



**Barking and Dagenham,
Havering and Redbridge**
Clinical Commissioning Groups

Appendix 2

BHR Long Term Conditions Strategy



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Scope

The conditions within the scope of this strategy are set out below. Local and national data demonstrates a growth in the prevalence of all of these conditions, and with it an increase in cost. A coordinated strategic approach is required to impact growth rates, improve care and deliver savings.



Diabetes – A lifelong condition that causes a person's blood sugar level to become too high. It's important for diabetes to be diagnosed as early as possible as it can get progressively worse if untreated. It can also lead to heart disease and stroke, nerve damage, vision loss and blindness and kidney problems



Atrial Fibrillation - A heart condition that causes an irregular and often abnormally fast heart rate. Those with AF are at increased risk of having a stroke and in extreme cases, it can lead to heart failure.



Chronic obstructive pulmonary disease (COPD) – A group of lung conditions that cause breathing difficulties, typically affecting middle-aged / older adults who smoke. COPD is irreversible but can be managed to slow progression and control the symptoms



Coronary Heart Disease (CHD) – A major cause of death when the heart's blood supply is blocked often due to a build up of fatty substances in the coronary arteries. This can be caused by hypertension, diabetes, high cholesterol and smoking.



Asthma – A common lung condition which causes breathing difficulties through inflammation of the breathing tubes that carry air in and out of the lungs. Whilst it can be kept under control, it's still a serious condition that can cause stress, anxiety, or lung infection



Chronic Kidney Disease (CKD) – A condition often associated with getting older where kidneys do not function optimally. This is often caused by high blood pressure, diabetes, kidney infections, and long term / regular use of certain medicines



Hypertension – A condition which rarely has noticeable symptoms. But if untreated, it increases risk of serious problems such as heart disease, heart attack, kidney disease, or strokes



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Case for change



Prevalence Gap

There is a significant gap between the expected number diagnosed patients in the population compared to those patients actually identified with LTCs. There is a risk that patients are not diagnosed early, and do not access treatment earlier in the course of their condition resulting in avoidable unplanned care in the future. In addition as a result of an aging population and changing lifestyles the prevalence of all in scope conditions is increasing.

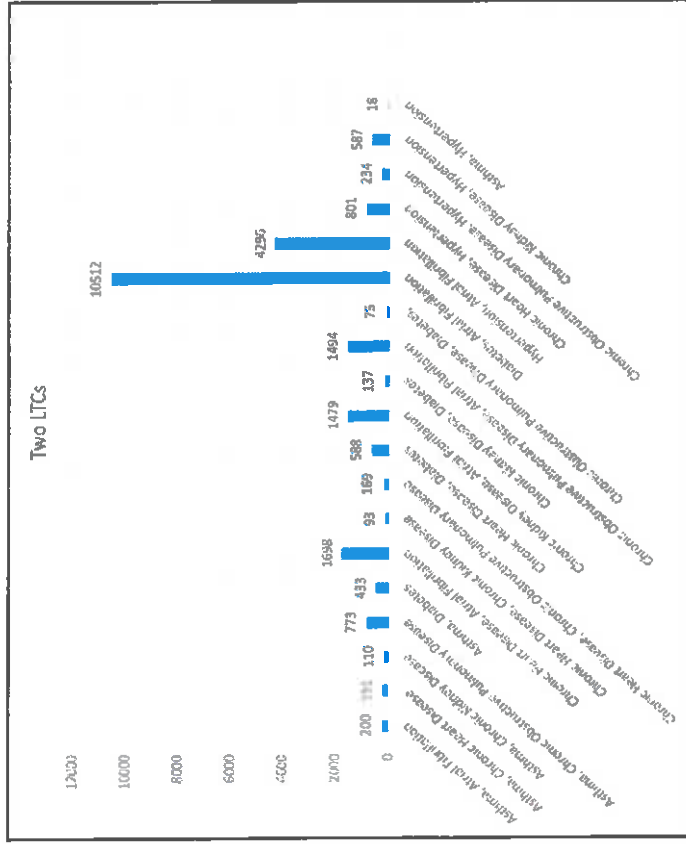
LTC	Expected Prevalence in BHR	Borough level prevalence gap		
		B&D CCG (pts)	Havering CCG (pts)	Redbridge CCG (pts)
Diabetes	14,019	624	5,983	7,412
AF	6,884	1,456	2,720	2,668
COPD	10,323	3,327	4,624	2,372
Asthma	36,556	9,567	13,055	13,934
CKD	23,028	4,367	10,063	8,598
Hypertension	68,206	14,350	27,470	26,386

- The overall population of BHR is 776,419, which has been used to calculate the figures shown in the table
- There is a risk of continued increase in diagnosis and patient gap if there is not imminent change



Multimorbidity

Patients with Two LTCs



• The most common combination affecting more than 10,000 patients is the combination of AF and Diabetes.

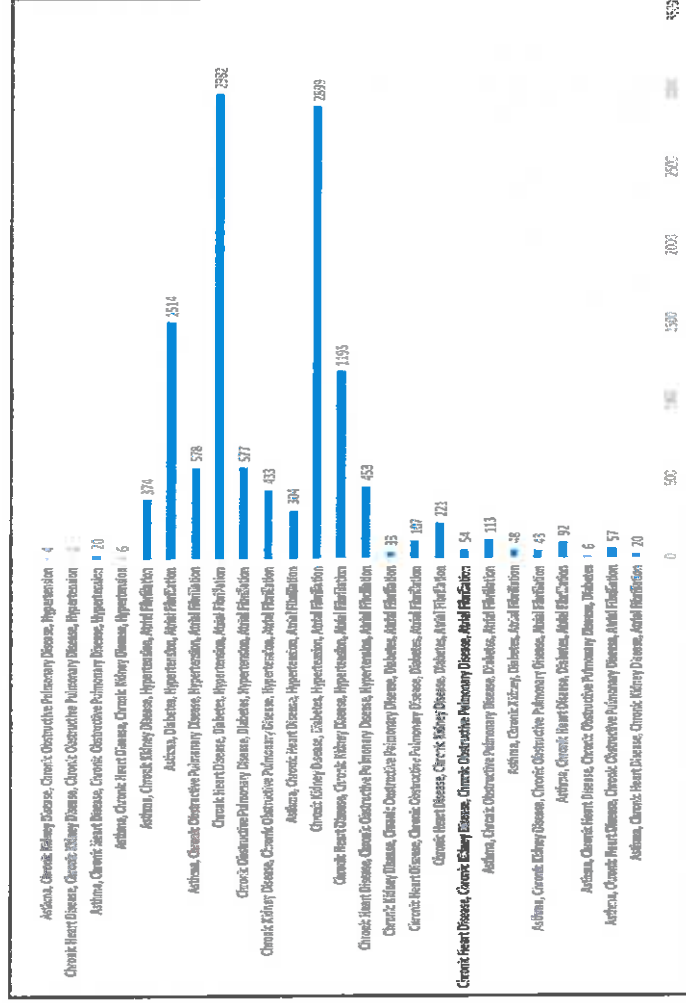
• The second highest combination is Hypertension and AF affecting 4,296 patients.

• CHD, CKD and COPD all contribute to the next three highest combinations



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Patients with Four LTCs

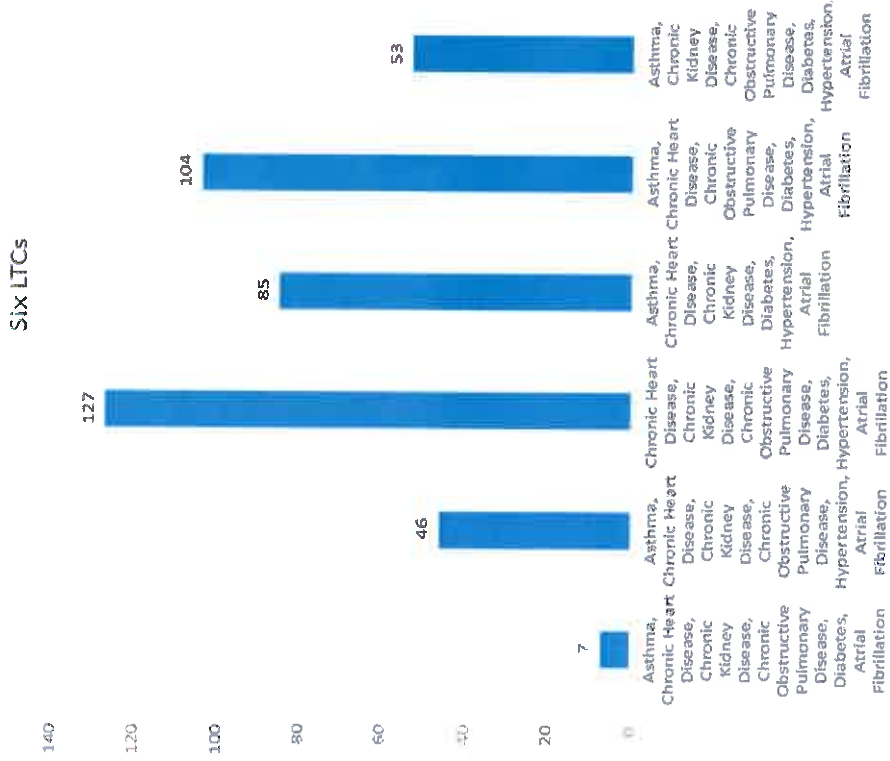


• More than 2,900 patients have a combination of CHD, Diabetes, Hypertension and AF

• Over 2,800 patients have a combination of CKD, Diabetes, Hypertension and AF

• COPD continues to be a condition affecting patients with Asthma

Patients with Six LTCs



- CHD, CKD, COPD, Diabetes, Hypertension and AF are the leading six combinations
- Asthma, CHD, COPD, Hypertension and AF is the second highest affecting patients.
- These are your complex, expensive cases for the health system

Whole System burden of LTCs



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This analysis includes admissions for both planned (day cases and electives) and unplanned (non-elective) for age group 18+ in BHR CCGs. The analysis is based on SUS+ data and Long term conditions are based on HRG codes identified by clinical leads. The long term conditions shown in this analysis are related to cardiovascular and diabetes conditions only.

Highlights

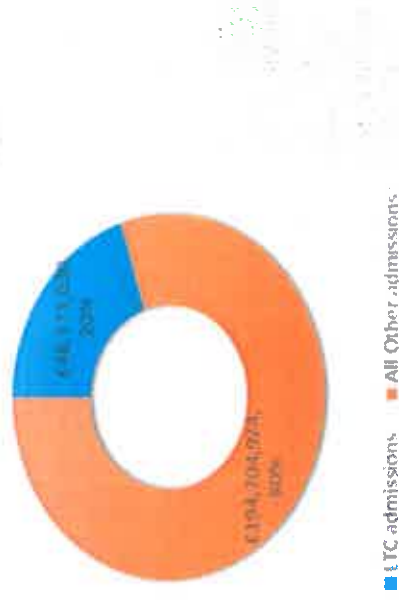
- BHR CCGs total spend for admissions both planned and unplanned in 2017/18 is £243m; of which £49m is related to admissions for long term conditions (LTC) (20%). Of the £49m spend for LTC
- 7.7% (4m) is attributed to day cases (DC),
- 4.8% (£2m) to elective admissions,
- 87.5% (£43m) is attributed to non-elective admissions.

Planned admissions: Day cases (DC) and Elective (EL) admissions

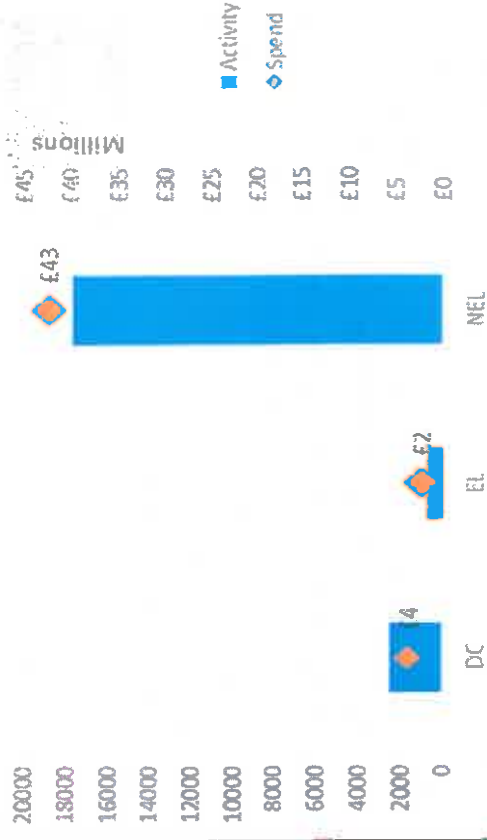
- Of the £4m spend in day cases, majority of the spend is around cardiac (78%), vascular procedures and disorders (8%), eyes and periorbital (6%).
- Of the £2m spend in elective admissions, majority of the spend is around vascular procedures and disorders (41%), cardiac (24%) hepatobiliary and pancreatic system (13%).

The charts on the right shows the percentage distribution of admissions related to LTC conditions and all other admissions by provider.

BHR CCG Acute spend on planned and unplanned admissions - 2017/18



BHR CCG spend on LTC admissions by POD - 2017-18

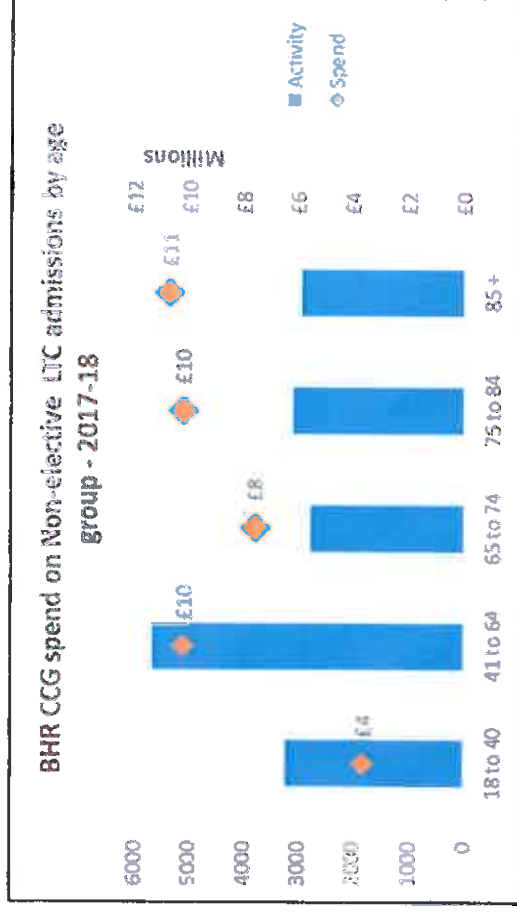


Whole System burden of LTCs

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Non-elective admissions

- 67% (£29m) of the non-elective spend in 2017/18 are for admissions related to 65+ age category, of which nearly 50% are for the 75+ age group.
- 33% (£14m) of the non elective spend are for admissions for working age group (age group 18-64).
- There is an increasing trend in 17/18 and 18/19 (based on M6 forecast) toward non-elective admissions related to long term conditions across all age groups.



Non-elective admissions	Age_Categories	2015/16	2016/17	2017/18	movement			
					2018/19 M6	from 15/16 to 16/17	from 16/17 to 17/18	from 17/18 to 18/19
No of admissions for LTC	18 to 40	1139	1098	1179	1216	-4%	7%	3%
	41 to 64	2751	2593	2827	2904	-6%	9%	3%
	65 to 74	1397	1467	1672	1844	5%	14%	10%
	75 to 84	1846	1876	2125	2402	2%	13%	13%
	85 +	1441	1639	2040	2090	14%	24.5%	2.5%
All other admissions	18 to 40	12902	12658	12774	13238	-2%	0.9%	3.6%
	41 to 64	13511	12790	13374	14316	-5%	4.6%	7.0%
	65 to 74	6505	6132	6517	6694	-6%	6.3%	2.7%
	75 to 84	8073	7738	8040	8390	-4%	3.9%	4.4%
	85 +	7859	7748	9120	9710	-1%	17.7%	6.5%

Conclusions

1. Increasing prevalence is a growing challenge with more and more people having a condition and not being identified / managed at an earlier stage, leading to unplanned care and possible admission.
2. The need to shift care from NEL to elective, this focus on proactive care and patient empowerment will drive better outcomes and deliver financial savings across the system.
3. Year one focuses on Diabetes and Cardiology
4. Strategic focus at national level

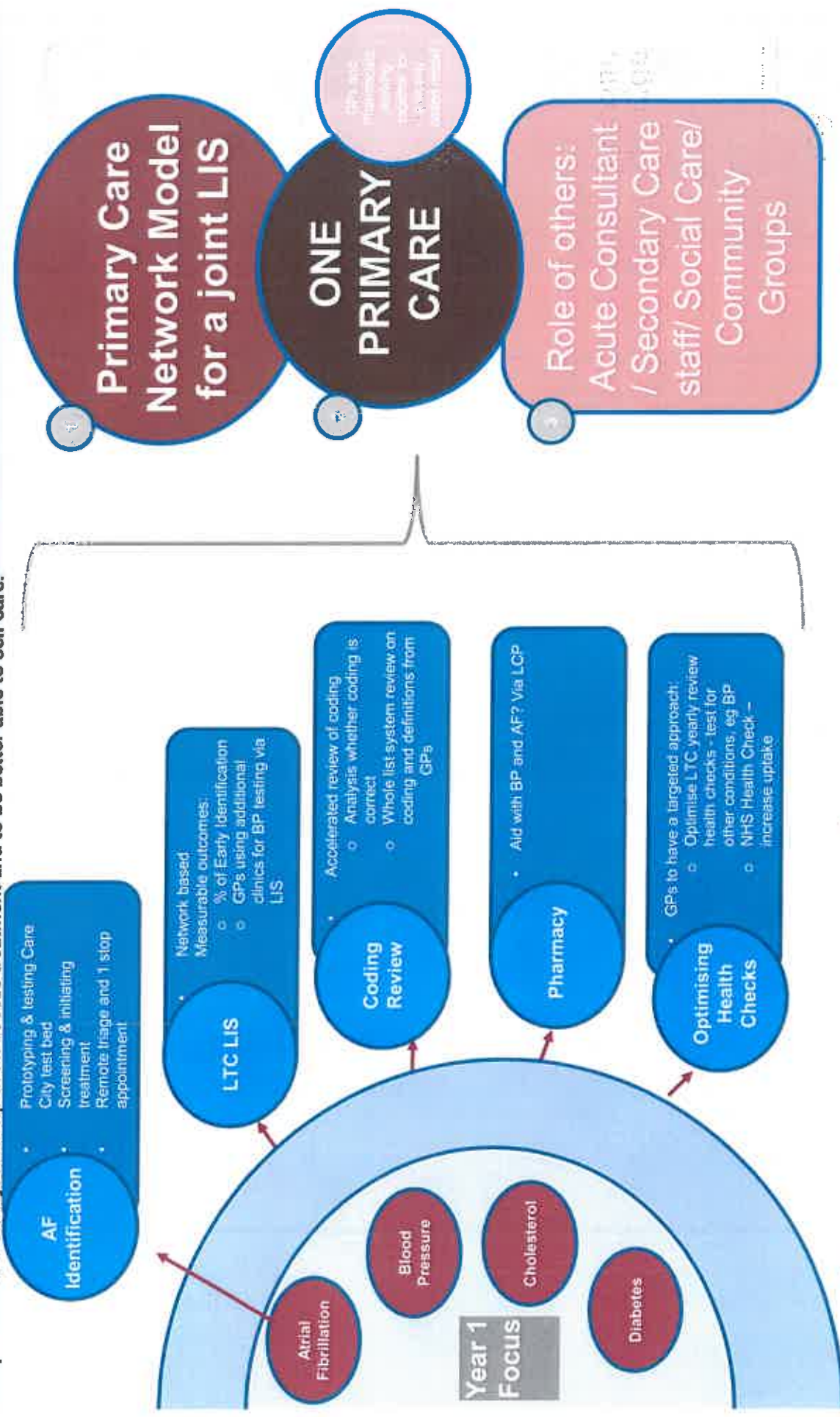


Model of Care Overview



Early Identification

Early identification and proactive disease management are key to tackling high hospital admissions, this strategy aims to identify people with in scope conditions early and help them access treatment and to be better able to self care.

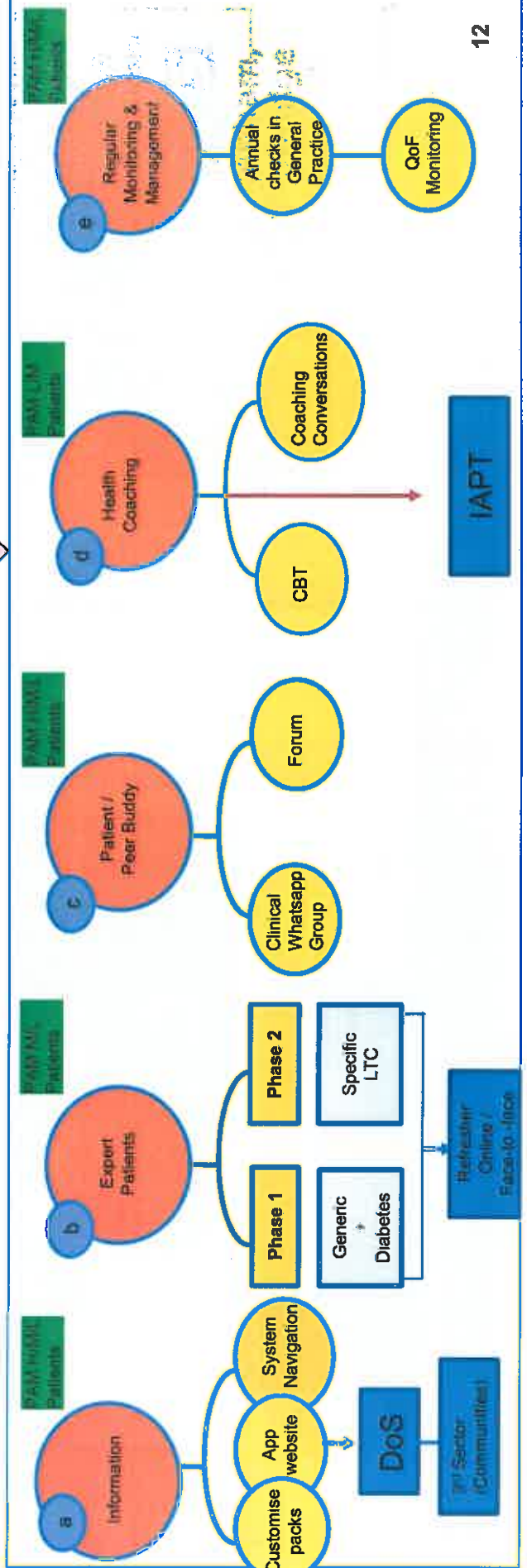
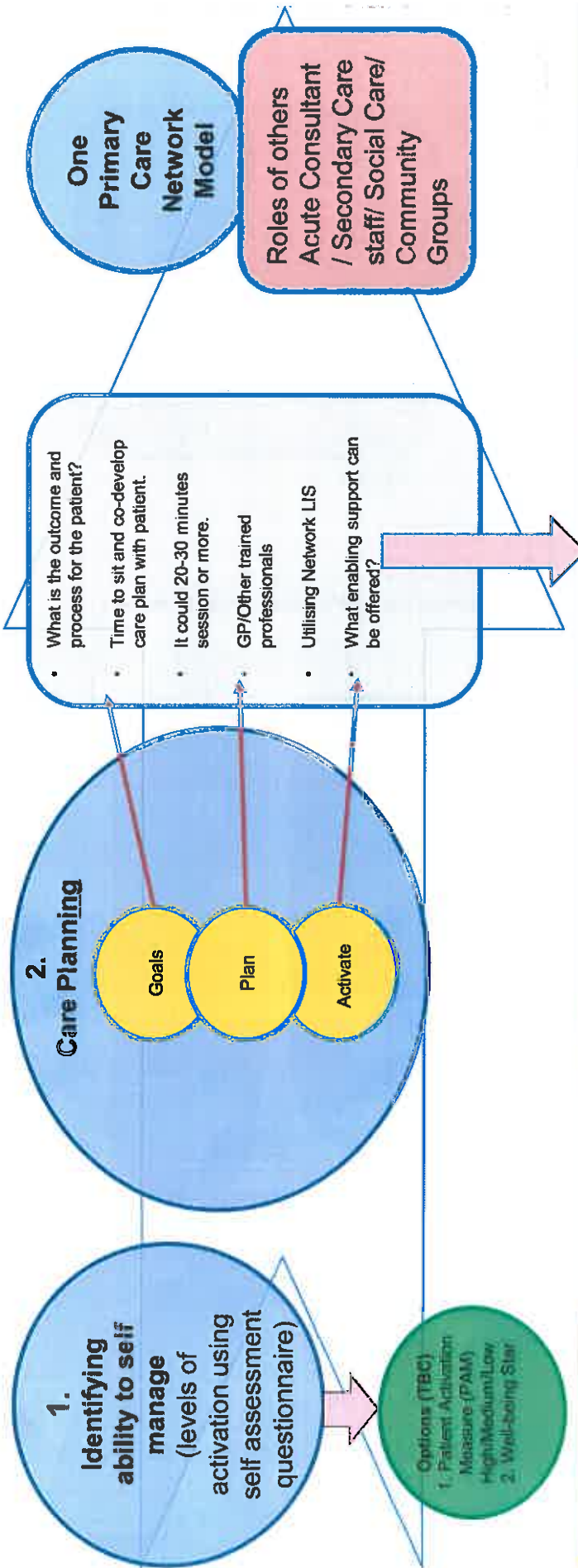


Year 1 focus on four key areas

Interventions that support Early Identification

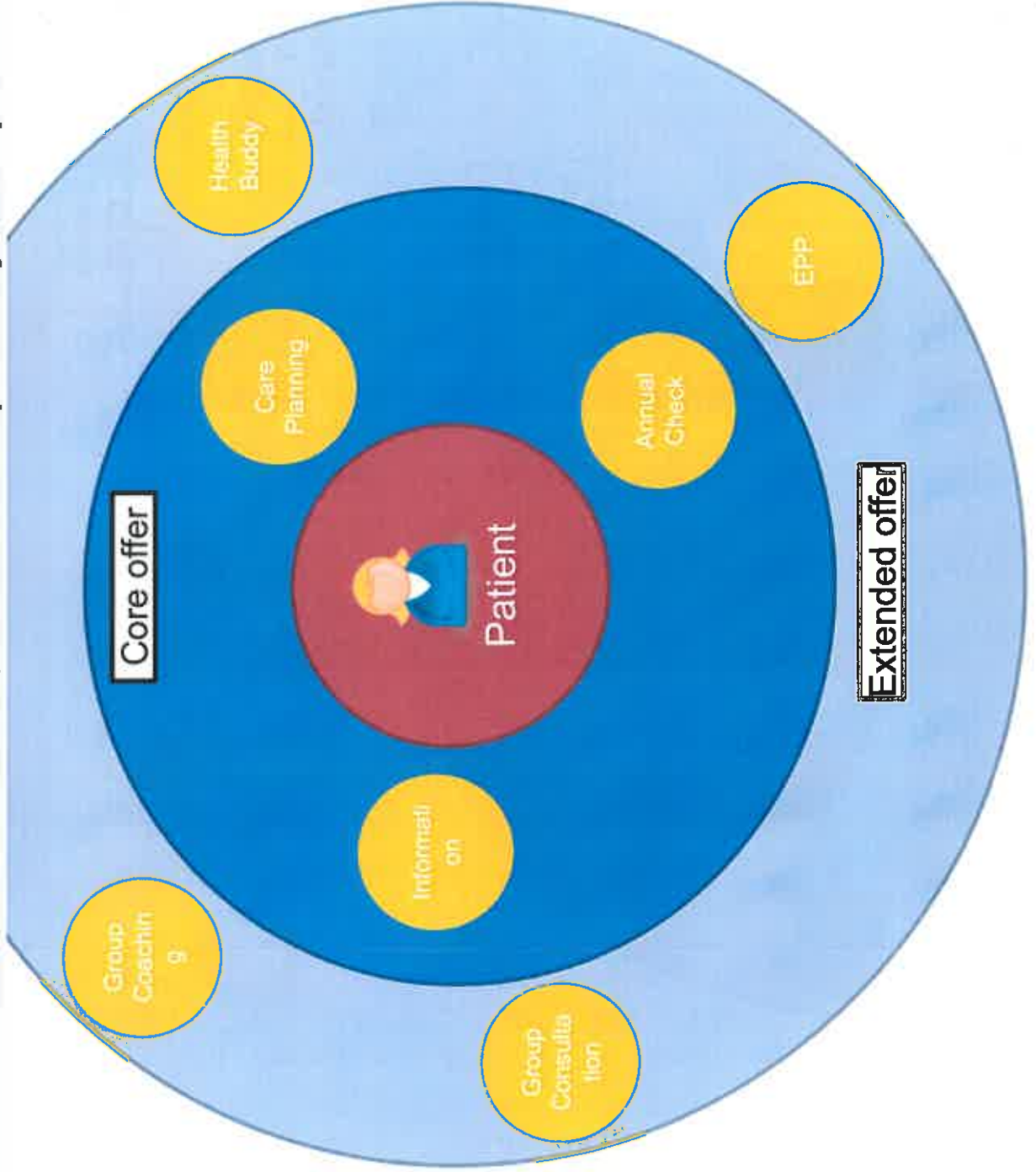
How would we deliver

This element of the strategy deals with the first contact a health Profession has with a newly diagnosed patient. This is the first opportunity to provide support, enable self-care and provide management. The aim is to have a comprehensive set of tools and enablers we would provide to a person.



Managing Well

Focusing and retaining patients in this category for as long as possible is vitally important: to proactively manage the condition so it does not deteriorate, and to decrease probability of multiple LTCs occurring.



Questions?



