London Ambulance Service NHS
NHS Trust

Long Term Conditions Strategy

Kiran Chauhan
Policy, Evaluation & Development

June 2008

London Ambulance Service NHS Trust

Long Term Conditions Strategy

Contents

1. Introduction

This paper sets out an update and the next steps for the London Ambulance Service NHS Trust's (LAS) strategy for involvement with the management of long term conditions in London's health communities.

Recent information from the Department of Health reports that over fifteen million people in the UK live with a long term condition (LTC)[1]. These are conditions that at present cannot be cured, but can be managed by medication and therapies. They include asthma, diabetes, epilepsy, chronic obstructive pulmonary disease, conditions related to old age and cardiac and stroke-related conditions. While various mental health conditions are long term conditions, they are addressed within a specific mental health strategy and therefore outside of the scope of this strategy.

Treatment for exacerbations of these conditions accounts for a significant proportion of resource use in the National Health Service; people with LTCs, and especially those with co-morbidities, are reported to be the most intensive users of the most expensive services. The government is keen to see these conditions better managed using whole-systems approaches, broadly following lessons learnt from the United States adapted to fit the social care model. One aspect of this is enabling patients living with LTCs to self-care more effectively; another is ensuring that support services are adequate, responsive, and joined-up to provide case- and disease-management as appropriate.

As a key part of front-line care and the only pan-London provider NHS organisation, the LAS will need to be an integral part of any improved or reconfigured system.

2. Background

The case for change

A limited, high level analysis of 2006/07 hospital episodes data restricted to LTCs provides some interesting results[2]:

- 16% of patients admitted to hospitals in England had primary diagnoses coded as relating to LTCs ("LTC admissions" hereafter). These admissions accounted for 24% of all occupied bed days.
- Mean and median lengths of stay for LTC admissions (14 and 5 days, respectively) were more than double the averages for total admissions (6.3 and 2 days respectively).
- 41% of LTC admissions were coded as emergency admissions compared to 36% of all admissions indicating that patients with LTCs are more likely than average to require emergency admission to hospital.

Chronic care models, such as those used by Kaiser Permanente, Pfizer and Evercare groups in the United States are seen to be a means of reducing the number of unscheduled LTC admissions through case management strategies. As well as being indicative of poorly controlled illness, unscheduled admissions for exacerbations of LTCs clearly create what could be seen to be avoidable expenditure for the NHS; adopting versions of these systems has understandably been strongly advocated by the current government in keeping with its broad aim to encourage greater efficiency within the health service set out in the 2000 NHS Plan.[3]

High level outcomes for people with LTCs

The Department of Health's document *Raising the Profile of Long Term Conditions Care* [4] suggests the following high level outcomes for patients with LTCs:

- People have improved quality of life, health and well-being 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.

These indicate broad aims for improving care for patients with LTCs; more detail regarding the role that Ambulance Services can play in providing this is found in the *National Service Framework for Long Term Conditions*, issued in March 2005. This document sets out a strategy for improving the integration of services for patients with chronic illness and disease.

The National Service Framework for Long Term Conditions

The National Service Framework for (neurological) Long Term Conditions[5] is arguably the most important recent relevant publication that mandates the development of this strategy. The NSF sets out eleven Quality Requirements for an integrated system for long term neurological conditions but states that "much of the guidance […] can apply to anyone living with a long-term condition." These quality requirements are listed in Box 2.1.

Quality requirement 1: A person centred service
People with long term neurological conditions are offered integrated assessment and planning of their health and social care needs. They are to have the information they need to make informed decisions about their care and treatment and, where appropriate, to support them to manage their condition themselves.

Quality requirement 2: Early recognition, prompt diagnosis and treatment
People suspected of having a neurological condition are to have prompt access to specialist neurological expertise for an accurate diagnosis and treatment as close to home as possible.

Quality requirement 3: Emergency and acute management
People needing hospital admission for a neurosurgical or neurological emergency are to be assessed and treated in a timely manner by teams with the appropriate neurological and resuscitation skills and facilities.

Quality requirement 4: Early and specialist rehabilitation
People with long term neurological conditions who would benefit from rehabilitation are to receive timely, ongoing, high quality rehabilitation services in hospital or other specialist settings to meet their continuing and changing needs. When ready, they are to receive the help they need to return home for ongoing community rehabilitation and support.

Quality requirement 5: Community rehabilitation and support
People with long term neurological conditions living at home are to have ongoing access to a comprehensive range of rehabilitation, advice and support to meet their continuing and changing needs, increase their independence and autonomy and help them to live as they wish.

Quality requirement 6: Vocational rehabilitation
People with long term neurological conditions are to have access to appropriate vocational assessment, rehabilitation and ongoing support, to enable them to find, regain or remain in work and access other occupational and educational opportunities.

Quality requirement 7: Providing equipment and accommodation
People with long term neurological conditions are to receive timely, appropriate assistive technology/equipment and adaptations to accommodation to support them to live independently, help them with their care, maintain their health and improve their quality of life.

Quality requirement 8: Providing personal care and support
Health and social care services work together to provide care and support to enable people with long term neurological conditions to achieve maximum choice about living independently at home.

Quality requirement 9: Palliative care
People in the later stages of long term neurological conditions are to receive a comprehensive range of palliative care services when they need them to control symptoms, offer pain relief, and meet their needs for personal, social, psychological and spiritual support, in line with the principles of palliative care.

Quality requirement 10: Supporting family and carers
Carers of people with long term neurological conditions are to have access to appropriate support and services that recognise their needs both in their role as carer and in their own right.

Quality requirement 11: Caring for people with neurological conditions in hospital or other health and social care settings
People with long term neurological conditions are to have their specific neurological needs met while receiving treatment or care for other reasons in any health or social care setting.

Box 2.1: The National Service Framework for (neurological) Long Term Conditions: Quality Requirements

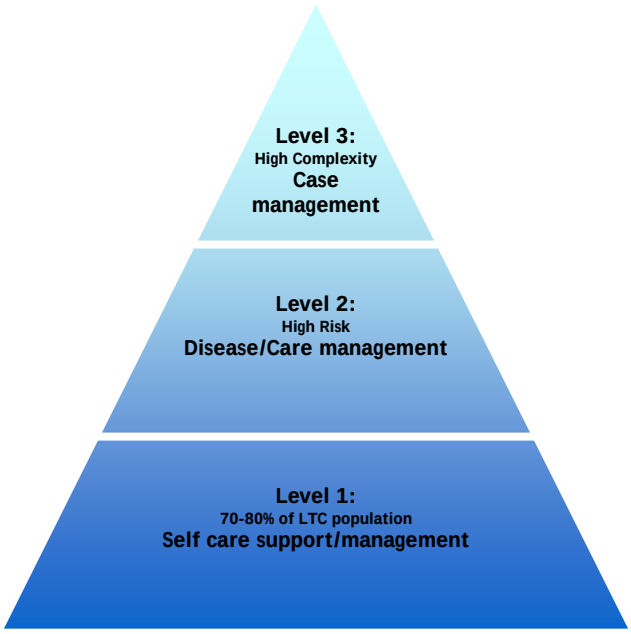
Schematically, Quality Requirements 1 – 3 relate approximately to pre-diagnosis phases of care, and 4 – 11 to post-diagnosis phases of care. Ambulance services will be particularly important for the pre-diagnosis phase, and so this paper will consider the LAS's role in relation to QRs 1 – 3 in the first instance.

2.3.1 Quality requirement 1: a person centred service

People with LTCs are offered integrated assessment and planning of their health and social care needs. They are to have the information they need to make informed decisions about their care and treatment and, where appropriate, to support them to manage their condition themselves.

For ambulance crews, there is a clear drive to ensure that treatment ultimately follows the wishes of the patient. At the same time, however, there is a need for crews to ensure that patients are provided with enough information to be able to make informed choices so that those wishes are in the patient's best interests. This may involve informing the patient about local services and will rely on establishing a common language between ambulance staff and their Primary Care Trust colleagues.

Primary Care Trusts are in the process of developing case and care management systems using variations of the Kaiser Permanente, Pfizer and Evercare models. These are at various stages of implementation and consequently it is difficult for ambulance crews to approach patients in a systematic way.



(Source: DH 2008)

There is also a need for robust communication channels so that all ambulance encounters can be reported back to primary care practitioners (GPs, community matrons, case managers, etc.) so that appropriate action can be taken if necessary.

2.3.2 Quality requirement 2: early recognition, prompt diagnosis and treatment

People suspected of having a long term condition are to have prompt access to specialist expertise for an accurate diagnosis and treatment as close to home as possible.

Intuitively, there seems to be great scope for crews to assist in the identification of patients with LTCs, and in particular high-risk patients who might benefit from pro-active case management. The cost benefits of reducing admissions through better management are potentially huge and the LAS is well-placed to contribute to this significantly.

The LAS has a role beyond emergency first aid within a patients care pathway. Shifting the culture of the LAS is perhaps the most difficult barrier to be overcome, but work is underway in the form of the *New Ways of Working* initiative to address this.

The first phase of this programme, entitled 'Transforming Clinical Leadership' brings together various strands of the overall Service Improvement Programme and focuses them on the delivery of patient care by staff working on station complexes. The aim is to create the best possible environment for clinical leadership, and so improve both the care given to patients and the job satisfaction of staff.

Within the current provision, Emergency Care Practitioners (ECPs) are well-placed to contribute to the management of patients with LTCs. Already having additional training in chronic conditions, ECPs can build and use referral routes in their areas to ensure patients receive the most appropriate care in keeping with PCT initiatives. These referral routes are available to all front-line ambulance staff, but uptake has been variable.

Many ECPs are already involved in projects around LTCs and, in the areas they are operating, have formed a natural link between primary and secondary care and the LAS. In turn, many community teams, GPs and professionals in the acute sector are keen to learn more about the role and skills of ECPs, and are also keen to have more of them operating in more areas. The LAS will be significantly increasing the numbers of ECPs it employs by April 2010. The challenge will be to keep ECP work on specification while performance pressure inevitably mounts for the ambulance service. There is a strong argument to suggest that ensuring this work remains focussed will bring significant long-term benefits to the health population thus *reducing* demand on the service.

2.3.3 Quality requirement 3: emergency and acute management

People needing hospital admission for a long term condition-related emergency are to be assessed and treated in a timely manner by teams with the appropriate resuscitation skills and facilities.

However well cases and diseases are managed, there will still be LTCs related emergencies. These should continue to be managed using local specialist centres and Accident and Emergency departments as appropriate in keeping with the outcomes of the Healthcare for London review. There may be opportunities to refer these patients to alternative practitioners if suitable case management structures are available within the local Primary Care Trust's provision and the Policy, Evaluation and Development team, and complexes' Pathway Champions are working with London providers to forge links and establish pathways accordingly.

3. Strategy Method

This strategy has been developed with the input of interested people from a range of professions, both from within the LAS and external organisations.

In additions to interviews with relevant members of LAS and PCT staff, a half-day stakeholder event was held in April 2008 to look at:

- the opportunities available for the LAS to help manage patients with LTCs in London's health population; and
- how success could be measured.

A summary of the feedback received from this workshop can be found in Appendix A.

4. Implementation Structure

The priorities for the LTCs strategy that have been determined through stakeholder and policy research are largely concerned with making improvements to existing protocols, or using existing mechanisms. The strategy recommendations in this document specify areas of work; these will be adapted to produce project plans that will need local adaptation. The recommendations will be ratified and fed into the workstreams defined by the Service Improvement Programme.

It is important that implementation of these project plans is not undertaken in a directive manner; there is sufficient evidence to suggest that an approach that engages the individuals who will be responsible for delivering the projects will be most effective. The risk of not using this approach is

significant failure to produce the intended outcomes, and indeed for local action to block the desired direction of progress.

5. Strategy Priorities and Action Plan

5.1 Options analysis

- The following actions are methods by which the LAS could help to better manage LTCs in London.
- Feasibility and indicative timescales are considered for each option in the suggested action plan.
- These are subject to ratification and subsequent resource allocation.

5.1.1 PCT/LAS Joint Contact List

It is recognised that, if local solutions to LTC management are to be developed, there needs to be good communication between Ambulance Operations Managers and local LTC leads in primary care. Currently, many PCT leads do not know who their local AOMs are, and vice versa, and this is not unique to the LTC workstream. A local 'directory' maintained by the Community Involvement Officer is therefore recommended as a means of improving communication channels. This is, however, only the first step: the aim is to initiate local dialogue between PCTs and the LAS about how to work in partnership to produce service improvement.

ACTION: **Produce a local directory of service** in which PCT and Complexes can share contact details that include the AOM, PEDT staff at the LAS, PCT leads for LTCs, Older People, Pharmacy, etc. This could briefly outline current strategies for each workstream. This should be kept under review by Community Involvement Officer and be sent out via e-bulletin/in hard copy on a quarterly basis.

5.1.2 Increase awareness of LTCs

It is recognised that LTCs do not have a high profile in the LAS's field of vision because of the tendency for front-line staff to approach patients as a 'first aid' service. A theme that runs through the NSF quality requirements is to deliver care in more holistic way; this is supported by the LAS's own strategic plan which advocates the appropriate treatment of each patient, rather than conveying to an Accident and Emergency Department by default.

Currently, the Emergency Care Practitioner programme is engaged with this kind of approach, and the scheme is undergoing a rapid expansion in the near future. It is understood that a change in the focus of front-line staff is a difficult task, and that the *New Ways of Working* initiative, amongst others, is aiming to tackle this issues. These large-scale cultural changes will take time to produce results.

The actions that can currently be taken, however, are to raise the awareness of LTCs, so that when the *New Ways of Working* initiative becomes more wide-spread, front-line staff will already be more aware of the conditions they might encounter.

The training programme for front-line staff already includes aspects of LTC care, however, additional work is required if these conditions are to gain a higher profile.

ACTIONS:
- Include articles focussing on specific LTCs in the LAS News on a regular basis
- Increase training in LTCs more generally where possible and appropriate

5.1.3 Patient specific protocols

Patients suffering from LTCs will often have established care pathways/contacts for dealing with exacerbations of their conditions. These can be created in conjunction with all of the providers (in

primary and secondary care) involved in the patient's care, and can be recorded in their Care Management folder, on an instruction sheet, or using the Message in a Bottle.

ACTION: Improve use of Message in a Bottle/Ambulance Instruction Cards systems to better tailor care to the individual

5.1.4 Reporting non-conveyance of patients to primary care

Currently, attendance of a patient who does not go on to get conveyed to an Emergency Department is not reported back to that patient's primary care practitioner. A copy of the Patient Record Form (PRF) is given to the patient to deliver to their General Practitioner; this may or may not happen. It is clearly important for the primary care practitioners involved in the care of patients with LTCs to be notified of any attendance by the LAS, as calls to emergency services may indicate poor disease control in some cases.

ACTION: Create a method for feeding back non-conveyances to primary care practitioners

5.1.5 Referral Pathways

When a patient doesn't need to be conveyed to an Emergency Department but does require some follow up, it is possible for front-line ambulance staff to refer these patients to suitable community services. These may be community nurses, physiotherapists, falls teams, etc., with whom the LAS has a referral pathway agreement.

A number of such pathway agreements are established in various parts of London, but the uptake of these pathways is variable. This is for a number of reasons: sometimes pathways are under-resourced and so cannot meet the needs of the LAS; services may not be available 24 hours a day; crews may not feel confident in making referrals; patients may not want to be referred to another service; crews may consider conveyance to hospital a safer option; or, it is sometimes just easier to take the patient to hospital.

ACTION: Continue to monitor and increase use of referral pathways

5.1.6 Avoidable use of ambulance services

It is important for PCTs to understand where their current care provision is lacking so that appropriate measures can be taken to fill the gaps in service. Calls to emergency services from patients for avoidable reasons (eg. exacerbations of LTCs due to inadequate management) are a good indicator of the adequacy of provision so a means of feeding back this information would be useful. PCTs already receive feedback from the Commercial Analysis department of LAS, but it is not certain that this is well-utilised.

ACTION:
- Adapt feedback capability to highlight service provision gaps
- Liaise with PCT colleagues to better utilise this information

5.1.7 Screening for LTCs

In relation to the NSF's second quality requirement, there is a requirement for local health services to find ways to identify patients who are at risk. As well as broader public education campaigns, it is recommended that avenues by which LAS staff could be involved in pro-actively screening all patients attended for detectable LTCs are explored.

ACTION: Complexes to liaise locally with PCTs to identify areas where LAS crews can assist in early identification and screening for long term conditions.

5.2 Suggested Action Plan

Supporting actions	Resources required	Benefits	Timescales	Outcome measures	Workstream
5.1.1 Produce a local directory of service for PCTs and Complexes					
• Engage AOMs/NWOW team • Compile data • Establish roles for updating data • Compile distribution lists	•Local network researcher, e.g. the Community Involvement Officer •Communications team guidance on style	•Developed and maintained local networks •Better communication between agencies • Greater awareness of local initiatives • More joined-up care for patients	•Constrained only by availability of CIO/ local network development capacity. •Go-live in line with NWOW timeframes. **SHORT/MEDIUM TERM**	•Existence of up-to-date directory, held by PCTs and Complexes, and updated regularly. •Higher levels of patient satisfaction	Access programme
5.1.2 Increase awareness of LTCs • Include articles focussing on specific LTCs in the LAS News on a regular basis • Increase training in LTCs more generally where possible and appropriate					
•Identify and engage potential contributors to the LAS news •Liaise with Communications Team •Develop training package for LTCs (esp for PTS and Urgent Care teams) •Identify internal and external professionals who could assist in providing training.	• Clinical staff to provide information for articles • Communication team guidance • LAS news • Training capacity • Professional expertise/trainer	• Increased awareness about particular LTCs will allow front-line staff to make more informed assessments when visiting patients with these conditions •More appropriate care for patients	•This project should be initiated as soon as possible. **SHORT TERM**	•Articles in the LAS news •Training sessions provided by suitable professionals •Improvement in relevant staff survey result (would require adaptation of standard staff survey questions) •Improvement in patient satisfaction survey results	Business as usual

5.1.3 Patient specific protocols • Improve use of Message in a Bottle/Ambulance Instruction Cards systems to better tailor care to the individual					
•Identify areas of good practice – find out why these are working well •Consult with AOMs about barriers to success •Develop a project to roll-out the scheme London-wide if desirable and practicable •Design a system to monitor usage (via PRF or other audit mechanism)	•Personnel •Buy-in from local complexes and providers (eg. PCTs, Age Concern, etc.)	• More information available when crews attend individual patients, thereby creating more opportunities to provide personalised, appropriate care • Greater patient satisfaction with service received	Timescales will depend upon what arrangements are currently in place in local stations, but conversations should begin as soon as possible. **SHORT/MEDIUM TERM**	•An increase in the number of patients linked in with primary and secondary care practitioners •Improved patient satisfaction survey (indirect) •Reduction in hospital admissions (indirect)	Business as usual
5.1.4 Reporting non-conveyance of patients to primary care • Create a method for feeding back non-conveyances to primary care practitioners					
•Identify the information that needs to be fed back •Identify who the information needs to be sent back to (presumably the patient's primary care practitioner) •Communicate the need for a feedback system to the LAS team developing the hand-held computers so that this may be part of	*(dependent upon the solution devised)*	•Primary care practitioners (who are responsible for ongoing care) will have more clinical information about their patients •Primary care practitioners will have the potential to identify changes in illness patterns •Better clinical outcomes for the patient	•Currently, it is not feasible to engineer a paper-based solution to feeding back information about non-conveyances to primary care. There are plans in plans, however, to introduce hand-held computers for front-line crews to use on-scene. **MEDIUM/LONG TERM**	•Better clinical outcomes	Access programme

the design. •Devise an auditable system – eg. record on PRFs					
5.1.5 Referral Pathways • Continue to monitor and increase use of referral pathways					
•Devise a means of identifying LTC patients using the PRF •Establish expected/current usage & bring actual usage more into line with expected usage •Develop crew confidence in using pathways (via NWOW) •Improve technological data management – eg. palm pilots, EMS, CSD •Encourage 24 hour services from providers and, eg. ECPs.	•Training capacity •Primary care services	•Patients will receive appropriate care without being transferred to hospital. •Primary care practitioners will be more involved in looking after patients within their own catchment areas, thereby providing a more joined-up service •Financial benefits to the health economy due to reduced hospital episodes	•Already in progress and linked in with *New Ways of Working* **SHORT/MEDIUM TERM**	•Increase in the number of referrals made •Decrease in the number hospital admissions relating to LTCs.	Operational model
5.1.6 Avoidable use of ambulance services • Adapt feedback capability to highlight service provision gaps • Liaise with PCT colleagues to better utilise this information					
•Establish how information received is used by PCTs •Develop the existing feedback function to highlight	•Management Information capacity to adapt current data set •Data management skills in primary care to make use	•A better understanding of the needs of the local community for primary care providers •Awareness of trends in illness to better inform service planning/ gap	Information of this sort is already available in some form, so resource will indicate timescales for further software development work.	•Fewer attendances to patients with LTCs in both quantity and proportion of all attendances (indirect)	Access programme

LTC patients	of the data produced for business planning	analyses	**SHORT TERM**		
5.1.7 Screening for LTCs • Complexes to liaise locally with PCTs to identify areas where LAS crews can assist in early identification and screening for long term conditions.					
•Identify which LTCs could be screened for in liaison with PCTs •Establish resource requirement, eg. training, test kits •Establish how to feedback information received to primary care •Carry out an audit on crews routinely screening those over 40 years for diabetes	•Training capacity •Screening kit •Method for referring/feeding back any suspected cases •?Central database •CARU input for audit	•Earlier identification of LTCs •Prompter referral and treatment for patients with LTCs	This will depend upon the allocation of resources for scoping and purchase of necessary kit. **MEDIUM TERM**	•increased referrals to LTC management services (eg. diabetes team)	Development of a public health strategy

6. Measurement & Evaluation

This LTCs strategy will need to be evaluated to ensure that any changes are an improvement in the services provided, and to enable communication and dissemination of successes achieved as well as to enable the LAS to learn from any problems.

Each recommendation is accompanied by suggested outcome measures and these will be good indicators for success in each area.

Evaluation does need to include patient outcome measures and satisfaction where possible however, and not just focus on reducing demand or decreasing A&E attendances for example – though these remain valuable indicators.

There is a particular need for ongoing conversation with the front-line staff about their perceptions of the strategy, to ensure that there is fit with their experiences of the operating environment.

It is anticipated that the overall strategy will be reviewed in five years' time. It is acknowledged, however, that what works for one complex may not work for another; ongoing **local** evaluation is therefore required to be undertaken in addition to wider strategy evaluation to ensure that projects remain relevant to practice.

References

[1] DH – LTC background, accessed online on 02.01.2008 at http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Longtermconditions/DH_4128521

[2] Primary diagnosis: 3 character 2006-07, HES online, accessed online on 02.01.2008 at http://www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937&categoryID=203; extracted codes sourced from "Disease coding from HES to assist with case finding" accessed online on 02.01.2008 at http://www.networks.nhs.uk/80.php

[3] Ham, C. & Singh, D. (2006) *Improving Care for People with Long-Term Conditions: A review of UK and international frameworks* accessed online on 02.01.2008 at http://www.improvingchroniccare.org/downloads/review_of_international_frameworks__chris_hamm.pdf

[4] DH – *Raising the Profile of Long Term Conditions Care* accessed online on 02.01.2008 at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082069

[5] DH – *The National Service Framework For Long Term Conditions,* accessed online on 02.01.2008 at http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Longtermconditions/Long-termNeurologicalConditionsNSF/DH_4128647