |
| Fenland | 17,400 | 19,000 | 22,000 | 24,600 | 9.2% | 15.8% | 11.8% | 41.4% | 7,200 |
| Huntingdonshire | 22,700 | 27,200 | 32,900 | 36,500 | 19.8% | 21.0% | 10.9% | 60.8% | 13,800 |
| South Cambridgeshire | 21,500 | 27,000 | 34,300 | 40,100 | 25.6% | 27.0% | 16.9% | 86.5% | 18,600 |
| Cambridgeshire | 88,100 | 103,000 | 124,200 | 140,800 | 16.9% | 20.6% | 13.4% | 59.8% | 52,700 |

Source: Cambridgeshire County Council Research Group 2005-based population forecasts
 Note: These forecasts are based on a series of assumptions and are indicative only; they do not represent the policy of the County Council or any district council.

The forecast rise in the population of children aged 0-19 between 2006 and 2021 is much smaller at only 4%. There is variation between districts – with a forecast rise of 40% in the child population aged 0-19 predicted in Cambridge City, compared with a fall of 17% predicted in Huntingdonshire.

This change in the population demographic will mean that a greater number of people will be living to an age at which they become frail. As shown in table 4, the number of physically frail older people across Cambridgeshire is projected to rise by 53% by 2021. The number of cognitively impaired older people is projected to increase by 59% and the number of people who are both physically and cognitively frail is projected to increase by 54%.

Table 4: Estimated number of frail older people, Cambridgeshire, 2006-2021 by age

| | Age | 2006 | 2011 | 2016 | 2021 | % change |
|--------------|-------|--------|--------|--------|--------|----------|
| Physical | 65-74 | 2,030 | 2,510 | 3,130 | 3,350 | 65% |
| | 75-84 | 3,580 | 3,850 | 4,380 | 5,300 | 48% |
| | 85+ | 3,020 | 3,360 | 3,960 | 4,590 | 52% |
| | Total | 8,620 | 9,720 | 11,470 | 13,240 | 54% |
| Cognitive | 65-74 | 670 | 830 | 1,040 | 1,100 | 64% |
| | 75-84 | 1,100 | 1,190 | 1,370 | 1,700 | 55% |
| | 85+ | 930 | 1,050 | 1,250 | 1,460 | 57% |
| | Total | 2,700 | 3,070 | 3,650 | 4,260 | 58% |
| Combined | 65-74 | 290 | 360 | 450 | 480 | 66% |
| | 75-84 | 880 | 950 | 1,080 | 1,340 | 52% |
| | 85+ | 1,400 | 1,570 | 1,870 | 2,170 | 55% |
| | Total | 2,570 | 2,880 | 3,390 | 3,990 | 55% |
| All disabled | Total | 13,890 | 15,670 | 18,510 | 21,490 | 55% |

Source: MRC CFAS Study estimates applied to Cambridgeshire County Council 2005-based ward age forecasts.

3.2 Health Equity Audits and Joint Strategic Needs Assessment

The PCT Public Health Department Joint Strategic Needs Assessments can be found on the PCT website available at www.cambridgeshirepct.nhs.uk. These are under “about us”, and then under “public health” and can be retrieved by scrolling down. The series includes JSNA on older people, JSNA on children, JSNA on mental health, JSNA on learning difficulties and JSNA on adults with physical disabilities and illnesses (in preparation). There are also Health Equity Audits for coronary heart disease and for mental health.

3.3 Consultation With Users, Carers and Other Stakeholders

Feedback from ‘Your health, your care, your say’ consultation

Of nearly 1,000 participants at the National Citizens’ Summit, 86% of people thought that professionals in their local GP practice should provide more support to help them take care of their own health and wellbeing.

Some 61% said that being given more information about their health and the services available to them locally would make a big difference. They particularly want to know more about the availability of social care services.

Half of all people with long term conditions were not aware of treatment options and did not have a clear plan that lays out what they can do for themselves to manage their condition better. As a consequence, a significant proportion of all medicines are not taken as directed.

Department of Health MORI Survey 2005 – supporting statistics

- Some 82% of those with a long term condition say that they already play an active role in their care but they want to do more to self care.
- More than 90% are interested in being more active self carers.
- More than 75% say that if they had guidance/support from a professional or peer they would feel far more confident about taking care of their own health.
- More than 50% who had seen a care professional in the previous six months said that they had not often been encouraged to self care.

3.4 Clinical Engagement

The PCT's Long Term Conditions Board and Service Redesign Board works with the East of England Clinical Pathway Group to specify and commission pathways for people with long term conditions including appropriate self care and education programmes. Care pathways will be comprehensive and include prevention, diagnosis and assessment, treatment, rehabilitation and continuing care, and end of life care. The PCT also contributes to the Anglia Health and Stroke Network and to the Anglia Cancer Network. Practice Based Commissioners are represented on all groups. The PCT has a Cancer Local Implementation Team and a Heart and Stroke Local Implementation Team.

3.5 Gap Analysis

The PCT has responded to gaps in services by pledging to improve health and social care in line with the East of England pledges.

Cambridgeshire PCT pledges to work with the Cardiac and Cancer Networks to develop interventions and clinical pathways that will reduce the avoidable burden of morbidity and premature death from heart disease, stroke and cancer. This will include a combination of prevention, early detection (including screening), rapid access to treatment, enhanced quality and length of life, and a well-managed terminal phase and death at the place of the patient's choosing.

This work will be taken forward locally through the PCT Long Term Conditions Board, the Coronary Heart Disease and Stroke Cambridgeshire Local Implementation Team and the Cancer Local Implementation Team.

The PCT will support the implementation of the Mental Health Joint Commissioning Strategy and the Alcohol Strategy and their Action Plans.

To address specific priorities in 2008/2009 the PCT will invest in further development and use of registers for primary and secondary prevention of heart disease by strengthening of the local primary care facilitators team. The team will support and facilitate GP practices to improve data quality, identify patients with risk factors, and utilise patient alerts to indicate when preventive interventions are required, in line with NICE guidance.

The PCT will invest in addressing identified inequity in cardiac rehabilitation services in Cambridgeshire by investing in cardiac rehabilitation services in Fenland, working closely with Fenland District Council Leisure Services and providers.

The PCT will develop and implement a Cardiac Rehabilitation Service review framework across Cambridgeshire to ensure consistent provision and standards in relation to need.

The PCT will initiate development of a 'hub and spoke' model of stroke services across Cambridgeshire, with investment in a stroke physician and a specialist stroke nurse working across Addenbrookes and Hinchingsbrooke Hospitals. This will support triage of fast track stroke patients to Addenbrooke's for thrombolysis, with subsequent return for early acute stroke care at Hinchingsbrooke.

The PCT will ensure that disease registers are in place for people with long term conditions including diabetes, COPD and heart failure. Investment in primary care facilitators described under pledge 5 will help to support this.

The PCT's Long Term Conditions Board and Service Redesign Board will work with the East of England Clinical Pathway Group and the Cardiac Network to specify and commission care pathways for people with long term conditions including appropriate self care and patient education programmes. Care pathways will be comprehensive and include prevention, diagnosis and assessment, treatment rehabilitation and continuing care and end of life care.

The PCT will continue to work with CUHFT to take forward 'Co-creating Health' – a three year programme to support self-management for COPD patients involving the training of clinicians and patients, and testing of different models of pathway redesign.

The PCT will provide pump priming investment for pathway redesign work in diabetes with a focus on providing continued appropriate enhanced care in the primary care setting.

The PCT will support the assessment and treatment of patients with heart failure in a community setting, throughout the county.

4 PERFORMANCE MONITORING

4.1 Prevalence and Incidence Rates

These are found in the relevant chapters as excerpts from the Joint Strategic Needs Assessments.

4.2 Comparative Performance

The PCT routinely provides performance data as below.

4.3 Progress Against National and Local Targets

This is included below.

2007-08 – Indicators for Cambridgeshire PCT Long Term Conditions Programme

The overall target for long term conditions is to improve health outcomes for people with long term conditions by offering a personalised care plan for vulnerable people most at risk; and to reduce emergency bed days by 5% by 2008, through improved care in primary care and community settings for people with long term conditions.

This is measured by proxy targets below.

| Supporting Targets | Period covered by actual data | Plan/Target | Actual | Annual Plan 2007-08 | Comments |
|--|-------------------------------|-------------|---------------------------------|---------------------|---|
| PSA08a - Number of 4-week smoking quitters, who attended NHS Stop Smoking Services, per 100,000 population. | Cumulative to Oct 07 | 1295 | 1300 | 2837 | |
| PSA08b - Smoking status among the population aged 16 and over, as recorded in GP records. Numbers recorded should increase and proportion of smokers should decrease | 15 months to March 2007 | 60.99% | 48.04% | 70% | No data collection in 07-08 organised yet.* |
| PSA10a - Prevalence of obesity in primary school age children. PCTs should have measured baseline 2006/07 for 80% of reception and year 6 children and show an increase in 2007/08. | 2006-07 school year | 80% | Reception - 73% Year 6 - 69% | | |
| PSA10b - Obesity status among people aged 16 and over, as recorded in GP records. Percentage of total patients aged over 16 with BMI recorded should increase, and proportion of that with BMI more than 30 should decrease | 15 months to March 2007 | 35.19% | 28.32% | 36% | No data collection in 07-08 organised yet.* |
| PSA01b - numbers of practices with PCT-validated registers of patients without symptoms of cardiovascular disease but who have an absolute risk of CVD events greater than 20% over the next 10 years. 2003-2006 PPF required a majority by March 2006, expectation now is 75% by March 2008 | Mar-07 | 89.47% | 0.00% | 100% | No data collection in 07-08 organised yet.* |
| PSA01c - Percentage of patients predicted to have high blood pressure whose last blood pressure reading (measured within the last 9 months) is 150/90 or less. | 15 months to March 2007 | 77.86% | 85.55% | 75.92% | No data collection in 07-08 organised yet.* |

* See pledge proposals for collection of data

| | | | | | |
|---|---------------------------|---------|---------|--------|--|
| PSA01d - Percentage of patients expected to have CHD whose last measured cholesterol (measured within the last 15 months) is 5mmol/l or less. | 15 months to March 2007 | 64.25% | 74.59% | 70.40% | No data collection in 07-08 organised yet.* |
| PSA12a - Reduction in emergency bed days | April to December 2006-07 | 227,206 | 200,598 | 222139 | So comparison to 2006-07 can be made 2007-08 is 75% of plan only. Full year plan is 296185 bed days. |
| PSA12b Part 1 - Number of Community Matrons | Sep-07 | 19.2 | 11 | 19.2 | |
| PSA12b Part 2 - Number of additional case managers | Sep-07 | 10 | 5 | 10 | |
| PSA12c - Number of Very High Intensity Users (VHIUs) under the case management of a Community Matron or Additional Case Manager | Sep-07 | 538 | 259 | 1495 | |
| PSA18a - Increase the proportion of older people being supported to live in their own home. Increase the proportion of those supported intensively to live at home as a proportion of those being supported at home or in residential care. (see PAF C32 below) | | | | | See C32 below. |
| SUP06m - Echocardiography tests commissioned by the NHS | | | | | This is not a target |

* See pledge proposals for collection of data

| Other measures | Period covered by actual data | Plan/target | Actual | Annual Plan 2007-08 | Comments |
|--|-------------------------------|----------------|--------|---|---|
| - NSFs targets/actions (Long Term Conditions, Older People, CHD, Renal, Diabetes) | | | | | Need to define a) what this is. B) is Cambridgeshire PCT delivering them. |
| Digital retinopathy screening for people with diabetes. 100% of people over 12 years of age with diabetes to be offered digital screening by December 2007. 80% of those to received screening by March 2008 | Q2 2007-08 | 80% | 97.8% | 100% received by Dec 07 80% received by Mar 08 | Recording not compliant yet with national guidelines. Will be by end 08-09. |
| Structured education for people with diabetes (NICE HTS No.60 Guidance on the use of Patient Education Models for Diabetes required this to be in place from January 2006 | | | | | Need to define a) what this is. B) is Cambridgeshire PCT delivering them. |
| First attendance: follow up ratios - EoE position in relation to England | | | | | Not applicable until third quarter of 2007-08. |
| Ambulatory Emergency Care planning - see Directory of Ambulatory Emergency Care for Adults, NHS Institute for Innovation and Improvement, ?month 2007 | | | | | Need to define a) what this is. B) is Cambridgeshire PCT delivering them. |
| Key Social Care Targets | Period covered by actual data | Plan/target | Actual | Annual Plan 2007-08 | Comments |
| PAF C29 Adults with physical disabilities aged 18-64 helped to live at home per 1000 people aged 18-64 | provisional 31st Aug 2007 | as annual plan | 2.5 | 3.3 | |
| PAF C73 Admissions of adults aged 18-64 to residential / nursing care per 10,000 population | provisional 31st Aug 2008 | as annual plan | 1.1 | 1.2 | Section 31 joint target with PCT |
| PAF C32 Older People Helped to Live at Home per 1,000 population aged 65 and over | provisional 31st Aug 2009 | as annual plan | 52.4 | 65 | Section 31 joint target with PCT |

Source: Cambridgeshire County Council, LDPR returns, Health Commission Annual Health Check
For further information contact alex.innes@cambridgeshirepct.nhs.uk

5 FINANCIAL MANAGEMENT AND VALUE FOR MONEY



5.1 Programme Budgeting Categories

| Programme Budgeting Category | | Total expenditure for unified weighted population in Cambridgeshire PCT, 2006/07 |
|------------------------------|---|--|
| 1 | Infectious Diseases | 7,623,007 |
| 1a | HIV and AIDS | 236,000 |
| 1x | Infectious diseases (Other) | 7,387,006 |
| 2 | Cancers and Tumours | 40,908,036 |
| 2a | Cancer, Head and Neck | 663,001 |
| 2b | Cancer, Upper GI | 1,298,001 |
| 2c | Cancer, Lower GI | 2,590,002 |
| 2d | Cancer, Lung | 1,432,001 |
| 2e | Cancer, Skin | 1,022,001 |
| 2f | Cancer, Breast | 4,319,004 |
| 2g | Cancer, Gynaecological | 811,001 |
| 2h | Cancer, Urological | 4,030,004 |
| 2i | Cancer, Haematological | 2,854,003 |
| 2x | Cancers and Tumours (Other) | 21,889,019 |
| 3 | Disorders of Blood | 10,279,009 |
| 4 | Endocrine, Nutritional and Metabolic | 27,178,024 |
| 4a | Diabetes | 12,317,011 |
| 4b | Endocrine, Nutritional and Metabolic problems | 8,031,007 |
| 4x | Other Endocrine, Nutritional and Metabolic | 6,830,006 |
| 5 | Mental Health Disorders | 81,127,071 |
| 5a | Substance Misuse | 8,461,007 |
| 5b | Organic Mental Disorders | 9,046,008 |
| 5c | Psychotic Disorders | 27,726,024 |
| 5d | Child and Adolescent Mental Health Disorders | 6,227,005 |
| 5x | Other Mental Health Disorders | 29,667,026 |
| 6 | Problems of Learning Disability | 17,167,015 |
| 7 | Neurological | 32,118,028 |
| 7a | Chronic Pain | 7,359,006 |
| 7x | Neurological (Other) | 24,759,022 |
| 8 | Problems of Vision | 16,161,014 |

| | | |
|-----------|--|--------------------|
| 9 | Problems of Hearing | 3,423,003 |
| 10 | Problems of Circulation | 48,704,043 |
| 10a | Coronary Heart Disease | 16,074,014 |
| 10b | Cerebrovascular disease | 4,535,004 |
| 10c | Problems of Rhythm | 2,958,003 |
| 10x | Problems of circulation (Other) | 25,137,022 |
| 11 | Problems of the Respiratory System | 34,402,030 |
| 11a | Obstructive Airways Disease | 4,542,004 |
| 11b | Asthma | 9,079,008 |
| 11x | Problems of the respiratory system (Other) | 20,781,018 |
| 12 | Dental Problems | 26,098,023 |
| 13 | Problems of Gastro Intestinal System | 35,558,031 |
| 13a | Upper GI | 7,894,007 |
| 13b | Lower GI | 9,381,008 |
| 13c | Hepatobiliary | 5,798,005 |
| 13x | Problems of the gastro intestinal system | 12,485,011 |
| 14 | Problems of the Skin | 18,440,016 |
| 14a | Burns | 206,000 |
| 14x | Problems of the Skin | 18,234,016 |
| 15 | Problems of Musculo Skeletal System | 34,780,030 |
| 16 | Problems due to Trauma and Injuries | 18,775,016 |
| 17 | Problems of Genito Urinary System | 36,111,032 |
| 17a | Genital tract problems | 8,007,007 |
| 17b | Renal problems | 11,513,010 |
| 17c | STD | 3,526,003 |
| 17x | Problems of Genito Urinary system (Other) | 13,065,011 |
| 18 | Maternity and Reproductive Health | 26,242,023 |
| 19 | Conditions of Neonates | 8,845,008 |
| 20 | Adverse effects and poisoning | 7,879,007 |
| 20a | Unintended consequences of treatment | 4,982,004 |
| 20b | Poisoning | 1,019,001 |
| 20c | Violence | 308,000 |
| 20x | Poisoning and adverse effects | 1,570,001 |
| 21 | Healthy Individuals | 62,358,055 |
| 21a | NSF Prevention programme | 164,000 |
| 21b | NSF Mental health prevention | 1,000 |
| 21x | Healthy Individuals (Other) | 62,193,055 |
| 22 | Social Care Needs | 7,906,007 |
| 23 | Other | 95,247,083 |
| 23a | General Medical Services/ Personal Medical Services | 85,307,075 |
| 23b | Training (Workforce Development Confederation) | 0 |
| 23x | Miscellaneous | 9,940,009 |
| | Total – all 23 PBC | 697,329,611 |

5.2 Programme Budgeting Summary

Table 5: Cambridgeshire PCT programme budgeting summary expenditure 2006/07

| Programme Budgeting Category | | £ per 100,000 unified weighted population, 2006/07 | | | |
|------------------------------|--------------------------------------|--|--------------------|--------------------|--------------------|
| | | Cambridge-shire PCT | Cluster Average | EoE SHA | National Average |
| 1 | Infectious Diseases | 1,525,877 | 1,824,737 | 1,866,006 | 2,087,614 |
| 2 | Cancers and Tumours | 8,188,453 | 8,874,235 | 7,794,223 | 8,166,992 |
| 3 | Disorders of Blood | 2,057,522 | 1,811,209 | 1,714,675 | 1,658,256 |
| 4 | Endocrine, Nutritional and Metabolic | 5,440,153 | 4,087,719 | 3,844,890 | 3,670,290 |
| 5 | Mental Health Disorders | 16,238,990 | 15,027,514 | 16,345,626 | 16,652,741 |
| 6 | Problems of Learning Disability | 3,436,276 | 6,323,010 | 5,641,242 | 4,835,786 |
| 7 | Neurological | 6,428,980 | 5,819,651 | 5,417,367 | 5,527,203 |
| 8 | Problems of Vision | 3,234,907 | 2,815,378 | 2,850,319 | 2,697,436 |
| 9 | Problems of Hearing | 685,173 | 583,396 | 546,472 | 621,276 |
| 10 | Problems of Circulation | 9,748,959 | 11,635,038 | 11,354,562 | 12,205,833 |
| 11 | Problems of the Respiratory System | 6,886,163 | 5,987,911 | 5,888,484 | 6,507,457 |
| 12 | Dental Problems | 5,223,972 | 4,919,879 | 5,428,537 | 5,193,296 |
| 13 | Problems of Gastro Intestinal System | 7,117,557 | 7,010,386 | 6,906,383 | 7,330,113 |
| 14 | Problems of the Skin | 3,691,089 | 3,001,185 | 2,989,763 | 2,830,763 |
| 15 | Problems of Musculo Skeletal System | 6,961,826 | 7,191,635 | 5,877,431 | 6,617,053 |
| 16 | Problems due to Trauma and Injuries | 3,758,145 | 5,930,468 | 5,222,987 | 5,728,701 |
| 17 | Problems of Genito Urinary System | 7,228,249 | 7,162,325 | 6,388,533 | 6,898,144 |
| 18 | Maternity and Reproductive Health | 5,252,796 | 5,844,108 | 6,147,031 | 5,764,154 |
| 19 | Conditions of Neonates | 1,770,482 | 1,500,543 | 1,207,432 | 1,317,178 |
| 20 | Adverse effects and poisoning | 1,577,120 | 1,545,145 | 1,428,766 | 1,459,199 |
| 21 | Healthy Individuals | 12,482,046 | 3,325,182 | 3,717,566 | 2,684,936 |
| 22 | Social Care Needs | 1,582,524 | 2,917,275 | 2,682,583 | 3,028,804 |
| 23 | Other | 19,065,355 | 21,445,854 | 21,014,501 | 20,969,582 |
| | Total | 139,582,613 | 136,583,786 | 132,275,377 | 134,452,805 |

Shaded areas represent where Cambridgeshire PCT spend is higher than both the cluster average and the national average. The PCT is working with these areas for efficiency savings. Programme area 21 on Healthy Individuals is inflated due to costs of ex regional units which the PCT hosts

6 SUMMARY TARGETS

6.1 Generic Patient Pathways

The PCT has access to pathways from various sites including the Department of Health 18 week wait website (www.18weeks.nhs.uk) and the pathways which are being produced in the East of England as part of the Darzi review.

6.2 Specific Patient Pathways

6.2.1 Chronic Obstructive Pulmonary Disease (COPD)

Programme purpose

To reduce the avoidable burden of respiratory problems in Cambridgeshire by a combination of prevention, early detection, rapid access to treatment, enhanced quality and length of life, and a well-managed terminal phase and death at the place of the patient's choosing that specifically includes:

- Reducing the prevalence of smoking.
- Comprehensive TB services and New Entrant Screening services.
- Reduce premature mortality from respiratory diseases (eg under age of 75 years).
- Promote pulmonary rehabilitation – restoration of maximum lung function and activities of daily living following bouts of respiratory illness.
- Support for carers.

Table 6: Quality and Outcomes for Chronic Obstructive Pulmonary Disease (COPD)

| | Disease Register COPD 2006/07 | Unadjusted Recorded Prevalence (95% CI) | Range in GP Practices |
|-------------------------------|-------------------------------|---|-----------------------|
| East Cambridgeshire & Fenland | 2,854 | 1.6% (1.6 - 1.7%) | 0.9 - 2.6% |
| Greater Cambridge | 2,406 | 0.9% (0.9 - 1.0%) | 0.2 - 1.7% |
| Huntingdonshire | 1,947 | 1.3% (1.2 - 1.3%) | 0.5 - 1.9% |
| Cambridgeshire PCT | 7,207 | 1.2% (1.2 - 1.3%) | 0.2 - 2.6% |

Quality and Outcomes Framework (QoF) is the system by which achievement against clinical and other outcome indicators for the new General Medical Services contract (nGMS) is measured. Since 2005, data have been published at GP practice level for a number of clinical, organisational, patient experience and additional service domains.

The data shown here are 'recorded prevalence' data at PCT area. The prevalence counts are unadjusted for age or sex (crude or raw prevalence) and are based on the counts of people (at all ages) forming the disease registers and on GP practice list sizes. There is no other demographic breakdown within QoF data as published.

It is generally recognised that these data are not yet of sufficient accuracy or completeness in many areas to be measuring actual prevalence of these conditions. Hence this is described in the tables as 'Recorded Prevalence'.

Programme Budgeting Atlas

Outcome data available for COPD includes:

- Quality and Outcomes Framework indicators including prevalence of COPD (with and without spirometry confirmation), FEV1 measurement checks, inhaler technique checks, smoking cessation advice and influenza vaccination in patients with COPD.
- Mortality from bronchitis and emphysema (the two diseases which cause COPD).

Outcome data related to hospital admissions is available for all respiratory diseases.

NCHOD key outcomes

- The programme expenditure for respiratory problems was greater in 2005/6 than the national average (£6.9M per 100,000 UWP) in Huntingdonshire (£10.2M per 100,000 UWP), South Cambridgeshire (£9.4M per 100,000 UWP), Cambridge City (£8M per 100,000 UWP) and East Cambridgeshire and Fenland (£7.4M per 100,000 UWP).
- All the localities in Cambridgeshire had a FHS prescription expenditure rate per UWP higher than the national average in 2005/6.
- The QOF prevalence of COPD in 2005/6 was measured to be significantly higher in East Cambridgeshire and Fenland (1.6%) than the national average (1.4%), in all other areas it was significantly below the national average. All localities had a proportion of those with a diagnosis confirmed by spirometry which was significantly greater than the national average.
- The percentage of smokers receiving smoking cessation advice was significantly higher than the national average in South Cambridgeshire and Cambridge City in 2005/6.
- The SMR from bronchitis and emphysema in 2002-2004 was not significantly different from the national average in all localities.
- Hospital admissions data are available for 2005/6 only at the level of "respiratory system admissions", the rate for "all admissions" was higher for Huntingdonshire than the national average, but the rate for "non-elective admissions" was not higher. Measures of significance were not available on these data.
- Cambridge City had a significantly higher "non-elective bed days rate" for respiratory conditions than the national average in 2005/6, but it is not possible to attribute this specifically to COPD.

The Health Foundation Co-creating Health Initiative Nov 2007 – June 2010

The aim is to improve outcomes for people living with long term conditions through self management support. This is a £5m initiative funded by The Health Foundation (THF). It brings together four organisations, which form the National CCH Support Team (NST) to deliver and evaluate the initiative. The initiative draws on the chronic care model developed by Professor Wagner and his colleagues in Seattle, USA. There are three dimensions to the project: the self management programme for patients, advanced development programmes for clinicians, and service improvement programme. Cambridgeshire PCT and Cambridge University Hospitals NHS Foundation Trust are the national lead for improving outcomes for patients with COPD. They are paired with North Ayrshire, South Ayrshire and East Ayrshire Community Health Partnerships and Ayrshire and Arran NHS Board. The project works with local teams to co-design and implement optimal health systems (for agenda setting, goal setting and follow up, which support people with long term conditions to self manage. There are three key enablers. The patient and clinicians agree the aims of each. The clinician supports the patient in choosing small and achievable goals. These do not necessarily need to be clinical. This becomes a core part of the patient – clinical interactions, fully supported by system support. Proactive follow up occurs fairly soon after the goal has been agreed, in order to provide encouragement and support.

East of England Pathway.

A pathway is being developed as part of the Darzi review in the East of England.

Summary of commissioning interventions for respiratory system problems
Commissioning contact Vinny Logan

Prevention

- Self care, learn from Co-creating Health.
- Smoking cessation for patients and their families, with special emphasis on pregnant mothers and patients awaiting routine surgery.
- Improvement of indoor and outdoor (and occupational) air quality.
- Promotion of physical activity at all ages.
- Provision of BCG vaccine for children and newborns at higher risk of TB, in accordance with national policy.
- Robust “new entrant” screening programme for TB.

Diagnosis and Assessment

- Diagnosis of COPD in line with NICE Guidance: Clinical Guideline 12.
- TB contact tracing and assessment services in accordance with NICE and the TB Commissioning Toolkit 2007.
- Regular lung function testing in primary care for patients with COPD.

Treatment

- Ensure provision of TB treatment services in accordance with NICE and the TB Commissioning Toolkit 2007.
- Dissemination, implementation and monitoring of NICE guidance.

Rehabilitation and Continuing Care

- Promote pulmonary rehabilitation and explore partnerships outside the NHS, eg leisure centres.
- Support for carers.

Palliative Care

- For end-stage respiratory disease support informed planning for terminal illness, respecting patient choice for place of death whenever possible.

NICE GUIDANCE

| Published Guidance Publication date | Type of guidance | Topic |
|--|-----------------------------|--|
| March 2006 | Clinical guideline | Tuberculosis |
| March 2006 | Public health interventions | Brief interventions and referral for smoking cessation |
| April 2007 | Public health interventions | Workplace interventions to promote smoking cessation |
| July 2007 | Technology appraisal | Smoking cessation - varenicline |
| November 2007 | Single technology appraisal | Asthma (uncontrolled) - omalizumab |
| November 2007 | Technology appraisal | Asthma (in children) - corticosteroids |
| February 2008 | Public health programmes | Smoking cessation services |
| March 2008 | Technology appraisal | Asthma (in adults) - corticosteroids |
| March 2008 | Technology appraisal | Sleep apnoea - continuous positive airways pressure (CPAP) |

| In Progress Guidance Publication date | Type of guidance | Topic |
|--|--------------------------|--|
| July 2008 | Short Clinical guideline | Respiratory tract infection in Primary Care |
| August 2008 | NPSA pilot | Prevention of ventilator-associated pneumonia (VAP) |
| October 2008 | Technology appraisal | Influenza (prophylaxis) amantadine, oseltamivir (and inclusion of zanamivir) |
| February 2009 | Technology appraisal | Influenza – zanamir, amantadine and oseltamivir (review) |

6.2.2 Diabetes

There are many published studies on the incidence and prevalence of diabetes in various parts of the UK. Most studies involve Caucasian populations and the results are not applicable to non-Caucasian populations. It is known that the prevalence of diabetes is higher in people of South Asian and Afro-Caribbean origin. When estimating local incidence or prevalence it is preferable, rather than extrapolating findings from elsewhere to use data from local studies if these are available. The incidence of type II diabetes is difficult to determine given the latency of the condition. The overall prevalence of clinically diagnosed diabetes in all ages in the UK is between 2 and 3%. For the population of Cambridgeshire this would mean an estimate of between 11,900 and 17,900 people having clinically diagnosed diabetes. The total number of people on the QoF register for diabetes in 2006/07 in Cambridgeshire GP practices is 19,579.

Intensive management of diabetes in primary care, patient education, primary care support and practice development proposal

Discussion at the Southern Cambridgeshire Managed Care Network for diabetes has highlighted that locally the specialist services are keen to discharge patients with type II diabetes mellitus to primary care, and practices are keen for such discharge, but both sides find that many patients are not currently ready for discharge. Effective strategies for appropriate relocation of care at primary care are warranted.

While many patients may need to continue in secondary care, it is felt that with community diabetes specialist nurse support where necessary, it would be possible to develop agreed management plans resulting in discharge from the specialist clinic, with a follow up appointment only created if (agreed) targets are not met.

There are several models for providing continued appropriate enhanced care in the primary care setting, and the PCT wants to work with Practice Based Commissioners to develop and appraise the different models.

There is for example a draft Local Enhanced Service – ‘Diabetes care for adults’ which has been crafted by CATCH and has been forwarded for development with the PCT commissioning and public health directorates. Likewise there is a resume of the Steno 2 follow up model produced as a discussion paper by the diabetes network. Different localities may choose different solutions according to the needs of the local population and the pattern of services in place.

The purpose of this bid is to use the pledge allocation for long term conditions to define and then to “pump prime” a Local Enhanced Service for diabetes. Additional funding may come from Practice Based Commissioning Savings.

Neighbouring groups of Practice Based Commissioners are keen to learn from the South Cambridgeshire experience and also to make savings from admission avoidance.

Public health are supportive of the project. Metanalyses of studies comparing primary and secondary care for type II diabetes has suggested that when general practice is supported by hospital diabetes specialist services, comparable outcomes can be achieved. In addition the proposal includes the PCT allowing PRIMIS facilitators to work with a Diabetes Clinical Information Group to develop linkage of diabetes information systems, for performance management and evaluation.

It will also be important to continue to improve the availability of NICE approved Structured Education for all type II patients across Cambridgeshire.

As part of the Joint Strategic Needs Assessment, the PCT will carry out a comprehensive needs assessment of the diabetes population, including the use of predictive public health analysis to identify poorly represented groupings.

Much of the costs are on prescribing. Medicines management will work on diabetes as a project using PCT data and evaluations to bring spending back to benchmark.

A draft Local Enhanced Service has been crafted by CATCH along with initial analyses partly using the diabetes commissioning toolkit. A PCT working group will scope the interface between primary and secondary care to ensure repatriation of patients for care in the most appropriate setting, by the most appropriate professionals, in the most appropriate place.

The diabetes information management will be improved using project management skills and involving the NPfIT team with a steering group. The diabetes network will expand to allow representation and contributions from neighbouring Huntingdonshire and East Cambridgeshire and Fenland. The findings will report to the PCT Clinical Services Redesign Board. The needs assessment will include adequate support for primary care, in terms of patient education, and the areas for improvements listed in the draft CATCH Local Enhanced Service. The savings will be monitored by the finance division of the Primary Care Trust.

Stage 1

Services are to be commissioned in line with the new NICE guidance on diabetes in preparation.

Develop and implement with CATCH and the diabetes network a review framework which identifies the level of provision, governance, number of attendances, number of trained staff, annual costs, future resource and training needs, etc.

Develop and implement a review to compare needs and services across all localities in Cambridgeshire which identifies gaps and inequalities. This would include a visit to the 43 practices in South Cambridgeshire and City initially and then roll out across the county facilitated by CATCH.

Build on the programme budgeting data to monitor costs and outcomes in all localities and practices.

Stage 2

Develop the Local Enhanced Service to ensure that practices are supported in accordance with local population needs and settings eg rural v urban, disabled v fit. Include the views of the diabetic patients and their families on each locality in the roll out of the enhanced services.

Ensure patients' choice so that local primary enhanced care services are available.

Ensure that practices have each considered the different models eg such as Bolton where the integrated approach to diabetes care between primary and secondary care involves secondary and community care service supporting practices in a structured outreach, or the model of virtual clinics, or for the majority (approximately 80%) care in the primary care setting.

Stage 3

Initially part of the pump prime would be in supporting employees to conduct the baseline and plan the practice involvement. Then when the support and funding for primary care was agreed, this would convert into the Local Enhanced Service, with a review of the support roles required by the Practice Based Commissioners.

Programme budgeting data for 2006/7 shows that spend against diabetes by Cambridgeshire Primary Care Trust is £12,317,011. This makes Cambridgeshire PCT the sixth highest expenditure on diabetes out of 152 PCTs in England. Spend per £100,000 weighted population in Cambridgeshire is £2,465,463 against a cluster average (for similar PCTs) of £1,869,412. Spend is also higher than the East of England average of £1,856,446 and the national average of £1,776,319.

However there is room for improvement in population measures such as glycosylated haemoglobin. For example the QMAS data shows that only 63% of patients having a glycosylated haemoglobin of equal to or less than 7.5.

Programme Budgeting Atlas

Outcome data available for diabetes includes:

- Quality and Outcomes Framework indicators including prevalence of diabetes, retinal screening, neuropathy testing.
- Mortality from diabetes.
- Hospitalisation for diabetes (all admissions, day cases, elective and non-elective).
- Bed days for diabetes (all admissions, elective and non-elective care).
- Spell length of stay for diabetes (admissions excluding day cases, elective excluding day cases and non-elective).
- Death within 30 days of admission.
- Emergency readmission to hospital within 28 days of discharge.
- Hospital procedures: lower limb amputations in diabetic patients.
- Emergency hospital admission: diabetic ketoacidosis coma.

Over half of the allocated expenditure is from primary care prescribing (55%).

A LES is for one year, and the initial preparatory work will be done in the first year.

Programme objectives

To reduce the avoidable burden of diabetes in Cambridgeshire by a combination of prevention, early detection, rapid access to treatment, enhanced quality and length of life. This includes:

- Continuing patient and professional education to encourage confidence and competence in self care and in conditions like diabetes.
- In primary care achieving a year-on-year reduction in the average HbA1c for Cambridgeshire (a summary measure of blood glucose control).
- Establish and then reduce the prevalence of childhood obesity as measured at school entry and at periods thereafter.
- Roll-out of Adult Weight Management (Obesity) Programmes, in line with Obesity Commissioning priorities
- Prevention or postponement of complications of diabetes, including heart attack, leg amputation, visual impairment and renal failure.

NCHOD key outcomes

- The programme expenditure for the endocrine system was greater in 2005/6 than the National average (£3.7M per 100,000 UWP) in South Cambridgeshire (£7.3M per 100,000 UWP) and Cambridge City (£5.9M per 100,000 UWP).
- East Cambridgeshire and Fenland, and South Cambridgeshire had a higher FHS prescription expenditure rate per UWP for diabetes than the national average in 2005/6.

- The QOF prevalence of diabetes in 2005/6 was measured to be significantly higher in East Cambridgeshire and Fenland (4.3%) than the national average (3.6%), in the rest of Cambridgeshire it was significantly lower.
- QOF data from 2005/6 showed that a significantly smaller proportion of patients in East Cambridgeshire and Fenland, and South Cambridgeshire had controlled blood glucose levels, with significantly fewer having HbA1C levels ≤ 10 .
- QOF data from 2005/6 showed that South Cambridgeshire had significantly fewer patients receiving retinal screening than the national average; the proportion was higher than the national average in East Cambridgeshire and Fenland and Huntingdonshire.
- QOF data from 2005/6 showed that the proportion of patients with blood pressure $\leq 145/85$ was significantly smaller than the national average in South Cambridgeshire, East Cambridgeshire and Fenland scored significantly higher on this outcome than the national average.
- The SMR for diabetes was significantly high, compared with the national average, in East Cambridgeshire and Fenland and Cambridge City, and significantly low in South Cambridgeshire and Huntingdonshire in 2002-2004.
- The all-admissions rate for diabetes in 2005/6 was higher than the national average in East Cambridgeshire and Fenland; in 2003/4 East Cambridgeshire and Fenland also had a significantly higher than average admission rate for diabetic ketoacidosis and coma, but in 2005/6 the non-elective admission rate for diabetes was not significantly different from the national average in East Cambs and Fenland.
- East Cambridgeshire and Fenland had a significantly higher rate of lower limb amputations than the national average in 2003/4.

Summary of commissioning interventions for endocrine, nutritional and metabolic problems

Commissioning contact Dennis Cox

Prevention

- Self care.
- Smoking cessation – patients and their families.
- Weight management, including increase in physical activity levels and healthy eating – patients and their families – in line with Cambs Obesity Strategy
- Secondary prevention of complications of diabetes – in particular in screening for diabetic retinopathy (eye damage) where our screening methods do not meet new accepted standards. It may be possible to redeploy some of the annual investment in blood glucose testing strips to help meet the cost of retinopathy screening.

Diagnosis and Assessment

- Maintain vigilance in primary care to the possibility of diabetes, especially type II.
- Be alert to possibility of hypothyroidism in older patients.

Treatment

- Attention to the dissemination and implementation of NICE guidance.
- In primary care settings promote self-confidence and competence in self-management of diabetes where appropriate, or help their carers with the same.
- In hospital settings look at management of diabetes in other clinical situations, egsurgery, renal disease, cardiology and obstetrics, perhaps through greater use of diabetes liaison.
- Smoking cessation and weight management integrated into care pathway.

Rehabilitation and Continuing Care

- Involve community pharmacies to a greater extent in checking blood glucose, measuring blood pressure and advising on chronic disease management.
- Aim for minimum disruption of daily living compatible with adequate control.
- Full implementation of screening checks eg retinopathy screening as above.

Palliative Care

- For end-stage infections disease, support informed planning for terminal illness, respecting patient choice for place of death whenever possible.

NICE GUIDANCE

| Published Guidance Publication date | Type of guidance | Topic |
|--|--------------------------------|--|
| February 2006 | Clinical guideline | Nutrition support in adults |
| September 2006 | Clinical guideline | Anaemia management in chronic kidney disease |
| December 2006 | Clinical guideline | Obesity |
| December 2006 | Technology appraisal | Diabetes (type 1 and 2) - inhaled insulin |
| January 2007 | Technology appraisal | Diabetes (type 1 and 2) - inhaled insulin |
| January 2007 | Technology appraisal | Hyperparathyroidism - cinacalcet HCl |
| July 2007 | Short clinical guideline | Acutely ill patients in hospital |
| October 2007 | Public health programmes | Behaviour change |
| December 2007 | Patient safety solutions pilot | Technical patient safety solutions for medicines reconciliation on admission of adults to hospital |
| March 2008 | Clinical guideline | Diabetes in pregnancy |
| March 2008 | Public health programme | Maternal and child nutrition |
| April 2008 | Clinical guideline | Perioperative hypothermia (inadvertent) |
| May 2008 | Clinical guideline | Diabetes - Type 2 (Update) |

| In Progress Guidance Publication date | Type of guidance | Topic |
|--|-----------------------------|---|
| May 2008 | Technology appraisal | Diabetes - insulin pump therapy |
| June 2008 | Single Technology Appraisal | Rimonabant for the treatment of overweight and obese patients |
| December 2008 | Technology appraisal | Growth failure (in children) - human growth hormone (HGH) |
| January 2009 | Clinical guideline | Medicines concordance |
| February 2009 | Clinical guideline | Diabetes (type 2) – newer agents |
| January 2010 | Public health interventions | Prevention of excessive weight gain in pregnancy |
| July 2010 | Public health interventions | Effective weight maintenance following childbirth |
| TBC | Single Technology Appraisal | Diabetic retinopathy - ruboxistaurin |

6.2.3 Vulnerable Older People

Cambridgeshire's changing population

The Cambridgeshire population is both growing and ageing. Between 2006 and 2011 the Cambridgeshire population is expected to grow from 579,000 to 622,700, an increase of 43,700 people. The greatest proportional increase will be in those aged over 75, with an increase of 4200 people (from 42,200 to 46,200). Of these 2,600 will be in the age group 75-84 and 1,400 in the age group 85+. People aged 85 and over – often need higher levels of support.

However by the year 2016 the population aged 75 – 84 will increase by 24% and the population aged 75 – 84 will increase by 54%, and the population aged 85 and over will increase by 57%.

Figure 2: Population projections – people over 65 Years

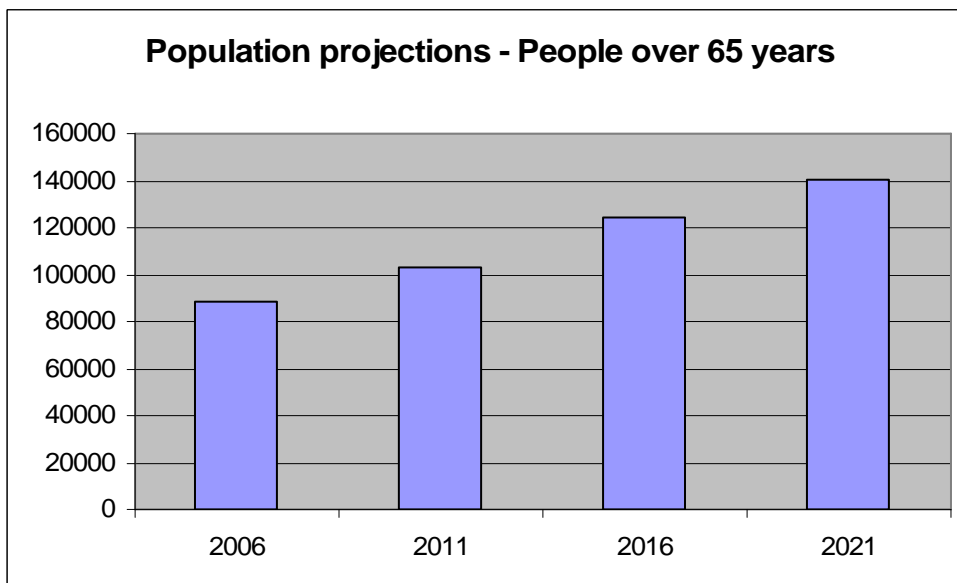
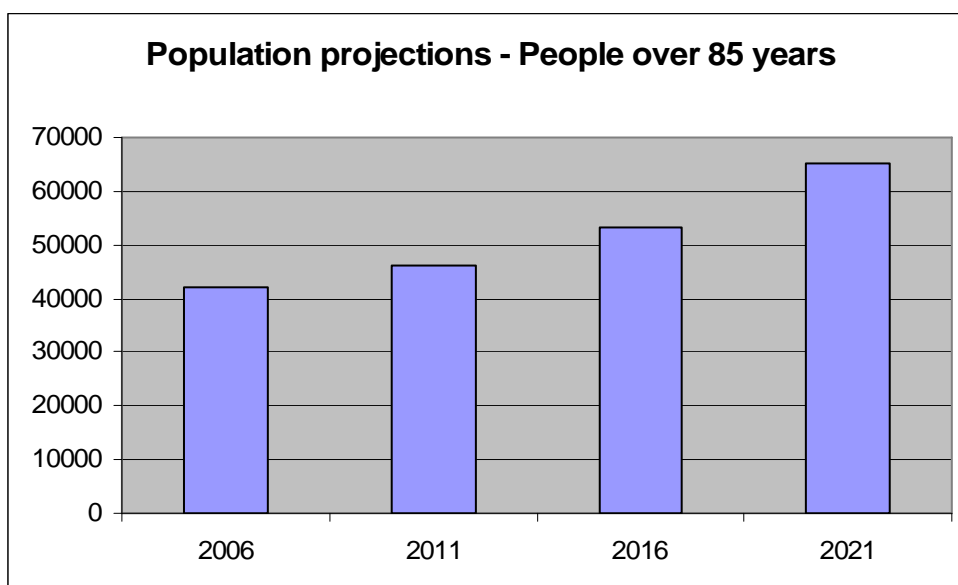


Figure 3: Population projections - People over 85 Years



With increasing life expectancy, more people (particularly men) are living to an age where they are more likely to be physically frail or confused. There are about 13,900 frail people aged over 65 in Cambridgeshire. About 8,620 are physically frail, about 2,500 are mentally frail and 2,700 have combined mental and physical frailty.

Between 2006 and 2011, the numbers of elderly frail people is predicted to rise from 2,370 to 2,500 in Cambridge City, increase from 1,960 to 2,200 in East Cambridgeshire, from 2,650 to 2,930 in Fenland, from 3,470 to 4,020 in Huntingdonshire and from 3,450 to 4,000 in South Cambridgeshire.

By 2011 the estimated increase in Cambridgeshire is to 15,700, by 2016 to 18,600 and by 2021 to 21,500.

Those with combined mental and physical frailty are likely to be heavy users of services, and to be more difficult to place. This group of people aged over 65 is likely to increase from 2,570 in 2006, to 2,880 in 2011, and 3,390 in 2016.

Figure 4: Projection of the elderly frail population in Cambridgeshire:

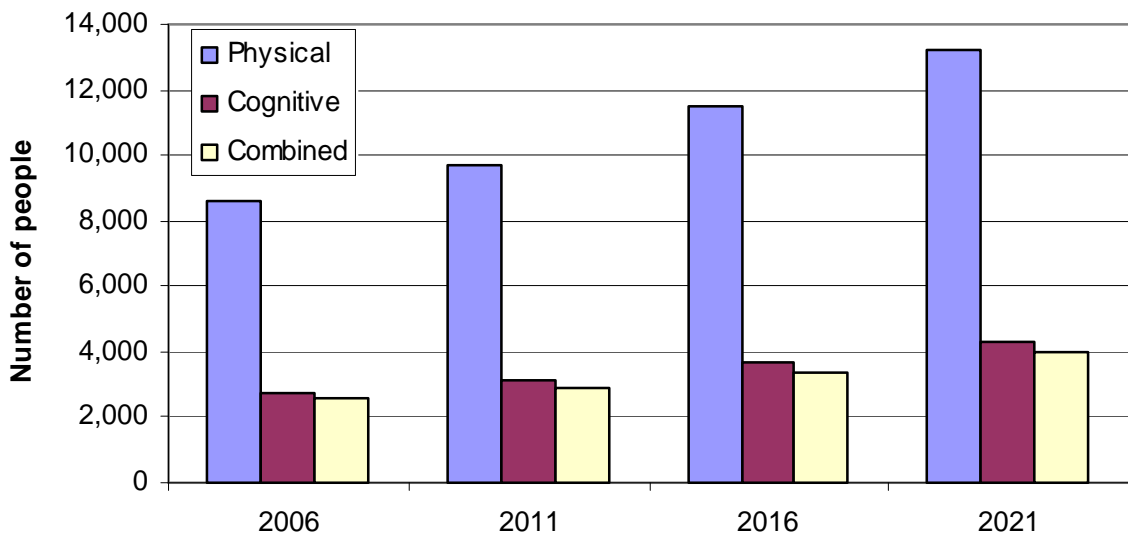


Table 7: Projection of the elderly frail population by Local Authority

| Cambridge City | | | | | | |
|----------------|-------|-------|-------|-------|-------|----------|
| | Age | 2006 | 2011 | 2016 | 2021 | % change |
| Physical | 65-74 | 290 | 360 | 450 | 500 | 72% |
| | 75-84 | 590 | 580 | 610 | 710 | 20% |
| | 85+ | 580 | 610 | 630 | 660 | 14% |
| | Total | 1,470 | 1,550 | 1,690 | 1,870 | 27% |
| Cognitive | 65-74 | 100 | 120 | 150 | 170 | 70% |
| | 75-84 | 180 | 180 | 190 | 230 | 28% |
| | 85+ | 180 | 190 | 190 | 200 | 11% |
| | Total | 450 | 480 | 530 | 590 | 31% |
| Combined | 65-74 | 40 | 50 | 60 | 70 | 75% |
| | 75-84 | 140 | 140 | 150 | 180 | 29% |
| | 85+ | 270 | 280 | 290 | 300 | 11% |
| | Total | 450 | 470 | 510 | 560 | 24% |
| All disabled | Total | 2,370 | 2,500 | 2,730 | 3,020 | 27% |

| East Cambridgeshire | | | | | | |
|---------------------|-------|-------|-------|-------|-------|----------|
| | Age | 2006 | 2011 | 2016 | 2021 | % change |
| Physical | 65-74 | 290 | 340 | 410 | 440 | 52% |
| | 75-84 | 520 | 560 | 640 | 750 | 44% |
| | 85+ | 400 | 470 | 540 | 630 | 58% |
| | Total | 1,210 | 1,370 | 1,590 | 1,830 | 51% |
| Cognitive | 65-74 | 100 | 110 | 140 | 150 | 50% |
| | 75-84 | 160 | 180 | 210 | 240 | 50% |
| | 85+ | 130 | 150 | 180 | 210 | 62% |
| | Total | 390 | 440 | 520 | 600 | 54% |
| Combined | 65-74 | 40 | 50 | 60 | 60 | 50% |
| | 75-84 | 130 | 140 | 160 | 190 | 46% |
| | 85+ | 190 | 220 | 260 | 310 | 63% |
| | Total | 360 | 410 | 480 | 560 | 56% |
| All disabled | Total | 1,960 | 2,220 | 2,590 | 2,990 | 53% |

Fenland

| | Age | 2006 | 2011 | 2016 | 2021 | % change |
|--------------|-------|-------|-------|-------|-------|----------|
| Physical | 65-74 | 400 | 440 | 530 | 590 | 48% |
| | 75-84 | 730 | 770 | 770 | 850 | 16% |
| | 85+ | 510 | 610 | 800 | 900 | 76% |
| | Total | 1,650 | 1,810 | 2,110 | 2,350 | 42% |
| Cognitive | 65-74 | 130 | 140 | 180 | 200 | 54% |
| | 75-84 | 230 | 240 | 240 | 270 | 17% |
| | 85+ | 160 | 190 | 260 | 290 | 81% |
| | Total | 520 | 580 | 680 | 760 | 46% |
| Combined | 65-74 | 60 | 60 | 80 | 80 | 33% |
| | 75-84 | 180 | 190 | 190 | 220 | 22% |
| | 85+ | 240 | 290 | 380 | 430 | 79% |
| | Total | 480 | 540 | 650 | 730 | 52% |
| All disabled | Total | 2,650 | 2,930 | 3,440 | 3,840 | 45% |

Huntingdonshire

| | Age | 2006 | 2011 | 2016 | 2021 | % change |
|--------------|-------|-------|-------|-------|-------|----------|
| Physical | 65-74 | 550 | 700 | 850 | 860 | 56% |
| | 75-84 | 870 | 960 | 1,170 | 1,440 | 66% |
| | 85+ | 740 | 850 | 970 | 1,160 | 57% |
| | Total | 2,170 | 2,510 | 3,000 | 3,460 | 59% |
| Cognitive | 65-74 | 180 | 230 | 280 | 280 | 56% |
| | 75-84 | 260 | 290 | 360 | 460 | 77% |
| | 85+ | 230 | 260 | 300 | 360 | 57% |
| | Total | 670 | 780 | 940 | 1,100 | 64% |
| Combined | 65-74 | 80 | 100 | 120 | 120 | 50% |
| | 75-84 | 210 | 240 | 290 | 360 | 71% |
| | 85+ | 340 | 390 | 450 | 540 | 59% |
| | Total | 630 | 730 | 860 | 1,030 | 63% |
| All disabled | Total | 3,470 | 4,020 | 4,800 | 5,590 | 61% |

South Cambridgeshire

| | Age | 2006 | 2011 | 2016 | 2021 | % change |
|--------------|-------|-------|-------|-------|-------|----------|
| Physical | 65-74 | 490 | 680 | 880 | 950 | 94% |
| | 75-84 | 860 | 980 | 1,190 | 1,560 | 81% |
| | 85+ | 780 | 830 | 1,010 | 1,240 | 59% |
| | Total | 2,130 | 2,480 | 3,080 | 3,740 | 76% |
| Cognitive | 65-74 | 160 | 220 | 290 | 310 | 94% |
| | 75-84 | 270 | 310 | 370 | 500 | 85% |
| | 85+ | 240 | 260 | 320 | 390 | 63% |
| | Total | 670 | 790 | 980 | 1,200 | 79% |
| Combined | 65-74 | 70 | 100 | 130 | 130 | 86% |
| | 75-84 | 210 | 240 | 290 | 390 | 86% |
| | 85+ | 360 | 390 | 480 | 590 | 64% |
| | Total | 650 | 730 | 900 | 1,110 | 71% |
| All disabled | Total | 3,450 | 4,000 | 4,960 | 6,050 | 75% |

Dementia

Much is being done to raise the awareness of mental issues relevant to older people such as depression and dementia. Prevalence estimates suggest that, in 2006, there were around 6,580 older people with dementia in Cambridgeshire. By 2021 this is forecast to rise by 56% to 10,240. The prevalence estimates are 7,380 people by 2011, 8,690 by 2016 and 10,240 by 2021. The incidence estimates are 1,720 in 2006, 1,950 in 2011, 2,310 in 2016 and 2,690 by 2021. As the incidence of dementia rises sharply with age, local estimates will vary according to the age structure of the older population. For example the incidence of dementia is 6.3 per 1,000 person years for women aged 65 to 69 and rises to 71.7 per 1,000 person years to women aged 85 and over.

The burden of mental health problems is also considerable with 7.6% of men over 65 years with depression and 11.3% of women.

Table 8: Estimates of population with dementia (prevalence), by age and local authority

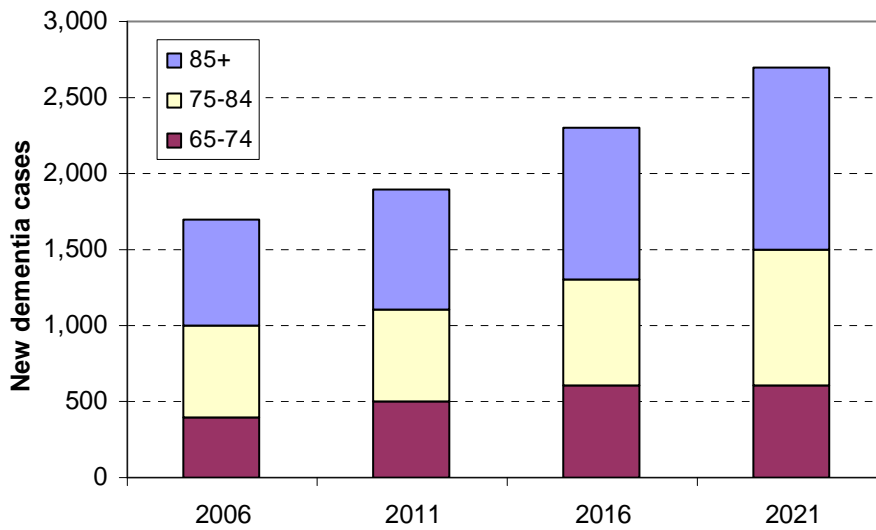
| Area | Age group | 2006 | 2011 | 2016 | 2021 | % change |
|---------------------------------------|-----------------------|-------|-------|-------|--------|----------|
| Cambridgeshire County Council | 65-74 | 890 | 1,100 | 1,370 | 1,460 | 64% |
| | 75-84 | 2,650 | 2,860 | 3,260 | 4,050 | 53% |
| | 85+ | 3,040 | 3,420 | 4,060 | 4,730 | 56% |
| | Total with dementia | 6,580 | 7,380 | 8,690 | 10,240 | 56% |
| | % population aged 65+ | 7.5% | 7.2% | 7.0% | 7.3% | |
| Cambridge City Council | 65-74 | 130 | 150 | 200 | 220 | 74% |
| | 75-84 | 440 | 430 | 450 | 550 | 25% |
| | 85+ | 580 | 610 | 630 | 660 | 14% |
| | Total with dementia | 1,140 | 1,190 | 1,280 | 1,430 | 25% |
| | % population aged 65+ | 8.3% | 7.8% | 7.2% | 7.1% | |
| East Cambridgeshire District Council | 65-74 | 130 | 150 | 180 | 200 | 52% |
| | 75-84 | 390 | 420 | 480 | 570 | 45% |
| | 85+ | 410 | 490 | 570 | 670 | 64% |
| | Total with dementia | 930 | 1,060 | 1,230 | 1,440 | 55% |
| | % population aged 65+ | 7.3% | 7.3% | 7.1% | 7.4% | |
| Fenland District Council | 65-74 | 180 | 190 | 230 | 260 | 47% |
| | 75-84 | 540 | 570 | 570 | 650 | 19% |
| | 85+ | 520 | 630 | 840 | 950 | 82% |
| | Total with dementia | 1,240 | 1,390 | 1,650 | 1,850 | 50% |
| | % population aged 65+ | 7.1% | 7.3% | 7.5% | 7.5% | |
| Huntingdonshire District Council | 65-74 | 240 | 310 | 370 | 370 | 54% |
| | 75-84 | 640 | 710 | 860 | 1,100 | 72% |
| | 85+ | 740 | 850 | 990 | 1,180 | 59% |
| | Total with dementia | 1,630 | 1,870 | 2,220 | 2,650 | 63% |
| | % population aged 65+ | 7.2% | 6.9% | 6.7% | 7.3% | |
| South Cambridgeshire District Council | 65-74 | 220 | 300 | 390 | 410 | 92% |
| | 75-84 | 640 | 730 | 890 | 1,180 | 86% |
| | 85+ | 790 | 850 | 1,030 | 1,280 | 61% |
| | Total with dementia | 1,650 | 1,870 | 2,310 | 2,870 | 75% |
| | % population aged 65+ | 7.7% | 6.9% | 6.7% | 7.2% | |

Table 9: Dementia incidence (per 1,000 person years)

| Age | Men | Women |
|-------|------|-------|
| 65-69 | 6.9 | 6.3 |
| 70-74 | 14.5 | 6.1 |
| 75-79 | 14.2 | 14.8 |
| 80-84 | 17.0 | 31.2 |
| 85+ | 58.4 | 71.7 |

The table shows the incidence of dementia per 1,000 people years at different ages. Figure 5 shows how this translates into number of new cases of dementia estimated for 2006 and forecast for 2011, 2016 and 2021. Incidence estimates suggest that, in 2006, there would have been around 1,700 new cases of dementia. By 2021, this annual number is forecast to have increased to 2,700, an increase of 56%.

Figure 5: Annual new dementia cases, Cambridgeshire, 2006-2021



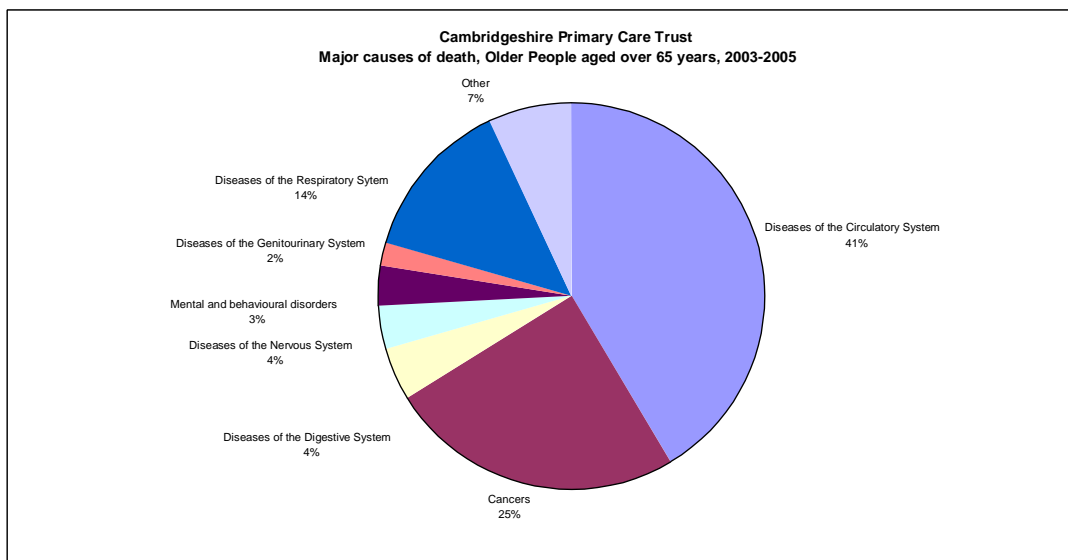
The number of new dementia cases is forecast to increase across all LAs by 2021. The smallest increase will be in Cambridge City, at just 29%, compared to a 74% increase in South Cambridgeshire.

Life expectancy

Life expectancy provides a good overall measure of the health of a population. In 2003-2005 life expectancy in Cambridgeshire was generally better than the national average, except in Fenland where it was slightly worse.

Circulatory diseases and cancer are the major causes of death. Both diseases accounted for approximately 66% of all deaths in people aged 65 years and over.

Figure 6: Major causes of death, older people over 65 years, 2003-2005



Nationally health outcomes are known to be closely associated with socio-economic deprivation. Most districts in Cambridgeshire are less socio-economically deprived than the England average. However Fenland is more socio-economically deprived than the England average. When smaller areas, roughly the size of housing estates, known as super output areas (LSOAs) are considered, of the most socio-economically deprived fifth of LSOAs in Cambridgeshire; 30 are in Fenland; 23 in Cambridge City; 13 in Huntingdonshire; 6 in East Cambridgeshire; and one in South Cambridgeshire.

The Income Deprivation Affecting Older People Index (IDAOPI) shows the percentage of pensioners living in a SOA who claim benefits. Although Fenland consistently scores as more deprived, deprivation in this domain is more evenly spread across the county, with local concentrations in many of the rural villages.

Pattern of Services

There are currently eight Community Matrons working with GP practices across Cambridgeshire. Community Matrons work in partnership with patients and their carers to develop a personalised care plan under the case management model. They are responsible for planning, proactively monitoring and anticipating the changing needs of these patients, coordinating their care across all parts of the health and social care system.

A full description of the pattern of services for vulnerable older people and intermediate care services are contained in the Cambridgeshire Joint Strategic Needs Assessment for Older People.

Programme Budgeting Atlas

Outcome data available for vulnerable older people includes:

- Data for trauma and injuries is available for all ages, not specifically for the elderly.
- Mortality from accidental falls (all ages).
- Mortality from fracture of femur (all ages).
- Hospitalisation for falls (all admissions, day cases, elective and non-elective; all ages).
- Bed days for falls (all admissions, elective and non-elective care).
- Spell length of stay for neurology (admissions excluding day cases, elective excluding day cases and non-elective; all ages).
- Deaths within 30 days of admission following a fall (all ages).
- Readmission to hospital within 28 days of hospital discharge following a fall (all ages).

Data which may be more specific to older people in the category of trauma and injuries includes:

- Emergency admission fractured proximal femur.
- Timely surgery for fractured proximal femur.
- Case fatality following fractured proximal femur.
- Emergency readmission following fractured proximal femur.

Data on dementia includes:

- Hospitalisation for dementia (all admissions, day cases, elective and non-elective).
- Bed days for dementia admissions (all admissions, elective and non-elective care).
- Spell length of stay for dementia admission (admissions excluding day cases, elective excluding day cases and non-elective).
- Deaths within 30 days of admission for dementia.
- Emergency readmission to hospital within 28 days of discharge.

In addition pattern of care data for mental health conditions in the over 65 years age group includes:

- Mean number of admissions for mental health (65+).
- Mean length of stay (65+).
- Composite Z-score for mean number of admissions and mean length of stay (65+).

The outcome, within the circulatory diseases category: "Return to usual place of residence following admission for stroke" is also pertinent to vulnerable older people.

- The outcomes for fractured proximal neck of femur (case fatality, timely surgery, emergency admission and re-admission rates) were similar to the national average across Cambridgeshire in 2005/6.
- All localities in Cambridgeshire had a higher FHS prescription expenditure rate per UWP for dementia than the national average in 2005/6.
- Cambridge City had a higher rate of hospitalisation for dementia in 2005/6 than the national average, although a measure of statistical significance was not available on these data. The "non-elective" admission rate was not higher than the national average. Cambridge City, East Cambridgeshire and Fenland and South Cambridgeshire had a significantly higher number of bed days for elective admissions than the national average, although the spell length of stay was significantly lower than the national average when day cases were excluded.

Summary of commissioning interventions for vulnerable older people

Commissioning Contact Vinny Logan and Nicola Clapperton

Prevention

- Promotion of healthy lifestyles to older people and their families and carers to slow the progress towards vulnerability.
- Falls prevention.
- Safer homes, fuel poverty.
- Nutrition and avoidance of malnutrition.
- Promotion of oral health.
- Mental health promotion and social inclusion.
- Smoking cessation.
- Target benefits claims.
- Continued partnership with the voluntary sector and care providers in the independent sector.

Diagnosis and Assessment

- To develop integrated access points for health and social care services.
- Provide more responsive and accessible care.
- Develop a strategy for the implementation and development of the single assessment process.

Treatment

- Reduction in the length of time people's discharge from hospital is delayed.
- Develop a holistic approach to those with physical and mental frailty.
- Measure outcome.
- Intermediate care services provide short term nursing, therapy, social assessment and support for people who have been discharged from hospital or to prevent unnecessary admissions to hospital or long term care.

Rehabilitation and Continuing Care

- Supporting carers.
- Efficient and integrated health and social care service provision.
- Develop intermediate care.
- Develop the role of community matrons

Supporting More People at Home

- Investment in independent sector home care services.
- Better care worker continuity and reliability.
- Develop the take-up of assistive technology.
- Best use of care homes and homes with nursing.
- Increasing home care capacity with the aim to support more people at home, rather than in residential care.
- Extra care housing, implement best value review.

NICE GUIDANCE

| Published Guidance Publication date | Type of guidance | Topic |
|--|-------------------------|---|
| June 2006 | Clinical guidance | Parkinson's disease |
| November 2006 | Clinical guidance | Dementia |
| December 2006 | Clinical guidance | Obesity |
| September 2007 | Technology appraisal | Alzheimer's disease – donepezil, galantamine, rivastigmine (review) and memantine |
| October 2007 | Technology appraisal | Rheumatoid arthritis – adalimumab, etanercept and infliximab |

| In Progress Guidance Publication date | Type of guidance | Topic |
|--|-----------------------------|---|
| July 2008 | Public health interventions | Mental Wellbeing and Older People |
| July 2008 | Clinical guidance | Respiratory tract infections |
| July 2008 | Clinical guidance | Stroke |
| September 2008 | Public health interventions | Identifying and supporting people most at risk of dying prematurely |
| September 2008 | Technology appraisal | Rheumatoid arthritis – adalimumab, etanercept and infliximab (sequential use) |
| October 2008 | Technology appraisal | Influenza (prophylaxis) – amantadine, oseltamivir and zanamir |
| February 2009 | Technology appraisal | Influenza – zanamir, amantadine and oseltamivir (review) |
| February 2009 | Clinical guidance | Rheumatoid arthritis in adults |

| In Progress Guidance Publication date | Type of guidance | Topic |
|--|--------------------------|--|
| March 2009 | Public health programmes | Management of long-term sickness and incapacity for work |
| November 2009 | Technology appraisal | Rheumatoid arthritis – certolizumab pegol |
| TBC | Technology appraisal | Osteoarthritis and Rheumatoid arthritis – cox-II inhibitors (review) |
| TBC | Clinical guidance | Osteoporosis |

6.2.4 Palliative and End of Life Care

Our aim is to ensure high quality, integrated end of life care that is available to all who need it, irrespective of diagnosis or place of care. There were 1,256 deaths that occurred at home in 2006 in Cambridgeshire (26%).

In recent years, there has been significant progress in increasing the profile of end of life care. This has been reflected nationally with the publication of a number of key policy documents, including 'Building on the Best; Choice, Responsiveness and Equity in the NHS' and the White Paper 'Our health, our care, our say' which have highlighted the need for service development to improve provision of end of life care. A National End of Life Care Programme has been established to help health and social care professionals improve end of life care. These initiatives have culminated in the development of the Department of Health National End of Life Care Strategy, due for publication in 2008, addressing the holistic end of life care needs of patients with all life-limiting conditions, in all settings. The national end of life strategy will include best practice quality standards.

Initial findings suggest that 90% of all people who die have had at least one hospital admission in the year before death. The majority of patients do not die in the place of their choice. Most deaths (55.7%) occur in hospital, whereas the preferred place of death for individuals is home (56 – 74%) or hospice (10 – 24%).

The PCT is currently conducting a baseline review of services for End of Life Care, to provide detailed information on local services and current gaps in care provision. The Public Accounts Committee has also tasked the National Audit Office to conduct a review of end of life care in 2008 in PCTs. In line with the National End of Life Strategy, end of life care delivery should be guided by an Integrated End of Life Care Pathway, which incorporates all aspects of health and social care planning and provision and includes regular review and assessment of the needs and choices of the patient and family/carers.

A consultation exercise in the East of England demonstrated a desire for the adoption of a more holistic assessment of people in their last year of life. This includes all domains of care, including the physical, psychological, social, spiritual and where appropriate, environmental spheres. Once a holistic assessment has been completed it should lead into a formal advance care planning process. Advance care planning (ACP), allows preferences to be recorded and a care plan developed which can guide future management. The care planning process can involve legal frameworks, such as the Mental Capacity Act (MCA). The MCA gives people specific ways to plan ahead about their care or treatment for a time when they may lack capacity. Thus the outcome of advance care planning may be either the completion of a statement of the person's wishes and preferences about their future care or an advance decision to refuse specific treatment. Alternatively, patients can appoint a proxy to make treatment decisions on their behalf, authorised by a Lasting Power of Attorney.

The Gold Standards Framework is a systematic approach to optimising the care of patients in the last year of life in the community. There is especially poor GSF uptake from practices, and care homes where there is no dedicated End of Life or Macmillan GP facilitator. Some areas have a Local Enhanced Service for practices to implement GSF. The Preferred Priorities for Care is an advance care planning document which records patients' key preferences and goals for care.

Palliative care provision is an intrinsic part of end of life care delivery. It incorporates the four domains of physical, psychological, social and spiritual care. The gold standard for supportive and palliative care has been laid down by NICE in their document 'Improving Supportive and Palliative Care for Adults with Cancer.' Drugs should be available in a timely fashion including co-ordination of medicines management and access to pain relief.

The majority of patients accessing specialist palliative care services have a malignant diagnosis. However, patients with other long term conditions may have the same levels of physical and holistic need as those with cancer. The ageing population is resulting in individuals suffering from multiple co-morbidities with complex end of life care needs and no clear pathway to address these. It is important that patients suffering from all long term conditions have, where appropriate, a palliative and end of life component within their planned pathways.

The needs assessment will include a review of specialist palliative care services. This is an example of a managed network approach.

Life-limiting illness can have a significant impact on the finances of patients and their carers who should therefore all have access to welfare benefits advice. The form DS 1500 is a fast track process to access benefits with a prognosis of less than 6 months.

The Liverpool Care Pathway (LCP) is a multi-professional integrated care pathway for the last days of life and provides an evidence based framework of best practice to enable staff to deliver high quality holistic care. For patients in hospital or hospice who wish to die at home, and there is adequate health and social care available to support this, organisations should have the ability to arrange rapid discharge home for end of life care.

End of life care does not cease when someone dies, but continues through the verification, certification and registration of death process and with ongoing practical and emotional support for families/carers. The final section of the Liverpool Care Pathway outlines the core components for care after death and can be modified for use in sudden as well as expected deaths.

In 2008/9 the PCT will be asked to:

- Implement the national and East of England end of life strategy.
- Complete the baseline stock take.
- Commission in partnership with social care, integrated care pathways for end of life care.
- Develop local workforce and education and training strategies to support provision.
- Performance manage providers of care.

Programme Budgeting Atlas

All ages outcome data is available for deaths at home from all cancers (rate and percentage).

NCHOD key outcomes

- The rate of deaths at home (all cancers) was significantly greater than the national average in East Cambridgeshire and Fenland, Huntingdonshire and South Cambridgeshire in 2002 – 2004.

Summary of commissioning interventions for palliative care

Commissioning contact Sandra Moore

Raising Awareness

- Of choice with the general public and with health and social care professionals.

Assessment and Care Planning

- Prognostic indicators eg Gold Standards Framework (GSF) criteria.
- Patient choice and need.
- Benefits eligibility eg DS1500 criteria.

Supportive and Palliative Care Delivery in Last Year of Life

- Best practice palliative care for advanced, progressive, life-limiting illness

Care of the Dying

- Last days of life, management of long term conditions and acute illnesses.
- Prognostic indicators eg Liverpool Care Pathway (LCP) criteria.

Care After Death

- Care of families and carers.

NICE GUIDANCE

| Published Guidance Publication date | Type of guidance | Topic |
|--|-------------------------|---|
| March 2004 | Cancer service guidance | Improving supportive and palliative care for adults with cancer |

| In Progress Guidance Publication date | Type of guidance | Topic |
|--|--------------------------|-----------------------------------|
| July 2008 | Public health programmes | Mental wellbeing and older people |

6.2.5 Coronary Heart Disease

The estimated number of new cases of coronary heart disease in the community in Cambridgeshire per annum is 785 in men and 312 in women (total 1,097 with 95% confidence intervals from 982 to 1,222 cases). In people aged 65 to 74 years there are estimated to be 313 cases in men and 133 in women (total 446 with 95% confidence intervals from 378 to 512 cases).

Table 10: Estimated number of new cases per annum of coronary heart disease in men in the community (incidence)

| Male | Exertional Angina | Unstable angina | Acute myocardial infarction | Sudden cardiac death | Total | 95% CI LL | 95% CI UL |
|-------|-------------------|-----------------|-----------------------------|----------------------|-------|-----------|-----------|
| 25-34 | 0 | 0 | 2 | 0 | 2 | 0 | 10 |
| 35-44 | 9 | 2 | 25 | 2 | 38 | 23 | 14 |
| 45-54 | 51 | 18 | 49 | 12 | 130 | 101 | 166 |
| 55-64 | 162 | 35 | 85 | 42 | 324 | 270 | 384 |
| 65-74 | 118 | 46 | 95 | 53 | 313 | 267 | 364 |
| 25-74 | 326 | 100 | 252 | 108 | 785 | 709 | 868 |

Source: Wood D et al. Chapter 5 in Health Care Needs Assessment Vol 1 (Eds Stevens A et al). Population: Exeter, April 2007. Incidence rates from Bromley Coronary Heart Disease Register. 95% confidence intervals available for individual disease categories but data not shown in these tables except for CHD Total).

Table 11: Estimated number of new cases per annum of coronary heart disease in women in the community

| Female | Exertional Angina | Unstable angina | Acute myocardial infarction | Sudden cardiac death | Total | 95% CI LL | 95% CI UL |
|--------|-------------------|-----------------|-----------------------------|----------------------|-------|-----------|-----------|
| 25-34 | 0 | 0 | 1 | 0 | 1 | 0 | 1 |
| 35-44 | 3 | 0 | 1 | 1 | 6 | 2 | 15 |
| 45-54 | 20 | 7 | 5 | 2 | 35 | 23 | 50 |
| 55-64 | 82 | 17 | 22 | 9 | 129 | 103 | 160 |
| 65-74 | 59 | 15 | 35 | 24 | 133 | 111 | 148 |
| 25-74 | 163 | 40 | 68 | 40 | 312 | 273 | 354 |

Source: Wood D et al. Chapter 5 in Health Care Needs Assessment Vol 1 (Eds Stevens A et al). Population: Exeter, April 2007. Incidence rates from Bromley Coronary Heart Disease Register. 95% confidence intervals available for individual disease categories but data not shown in these tables except for CHD Total).

The estimated number of new cases of heart failure per annum in men and women of 25 years and over in the community in Cambridgeshire is 3,477 in men and 3,101 in women.

Table 12: Estimated number of new cases (incidence) per annum in men and women in Cambridgeshire aged 25 years and over in the community

| Age | Men | Women |
|-------|-------|-------|
| 25-34 | 0 | 2 |
| 35-44 | 8 | 8 |
| 45-54 | 10 | 3 |
| 55-64 | 61 | 24 |
| 65-74 | 88 | 54 |
| 75-84 | 133 | 105 |
| 85+ | 3,176 | 2,905 |
| 25 + | 3,477 | 3,101 |

Source: Wood D et al. Chapter 5 in Health Care Needs Assessment Vol 1 (Eds Stevens A et al). Population: Exeter, April 2007. Incidence rates from London Heart Failure Study II.

Table 13: Estimated number of new cases of symptomatic disease per annum in 25-74 year olds in Cambridgeshire

| Age | All | Male | Female |
|--|-----|------|--------|
| Number of cases | 541 | 175 | 99 |
| Sudden cardiac death | 31 | 26 | 9 |
| Chest pain, cardiac in origin, no history of CHD | 420 | 271 | 155 |
| Exertional angina, no history of CHD | 106 | 80 | 36 |
| Non-fatal acute MI, no history of CHD | 65 | 62 | 15 |
| Unstable angina, no history of CHD | 30 | 25 | 9 |

Source: Wood D et al. Chapter 5 in Health Care Needs Assessment Vol 1 (Eds Stevens A et al). Population: Exeter, April 2007. Incidence rates from Bromley Coronary Heart Disease Register

Programme Budgeting Atlas

Outcome data available for Coronary Heart disease (CHD) includes:

- Quality and Outcomes Framework indicators
- Prevalence of coronary heart disease.
- Physical activity referral for patients with newly diagnosed angina.
- Smoking cessation advice for smokers with CHD.
- Blood pressure < or = 150/90 in patients with CHD.
- Cholesterol level < or = 5mmol/l in patients with CHD.
- Beta blocker therapy for patients with CHD.
- ACE inhibitor therapy for patients with myocardial infarction.
- Vaccination against influenza in patients with CHD.
- Prevalence of Left Ventricular Dysfunction (LVD).
- ACE inhibitors for patients with LVD and CHD.
- Mortality from acute Myocardial Infarction (AMI) and mortality from ischaemic disease other than AMI.
- Hospitalisation for CHD (all admissions, day cases, elective and non-elective).
- Bed days for CHD (all admissions, elective and non-elective care).
- Spell length of stay for CHD (admissions excluding day cases, elective excluding day cases and non-elective).

- Deaths within 30 days of admission for CHD.
- Emergency readmission to hospital within 28 days of discharge.

Programme outcomes

Being much more aggressive in the intensity and coverage of programmes to tackle obesity, smoking and excessive alcohol intake.

Indicators of premature mortality – eg death rates under the age of 75.

Reducing the inequality in risk factors and health with respect to circulatory diseases that are observed in Cambridgeshire.

To promote greater uptake of cardiac rehabilitation, especially in partnership with leisure centres and non-clinical settings (getting back to normal after a cardiac event).

To support carers.

Summary of commissioning interventions for circulation problems.

Commissioning contact Karen Hayton and Christine Macleod

Prevention

- Smoking cessation – patients and their families.
- Weight management including increase in physical activity levels and healthy eating – patients and their families.
- Intensive work in general practice to identify and treat high blood pressure, high blood lipids and lifestyle (smoking, alcohol use, diet and activity).
- Secondary prevention following angina, heart attack or stroke.

Diagnosis and Assessment

- Review current diagnostic pathways in line with national guidance.
- Regard suspected strokes as “brain attacks” and therefore as emergencies, just as we do with “heart attacks”.

Treatment

- Give attention to NICE and related evidence-based guidance in primary, secondary and tertiary care, with at least once-yearly joint clinical governance review of the major patient pathways across primary, secondary and community care (eg myocardial infarction and stroke), including the ambulance service.
- In clinical liaison discussions explore the techniques of “marginal analysis” to redeploy funds from areas of lower cost-effectiveness to areas of higher cost-effectiveness.
- Give regular feedback to every GP practice showing prescribing, referral and other activity data to show their practice in relation to the others, and hold discussions with “outliers”.
- Implement in full the national stroke pathway guidance.
- Smoking cessation, weight management integrated into care pathway.

Rehabilitation and Continuing Care

- Cardiac rehabilitation after myocardial infarction, angioplasty, CABG and other relevant cardiac surgery.
- Stroke rehabilitation after stroke, beginning early in the episode.
- Intensive active case management for individuals with greater morbidity or at higher risk.

Palliative Care

- Informed planning for terminal illness, respecting patient choice for place of death whenever possible.

NICE GUIDANCE

| Published Guidance Publication date | Type of guidance | Topic |
|--|-----------------------------|--|
| January 2006 | Technology appraisal | Cardiovascular disease - statins |
| March 2006 | Public health interventions | Brief interventions and referral for smoking cessation |
| May 2007 | Technology appraisal | Heart failure – cardiac resynchronisation |
| October 2007 | Public health programmes | Behaviour Change |
| November 2007 | Technology appraisal | Hypercholesterolemia – ezetimibe |
| May 2008 | Clinical guidelines | Lipid modification |

| In Progress Guidance Publication date | Type of guidance | Topic |
|--|--------------------------|---|
| March 2009 | Public health programmes | Management of long-term sickness and incapacity for work |
| December 2010 | Clinical guideline | Stable angina |
| TBC | Clinical guideline | Acute coronary syndromes |
| TBC | Technology appraisal | Ischaemic heart disease – coronary artery stents (review) |

Disease registers in primary care

The disease registers in primary care were established through the PRIMIS facilitators. This project is to expand the capacity of the team to improve on disease registers in primary care.

The EoE pledge asks that Cambridgeshire improves coverage of registers for both the primary and secondary prevention of heart disease.

PRIMIS+ provides training and assistance to information/data quality facilitators employed by Primary Care Trusts or local Health Informatics Services. These facilitators then "cascade" their knowledge and skills to GPs and practice staff in their local health communities.

The appointment of 2 PRIMIS facilitators to work in the Public Health Network environment and with the Practice Based Commissioners to improve the quality of data. They will major on the reduction of the risk factors for coronary heart disease and stroke. For example in terms of risk factors for stroke.

Commissioners and providers use ASSET to establish a baseline and to ensure that there are systems in place locally for the following key prevention measures:

- Managing hypertension so systolic blood pressure is below 140 mmHg.
- Warfarin for individuals with atrial fibrillation.
- Statin therapy for all people with more than 20 per cent risk of cardiovascular disease within ten years.
- Smoking cessation for all individuals who have had a stroke or TIA.

Review information and advice strategies to ensure that clear, consistent, culturally sensitive messages are being given to those who are at risk and their families.

Ensure that primary care data features in local needs assessment activities.

Work with the Director of Public Health to support the prevention messages, particularly in disadvantaged areas and groups, and incorporate stroke into existing healthy lifestyle or information programmes. Where appropriate, links will be made to the forthcoming cross-government strategy for tackling obesity.

As part of the Quality and Outcomes Framework, participating GPs will produce a register of patients who have had a stroke or TIA, which forms the basis of a suite of indicators to provide quality of care. GPs should maintain the stroke register in line with the business rules and guidance that support the Quality and Outcomes Framework.

Cardiac rehabilitation

NICE will shortly produce an evidence based guide for commissioning cardiac rehabilitation services. There is inequality of access across the county. The PCT will review how it commissions sustainable services.

The overall aims of this proposal are to ensure:

- The continuation of the Cardiac Rehabilitation (CR) Service in the Fenland area, complementing PCT provision with increased Local Authority provision in the community.
- Equal access - all Cambridgeshire patients post MI have access to a menu of CR services provided in secondary care, primary care and community settings.
- Cardiac rehabilitation services across Cambridgeshire are co-ordinated and delivering a consistent approach.
- Cardiac rehabilitation is a vital part of caring for patients with heart disease. It is an evidence based and cost effective intervention that reduces future mortality and morbidity.

According to the British Heart Foundation Care and Education Research Group, only about one-third of patients who have had a heart attack receive cardiac rehabilitation. Several groups of people are less likely to receive help: the elderly, women, ethnic minorities and those who live in the countryside. The depressed, people on lower incomes, and smokers may also face barriers to access.

A Cambridgeshire & Peterborough CHD Health Equity Profile was completed in early 2007. The aspects of the patient pathway that showed greatest inequity were reported to include cardiac rehabilitation.

Expenditure on current services

Programme budgeting data for coronary heart disease shows that spend per 100,000 weighted population in Cambridgeshire is £3,217,493, ranking 112 out of 152 PCTs. This is below the cluster average for similar PCTs of £3,600,094, and below the EoE average of £3,852,453, and below the national average of £3,891,061.

6.2.6 Stroke

Using national study estimates, the estimated annual number of first new strokes for the Cambridgeshire population is 1,136 of which 872 are in people aged 65 and over.

Table 14: Estimated number of first strokes in Cambridgeshire PCT local areas

| PCT area | Estimated number of first strokes | |
|---------------------------------|-----------------------------------|-----------------|
| | People of all ages | People aged 65+ |
| Cambridge City | 226 | 175 |
| East Cambridgeshire and Fenland | 379 | 299 |
| Huntingdonshire | 308 | 227 |
| South Cambridgeshire | 223 | 170 |
| Cambridgeshire | 1,136 | 872 |

Source: Mant J et al. Chapter 3 in Health Care Needs Assessment Vol 1 (Eds Stevens A et al). Calculations use age and sex specific incidence rates from Oxford Community Stroke Project (OCSP) and assume a 20% decline in age specific incidence since the time the study was performed (1981-1986.) Population: Exeter, April 2007.

Table 15: Summary of epidemiology of stroke and risk factors for stroke in a population of 100,000 and for a GP with a list size of 2,000

| Sub category | Expected number of new cases per year (incidence) | | Expected number of existing cases (prevalence) | |
|--|---|-----------|--|-----------|
| | For a GP | For a PCT | For a GP | For a PCT |
| Risk factors for stroke | | | | |
| Atrial fibrillation | 7.0 | 330 | 22 | 1,100 |
| Hypertension (BP > 140/90 mmHg) | - | - | 680 | 34,000 |
| Current smokers | - | - | 560 | 28,000 |
| Diabetes mellitus | - | - | 40 | 2,000 |
| Ischaemic heart disease | - | - | 110 | 5,500 |
| Transient ischaemic attack | 0.7 | 35 | - | - |
| Stroke | | | 30 | 1,500 |
| First stroke (excluding sub-arachnoid haemorrhage) | 3.0 | 164 | - | - |
| Recurrent stroke | 1.0 | 57 | - | - |
| People with moderate disability from stroke | - | - | 20 | 1,000 |
| Sub-arachnoid haemorrhage | 0.2 | 10 | - | - |

Source: Mant J et al. Chapter 3 in Health Care Needs Assessment Vol 1 (Eds Stevens A et al. Number of first strokes derived from assumption in preceding table.

An estimate of the number of cases of atrial fibrillation in Cambridgeshire and local PCT areas is that there are 6,752 of which 81% (5,454) will be in people aged 65 and over and 51% (3,707) in people aged 75 and over.

Table 16: Estimate of age-specific numbers of cases of atrial fibrillation in Cambridgeshire and PCT areas

| Age group | Cambridge City | East Cambs & Fenland | Hunts | South Cambs | Cambridgeshire |
|-----------|----------------|----------------------|-------|-------------|----------------|
| 40 - 44 | 10 | 13 | 14 | 9 | 47 |
| 45 - 49 | 24 | 36 | 39 | 25 | 125 |
| 50 - 54 | 36 | 54 | 55 | 36 | 182 |
| 55 - 59 | 55 | 92 | 92 | 60 | 299 |
| 60 - 64 | 91 | 163 | 159 | 103 | 515 |
| 65 - 69 | 132 | 250 | 225 | 145 | 752 |
| 70 - 74 | 192 | 377 | 288 | 205 | 1,062 |
| 75 - 79 | 239 | 456 | 321 | 246 | 1,262 |
| 80 - 84 | 281 | 457 | 323 | 260 | 1,320 |
| 85 - 89 | 179 | 249 | 193 | 154 | 775 |
| 90+ | 110 | 127 | 94 | 83 | 413 |
| All ages | 1,349 | 2,274 | 1,803 | 1,326 | 6,752 |
| <40 | 2,293 | 2,044 | 2,102 | 1,336 | 7,775 |
| 65+ | 1,058 | 1,874 | 1,460 | 1,062 | 5,454 |
| 75+ | 783 | 1,277 | 918 | 729 | 3,707 |

Source: Mant J et al. Chapter 3 in Health Care Needs Assessment Vol 1 (Eds Stevens A et al). Population: Exeter, April 2007.

Developing a hub and spoke model for stroke services

A proposal to establish a viable stroke network across Cambridgeshire and hence equity and equality of access for stroke victims and their carers. This proposal includes a stroke physician and a specialist stroke nurse shared between Hinchingsbrooke and Addenbrookes Hospitals. The purpose of the case is to provide improved stroke services by the establishment of two posts to act as catalysts for change to improve the whole pathway for stroke across the two hospital sites and directly facilitate the objectives set out below.

To provide a “hub” and “spoke” model for stroke services. The multidisciplinary stroke group in collaboration with the Anglia Heart and Stroke Network envisage ambulance triage of fast track from A&E to Addenbrookes for thrombolysis with subsequent return for early acute stroke care at Hinchingsbrooke.

To ensure that people receive the high quality services most appropriate to their needs in the right place, whether in hospital or community, at the right time and with the best possible outcome. This will achieve the following objectives:

- Specialist acute and rehabilitation stroke unit at Hinchingsbrooke.
- Regarding stroke as an emergency.
- Rapid access to services for people who have had a TIA or minor stroke.
- Immediate access to diagnostic scans and to thrombolysis for people whose stroke was caused by a clot.

- Early supported discharge for patients with moderate disability as a result of stroke.
- More emphasis on prevention and public awareness.

Promoting healthy living is very important in helping to prevent stroke, particularly in disadvantaged areas and groups. Healthy lifestyles and management of specific risk factors reduce the risk of an initial stroke and the risk of a subsequent stroke. It is estimated that 20,000 strokes a year could be avoided through preventive work on high blood pressure, irregular heartbeats, smoking cessation, and wider statin use. Preventing strokes can not only reduce the associated suffering, morbidity and mortality caused by strokes; it may also lead to NHS savings, as each stroke costs approximately £15,000 to treat over five years.

A more urgent response to both stroke and TIA will save lives and reduce long term disability. Stroke is a treatable condition. Intensive physiological and neurological monitoring in the early phase of a stroke supports early treatment that halts stroke progression and prevents more brain cells being damaged. Investigating and treating high risk patients with TIA within 24 hours could produce an 80% reduction in the number of people who go on to have a full stroke.

Current expenditure

The programme budget data shows that the total expenditure for Cambridgeshire for problems of the circulation is £48,704,043. Of this £16m is attributed to coronary heart disease and £4,535,004 to cerebrovascular disease. In this programme budget area the PCT ranks 138 out of 152 PCTs in England. Cambridgeshire PCT is currently spending less for problems of circulation as spend in £ per 100,000 unified weighted population for comparison with its peers, 2006/07. The Cambridgeshire spend for cerebrovascular disease is £907,760 per 100,000 weighted population in comparison with £1,289,814 for the cluster average, and £1,510,812 for the EoE SHA average and £1,605,227 for the national average.

Programme Budgeting Atlas

Outcome data available for stroke includes:

- Quality and Outcomes Framework indicators.
- Prevalence of stroke/ TIA.
- CT/ MRI referral for presumptive stroke.
- Smoking cessation advice for smokers with stroke/ TIA.
- Blood pressure < or = 150/90 in patients with stroke/ TIA.
- Cholesterol level < or = 5mmol/l in patients with stroke/ TIA.
- Anti-platelet/ Anti-coagulant therapy for patients with stroke/ TIA.
- Vaccination against influenza in patients with stroke/ TIA.
- Mortality from stroke.

- Hospitalisation for cerebrovascular disease (all admissions, day cases, elective and non-elective).
- Bed days for cerebrovascular disease (all admissions, elective and non-elective care).
- Spell length of stay for cerebrovascular disease (admissions excluding day cases, elective excluding day cases and non-elective).
- Deaths within 30 days of admission for cerebrovascular disease.
- Emergency readmission to hospital within 28 days of discharge.
- Return to usual place of residence following admission for stroke.

NCHOD key outcomes for coronary heart disease and stroke

- The programme expenditure for the circulatory system was higher in 2005/6 than the National average (£12.4M per 100,000 UWP) in South Cambridgeshire (£14.3M per 100,000 UWP) and East Cambridgeshire and Fenland (£13.9M per 100,000 UWP) and lower in Cambridge City (£12.2M per 100,000 UWP) and Huntingdonshire (£11.9M per 100,000 UWP).
- Cambridge City FHS prescription expenditure rate for Coronary Heart Disease per UWP for CHD in 2005/6 was lower than the national average in Cambridge City, but the prevalence of CHD in City is also significantly lower than the National average at only 2.3%. South Cambridgeshire and East Cambridgeshire and Fenland had a high prescription volume than the National average in 2005/6.
- The QOF prevalence of CHD in 2005/6 was significantly lower than the National average (3.6%) in all areas of Cambridgeshire except in East Cambs and Fenland, where the prevalence was significantly higher at 4.1%.
- QOF indicators for physical activity referral for patients with a new diagnosis of angina in Cambridgeshire for 2005/6 compared favourably with the National average. In South Cambridgeshire significantly fewer patients with CHD had a Blood pressure measurement of <150/90 than the national average in 2005/6. Significantly fewer patients with CHD in South Cambridgeshire and East Cambs and Fenland received anti-platelet and Beta-blockade therapy than the national average in 2005/6.
- The QOF prevalence of stroke and TIA in Cambridgeshire in 2005/6 was significantly lower than the national average, except in East Cambs and Fenland, where it was significantly higher than the national average.
- The mortality from AMI in Cambridgeshire in 2002-4 was significantly lower than the national average in Cambridge City, South Cambridgeshire and Huntingdonshire; the mortality from AMI in East Cambridgeshire and Fenland was higher than in other parts of Cambridgeshire.
- CHD admission rates for 2005/6 were higher than the national average, particularly in Huntingdonshire where the day case admission rate was nearly double the national average rate.

Programme outcomes

Be much more aggressive in the intensity and coverage of programmes to tackle obesity, smoking and excessive alcohol intake.

Indicators of premature mortality – eg death rates under the age of 75.

To implement the latest national stroke pathway guidance.

To support carers.

Summary of commissioning interventions for stroke

Commissioning contact Karen Hayton and Christine Macleod

Prevention

- Smoking cessation – patients and their families.
- Weight management including increase in physical activity levels and healthy eating – patients and their families – in line with Cambs Obesity Strategy.
- Intensive work in general practice to identify and treat high blood pressure, high blood lipids and lifestyle (smoking, alcohol use, diet and activity).
- Secondary prevention following stroke.

Diagnosis and Assessment

- Review current diagnostic pathways in line with national guidance.
- Regard suspected strokes as “brain attacks” and therefore as emergencies, just as we do with “heart attacks”.

Treatment

- Give attention to NICE and related evidence-based guidance in primary, secondary and tertiary care, with at least once-yearly joint clinical governance review of the major patient pathways across primary, secondary and community care, including the ambulance service.
- In clinical liaison discussions explore the techniques of “marginal analysis” to redeploy funds from areas of lower cost-effectiveness to areas of higher cost-effectiveness.
- Give regular feedback to every GP practice showing prescribing, referral and other activity data to show their practice in relation to the others, and hold discussions with “outliers”.
- Implement in full the national stroke pathway guidance.
- Smoking cessation, weight management integrated into care pathway.

Rehabilitation and Continuing Care

- Stroke rehabilitation after stroke, beginning early in the episode.
- Intensive active case management for individuals with greater morbidity or at higher risk.

Palliative Care

- Informed planning for terminal illness, respecting patient choice for place of death whenever possible.

| Published Guidance Publication date | Type of guidance | Topic |
|--|-----------------------------|--|
| May 2005 | Technology appraisal | Vascular disease - clopidogrel and dipyridamole |
| January 2006 | Technology appraisal | Coronary heart disease - statins |
| January 2006 | Technology appraisal | Arrhythmia - implantable cardioverter defibrillators (ICDs) (review) |
| June 2006 | Clinical guideline | Atrial fibrillation |
| June 2006 | Clinical guideline | Hypertension (partial update of CG18) |
| April 2007 | Clinical guideline | Venous thromboembolism |
| May 2007 | Technology appraisal | Heart failure - biventricular pacing (cardiac resynchronisation) |
| May 2007 | Clinical guideline | MI: secondary prevention |
| June 2007 | Single Technology Appraisal | Ischaemic stroke - alteplase |
| November 2007 | Technology appraisal | Hypercholesterolemia - ezetimibe |
| March 2008 | Clinical guideline | Prophylaxis against Infective Endocarditis |

| In Progress Guidance Publication date | Clinical guideline | Topic |
|--|-----------------------------|---|
| July 2008 | Technology appraisal | Pulmonary arterial hypertension (adults) - drugs |
| July 2008 | Clinical guideline | Stroke |
| August 2008 | Clinical guideline | Familial hypercholesterolaemia |
| November 2008 | Technology appraisal | Abdominal aortic aneurysms - endovascular stent-grafts |
| TBC | Technology appraisal | Stroke - Idraparinux Sodium |
| TBC | Single Technology Appraisal | Atrial fibrillation - idraparinux sodium |
| TBC | Single Technology Appraisal | Venous thromboembolism (recurrent) - idraparinux sodium |
| TBC | Technology appraisal | Heart failure (acute decompensated) - nesiritide |
| TBC | Technology appraisal | Thrombophilia |
| TBC | Technology appraisal | Ischaemic heart disease - coronary artery stents (review) |

6.2.7 Children

Long term conditions for children include predominantly single organ problems such as diabetes, epilepsy, renal failure and asthma, and multi-system disorders such as cancer, cystic fibrosis or cerebral palsy.

Key facts

| | |
|---|--|
| <p>18% of children have a long-standing illness or disability¹</p> <ul style="list-style-type: none"> • 42% of them have asthma • 8% have skin conditions • 6% have lung or respiratory disease • 6% deafness or ear defects • 5% have musculoskeletal conditions • 4% digestive disorders • 4% nervous system disorders • 3% heart disease • 3% urogenital disorders • 19% other <p>¹Children 0-19 years old in GB (ONS 2000)</p> | <p>8 children per 10,000 population have a severe disability²</p> <ul style="list-style-type: none"> • 25% of them have autism and behavioural disorders • 15% have severe learning difficulties • 8% cerebral palsy • 4% global developmental delay • 3% epilepsy • 2% asthma <p>²Children 0-16 years old in UK (ONS 2000)</p> |
|---|--|

Long term conditions starting in childhood have maximum to gain as a result of prevention (where possible), early detection, stabilization and prevention from deterioration. The services for children with long term conditions is a partner document to this document and is derived from the Modeling the Future RCPCH 2007.

Some of the solutions in the children’s strategy include:

- Develop and roll out the expert patient model.
- Continue to develop community children’s nursing and multidisciplinary teams.
- Improve the quality and initial assessment and link to decision support tools and protocols for referrals.
- Invest more in support services.
- Invest in research for prevention of long term conditions and interventions for management and support.

What are the solutions?

Model of care

The management of children with long term conditions is evolving from an acute care model to a chronic care model. Diabetes is a good example. In the past care was medically-centered, with doctors altering insulin regimes at hospital clinic appointments and patients being admitted when their diabetic control failed in between times. The new model (DH, 2007) promotes knowledgeable expert patients being supported by multidisciplinary community hospitals, children's centres and extended schools should enable community-based multidisciplinary teams to better manage children with long term conditions in their environments and so improve their long term health and wellbeing.

Commissioning pathways and networks

Services for children with long term conditions could be greatly improved by being commissioned and organised according to pathways of care. An incremental move towards delivering care in networks is needed starting by working with specific condition groups, ensuring that all the components of the pathway are in place and are working well. A network for cystic fibrosis will be very different from a network for children with cerebral palsy, but the principles will be the same and some components may be shared.

Better information

A high quality information system to enable better decision-making, audit and improvement and communication is needed urgently. Such a system would have the immeasurable benefit of enabling rigorous needs assessments and resource allocation across primary, secondary, and tertiary health care, education and social services.

The recent development of the Common Assessment Framework is a welcome first step but it needs to be more detailed and nuanced to cater for the needs of children with complex and ongoing health care needs. Traditional information systems based on defects, disability, and disadvantage are too cumbersome in practice. A more pragmatic approach is needed, one which can describe the difficulty (disability), the diagnosis (medical cause of difficulty) and the impact on daily living (the interaction between the child and family and their physical and social environment). This would assist with determining a package of care tailor-made for a particular child. A seven-level system, known as WeeFIM, which describes level of need from independence to complete dependence, is available and a similar model could be adapted for the majority of long term conditions.

Community nursing and multidisciplinary teams

The recent investment in services for children with life-threatening conditions by the New Opportunities Fund has enabled the development of a substantial number of multidisciplinary community children's teams. Initial evaluation suggests that having a comprehensive assessment, continuity of health provision, ideally with 24-hour a day access, and backed up with adequate therapy services and short-term breaks, can lead to a substantial improvement in quality of life for families. Development of community children's nursing teams allows a re-evaluation of the role of paediatricians in the review and management of children and families with long term conditions. Rather than paediatricians reviewing children on an annual basis, the review can be undertaken by a nurse, who discusses or refers specific problems to a paediatrician.

Multiagency multidisciplinary teams should be co-located to facilitate communication and joint working. Further work needs to be undertaken to determine the potential for more specialist knowledge and expertise to be devolved down to local teams.

Models of service delivery

In the longer term, a Community Children's Nursing Team appropriate to the population would be available in small, medium and large places. They would form the core of the larger multi-agency team supporting children with a range of long term conditions. The work of paediatricians generally maps onto the frequency and severity of conditions and their treatability. Treatable rare and multi-system conditions generally require the input of specialists (eg cancer, rheumatological disorders), care for more common treatable conditions should be with a paediatrician who has a special interest (eg diabetes, cystic fibrosis, epilepsy). Children who require largely symptomatic management because the underlying disorder is untreatable (eg cerebral palsy, learning difficulties) need a general paediatrician who can access specialists as required.

Programme Budgeting Atlas

There are no specific outcome data for children with long term conditions.

- The Quality and Outcomes Framework indicators for diabetes (listed in the diabetes chapter) are for those aged 17+ years.
- The Quality and Outcomes Framework indicators for asthma include: prevalence of asthma (all ages), prevalence confirmed by peak flow/ spirometry in 8+ year olds, asthma review in patients with asthma (all ages), influenza vaccination in patients with asthma (16+ years).
- A directly standardised mortality rate for asthma is available for those 5-44 years old.
- There are outcomes for vaccination with MMR (by 2nd and 5th birthday) and whooping cough (by 1st and 5th birthday).

Summary of commissioning interventions for children's long term conditions

Commissioning Contact Bob Dawson and Fay Haffenden

Prevention

- Health protection.
- Community development.
- Whole population / targeted.
- Health promotion / education.

Identification

- Parental concern.
- Professional concern.
- Screening.
- Surveillance.

Assessment

- Condition
- Child
- Family
- Environment / Community

Treatment

- Medical.
- Surgical.
- Behavioural.
- Allied Health Professionals / others.

Continuing Care

- Therapies.
- Environmental modification.
- Family adjustment.
- Education.
- Social Services.

Terminal Care

- Informed planning for terminal illness, respecting patient and family choice for place of death whenever possible.

NICE GUIDANCE

| Published Guidance Publication date | Type of guidance | Topic |
|--|-----------------------------|---|
| July 2005 | Technology appraisal | Tooth decay – HealOzone |
| March 2006 | Technology appraisal | Attention deficit hyperactivity disorder (ADHD) – methylphenidate, atomoxetine and dexamfetamine (review) |
| April 2006 | Technology appraisal | Renal transplantation – immunosuppressive regimens for children and adolescents |
| December 2006 | Technology appraisal | Epilepsy (children) – newer drugs |
| February 2007 | Public health interventions | Prevention of sexually transmitted infections and under 18 conceptions |
| March 2007 | Public health interventions | Interventions to reduce substance misuse among vulnerable young people |
| October 2007 | Public health interventions | Behaviour change |
| November 2007 | Public health interventions | School-based interventions on alcohol |
| December 2007 | Clinical guidance | Atopic eczema in children |
| January 2008 | Public health interventions | Physical activity and the environment |
| March 2008 | Public health interventions | Maternal and child nutrition |
| March 2008 | Public health interventions | Social and emotional wellbeing in primary education |
| May 2008 | Technology appraisal | Asthma (in children) – corticosteroids |

| In Progress Guidance Publication date | Type of guidance | Topic |
|--|-----------------------------|---|
| July 2008 | Public health interventions | Preventing the uptake of smoking by children and young people |
| December 2008 | Technology appraisal | Growth failure (in children) – human growth hormone (HGH) (review) |
| May 2009 | Clinical guidance | When to suspect child maltreatment |
| July 2009 | Public health interventions | Promoting the social and emotional wellbeing of young people in secondary education |
| December 2009 | Public health interventions | School-based interventions to prevent the uptake of smoking |
| February 2011 | Clinical guidance | Autism in children and adolescents |
| March 2010 | Clinical guidance | Idiopathic childhood constipation |
| August 2010 | Clinical guidance | Nocturnal enuresis in children (bedwetting) |
| September 2010 | Public health programmes | Looked after children |
| TBC | Public health interventions | Accidental injuries in the home – children under 15 |
| TBC | Public health interventions | Accidental injuries on the road – children under 15 |
| TBC | Public health interventions | Reducing infant mortality among those living in disadvantaged circumstances |

6.2.8 Neurological Conditions

The table following shows the estimated number of people with selected long term conditions using study estimates from Annex A of the National Service Framework for Long Term Conditions.

The PCT and County Council is currently preparing a Joint Strategic Needs Assessment for Physical Disability. This will include sensory and physical impairments. It will also include HIV and AIDS.

Programme Budgeting Atlas

Outcome data available for neurological conditions includes:

- Quality and Outcomes Framework indicators.
- Prevalence of epilepsy.
- Record of seizure frequency in those with a diagnosis of epilepsy.
- Percentage of patients with epilepsy on drug treatment who are seizure free.
- Mortality from epilepsy.
- Hospitalisation for a neurological condition (all admissions, day cases, elective and non-elective).
- Bed days for neurology (all admissions, elective and non-elective care).
- Spell length of stay for neurology (admissions excluding day cases, elective excluding day cases and non-elective).
- Deaths within 30 days of neurology admission.
- Emergency readmission to hospital within 28 days of discharge.

NCHOD key outcomes

- The programme expenditure for neurological conditions was greater in 2005/6 than the National average (£4.1M per 100,000 UWP) in South Cambridgeshire (£7.7M per 100,000 UWP), Cambridge City (£7M per 100,000 UWP), East Cambridgeshire and Fenland (£5.2M per 100,000 UWP) and Huntingdonshire (£4.9M per 100,000 UWP).
- FHS prescription expenditure rate per UWP was higher across Cambridgeshire than the national average for neurology in 2005/6.
- The QOF prevalence of epilepsy in over 16's in 2005/6 was measured to be significantly higher in East Cambridgeshire and Fenland (0.7%) than the national average (0.6%).
- Huntingdonshire and South Cambridgeshire had a significantly greater proportion of people with epilepsy on anticonvulsants who were convulsion-free in 2005/6 than the national average.
- Mortality from epilepsy was similar to the National average in 2002-4.

- East Cambridgeshire and Fenland and Huntingdonshire had a higher admission rate for neurological conditions in 2005/6 than the national average, but in all areas non-elective admission rates were significantly lower than the national average.
- Cambridge City, East Cambridgeshire and Fenland and South Cambridgeshire had a significantly greater spell length of stay for neurological conditions in 2005/6 than the national average.

Programme Objectives

To reduce the avoidable burden of neurological system problems in Cambridgeshire by a combination of prevention, early detection (including screening), rapid access to treatment, enhanced quality and length of life, and a well-managed terminal phase and death at the place of the patient's choosing. Given the chronic and disabling nature of many neurological conditions, support for carers is a major objective.

From Annex A - NSF for Long Term Conditions

| | Incidence | Prevalence | Population: all ages | 584,332 | 176,293 | 151,514 | 256,525 | 167,332 |
|---|---|----------------------|----------------------|-----------|----------|----------|--------------|----------|
| | Approximate number of people (prevalence) | | | | | | | |
| | per 100,000 per year | per 100,000 per year | England | Cambs | ECF | Hunts | City & South | Pbro |
| Cerebral palsy | N/k | 186 | 110,000 | 1,087 | 328 | 282 | 477 | 311 |
| Charcot-Marie-Tooth disorder | N/k | 40 | 23,600 | 234 | 71 | 61 | 103 | 67 |
| Dystonia[i] | N/k | 65 | 38,000 | 380 | 115 | 98 | 167 | 109 |
| Early onset dementia[iii] | | N/k | 18,000 | | | | | |
| Epilepsy[iiii] | 24-58 | 430-1,000 | 182,750-425,000 | 2513-5843 | 758-1763 | 652-1515 | 1103-2565 | 720-1673 |
| Essential tremor | N/k | 850 | 500,000 | 4,967 | 1,498 | 1,288 | 2,180 | 1,422 |
| Huntingdon's disease | N/k | 13.5 | 6,000-10,000 | 79 | 24 | 20 | 35 | 23 |
| Migraine[iv] (England) | 400 | 15,000 | 8,000,000 | 87,650 | 26,444 | 22,727 | 38,479 | 25,100 |
| Motor neurone disease | 2 | 7 | 4,000 | 41 | 12 | 11 | 18 | 12 |
| Multiple sclerosis[v] | 03-Jul | 100-120 | 52,000-62,000 | 584-701 | 176-212 | 152-182 | 257-308 | 167-201 |
| Muscular dystrophy | N/k | 50 | 30,000 | 292 | 88 | 76 | 128 | 84 |
| Parkinson's disease | 17 | 200 | 120,000 | 1,169 | 353 | 303 | 513 | 335 |
| Post-polio syndrome | N/k | N/k | 120,000 | | | | | |
| Spinal cord injury[vi] | 2[vii] | 50 | 36,000 | 292 | 88 | 76 | 128 | 84 |
| Spina bifida and congenital hydrocephalus | N/k | 24 | 14,000 | 140 | 42 | 36 | 62 | 40 |
| Young onset stroke[viii] | 55[ix] | N/k | N/k | | | | | |

Population

[\[i\]](#)

[\[ii\]](#)

[\[iii\]](#)

[\[iv\]](#)

[\[v\]](#)

[\[vi\]](#)

[\[vii\]](#)

[\[viii\]](#)

[\[ix\]](#)

Exeter registered population at April 2007

Primary idiopathic, ie not associated with another condition.

For Alzheimer's disease/dementia, the incidence is 25,000 per 100,000 in over 65s, prevalence 1,000 per 100,000 in the general population and approximate total numbers 700,000.

Alzheimer's disease and other dementias are covered in the National Service Framework (NSF)for Older People.

Figures for England and Wales from National Institute for Clinical Excellence (NICE) guidelines.

Steiner TJ et al. (1999) Epidemiology of migraine in England. *Cephalgia*, 19: 305-6.

Figures from NICE guidelines for England and Wales.

Kurtzke JF (1978) Epidemiology of spinal cord injury. *Neurologia Neurocirugia Psiquiatria*, 18: 157-91.

The Spinal Injury Association gives 666 new patient admissions to spinal cord injury centres in the UK and Ireland in 2000 (equivalent to about 2 in 100,000).

For stroke in all ages the incidence is 204, prevalence 800, and approximate total numbers 300,000. Stroke is covered in the *NSF for Older People*.

Admissions to hospitals in England 2002/03.

Applying the OPCS prevalence rates to the Cambridgeshire population gives the estimated number of disabled children. In total the OPCS surveys would indicate 3,760 disabled children aged 0 to 15 in Cambridgeshire, of which 55% are boys and 45% are girls. The table also presents the number of children declared to have limiting long term illness for the 2001 census. Across Cambridgeshire, the number of children declared to have limiting long term illness is around 5% higher than the OPCS disability estimate at 3,950. The table also shows the number of children with a statement of special educational needs at ages 5-9 and 10-15.

Table 17: Cambridgeshire estimated disability prevalence

| | Age | OPCS Disability Surveys | 2001 Census LLTI | % difference | Statement of SEN excl behavioural No's at Oct 05 | Children in receipt of Disability Living Allowance No's at May 01 |
|--------|-------|-------------------------|------------------|--------------|---|--|
| Male | 0-4 | 440 | 480 | 9.1% | - | 100 |
| | 5-9 | 800 | 840 | 5.0% | 484 | 600 |
| | 10-15 | 830 | 1,050 | 26.5% | 988 | 500 |
| | Total | 2,070 | 2,370 | 14.5% | | 1,200 |
| Female | 0-4 | 340 | 320 | -5.9% | - | 100 |
| | 5-9 | 720 | 530 | -26.4% | 155 | 300 |
| | 10-15 | 640 | 730 | 14.1% | 413 | 300 |
| | Total | 1,700 | 1,580 | -7.1% | | 700 |
| Total | 0-4 | 780 | 810 | 3.8% | - | 200 |
| | 5-9 | 1,510 | 1,370 | -9.3% | 639 | 900 |
| | 10-15 | 1,470 | 1,770 | 20.4% | 1,401 | 800 |
| | Total | 3,760 | 3,950 | 5.1% | - | 1,900 |

The table below shows that the OPCS prevalence rates would suggest that in 2001 there were around 62,500 people aged over 16 in Cambridgeshire with some form of disability. Figures of the number of people who self defined as having a limiting long term illness, health problem or disability in the 2001 Census were 23% higher at 76,400. For the population aged 16-59, OPCS prevalence rates suggest there are around 20,900 disabled people, while the Census showed 32,000 people declaring a LLTI (this is over 50% higher). In comparison the number of people aged 16 – 59 claiming Disability Living Allowance was significantly lower, at just 8,700.

Table 18: Cambridgeshire estimated disability prevalence - adults

| | Age | OPCS Disability Surveys | 2001 Census LLTI | % difference | In receipt of Disability Living Allowance No's at May 01 |
|-------|-------|-------------------------|------------------|--------------|---|
| Total | 16-24 | 1,600 | 3,200 | 100% | |
| | 25-59 | 19,300 | 29,000 | 50% | 8,700 (aged 16-59) |
| | 60-74 | 18,400 | 21,700 | 18% | |
| | 75+ | 23,045 | 22,700 | -1% | |
| | Total | 62,300 | 76,400 | 23% | 8,700 |

Overall demographic changes would imply an 11% increase in the number of disabled children, amounting to an additional 410 children. The number of disabled adults would increase by 42%, amounting to nearly 26,000 additional people. We are updating the population projections for the Joint Strategic Needs Assessment 2008.

Table 19: Projected number of disabled children in Cambridgeshire, 2001-2021

| Sex | Age | 2001 | 2011 | 2021 | % change 2001-2021 |
|----------------|-------|-------|-------|-------|--------------------|
| Male | 0-4 | 440 | 450 | 520 | 18.2% |
| | 5-9 | 880 | 890 | 970 | 10.2% |
| | 10-15 | 1,000 | 1,030 | 1,070 | 7.0% |
| Female | 0-4 | 320 | 320 | 370 | 15.6% |
| | 5-9 | 560 | 570 | 620 | 10.7% |
| | 10-15 | 650 | 680 | 700 | 7.7% |
| Total | 0-4 | 760 | 770 | 900 | 18.4% |
| | 5-9 | 1,440 | 1,450 | 1,590 | 10.4% |
| | 10-15 | 1,650 | 1,710 | 1,770 | 7.3% |
| Total children | | 3,850 | 3,930 | 4,260 | 10.6% |

Source: OPCS Survey prevalence rates applied to CCC Research Group mid-2003 based population forecasts

Table 20: Projected number of disabled adults in Cambridgeshire, 2001-2021

| Age group | 2001 | 2011 | 2021 | % change 2001-2021 |
|--------------|--------|--------|--------|--------------------|
| 16-24 | 1,590 | 1,910 | 2,070 | 29.8% |
| 25-59 | 19,270 | 20,150 | 22,760 | 18.1% |
| 60-74 | 18,450 | 23,170 | 26,810 | 45.3% |
| 75+ | 23,040 | 27,480 | 36,590 | 58.8% |
| Total adults | 62,350 | 72,710 | 88,220 | 41.5% |

Source: OPCS Survey prevalence rates applied to CCC Research Group mid-2003 based population forecasts

Within the UK the most broadly used definition of disability is that set out in the Disability Discrimination Act (DDA). The Act defines a disabled person as someone who “has a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities”. Current estimates determine that there are likely to be around 11 million people in the UK who fall under this definition – the government’s recent “Improving the Life Chances of Disabled People”, report reached a figure of 11 million disabled adults and 770,000 disabled children. This will be one of the definitions to use in the Joint Strategic Needs Assessment.

It is now generally accepted that many disabled people will face additional costs that arise from managing their impairment. Such costs can take the form of extra expenditure on general items, for example having to spend extra on heating, or expenditure on disability related items, such as mobility or sensory aids. In broad terms it is possible to suggest that as the severity of impairment rises so do the extra costs of disability.

Disability Living Allowance (DLA) is the principal benefit aimed at meeting disabled people's extra costs of living. High numbers of respondents in surveys have no savings.

The employment rate among disabled people currently stands at about 50%, and, whilst this has been rising slowly in recent years, it still falls far short of the overall employment rate in the UK.

The Welfare Reform Act 2007 is the central part of the government's drive to increase the employment rate of disabled people. In particular the Act aims to get 1 million recipients of incapacity benefit back to work. The Act will replace Incapacity Benefit (IB) with a new Employment and Support Allowance (ESA) which will include a higher rate to help support those who cannot work. In tandem with this new benefit the Pathways to Work scheme, which currently operates only in certain parts of the UK, will be rolled out nationwide. The Access to Work scheme provides vital support to disabled employees and their employers.

Welfare benefits should play a crucial role in supporting those on low incomes out of poverty, in matching the extra costs of disability and in providing a safety net for those whose circumstances change. Recent reports highlight the problems experienced through disability poverty in the UK, with the need to assist people in taking up benefits for which they are eligible,

Summary of commissioning interventions for neurological system problems.

Commissioning contact Dr Christine Macleod

Prevention

- Where primary prevention is impossible, to what extent is secondary prevention (delaying disability and handicap) feasible in each individual?

Diagnosis and Assessment

- Minimise waiting times to achieve a diagnosis and therapeutic plan.

Treatment

- Disseminate, implement and monitor NICE guidance.
- Disseminate, implement and monitor NSF Neurological Conditions.

Rehabilitation and Continuing Care

- Neurological disorders are often chronic and intractable, so the aim is to minimise hospital attendance in favour of community or domiciliary treatments wherever practicable.
- Facilitate independent living, care planned around the needs and choices of individuals, easier timely access to services, joint working across all agencies

Terminal Care

- When disease reaches its end-stage, support informed planning for the terminal stage, respecting patient choice for place of death whenever possible.

NICE GUIDANCE

| Published Guidance Publication date | Type of guidance | Topic |
|--|-----------------------------|--|
| June 2006 | Clinical guideline | Parkinson's disease |
| August 2007 | Clinical guideline | Chronic Fatigue Syndrome / Myalgic Encephalomyelitis |
| August 2007 | Single Technology appraisal | Multiple Sclerosis - natalizumab |

| In Progress Guidance Publication date | Type of guidance | Topic |
|--|-------------------------|---|
| November 2008 | Technology appraisal | Pain (chronic neuropathic or ischaemic) – spinal cord stimulation |
| June 2009 | Clinical guideline | Meningococcal disease and meningitis |
| TBC | Technology appraisal | Multiple sclerosis – cannabinoids |

6.2.9 Head Injuries

Head injury in England is common. Head injury incidence in England varies by a factor of 4.6 across Primary Care Trusts. Planning head injury related services at the local level thus needs to be based on local incidence figures rather than regional and national estimates.

It has been estimated that 6.6% of those attending A&E in any given year have a head injury and over 100,000 people are admitted as a consequence. In 2002-3, the hospitalised incidence rate was 229.4 per 100,000 all ages. This is similar to the incidence of stroke although the latter is experienced in predominantly older people. However, head injury affects a predominantly younger population and carries with it a high economic impact. About 4700 people admitted in any one year out of 112,718, and who are considered to be economically active (aged 16 -74) and in employment at the time of their injury would be unable to return to their work at 6 weeks.

To assist in planning for services, data at the local level can now be downloaded from:
<http://www.dh.gov.uk/publicationsAndStatistics/Statistics/HospitalEpisodeStatistics/fs/en>

Table 21: Incidence of admission to hospital for head injury by PCT 2002-3. Estimated rate per 100,000; for those aged 0-15; 16-74; and 75 years and over, and in total.

| PCT | Under 16 | 16-74 | 75+ | All ages |
|---------------------------------|-----------------|--------------|------------|-----------------|
| Cambridge City | 299.59 | 280.04 | 673.70 | 311.40 |
| East Cambridgeshire and Fenland | 355.18 | 176.74 | 606.06 | 247.33 |
| Huntingdonshire | 329.18 | 136.40 | 542.41 | 202.69 |
| South Cambridgeshire | 266.36 | 159.74 | 713.21 | 220.37 |

Much also needs to be done on prevention. Road traffic accidents, for example are high in some parts of Cambridgeshire.

There are at least 70 people known to social services requiring significant follow up care for severe physical disabilities following a head injury.

6.2.10 Mental Health

Mental health is fundamental to good health, wellbeing and quality of life. It impacts on how we think, feel, communicate and understand. It enables us to manage our lives successfully and live to our full potential. Mental ill health is one of the long term conditions which significantly affects the quality of life.

There are a wide range of factors, which can give rise to poor mental health. The mental health status of populations can be assessed by looking at the risk and protective factors and determinants of mental health, the population mental health status and traditional outcomes such as suicide.

Deprivation

Many of the risk factors for mental illness are linked to deprivation. Given the evidence that adults and children from disadvantaged backgrounds are more likely to suffer mental health disorders, measures of deprivation can help to identify areas where the need for mental health services is likely to be greatest, thus ensuring that mental health service provision is targeted appropriately.

There is considerable variation within local districts in Cambridgeshire in the proportion of super output areas (SOAs) belonging to the most and least deprived fifths of all areas in England. Fenland is the only district in Cambridgeshire with SOAs in the 1st quintile representing the most deprived areas of England; it also does not have any SOAs in the 5th quintile. More than 70% of the SOAs in South Cambridgeshire are in the 5th quintile representing the least deprived areas of England.

Demography - Ethnicity

The provision of mental health care for people from black and minority ethnic communities raises important and complex issues including linguistic and cultural competence. Variations between ethnic groups in rates of various types of treatment and in particular of the use of compulsion of the Mental Health Act have been the subject of considerable debate over the last two decades.

Cambridge City has the highest proportion of people from a non-white ethnic group. The other districts have a significantly lower proportion of non-white ethnic group as compared with England and Wales.

Different ethnic groups have varying mental health experiences – for example, women living in England and Wales but born in Sri Lanka, India and the East African Commonwealth countries are 50% more likely to commit suicide than women in the population as a whole.

Employment

There is considerable evidence to support the beneficial effects of employment on an individual's mental health. Employment can protect a person's mental health by boosting confidence and self-esteem; unemployment can be both a consequence and cause of mental health problems.

Employment is thought to play an important role in rehabilitation. People suffering from mental health problems who are not in employment are thought to be less likely to recover from their illness.

Incapacity Benefit

Numbers claiming Incapacity Benefits (those with a diagnosis in the mental and behavioural disorders category) are significantly lower in Cambridgeshire (about 150 per 100,000 population) as compared to England (about 275 per 100,000 population). However, within Cambridgeshire these are substantially higher in Fenland and Cambridge City (between 225 - 250 per 100,000 population) and these are even higher than those in the East of England.

Limiting Long Term Illness

Poor quality of life through physical illness is closely related to mental health problems. People with mental health problems are up to twice as likely to report experiencing a long-term illness or disability; over two-thirds of people with a persistent mental health problem also have a long-term physical complaint.

This indicator measures the proportion of people living in a household who consider themselves to have a limiting long term illness (LLTI), health problem or disability that limits daily activities and work that the individual can undertake.

Data on limiting long-term illness is covered in details in section 3.1 on Demographic Trends.

Limiting long-term illnesses impact upon an individual's ability to work and be economically active, which increases the risk to one's mental health. The Census demonstrated that people who have never worked or are long term unemployed have the highest rates of limiting long term illness of all socio-economic groups, at 37%.

Serious physical illness is one of a number of stressful events that can be linked to a high prevalence of suicidal thoughts.

There is a fairly consistent pattern across the county, with residents being more likely to have a limiting long-term illness or to perceive their health to be poor in wards to the north of the county particularly in and around Wisbech, Huntingdon North, and in parts of Cambridge City. The pattern of poor health, as measured by the Census, is broadly similar to the pattern of deprivation as measured by the Index of Multiple Deprivation.

Alcohol

Evidence suggests an association between increased alcohol consumption and mental ill health. Alcohol consumption can be a cause of mental ill health, or a resulting factor. Less than 1% of the general population were classified as being moderately or severely dependent on alcohol, this increased to 2% in people with neurotic disorders, 5% among those with phobias and 6% among those with two or more neurotic disorders. Alcohol dependence is often treated within mental health services.

Table 22: Interpolated national figures using CCCRG mid-2006 population estimates, Cambridgeshire

| | Age | % | Source | CC | EC | Fen | Hun | SC | County |
|-----------------------------------|--------------------|-----|--------|--------|--------|--------|---------|--------|----------------|
| Do not experience Problems | 16 and over | 90 | ONS | 87,333 | 55,100 | 65,481 | 115,371 | 99,651 | 422,936 |
| Hazardous or harmful | men 16-64 | 32 | ANARP | 13,780 | 7,719 | 8,834 | 16,946 | 14,375 | 61,653 |
| Hazardous or harmful | women 16-64 | 15 | ANARP | 6,029 | 3,667 | 4,167 | 7,876 | 6,646 | 28,385 |
| Hazardous or harmful | all 16-64 | 23 | ANARP | 19,149 | 11,171 | 12,739 | 24,256 | 20,522 | 87,837 |
| Dependent | men 16-64 | 6 | ANARP | 2,584 | 1,447 | 1,656 | 3,177 | 2,695 | 11,560 |
| Dependent | women 16-64 | 2 | ANARP | 804 | 489 | 556 | 1,050 | 886 | 3,785 |
| Dependent | all 16-64 | 3.6 | ANARP | 2,997 | 1,749 | 1,994 | 3,797 | 3,212 | 13,748 |
| Binge drinkers | men 16-64 | 21 | ANARP | 9,043 | 5,066 | 5,797 | 11,121 | 9,433 | 40,460 |
| Binge drinkers | women 16-64 | 9 | ANARP | 3,617 | 2,200 | 2,500 | 4,726 | 3,987 | 17,031 |
| Alcohol use disorder | men 16-64 | 38 | ANARP | 16,364 | 9,166 | 10,490 | 20,123 | 17,070 | 73,213 |
| Alcohol use disorder | women 16-64 | 16 | ANARP | 6,431 | 3,912 | 4,445 | 8,401 | 7,089 | 30,278 |
| Alcohol use disorder | all 16-64 | 26 | ANARP | 21,647 | 12,628 | 14,400 | 27,420 | 23,199 | 99,295 |

Source: Office for National Statistics (ONS), Alcohol Needs Assessment Research Project (ANARP) 2004

Psychiatric Morbidity

Many people with mental health problems do not seek help for them. In order to identify the true extent of mental health problems in the community it is necessary to use the national prevalence figures and estimate the likely burden of illness in the local population.

Table 23: Estimate of number of adults with a mental health problem, mid 2006

| District | Estimated number of people with a mental health problem |
|----------------------|---|
| Cambridge City | 13,876 |
| East Cambridgeshire | 8,095 |
| Fenland | 9,231 |
| Huntingdonshire | 17,577 |
| South Cambridgeshire | 14,871 |
| Cambridgeshire | 63,650 |

Source: Mental Health National Service Framework and Mid 2006 population estimates, Cambridgeshire County Council Research Group

It is estimated that there are up to 2,890 people with schizophrenia in Cambridgeshire, 2,890 with affective psychosis, 28,930 with depressive disorders and 34,720 with anxiety states.

The estimates for neurotic disorders show that 37,640 people have mixed anxiety and depressive disorder in Cambridgeshire, 18,820 people have a generalized anxiety disorder, 11,120 have a depressive disorder, 7,700 have a phobia, 4,710 have an obsessive-compulsive disorder and 2,990 have a panic disorder.

Dementia

The incidence of dementia rises considerably with age particularly among women. With the ageing population, this is an important indicator to plan and provide services, particularly for the older population.

Dementia is covered in further details in the section 6.2.3 on Vulnerable Older People.

Severe Mental Illness on GP Register

The GPs register patients who have severe mental health problems in the QOF register. According to the definition used by the national QOF dataset this indicator records only people who are registered with a GP, and who have agreed to treatment/follow up in primary care settings.

Table 24: Mental health disease register by district – recorded prevalence 2006/07

| District | Disease Register Mental Health 2006/07 | Unadjusted Recorded Prevalence (95% CI) | Range in GP Practices |
|----------------------|--|---|-----------------------|
| Cambridge City | 1,496 | 1.0% (1.0 - 1.1%) | 0.2 - 1.1% |
| East Cambs | 325 | 0.5% (0.5 - 0.6%) | 0.8 - 1.2% |
| Fenland | 487 | 0.5% (0.4 - 0.5%) | 0.3 - 1.7% |
| Huntingdonshire | 945 | 0.6% (0.5 - 0.6%) | 0.4 - 0.7% |
| South Cambridgeshire | 625 | 0.6% (0.5 - 0.6%) | 0.2 - 0.6% |
| Cambridgeshire | 3,878 | 0.7% (0.6 - 0.7%) | 0.2 - 1.7% |

Source: QoF 2006/07 (QMAS Information Centre)

From the QOF registers, Cambridge City has an unadjusted prevalence rate of 1%, which is statistically significantly higher than that seen in other districts of Cambridgeshire. It will be worth investigating this further to see if proximity to the Mental Health Trust could be one of the major reasons for this high prevalence. The unadjusted prevalence for Cambridgeshire as a whole is 0.7%.

Suicides

Suicide rates have been used as a target since 'The Health of the Nation' in the early 1990s.

Table 25: Mortality: Suicide and Injury Undetermined, all ages, 2003-2005

| Local Authority | Average annual deaths | Rate/100,000 | 95% CI |
|-----------------------|-----------------------|--------------|----------|
| England & Wales | 4,775 | 8.59 | (8 - 9) |
| Cambridge | 11 | 9.88 | (6 - 13) |
| East Cambridgeshire | - | 4.95 | (2 - 8) |
| Fenland | - | 7.17 | (4 - 11) |
| Huntingdonshire | 9 | 5.69 | (4 - 8) |
| South Cambridgeshire | 12 | 8.79 | (6 - 12) |
| Cambridgeshire County | 43 | 7.10 | (6 - 8) |

Source: Compendium of Clinical and Health Indicators 2006 based on ONS mortality data

Overall Cambridgeshire has a statistically significantly lower rate than England and Wales. However, there is considerable variation across the county, with Cambridge City having the highest rate at 9.88 per 100,000 and East Cambridgeshire with the lowest at 4.95 per 100,000.

East Cambridgeshire and Huntingdonshire have rates that are low compared to both England and Wales and Cambridgeshire County but do not differ significantly. It is important to note that the number of deaths are small and therefore prone to annual fluctuations.

Commissioning of current MH Services and Major Gaps

Progress towards delivery of the National Service Framework milestones and other key measures of local mental health service improvement is assessed annually each December on a “traffic-light” basis by Local Implementation Teams (LITs) and then jointly validated by the Strategic Health Authority and the regional Care Services Improvement Partnership.

The results from the 2006 Self-Assessment for Cambridgeshire show two major gaps in Cambridgeshire classified as “RED”:

- The lack of primary mental health workers in East Cambridgeshire and Fenland;
- The lack of a sufficient number of community development workers to enhance access to services for patients from black and other ethnic minority (BME) groups.

The other gaps classified as “AMBER”:

- Access for all patients to crisis resolution services;
- The full implementation of a three-year early intervention service;
- Local access to secure or intensive care places;
- Work with the Local Strategic Partnership to promote social inclusion;
- Mental health services for people with a learning disability;
- Vocational support services;
- User and carer involvement;
- The employment of service users;
- Mental health promotion;
- Specialist services for people with a personality disorder;
- The provision of “places of safety”;
- Improved access to psychological therapies;
- Patient choice.

Plans to address most of these issues were already in place at the time of the assessment, or have been developed in recent months.

Programme Budgeting Atlas

Outcome data available for mental health includes:

- Quality and Outcomes Framework indicators including:
 - Prevalence of mental illness,
 - Treatment checks on mental illness patients
 - Lithium level, serum creatinine and TSH level checks on patients receiving lithium therapy
- Mortality from suicide, suicide and injury undetermined, schizophrenia and death recorded with a mention of schizophrenia.

- Hospitalisation for all mental health, substance misuse and dementia (all admissions, day cases, elective and non-elective).
- Bed days for all mental health, substance misuse and dementia (all admissions, elective and non-elective care).
- Spell length of stay for all mental health, substance misuse and dementia (admissions excluding day cases, elective excluding day cases and non-elective).
- Deaths within 30 days of admission: all mental health, substance misuse and dementia.
- Emergency readmission to hospital within 28 days of discharge: all mental health, substance misuse and dementia.
- Patterns of care for all mental health (17-64 years and 65+):
 - Mean number of admissions for mental health.
 - Mean length of stay.
 - Composite Z-score for mean number of admissions and mean length of stay.

NCHOD key outcomes

- The programme expenditure for mental health was greater in 2005/6 than the national average (£15.7M per 100,000 UWP) in Cambridge City (£26.1M per 100,000 UWP); it was lower in South Cambridgeshire (£13.9M per 100,000 UWP), East Cambridgeshire and Fenland (£13.3M per 100,000 UWP) and Huntingdonshire (£10.3M per 100,000 UWP).
- The FHS prescription expenditure rate per UWP was higher across Cambridgeshire than the national average for “other mental health” (excludes dementia and substance misuse) in 2005/6.
- The QOF prevalence for mental illness was measured to be significantly higher than the National average in East Cambridgeshire and Fenland and Cambridge City, and significantly lower in Huntingdonshire and South Cambridgeshire.
- Significantly fewer patients in South Cambridgeshire had treatment checks for Mental Health conditions in 2005/6 than the national average.
- The mortality rates from suicide in 2002-4 in Cambridge City and South Cambridgeshire were significantly higher than the national average; the rate in Huntingdonshire was significantly lower.
- Cambridge City had a significantly higher admission rate and non-elective admission rate than the national average for mental illness in 2005/6; all other areas had admission rates that were significantly lower. There was also a significantly higher rate of readmission to hospital within 28 days of discharge in Cambridge City when compared to the national average in 2005/6.

Programme objectives

To reduce the avoidable burden of mental health problems in Cambridgeshire by a combination of prevention, early detection, rapid access to treatment, enhanced quality and length of life. This includes:

- Promoting positive mental health and preventing relapse.
- Alleviating symptoms when mental illness does occur.
- Restoring patients to their maximum potential as functioning members of society.
- Supporting carers.

Summary of commissioning interventions for mental health

Commissioning contact: John Ellis and Abhijit Bagade

Prevention

- Much greater use of physical activity, creative arts and flexible employment opportunities to protect mental health and prevent relapses.
- Social support, access to social networks, community cohesion, reduction in stigma and discrimination.
- Learning and skills development, access to employment.
- New Growth – New Communities – take forward recommendations of review by Dr. Suan Goh.
- This is a major area for Joint Strategic Needs Assessment and joint working.
- The overlap with the alcohol strategy, and local strategies is a prime example of the need for collaboration.

Diagnosis and Assessment

- Implementation of the National Service Framework, including case management and crisis intervention.

Treatment

- Dissemination and implementation of NICE guidance.
- Greater emphasis on alternatives to medicines, eg “talking therapies”.
- Greater investment in liaison between district general hospitals (eg in Accident and Emergency, alcohol-related diseases and medicine for the elderly) and the expert psychiatric services merits further consideration: it could improve patient outcomes and be cost-effective.

Rehabilitation and Continuing Care

- Since chronic mental illness is common, “being all you can be” and support to carers are major objectives of the programme.
- Case management should be developed to its full potential.

Terminal Care

- The needs and wishes of the individual at the end of life require special handling.

NICE GUIDANCE

| Published Guidance Publication date | Type of guidance | Topic |
|--|-----------------------------|---|
| September 2005 | Clinical guideline | Depression in children and young people |
| November 2005 | Clinical guideline | Obsessive-compulsive disorder (OCD) |
| February 2006 | Technology appraisal | Attention deficit hyperactivity disorder - methylphenidate, atomoxetine and dexamfetamine |
| February 2006 | Technology appraisal | Depression and anxiety - computerised cognitive behaviour therapy (CCBT) |
| July 2006 | Clinical guideline | Bipolar disorder |
| July 2006 | Technology appraisal | Conduct disorder in children - parent-training/education programmes |
| December 2006 | Clinical guideline | Dementia |
| January 2007 | Technology appraisal | Drug misuse - methadone and buprenorphine |
| January 2007 | Technology appraisal | Drug misuse - naltrexone |
| February 2007 | Clinical guideline | Antenatal and postnatal mental health (APMH) |
| March 2007 | Public health interventions | Interventions to reduce substance misuse among vulnerable young people |
| April 2007 | Clinical guideline | Depression & Anxiety (amendment) |
| July 2007 | Clinical guideline | Drug misuse - Psychological Interventions |
| September 2007 | Technology appraisal | Alzheimer's disease – donepezil, galantamine, rivastigmine (review) and memantine |
| November 2007 | Public health interventions | School-based interventions on alcohol |

| Published Guidance Publication date (Continued) | Type of guidance | Topic |
|--|-----------------------------|---|
| February 2008 | Technology appraisal | Structural neuroimaging in first-episode psychosis |
| March 2008 | Public health interventions | Social and emotional wellbeing in primary education |
| May 2008 | Public health interventions | Promoting physical activity in the workplace |

| In Progress Guidance Publication date | Type of guidance | Topic |
|--|-----------------------------|---|
| | | |
| | | |
| June 2008 | Public health interventions | Promoting mental wellbeing at work |
| July 2008 | Public health interventions | Mental wellbeing in older people |
| September 2008 | Clinical guideline | Attention deficit hyperactivity disorder (ADHD) |
| January 2009 | Clinical guideline | Antisocial personality disorders (ASPD) |
| January 2009 | Clinical guideline | Personality disorders - borderline |
| January 2009 | Public health programmes | Promoting physical activity for children |
| March 2009 | Clinical guideline | Schizophrenia (update) |
| June 2009 | Public health interventions | Promoting the social and emotional wellbeing of young people in secondary education |
| June 2009 | Clinical guideline | Depression – chronic health problems |
| June 2009 | Clinical guideline | Depression – primary and secondary care |

| | | |
|-----------------------|--------------------------|---|
| September 2009 | Public health programmes | Personal, social and health education focusing on sex and relationships and alcohol education |
| April 2010 | Clinical guideline | Delirium |
| March 2010 | Public health programmes | Alcohol-use disorders in adults and young people |
| March 2010 | Public health programmes | Alcohol-use disorder in adults and young people |
| TBC | Clinical guideline | Severe mental illness with problematic substance misuse |
| TBC | Technology appraisal | Dementia (non-Alzheimer) - new pharmaceutical treatments (suspended) |

7 PANDEMIC INFLUENZA PLANNING

7.1 Long Term Conditions and Pandemic Influenza Planning

People aged 6 months and over with the following long term conditions are targeted by the annual seasonal 'flu vaccination campaign. In addition GPs are asked to consider whether individuals with other conditions may be at risk from an exacerbation of their condition or a deterioration in their situation if they should catch 'flu, and are encouraged to immunise where they feel the person will benefit (reference: PL/CMO/2008/3):

- Chronic respiratory disease (including asthma that requires steroid treatment or hospital admission).
- Chronic heart disease.
- Chronic renal disease.
- Chronic liver disease (including viral hepatitis).
- Chronic neurological disease (including transient ischaemic attacks).
- Diabetes (whether controlled by insulin, tablets or diet alone).
- Immunosuppression (whether due to disease or treatment).

In the event of a pandemic, and in the absence of an effective vaccine against the pandemic strain for the first few months of the pandemic, it is inevitable that people with these conditions will make greater use of diagnostic and treatment services than under normal conditions.

Part of pandemic contingency planning involves drawing up plans to ensure fair access to limited resources (such as ITU facilities), and such plans will need to be informed by local data on the number of people who may experience a higher rate of complications.

In addition, there are people whose physical, psychological and social circumstances mean that they have complex care needs. Consideration will have to be given to how influenza affecting them or their main carer will impact on their care plans. Services should begin now to draw up individual contingency plans identifying the person's preferences for treatment, access to anti-viral medication, and suitable alternative care settings as appropriate.

8 ACTION PLANS

8.1 ACTION PLAN 2008 – 2009

| | April – June 2008 | July –September 2008 | October – December 2008 | January – March 2009 | Lead commissioner |
|---|---|--|---|----------------------|-------------------|
| COPD | Co-creating health Improve referrals to smoking cessation Develop plans for pulmonary rehabilitation. | | | Monitoring outcomes | Lead Sandra Moore |
| Diabetes (link with Cambs Obesity Strategy) £150k investment | Recruit diabetes commissioner and diabetes network administrator Improve referral to smoking cessation Review implications of new NICE guidance | Educational plan for diabetes Design Local Enhanced service Extend diabetes network to county wide | Information plan for diabetes Pathway redesign | Monitoring outcomes | Lead Dennis Cox |
| Vulnerable Older People | Use Joint Strategic Needs Assessments to inform models of service for vulnerable older people Publication of older people's strategy with CCC and PCT. | Publication of Joint Commissioning Strategy for Older people with CCC and PCT Clarification of models for intermediate care and community matrons | Celebrating Age programme | Monitoring outcomes | Lead Vinny Logan |

| | | | | | |
|---|---|--|-------------------------------------|---------------------|---|
| | Baseline data for Local Area Agreement Review falls prevention programme | Expansion of care closer to home. | | | |
| Palliative and End of Life Care | Complete baseline stock take | Action plan following on from national and EoE strategy | | Monitoring outcomes | Lead Sandra Moore |
| Coronary Heart Disease (link with Cambs Obesity Strategy) £64k investment Disease registers £70k investment Heart failure services £46k investment | Review cardiac rehabilitation services in line with NICE commissioning guidance Recruit 2 primary care facilitators Plan to improve drug treatments and dose titration in patients with heart failure funded by Anglia Heart Network. | Re-commission modern sustainable cardiac rehabilitation services. Improve coverage of heart and stroke registers in primary care linking to outcomes and treatments. Operation risk assessments in primary care. | | Monitoring outcomes | Lead Christine Macleod and Karen Hayton |
| Stroke | Recruit to Consultant in Stroke medicine | Unbundle tariff | Further develop hub and spoke model | Monitoring outcomes | Lead Christine Macleod and Karen |

| | | | | | |
|-------------------------|---|---|--|--|------------------------------------|
| | and specialist nurse in Hinchingsbrooke | Create patient education material | | | Hayton |
| Children | Introduction of schemes to reduce childhood obesity | | | Monitoring outcomes | Lead Bob Dawson |
| Neurological Conditions | Finish Joint Strategic Needs Assessment | | | Monitoring outcomes | Lead Christine Macleod |
| Mental Health | 1. Finalise Action Plan for the MH Joint Commissioning Strategy. 2. Complete Alcohol Strategy and Action Plan. | 1. Monitoring outcomes 2. Finalise Action Plan | 1. Monitoring outcomes 2. Monitoring outcomes | 1. Monitoring outcomes 2. Monitoring outcomes | Lead Abhijit Bagade and John Ellis |

8.2 2008 - 2011

There are a number of policy areas which the Long Term Conditions Board will consider in the longer term.

We will review the expert patient programme and the annual mapping exercise of support services for individuals.

There is an expectation that individuals will have personalised care plans and that information will be available at the point of care.

This strategy lists some of the outcomes, which are monitored through the programme budget atlases for each client group, and in addition we have the set of National Indicators for the Local Area Agreements and the vital signs for the NHS. Over the next few months we will review the outcomes which we use in surveillance and for commissioning for outcomes.

Predicting risk is important for both commissioners and providers of care. We will decide our policy on the use of the PARR+ and the combined model working with practices.

The PCT has purchased software for developing pathways of care and will work in partnership with the East of England pathway groups.

For several pathways the commissioner will unbundled the tariff, such as with the stroke pathways.

Workforce plans become increasingly important as patients demand care closer to home and in their local communities, and we will develop these in the context of population growth.

Prevention is key and the Long Term Conditions Board will consider the implication of the Joint Strategic Needs Assessments for physical disability and the Joint Strategic Needs Assessment for prevention.

The PCT is investing in primary care systems for the identification of individuals at high level of risk of developing a long term condition such as a myocardial infarction, or a stroke. We will build on the QoF data to monitor improved access to treatments and prevention and improved outcomes for people with long term conditions. This will enhance the mechanisms to deliver optimum care to all on disease registers.

In each area the Practice Based Commissioners use the NICE commissioning toolkits, the most recent of which is the NICE guidance on commissioning cardiac rehabilitation and we will strive to put in place modern, clinically and cost effective services.

The care teams for older people are advanced in that they are already integrated across health and social care. We will build on this.

The National Strategy for End of Life Care is due and will encourage the uptake of the Gold standards for palliative care, and anticipatory care. This work is being led by the PCTs palliative care group. We will encourage the use of prognostic indicators in the Gold Standards Framework and the Preferred Priorities for Care.

The PCT and Local Government are investing in assistive technology.

8.3 LTC Clinical Pathway Group Recommendations

| Empowering the individual and carers | | | | |
|---|------------|-------------------|----------------------------------|--------------------------|
| Commissioning Intention | WHO | TIME SCALE | RISKS/ISSUES DEPENDENCIES | POSITION/PROGRESS |
| A range of structured education, information and support, including the Expert Patients Programme, should be commissioned, which all individuals with long term conditions, including carers, can access in line with their specific needs. | | | | |
| Carers are considered throughout this pathway, both in terms of their right to have an assessment of their needs as an individual with caring responsibilities, and their role in supporting self care. | | | | |
| The PCT in partnership with Local Authorities will conduct an annual mapping exercise of the support services available for individuals and their carers, including support groups. | | | | |
| All people with a long term condition have a personalised “care”/ “health” plan which is ‘owned’ and held by them, includes anticipatory and advance care plans and is focussed on the individual’s desired processes and outcomes. | | | | |

| Information sharing | | | | |
|--|------------|-------------------|----------------------------------|--------------------------|
| Commissioning Intention | WHO | TIME SCALE | RISKS/ISSUES DEPENDENCIES | POSITION/PROGRESS |
| Information needs to be available at the point of care 24/7, and emergency service providers – Out of Hours Primary Care, Ambulance, A&E, emergency Social Services – need to know that information is available and how to access it, then ensure they feedback any incidents and action taken to GP practices and relevant others. Appropriate information should also be available in paper format, held by the individual. | | | | |
| To commission shared information systems with access based on need, robust identification of individual patients and mechanisms to ensure continuity of care in accordance with NHS best practice. | | | | |

| Commissioning across the whole system and for the long term | | | | |
|--|------------|-------------------|----------------------------------|--------------------------|
| Commissioning Intention | WHO | TIME SCALE | RISKS/ISSUES DEPENDENCIES | POSITION/PROGRESS |
| Clinical Networks should be reviewed and terms of reference revised to ensure consistency between Networks, clarity of purpose and the appropriate interface between commissioners and providers. | | | | |
| Ensure that Joint Strategic Needs Assessment, Local Public Health reports and the Local Area Agreements assess and take due regard of people with long term conditions and their needs in order to plan appropriate action and address inequity. | | | | |
| Adopt, as one of the case finding tools, the systematic and consistent use of population stratification (PARR++ or the Combined Model, to identify different segments of their population and their emerging or changing needs. This is required in order to appropriately target interventions on higher risk people and groups, and also to ensure that lower risk individuals are properly supported. | | | | |
| Ensure that individuals receive the appropriate intensity of support they require and that any change in level of intensity required is identified through regular review. Reviews could take place at any interval from daily to annually depending on individual need. | | | | |

| Commissioning across the whole system and for the long term | | | | |
|--|------------|-------------------|----------------------------------|--------------------------|
| Commissioning Intention | WHO | TIME SCALE | RISKS/ISSUES DEPENDENCIES | POSITION/PROGRESS |
| Use the population stratification (eg through PARR++) to examine current NHS utilisation rates and model the cost of different interventions against different degrees of impact on utilisation of all services including benefits, social services, cares and the voluntary sector. | | | | |
| Routinely and regularly work with service users and their representatives, involving clinicians, in describing the pathway of care from a person centred perspective. This should then be transformed into a specification with clear outcomes. | | | | |
| Contracts and Service Level Agreements (SLAs) with all providers should set out clear specific standards and outcome measures, against which the commissioner should monitor performance. This should take account of <i>all</i> pathway elements. | | | | |
| Ensure that individuals and their carers with long-term conditions have rapid access to appropriate advice. This could be face to face or by telephone or other remote media. This could be with a whole range of specialists (doctor, nurse, therapist, pharmacist). | | | | |

| Workforce | | | | |
|--|------------|-------------------|----------------------------------|--------------------------|
| Commissioning Intention | WHO | TIME SCALE | RISKS/ISSUES DEPENDENCIES | POSITION/PROGRESS |
| A review of the capacity and capability of the workforce is required in order to risk assess delivery of service recommendations, with clear lines of accountability for PCT/PBC Commissioners, Strategic Health Authority (SHA), Commissioners of Education and Training, PCT Providers and other provider organisations. | | | | |
| Service standards and process measures for the performance management of contracts should include staff attitude and ability to form supportive and empowering relationships of equal partnership (including not using inappropriate condition labels (eg “diabetic” or “asthmatic” for service users with LTC’s). | | | | |
| Ensure that there is access to, the competencies described in World Class Commissioning, which particularly relate to long-term conditions - ‘work with community partners’, ‘engage with public and patients’ and ‘collaborate with clinicians’. | | | | |
| Commissioners need to ensure that existing and potential providers have the necessary skills, including change management skills to deliver on the models of care, pathways and outcomes required. | | | | |

| Workforce | | | | |
|---|------------|-------------------|----------------------------------|--------------------------|
| Commissioning Intention | WHO | TIME SCALE | RISKS/ISSUES DEPENDENCIES | POSITION/PROGRESS |
| Ensure that process measures include specific feedback from people with long term conditions about their experience of staff attitude/approach and quality of relationship, and that suitable sanctions be in place if standards are not met. | | | | |

| Prevention | | | | |
|--|------------|-------------------|----------------------------------|--------------------------|
| Commissioning Intention | WHO | TIME SCALE | RISKS/ISSUES DEPENDENCIES | POSITION/PROGRESS |
| Identify vulnerable groups (eg those who are homeless, people with learning disability, those experiencing deprivation, people who are housebound, frail elderly people, people with mental health problems, prisoners, those with English as a second language, etc) in their areas who are at higher risk of both developing long term conditions and of experiencing the most adverse impact of long term conditions, in order to inform commissioning of equitable services. | | | | |
| Effective smoking cessation and weight management programmes should be commissioned as a priority, particularly targeting those vulnerable groups at risk of LTCs. | | | | |
| Use appropriate tools to address different areas of disease. For example prevention of heart disease can be delivered by ensuring that people at a greater than 20% risk of developing CVD over the next 10 years are identified by use of an appropriate risk assessment tool. | | | | |
| Risk registers should be constructed and the numbers of observed versus expected people on the risk registers should be within reasonable tolerances. | | | | |

| Prevention | | | | |
|--|------------|-------------------|----------------------------------|--------------------------|
| Commissioning Intention | WHO | TIME SCALE | RISKS/ISSUES DEPENDENCIES | POSITION/PROGRESS |
| Annual reviews of those identified as being at risk should be carried out and their particular risk factors should be managed to optimal levels with appropriate interventions, and changes in risk level monitored. | | | | |
| Target more general prevention activities as well as long-term condition specific prevention activities at children where they can have a demonstrable impact on the development of risky behaviours. | | | | |

| Screening and Diagnosis | | | | |
|--|-----|------------|---------------------------|-------------------|
| Commissioning Intention | WHO | TIME SCALE | RISKS/ISSUES DEPENDENCIES | POSITION/PROGRESS |
| <p>The PCT and PBCs will work together to embed structured, proactive processes in primary care which include:</p> <ul style="list-style-type: none"> • Opportunistic screening for risk factors of every person who periodically attends their GP practice, and who is not under a regular regime of review. This will need to include arrangements for follow up and recall, together with simple referral routes to services such as smoking cessation and weight loss. • Targeted screening through structured searches of practice records to identify those people with risk factors for LTCs, such as hypertension, BMI >25, smoking, family history. These people could then be invited for screening to establish if they have a >20% risk of developing CVD over the next 10 years (see prevention pathway elements). • Targeted and opportunistic screening for long term conditions in those with a specifically high level of risk. | | | | |

| Screening and Diagnosis | | | | |
|--|------------|-------------------|----------------------------------|--------------------------|
| Commissioning Intention | WHO | TIME SCALE | RISKS/ISSUES DEPENDENCIES | POSITION/PROGRESS |
| <ul style="list-style-type: none"> • Clinical decision support tools, training and education to help facilitate improvements in the identification of patients with symptomatic disease eg recurrent chest infections in a smoker and COPD. • Improving the management of people with hypertension but whose risk of CVD is less than 20%. • Examination of the observed patients (numbers on registers) compared with the expected prevalence of LTCs. • Involvement of other primary care providers who are accessed by the general public and vulnerable groups, such as community pharmacists. | | | | |
| To commission direct access to appropriate diagnostic tests and associated interpretation and management advice. | | | | |
| Where needed to contract for advice (face to face, by telephone, email etc) for community based health care professionals from secondary care consultants and other specialists to assist with this process. | | | | |

| Screening and Diagnosis | | | | |
|---|------------|-------------------|----------------------------------|--------------------------|
| Commissioning Intentions | WHO | TIME SCALE | RISKS/ISSUES DEPENDENCIES | POSITION/PROGRESS |
| Use appropriate guidance and commissioning toolkits (eg NICE Commissioning Toolkits) to support the process and ensure a comprehensive review of need informs the procurement of the appropriate range of treatments. | | | | |

| Management Plans | | | | |
|---|------------|-------------------|----------------------------------|--------------------------|
| Commissioning Intentions | WHO | TIME SCALE | RISKS/ISSUES DEPENDENCIES | POSITION/PROGRESS |
| Examine and review pathways across the whole range of individual long term conditions, ensuring that individuals with more than one condition are served by integrated, multi disciplinary service provision and support. Commissioners need to ensure that services provided by different teams/agencies are 'joined up' and include appropriate specialist input. | | | | |
| Ensure that the full range of equipment with appropriate expert advice to support independence and good quality care is available. This includes telecare and telehealth systems, as well as a range of equipment for specialist, mobility, nursing, sensory impairment and communication needs. | | | | |
| To develop plans to implement a mainstream system for delivering appropriate assistive technology to those who will benefit, including provision of advice to those buying their own equipment without formal assessment. | | | | |
| Stimulate the retail market to mainstream availability of this equipment at affordable prices, eg B&Q stock telecare sensors, Argos stock bathlifts, Boots and other pharmacists stock blood pressure monitors. | | | | |

| Management Plans | | | | |
|---|------------|-------------------|----------------------------------|--------------------------|
| Commissioning Intentions | WHO | TIME SCALE | RISKS/ISSUES DEPENDENCIES | POSITION/PROGRESS |
| Ensure that appropriately tailored training and ongoing advice is available so that people can understand the outcomes from telehealth monitors, the appropriate self care approaches and the threshold of when to seek further advice. | | | | |
| To harness where appropriate the potential of the internet and mobile phones for communication and ongoing support and coaching. | | | | |
| Implement a robust system for validating the Quality and Outcomes Framework (QOF) and use the resultant data to support commissioning activity particularly in relation to the needs of people with COPD, heart failure and diabetes. | | | | |
| Develop mechanisms for monitoring the delivery of optimum clinical care for all people on all disease registers (not just those relating to QOF). | | | | |

| Exacerbations | | | | |
|---|------------|-------------------|----------------------------------|--------------------------|
| Commissioning Intentions | WHO | TIME SCALE | RISKS/ISSUES DEPENDENCIES | POSITION/PROGRESS |
| Ensure that the people at high risk of exacerbation, or who have a history of repeated A&E attendances or admissions, are identified. | | | | |
| <p>To specify that personalised care plans must include:</p> <ul style="list-style-type: none"> • Advanced and anticipatory care plans with the necessary education, support and supplies. • A palliative and end of life component. • Rapid patient-initiated access to specialist advice (face to face, by telephone, email as appropriate to the individual). | | | | |
| Work with out of hours providers, the ambulance trust and social services to ensure a whole systems approach. | | | | |
| To specify use of prognostic indicators as in the Gold Standards Framework and Preferred Priorities for Care in relation to palliative care need for forward planning. | | | | |
| To specify use of appropriate assistive technology to aid early identification of exacerbations and to support management of exacerbations in individuals' own homes. | | | | |

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Self care

Self care and self management are more than giving people information about their condition. They are about acknowledging their central role in managing their own care and supporting them and their family and carers to manage their condition as effectively as possible. Self care is a well proven and highly effective means of improving LTC care.

Disease management

Proactive disease management can make a real difference to people with a single condition or a range of problems that impact on their health and wellbeing. Implementation of the National Service Frameworks is already demonstrating that this approach can have a radical impact on outcomes for individuals. Good disease management involves identifying needs early and responding promptly with the right care and support. Personalised care planning actively supports this approach.

Case management

Some people have an intricate mix of health and social care needs and simple problems can cause their condition to deteriorate rapidly, putting them at risk of unplanned hospital admission. Evidence has shown that intensive, ongoing, personalised case management can improve quality of life and outcomes for such people. Case management, led by a community matron or a case manager, has been rolled out as part of the LTC strategy. PCTs have been encouraged to undertake local evaluation of this service – below are a couple of examples.

Multidisciplinary teams

People with LTCs, in particular those with a range of complex needs, often require care or support from a range of different professionals and agencies. Bringing these together into multidisciplinary teams is therefore critical as it underpins a co-ordinated, seamless approach to delivery of care and support, avoiding fragmentation, confusion and duplication of effort. The case study below illustrates this.

Self directed care

Individual budgets and direct payments can improve people's lives, giving them more choice and control over services. They can also give people more purchasing power by bringing different sources of funding and support together in one place. There are currently individual budget pilots in 13 local authorities.

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CONDITIONS STRATEGY – FINAL
JULY 2008*