NHS Lancashire and South Cumbria Integrated Care Board

Long Term Condition LES Engagement session one

8th January 2025

Chaired by Peter Tinson - ICB Director of Primary and Community Commissioning

Purpose of the session:

- **engage with colleagues across ICB (clinical and non-clinical), GP practices, Local Medical Committee, stakeholders and partners**
- **focus on clinical elements of DRAFT LTC LES**
- **encourage colleagues to share feedback via Menti survey open until Friday 10th January.**

https://www.menti.com/alsvooqtze74

Contents

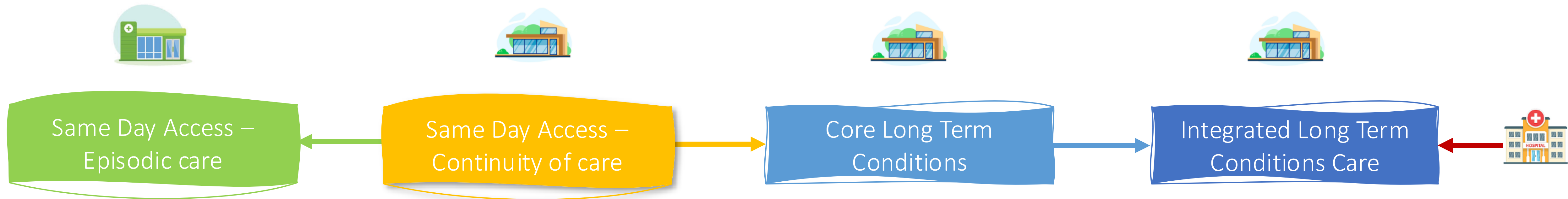
- Vision
- Integrated neighbourhood care
- Story board
- Long term condition service specification - draft
- Further engagement
- Menti survey open until Friday 10th Jan 2025
  https://www.menti.com/alsvooqtze74

NHS Lancashire and South Cumbria Integrated Care Board

LES approach 2025/26 onwards – the vision

- LES approach for 2025/26 onwards shaped by ICB vision and evolving general practice vision
- Specifically, a major shift from an acute to a community centred model with a focus on LTC management in primary care

General practice vision - a reminder



Core General Practice and primary care provision

Screening, health promotion, vaccinations and immunisations, safeguarding, routine medications, routine health checks, etc

Empowered

1. An empowered, sustainable primary care system...

...with agency to influence and innovate through parity of investment in capacity, leadership and research.

2. Citizens as partners...

...engaged in service design and equipped with the information and technology needed to self-manage their health and wellbeing.

Connected

3. Delivery of the right care, in the right place...

... a primary care landscape that acknowledges and embraces different models of scale to drive sustainability and enable transformation, innovation and improvement.

4. A commitment to access, continuity of care, personalised care with a focus on reducing health inequalities...

...moving away from siloed and competitive activity-led work to impact-led interactions.

Respected

5. Care provided by a connected, skilled and respected workforce...

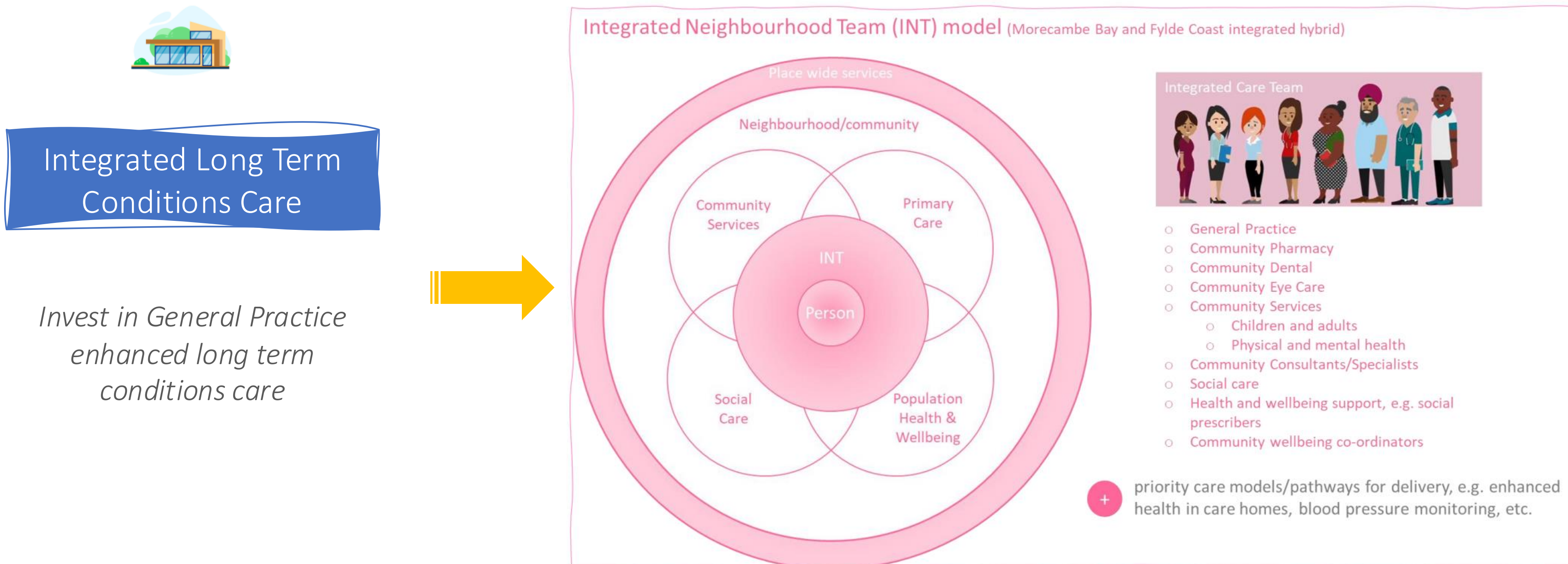
...with teams of teams in an integrated neighbourhood at the forefront.

6. Genuine commitment to primary care at scale as a key part of population health management and quality improvement...

...better outcomes for people, communities and staff.

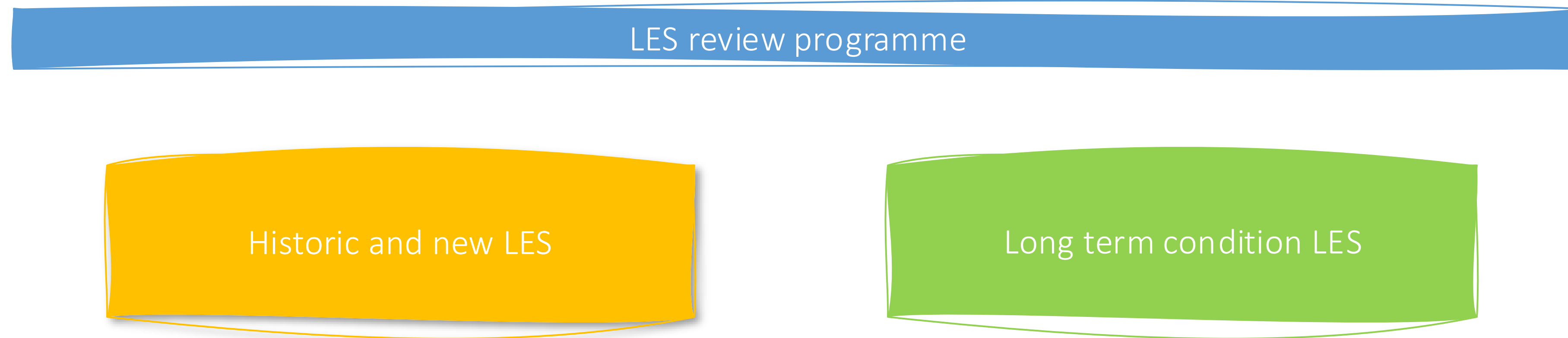
Integrated neighbourhood care

- Step in the journey towards fully integrated neighbourhood care
- Future steps include investment in community services to enable and support a growing left shift of care
- And formalising the integrated leadership and targeting of neighbourhood primary and community resources



NHS Lancashire and South Cumbria Integrated Care Board

LES review programme



Two areas of focus

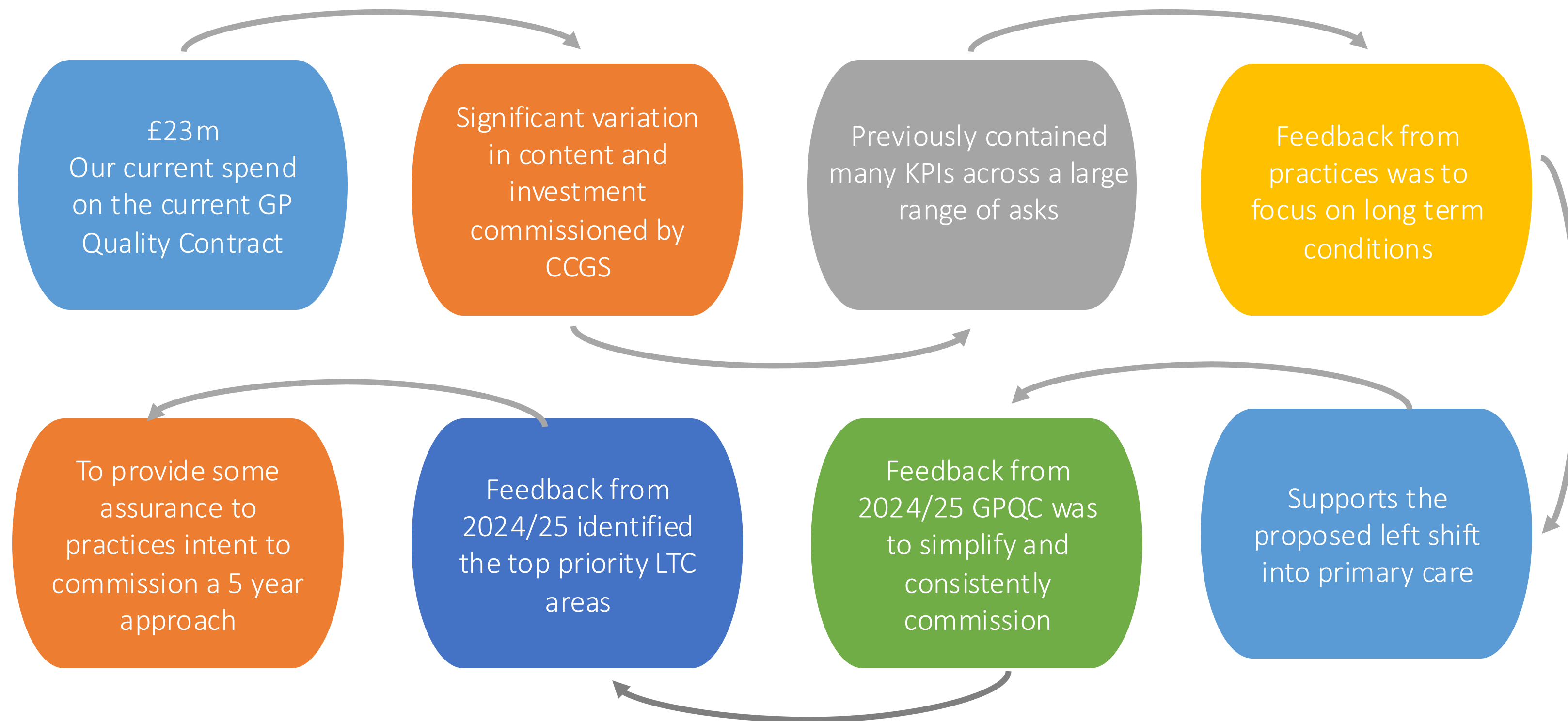
Initial commenced two individual pieces of work, these have now been merged into one overarching work programme with two areas of focus:

1. All LES inherited from former CCGs and a number of newly developed LES identified through collective action conversations

2. Long Term Conditions LES (former GPQuality Contract)

All activities are over and above core GMS contract

Story board – LTC LES



Long Term Condition LES
Service Specifications

Intentions of LTC LES:

The overarching aim of the LTC LES is to identify individuals with significant health, care or social needs registered with each practice, identify their unmet needs and provide relevant support.

The design and delivery of the LTC LES aims to balance the overlapping needs of:

- The unmet needs of the individual patient
- The needs of system by reducing pressure on the Urgent Care sector
- Effectively resourcing GP practices to provide sustainability in delivery and expectation of transformation.

Underpinning these is an intention to develop an inclusion health approach to ensure that those individuals whose needs are greatest are proactively given the opportunity of access to health services to support their needs.

Inclusion health is an umbrella term used to describe people who are socially disadvantaged and/or excluded, who typically experience multiple overlapping risk factors for poor health, such as poverty, violence, and complex trauma (these are the groups referred to as the ‘Core20plus’ in the national Core20plus5 frameworks).

Long Term Condition LES review

Following a review of the GPQC in Autumn 2024 the LTC LES has been designed with more flexibility for delivery and consideration around delivery support.

Indicative activity numbers will be provided to each practice ahead of contract implementation.

<table>
<tr><th>Resource %</th><th colspan="4">Activity Expectation</th><th>Outcome/monitoring</th></tr>
<tr><td>30%</td><td colspan="4">Implementation
Administration & support to care coordinator/navigation support
Case finding and risk stratification work
Monitoring of outcomes and reporting
Training needs assessment and meeting training requirements to deliver this LES
Building relationships across practices and partners and ‘headspace’ for leadership and transformation activity</td><td>High level practice plan of delivery</td></tr>
<tr><td rowspan="2">60%</td><td>Clinical Case Finding</td><td>Population health Management</td><td>Long term condition 1</td><td>Long term condition 2</td><td rowspan="2">Assessment number based on weighted population

Practice to deliver at least 10% of total activity from each segment

Generic template to be provided with codes and holistic health needs relevant to all LTCs, prevention and population health.</td></tr>
<tr><td>Case finding chosen according to variance from expected population prevalence</td><td>Use risk stratification and Inclusion Health knowledge to identify cohort.</td><td>Place based decision based on pop health and Place based knowledge</td><td>Place based decision based on pop health and Place based knowledge</td></tr>
<tr><td>10%</td><td colspan="4">MDT approach

Practice level MDT and PCN or collective MDT based on historic multi-practice working</td><td>High level practice plan of delivery

Coded for MDT, no specific target to be given.</td></tr>
</table>

Delivery of LTC LES Assessments

The delivery activity of the LTC LES is split across four domains, each practice will have to undertake activity in each segment:

	Clinical Case Finding project	Population health management project	Long term condition 1	Long term condition 2
Choice of one from each column	Flexibility to review own prevalence of individual conditions	Use of Population Segmentation tool within Aristotle to identify individuals most at risk	CVD Diabetes Respiratory Frailty SMI	CHD Diabetes Respiratory Frailty SMI
Number of patient assessments planned				

Each practice will need to undertake a minimum activity of 10% of their total allocated activity in each segment; for example, a practice with an allocated activity of 1000 would be required to undertake at least 100 assessments in case finding, population health management and each of the two LTC domains. Further allocation of activity is at the discretion of the practice.

The choice of which of the LTC to undertake will be derogated to each Place to decided. This is to ensure that there is local consistency of delivery to best meet the needs of the local population.

Lancashire and South Cumbria Integrated Care Board

Clinical Case Finding

- “A systematic or opportunistic process that identifies individuals (e.g., people with COPD) from a larger population” Variation in prevalence across practices. Opportunity to address and actively manage.

- This domain within the LTC LES will promote a systematic case finding approach to identify individuals with one or more of the following conditions:
  - Hypertension
  - Heart Failure
  - Asthma
  - COPD
  - Severe Mental Illness

- The approach will be to case find from a series of EMISWeb clinical code searches and to assess those at greatest risk of each clinical condition.

- Undertake clinical and holistic assessment of needs.

NHS Lancashire and South Cumbria Integrated Care Board

Population Health Management

- People from lower socio-economic groups and those in inclusion groups (as described in the national Core20plus5 frameworks) are disproportionally affected with significantly higher risk of experiencing ill health and barriers to accessing services.

- The aim of this contract is to promote a population health management approach using existing tools and data to identify and target segments or individuals within the registered population who are at higher risk of adverse health events

- Focus in individuals with 3 or more comorbidities (and/or greater risk of non-elective admission and linked with populations with socioeconomic need.

- Use LSC Population Segmentation tool in Aristotle to define

Frailty Service specification

The aim process for each practice will remain similar to 2024/25 but will focus solely on identifying and prioritising those individuals with **Moderate** or **Severe** Frailty (excluding Care Home residents).

Practice Activities Using the Aristotle LSC Population Segmentation tool each practice will be asked to identify individual patients most at risk within the moderate and severe frailty cohorts.
Enhanced review Practices will invite patients for an enhanced review appointment to undertake a brief-CGA type assessment. This face to face assessment should cover the individual's unmet health and care needs.
Enhanced care plan and interventions Any unmet needs identified should result in an action, signpost or referral where appropriate and recorded in the record. Individuals with multiple, significant or complex needs should be offered review by local Frailty MDT group. Guidance on requirements has been developed. At a minimum, the core proactive care team should consist of a GP with an interest in frailty, an Advanced Clinical Practitioner, and a Care Co-ordinator.

Respiratory Service specification

NHS Lancashire and South Cumbria Integrated Care Board

The aim is to ensure that those patients with an existing diagnosis of COPD and asthma who are at highest risk of worsening respiratory health and most likely to exacerbate are identified and offered enhanced reviews to ensure their respiratory care is optimal and additional unknown health needs are identified and met.

Practice activities
• Identify a practice Lead Clinician • Establish how the practice intends to access quality assured pulmonary function testing, building on the work of the GP quality contract 2024/5, including: o Spirometry + Bronchodilator Responsiveness Testing / FENO • Undertake a risk stratification of the patient cohort to identify those patients who may have the greatest health and care needs. Use the population health segmentation tool on Aristotle. • Establish a process for recalling patients who have suffered an exacerbation for an enhanced review.
Enhanced review Undertake an enhanced review by the most appropriate clinician to meet the needs of the patient, considering the importance of continuity of care and clinician.
Enhanced care plan and interventions Mutually agree with the patient the clear next steps for care and potential referral onwards for broader health and wellbeing needs, MDT etc.

Diabetes Service specification

NHS
Lancashire and South Cumbria
Integrated Care Board

The aim of the contract is to identify those patients with diabetes who have the highest risk of diabetes related complications, have comorbidities, and where diabetes is most likely to be impacting their health and wellbeing. Once identified to undertake a holistic enhanced review of their care and meets the needs of the patients.

Practice activities

- Undertake a risk stratification of the patient cohort to identify those patients who may have the greatest health and care needs. Use the population health segmentation tool on Aristotle.
- Identify the clinical and administrative team to support this LTC, identify any training needs and how these will be met.

Enhanced review

Undertake an enhanced review by the most appropriate clinician to meet the needs of the patient, considering the importance of continuity of care and clinician.

Address unmet medical needs and agree a care plan with the patient to meet ongoing care needs aiming to achieve the 3 key care targets for diabetes to reduce the risk of future complications.

Enhanced care plan and interventions

Mutually agree with the patient the clear next steps for care, considering:

- Medical needs and personalised goals for the 3 key care targets, BP, HbA1c and lipids, considering medication risks (hypoglycaemia), frailty and comorbidity
- Health and wellbeing needs and psychological support for long term conditions
- MDT referral where appropriate, at practice level or collaborative MDT

NHS
Lancashire and South Cumbria
Integrated Care Board

Cardiovascular Disease Service specification

The aim of the contract is to improve the detection, diagnosis and treatment of the ABC^2 of Cardiovascular Disease (**A**F, **B**lood Pressure (Hypertension), High **C**holesterol and **C**KD) to reduce CVD risk within the population.

Practice Activities

- Undertake a risk stratification of the patient cohort to identify those patients who may have the greatest health and care needs. Use the population health segmentation tool on Aristotle.
- Use the Aristotle CVD Prevention and Hypertension dashboards to benchmark starting points against national metrics.
- Utilise the UCL Partners risk stratification reporting already available on EMIS for hypertension and other risk stratification tools already available.
- Identify the clinical and administrative team to support this LTC, identify any training needs and how these will be met.
- Consider the use of pharmacy first and other community based services that could support patient care

Enhanced review

Invite patient into surgery to undertake an enhanced review by the most appropriate clinician to meet the needs of the patient, considering the importance of continuity of care and clinician.

Enhanced care plan and interventions

Mutually agree and record with the patient the clear next steps for care, considering:

- Medical needs
- Health and wellbeing needs
- MDT referral where appropriate
- Referrals and signposting to other services

Severe Mental Illness (SMI) Service specification

NHS Lancashire and South Cumbria Integrated Care Board

The aim is to provide more in-depth care planning, risk stratification and patient management of patients with SMI. As well as expanding the data collection with additional fields as recommended by National guidance[1] and includes an enhanced health check via a second appointment where results are discussed, and a Health Action Plan is agreed.

Practice Activities

- Identifying patients with SMI. Focus on hard-to-reach patients, patients who have not had a check in the last 2 years. Work with the commissioned Outreach 3rd sector provider in your area to increase uptake.
- Utilise the ICBs "Practical Guide to SMI Physical Health checks" to aid case finding, prioritizing and undertaking checks.
- Identify the clinical and administrative team to support this LTC, identify any training needs and how these will be met.
- Undertake the enhanced reviews

Enhanced review

Undertake an enhanced review by the most appropriate clinician to meet the needs of the patient, considering the importance of continuity of care and clinician. This will include 2 appointments:

- The first appointment would usually be undertaken by an HCA to undertake 6 QOF items - blood tests, measure BP, weight and collect the other data items.
- The 2nd appointment would be undertaken by a Nurse, Pharmacist or Dr and would include a review of the results, the Additional Questions and agreement of the Care Plan.

Enhanced care plan and interventions

Mutually agree with the patient the clear next steps for care, considering:

- Health and wellbeing needs
- MDT referral where appropriate
- Referrals and signposting to other services
- Agree a written Health Action Plan on measures to be taken to improve physical health
- A document will be provided via CSU that incorporates a Physical health action plan with a Psychiatry Care Plan

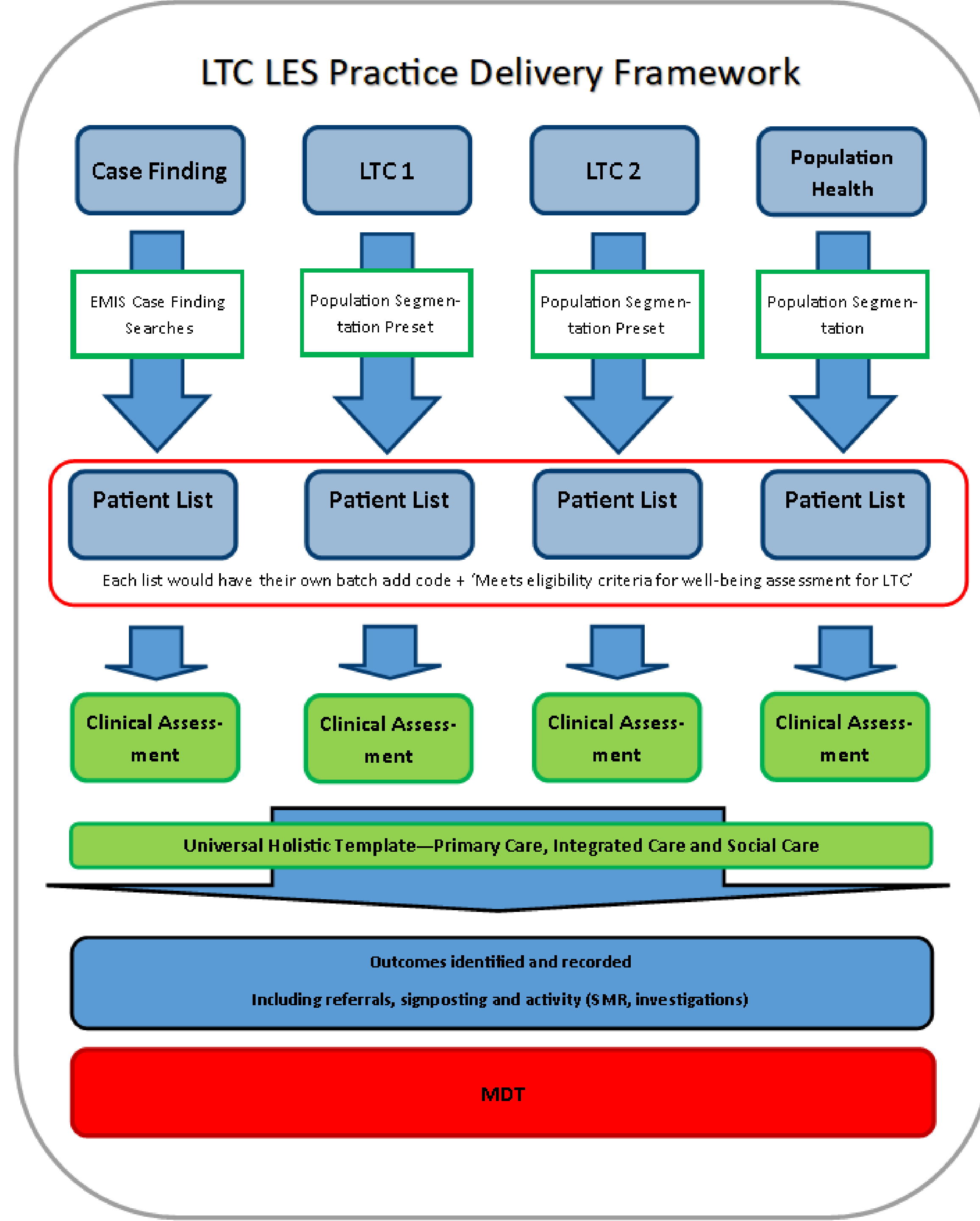
LTC Delivery Framework

Overview of activities each practice will be expected to undertake for successful delivery of the LTC LES.

ICB will provide necessary EMIS and Aristotle tools to identify cohorts.

ICB will provide necessary holistic clinical and care assessment templates.

ICB will provide detailed guidance on the development of the MDT portion.



NHS
Lancashire and South Cumbria
Integrated Care Board

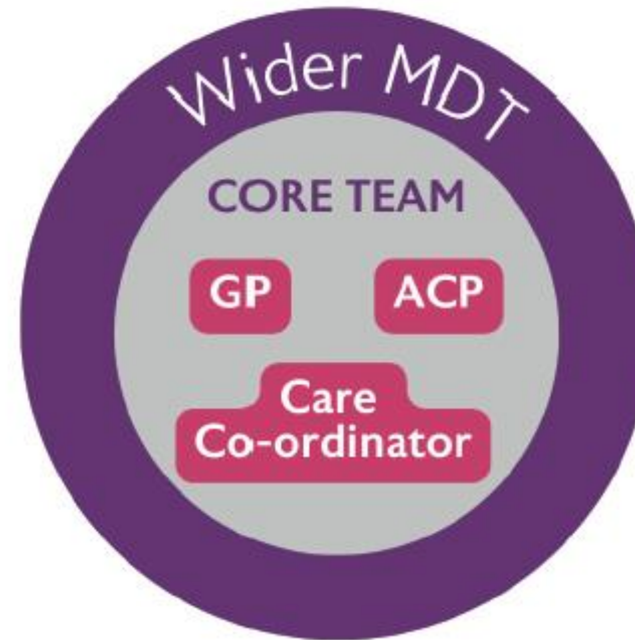
MDT Guidance

Guidance developed from Be Proactive: Delivering proactive care for older people with frailty [Not just for individuals with frailty]

Flexible and pragmatic approach for each practice to develop according to need and available participants.

Aim to have a single holistic MDT set up that each practice can contribute to.

For patients with either significant/complex/multiple health and care needs



Further engagement

- Feedback from you – Menti Survey open until Friday 10th Jan:
https://www.menti.com/alsvooqtze74
- Sharing specifications
- Webinar engagement outline for January:

Webinar date	Theme and content of webinar
Weds 8th January 12:30 to 1:30pm	LTC LES • Spec outline • Monitoring and reporting
Weds 15th January 12:30 to 1:30pm	Individual LES contracts • Spec outline • Monitoring and reporting
Weds 22nd January 12:30 to 1:30pm	Bundled LES contracts • Spec outline • Monitoring and reporting
Weds 29th January 12:30 to 1:30pm	Summary of feedback to date and next steps

Thank you
for your time
and contribution to
this engagement
session