Reading list

Improving care for long term conditions

February 2014

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About the Information and Library Service

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- holds a database of over 100,000 bibliographic records, catalogued using an authoritative thesaurus of over 11,000 indexing terms
- contributes health policy and management content to NHS Evidence
  Go to: http://www.evidence.nhs.uk/

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- A number of Reading Rooms for each of The King's Fund's areas of work: http://www.kingsfund.org.uk/library/reading-rooms
- photocopies of journal articles (for a small fee).
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Opening hours

Mon- Fri: 9.30am–5.30pm

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BOOKS / REPORTS

ISBN: 9781909029163
Goodwin, Nick, et al.
The King's Fund
Providing integrated care for older people with complex needs : lessons from seven international case studies.
London : The King's Fund, 2014 *QBFA (Kin)*
This report synthesises evidence from seven case studies covering Australia, Canada, the Netherlands, New Zealand, Sweden, the United Kingdom and the United States. It considers similarities and differences of programmes that are successfully delivering integrated care, and identifies lessons for policy-makers and service providers to help them address the challenges ahead.
http://www.kingsfund.org.uk/publications/providing-integrated-care-older-people-complex-needs

NHS England
Action for diabetes.
London : NHS England, 2014 *Web publication*
This document has been produced in response to the Public Accounts Committee report on adult diabetes services, published in 2012. It is for Clinical Commissioning Groups as a reference on the work that is going on across NHS England, and for the wider community interested in diabetes care to see what action NHS England is taking in this area.
http://www.england.nhs.uk/wp-content/uploads/2014/01/act-for-diabetes.pdf

Asthma UK
Compare your care : how asthma care in the UK matches up to standards.
London : Asthma UK, 2013 *Web publication*
Asthma UK wanted to know whether the care that people were receiving for their asthma matched up to the standards they should expect so they launched the Compare Your Care quiz. This report presents the findings and shows that there are some aspects of asthma care which many people are receiving. However, it finds that not everyone is receiving care that fully meets standards and some simple but effective aspects of care that could help prevent asthma attacks are not consistently being provided. The reports also include recommendations to help the NHS improve asthma care across the UK.
UK wide report http://www.asthma.org.uk/Handlers/Download.ashx?IDMF=17becabd-52bf-4fcd-8268-56febd9e7e4e
National reports: http://www.asthma.org.uk/compareyourcare-reports

Great Britain. Department of Health
Cardiovascular disease outcomes strategy : improving outcomes for people with or at risk of cardiovascular disease.
London : DH, 2013 *Web publication*
This strategy document provides advice to local authority and NHS commissioners and providers about actions to improve cardiovascular disease outcomes. It sets out outcomes for people with or at risk of cardiovascular disease in line with the NHS and public health outcomes frameworks.
https://www.gov.uk/government/publications/improving-cardiovascular-disease-outcomes-strategy

Diabetes UK
State of the nation 2013 : England.
London : Diabetes UK, 2013 *Web publication*
This report highlights the continuing challenge that diabetes continues to present to the NHS and that quality of care is uneven throughout the country. Checking against NICE standards people who live in the best-performing CCG area are four times more likely to be given eight of the vital health checks recommended by NICE as compared to people living in the worst-performing area. It argues that diabetes care is adequately funded but that the focus of the spending should be on prevention rather than treatment.
http://www.diabetes.org.uk/Documents/About%20Us/What%20we%20say/0160b-state-nation-2013-england-1213.pdf
Associated documentation http://www.diabetes.org.uk/About_us/What-we-say/Improving-services--standards/State-of-the-Nation-2013/

Digital Policy Alliance (EURIM). Digital Health Group
Living independently : shouldering the burden of chronic disease.
[Minehead] : EURIM, 2013 *Web publication*
This report is an analysis of the benefits and obstacles facing the delivery of telecare and telehealth in the healthcare industry.
http://dpalliance.org.uk/wp-content/uploads/2013/01/1301_Telecare-and-Telehealth-Briefing.pdf
Summary:
http://dpalliance.org.uk/wp-content/uploads/2013/01/1301_Telecare-and-Telehealth-Summary.pdf

ISBN: 9789289000215
Legido-Quigley, Helena Editor
Panteli, Dimitra Editor
European Observatory on Health Systems and Policies
Clinical guidelines for chronic conditions in the European Union.
Observatory Studies Series ; 30
Copenhagen : WHO Regional Office for Europe, 2013 *HPPPd (Leg)*
This report seeks to understand the definitions used for clinical guidelines relevant to chronic noncommunicable diseases and their relationship with related strategies to improve care for chronically ill patients; the regulatory basis for, actors involved and processes used in developing clinical guidelines across the European Union and the quality thereof; the strategies used to disseminate and implement clinical guidelines in various countries and what is known about their effectiveness; and whether clinical guidelines actually have an impact on processes of care and patients' health outcomes.
http://www.euro.who.int/__data/assets/pdf_file/0009/195876/Clinical-Guidelines-for-Chronic-Conditions-in-the-European-Union.pdf

ISBN: 9781906461454
Entwistle, Vikki A. and Cribb, Alan
Health Foundation
Enabling people to live well : fresh thinking about collaborative approaches to care for people with long-term conditions.
Original research ; (May 2013).
London : Health Foundation, 2013 *Web publication*
This paper reports the results of a research project that critically analysed the ways in which collaborative approaches are currently described; and started to examine what goes on in practice when clinicians and patients work together in ways they appreciate as meaningfully collaborative. It reflects on clinicians' and patients' experiences and draws on ideas from development economics and social justice.
http://www.health.org.uk/publications/enabling-people-to-live-well/

ISBN: 9781909029170
Coulter, Angela, et al.
The King's Fund
Delivering better services for people with long-term conditions : building the house of care.
London : The King's Fund, 2013 *HPPP (Kin)*
This paper describes a co-ordinated service delivery model - the â€˜house of care' - that aims to deliver proactive, holistic and patient-centred care for people with long-term conditions. It incorporates learning from a number of sites in England that are working to achieve these goals, and makes recommendations on how key stakeholders can work together to improve care for people with long-term conditions.
http://www.kingsfund.org.uk/publications/delivering-better-services-people-long-term-conditions

ISBN: 9781909029194
Goodwin, Nick, eta al.
The King's Fund
Co-ordinated care for people with complex chronic conditions : key lessons and markers for success.
London : The King's Fund, 2013 *HPPP (Kin)*
The costs of caring for people with age-related chronic and complex medical conditions are high and will continue to rise with population ageing. Yet people with multiple health and social care needs often receive a very fragmented service, resulting in less than optimal care experiences, outcomes and costs. Many countries have developed strategies to improve care co-ordination, but these have often failed to achieve their objectives. There is also a general lack of knowledge about how best to apply (and combine), in practice, the various strategies and approaches to care co-ordination.
http://www.kingsfund.org.uk/publications/co-ordinated-care-people-complex-chronic-conditions

Goodwin, Nick, et al.
The King's Fund and Nuffield Trust
Integrated care for patients and populations : improving outcomes by working together.
London : The King's Fund, 2013 *Web publication*
This paper has been written as a contribution to the work of the NHS Future Forum and in support of the government's espoused aim of placing integrated care at the heart of the programme of NHS reform. Integrated care is essential to meet the needs of the ageing population, transform the way that care is provided for people with long-term conditions and enable people with complex needs to live healthy, fulfilling, independent lives.
http://www.kingsfund.org.uk/publications/integrated-care-patients-and-populations-improving-outcomes-working-together

ISBN: 9781909029187
Duerden, Martin, et al.
The King's Fund
Polypharmacy and medicines optimisation : making it safe and sound.
London : The King's Fund, 2013 *HNI (Kin)*
Polypharmacy - the concurrent use of multiple medications by one individual - is an increasingly common phenomenon that demands attention at clinical policy and practice level. Driven by the growth of an ageing population and the rising prevalence of multi-morbidity, polypharmacy has previously been considered something to avoid. It is now recognised as having both positive and negative potential, depending on how medicines and care are managed.
http://www.kingsfund.org.uk/publications/polypharmacy-and-medicines-optimisation

Mental Health Foundation
Peer support in long term conditions : final report.
London : MHF, 2012 *Web publication*
This is the final report of the Developing Peer Support for Long Term Conditions project, which was funded by the Long Term Conditions Alliance Scotland (now known as the ALLIANCE) through their Self Management Fund 2011/2012. The purpose of this project was to take forward the findings from the feasibility study with the aim to: 1. Raise the credibility of peer support in long term conditions; 2. Increase access to peer support in long term conditions; 3. Improve the quality of peer support delivered and the support/supervision provided to those peer workers; 4. Influence the development of peer support in long term conditions to ensure that it has a mental health and wellbeing focus and meets the needs identified in the feasibility study; and 5. To gain resources and support to develop peer support.
http://www.mentalhealth.org.uk/content/assets/PDF/publications/developing-peer-support.pdf

National Endowment for Science, Technology and the Arts (NESTA) and Innovation Unit
The business case for People Powered Health.
London : NESTA, 2013 *Web publication*
The NHS in England could realise savings of at least £4.4 billion a year if it adopted People Powered Health innovations that involve patients, their families and communities more directly in the management of long term health conditions. These savings are based on the most reliable evidence and represent a seven per cent reduction in terms of reduced A&E attendance, planned and unplanned admissions, and outpatient admissions. There is therefore both a social and financial imperative to scale the People Powered health approach.
http://www.nesta.org.uk/sites/default/files/the_business_case_for_people_powered_health.pdf
Peple Powered Health: http://www.nesta.org.uk/project/people-powered-health

Smith, Judith, et al.
National Institute for Health Research
Commissioning high quality care for people with long-term conditions.
SDO project ; 08/1806/264 (March 2013)
Southampton : NIHR, 2013 *Web publication*
The aim of this research was to explore how NHS commissioning could be enacted to improve care for people living with long-term conditions. The objectives were to: identify the organisation and processes associated with effective commissioning; identify an appropriate set of outcomes, some developed in association with commissioners themselves; draw on experience from other sectors and international health systems in developing commissioning within study sites, developing and disseminating good practice guidance as a result; and consider how the learning from this research could be more widely applicable in the NHS.
http://www.netscc.ac.uk/hsdr/files/project/SDO_FR_08-1806-264_V10.pdf
Executive summary: http://www.netscc.ac.uk/hsdr/files/project/SDO_ES_08-1806-264_V02.pdf
Associated documentation: http://www.netscc.ac.uk/hsdr/projdetails.php?ref=08-1806-264

NHS Diabetes
Best practice for commissioning diabetes services : an integrated care framework.
[Newcastle upon Tyne] : NHS Diabetes, 2013 *Web publication*
This report was developed in response to the needs of new commissioners and health professionals involved in diabetes care. It aims to provide practical guidance and key principles for these groups to better commission and provide integrated care for people with diabetes; and to ensure that people with diabetes have access to a joined up service from the time of diagnosis, through more complex management, complications, inpatient care to end-of-life care.
https://www.diabetes.org.uk/Documents/nhs-diabetes/commissioning/best-practice-commissioning-diabetes-services-integrated-care-framework-0313.pdf

Grant, James and Holton, Kevin
NHS Networks
Partners in delivery : working in partnership with industry to support the implementation of the Outcomes Strategy for COPD and asthma.
[London] : NHS Networks, 2013 *Web publication*
This guide sets out the various models of partnership working with the pharmaceutical and wider healthcare industry, including case studies from the Department of Health respiratory programme. It aims to demonstrate how partnership projects can form an important part of the commissioning landscape, and improve patient outcomes to those working in services across long-term conditions
http://www.pcc-cic.org.uk/sites/default/files/articles/attachments/partners_in_delivery_final.pdf

ISBN: 9781905030644
Thorlby, Ruth
Nuffield Trust
Reclaiming a population health perspective : future challenges for primary care.
London : Nuffield Trust, 2013 *Web publication*
Over the next decade, the NHS will need to respond to the needs of a society with increasing levels of chronic ill health, on budgets which are unlikely to grow substantially. This Nuffield Trust research report explores the role general practices can play in meeting this challenge through analysis of routine data from a notional general practice of 10 000 patients. It also recounts some of the perspectives of GPs and practice managers involved in the NAPC's Practice Innovation Network, who have either already innovated in this area or would like to do so.
http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/130425_reclaiming-a-population-health-perspective.pdf

Smith, Judith, et al.
Nuffield Trust
Commissioning high-quality care for people with long-term conditions : research summary.
London : Nuffield Trust, 2013 *Web publication*
This study explored what commissioners actually do to commission care for people with long-term conditions, and how this might be improved. The research was based on 15 months of detailed observation from November 2010 to January 2012 in three commissioning communities: Calderdale, Somerset and the Wirral.
http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/nt_commissioning_high_quality_care_summary_.pdf

Glatter, Jackie and Reynolds, Philip
Prescription Charges Coalition
Paying the price : prescription charges and people with long-term conditions.
[London] : Prescription Charges Coalition, 2013 *Web publication*
This report examines the impact of prescription charges on people with long-term conditions in England.
http://www.prescriptionchargescoalition.org.uk/uploads/1/2/7/5/12754304/paying_the_price_report.pdf

ISBN: 9780108550492
Filkin, Geoffrey, Baron Filkin of Pimlico Chair
Great Britain. Parliament. House of Lords. Select Committee on Public Service and Demographic Change
Ready for ageing?
House of Lords papers. Session 2012-13 ; HL140
London : The Stationery Office, 2013 *QBFA (Gre)*
This report investigates the outcomes of a 50 per cent rise in the number of people aged over 65, and a 100 per cent increase in those aged over 85, expected to occur in England between 2010 and 2030. An ageing society will greatly increase the number of people with long-term health conditions, and health and social care services will need a radically different model of care to support them.
http://www.publications.parliament.uk/pa/ld201213/ldselect/ldpublic/140/140.pdf
Oral and written evidence:
http://www.parliament.uk/documents/lords-committees/Demographicchange/PublicServiceVol2.pdf
Associated documentation:
http://www.parliament.uk/business/committees/committees-a-z/lords-select/public-services-committee/news/report-press-release/

Great Britain. Department of Health
Long term conditions compendium of information.
Leeds : DH, 2012 *Web publication*
This guidance updates 'Raising the Profile of Long Term Conditions: A Compendium of Information' published in January 2008. It builds on the focus about care and support for those with long term conditions.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/152318/dh_134486.pdf.pdf
Associated documentation: http://longtermconditions.dh.gov.uk/

Great Britain. Department of Health
COPD commissioning toolkit : a resource for commissioners.
London : DH, 2012 *Web publication*
The COPD Commissioning Toolkit aims to make it easier to commission better services for people with COPD by bringing together the clinical, financial and commercial aspects of commissioning in one place.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/126896/chronic-obstructive-pulmonary-disease-COPD-commissioning-toolkit.pdf.pdf

Deloitte Centre for Health Solutions
Primary care : today and tomorrow : improving general practice by working differently.
London : Deloitte, 2012 *Web publication*
This report examines the capacity and capability of general practice now and in the future, with a focus on GPs and general practice nurses. The report highlights the need for general practice to work differently to cope effectively with the increasing demands it faces. This will be especially pertinent as GPs take on the role of commissioners of local healthcare services. Rising life expectancy, accompanied by increasingly complex long-term health conditions, a stretched primary care workforce and unprecedented financial and healthcare reform are amongst the greatest challenges facing primary care in the UK.
http://www.deloitte.com/assets/Dcom-UnitedKingdom/Local%20Assets/Documents/Research/Centre%20for%20health%20solutions/uk-chs-primarycare.pdf

Goodwin, Nick, et al.
The King's Fund
A report to the Department of Health and the NHS Future Forum : integrated care for patients and populations : improving outcomes by working together.
London : The King's Fund, 2012 *HIBO (Kin)*
This paper has been written as a contribution to the work of the NHS Future Forum and in support of the government's espoused aim of placing integrated care at the heart of the programme of NHS reform. Integrated care is essential to meet the needs of the ageing population, transform the way that care is provided for people with long-term conditions and enable people with complex needs to live healthy, fulfilling, independent lives. It can be delivered without further legislative change or structural upheaval. The aims of integrated care are widely supported by NHS staff as well as patient groups, and taking forward the proposals set out in this paper would therefore be welcomed by key stakeholders.
http://www.kingsfund.org.uk/sites/files/kf/TheKingsFundNuffieldTrustIntegratedCarePatientsPopulationsPaper.pdf

ISBN: 9781857176339
Naylor, Chris, et al.
The King's Fund
Long-term conditions and mental health : the cost of co-morbidities.
London : The King's Fund, 2012 *HPPP (Kin)*
People with long-term physical health conditions - the most frequent users of health care services - commonly experience mental health problems such as depression and anxiety, or dementia in the case of older people. As a result of these co-morbid problems, the prognosis for their long-term condition and the quality of life they experience can both deteriorate markedly. In addition, the costs of providing care to this group of people are increased as a result of less effective self-care and other complicating factors related to poor mental health.
http://www.kingsfund.org.uk/publications/long-term-conditions-and-mental-health

Cornwell, Jocelyn
The King's Fund
The care of frail older people with complex needs: time for a revolution.
London : The King's Fund, 2012 *Web publication*
In November 2011, The King's Fund invited academics, practitioners, policy-makers and representatives from patient and voluntary organisations to discuss the care of very old frail people with complex health problems. Mindful of the work of others (NHS Confederation, the Local Government Association and Age UK 2012; The Mid Staffordshire NHS Foundation Trust Inquiry 2009), we focused exclusively on what could be done to build the confidence of vulnerable older patients with complex needs and their carers in the quality of care in hospital and at home. This report summarises the discussion, including recommendations framed in relation to levels of authority in the health and social care system. The King's Fund is very grateful to the trustees of Leeds Castle for making the summit possible and to summit members for their contributions.
http://www.kingsfund.org.uk/publications/care-frail-older-people-complex-needs-time-revolution

Tian, Yang, et al.
The King's Fund
Emergency hospital admissions for ambulatory care-sensitive conditions : identifying the potential for reductions.
DATA briefing ; (April 2012)
London : The King's Fund, 2012 *Web publication*
This data briefing aims to highlight for commissioners the opportunity for improving the quality of care and saving costs that reducing emergency hospital admissions for ambulatory care-sensitive conditions (ACSCs) presents. It uses Hospital Episode Statistics (HES) data to examine the sociodemographic patterns of emergency admissions for each ACSC and calculates the cost of these admissions. It also investigates variations in admissions for ACSCs among local authority districts in England and estimates the potential for reducing these admissions and associated costs.
http://www.kingsfund.org.uk/publications/data-briefing-emergency-hospital-admissions-ambulatory-care-sensitive-conditions

Goodwin, Nick, et al.
The King's Fund
Integrated care for patients and populations : improving outcomes by working together.
London : The King's Fund, 2012 *HIBO (Kin)*
This paper has been written as a contribution to the work of the NHS Future Forum and in support of the government's espoused aim of placing integrated care at the heart of the programme of NHS reform. Integrated care is essential to meet the needs of the ageing population, transform the way that care is provided for people with long-term conditions and enable people with complex needs to live healthy, fulfilling, independent lives. It can be delivered without further legislative change or structural upheaval. The aims of integrated care are widely supported by NHS staff as well as patient groups, and taking forward the proposals set out in this paper would therefore be welcomed by key stakeholders.
http://www.kingsfund.org.uk/sites/files/kf/TheKingsFundNuffieldTrustIntegratedCarePatientsPopulationsPaper.pdf

ISBN: 9780102977127
Great Britain. National Audit Office
The management of adult diabetes services in the NHS.
House of Commons papers. Session 2012-13 ; HC 21 (23 May 2012).
London : Stationery Office, 2012 *Web publication*
Diabetes is a chronic condition where the body does not produce enough insulin to regulate blood glucose levels. In 2009-10, there were an estimated 3.1 million people aged 16 years and older with diabetes in England, of which 2.34 million were diagnosed and 760,000 were undiagnosed. The National Audit Office estimates that NHS spending on diabetes services in 2009-10 was at least £3.9 billion, or around 4 per cent of the NHS budget.
Full report:
http://www.nao.org.uk/wp-content/uploads/2012/05/121321.pdf
Associated documentation: http://www.nao.org.uk/publications/1213/adult_diabetes_services.aspx

Goodman, Claire, et al.
National Institute for Health Research
A study of the effectiveness of interprofessional working for community-dwelling older people.
SDO project ; 08/1819/216 (December 2012)
Southampton : NIHR, 2012 *Web publication*
This study examined the effectiveness of interprofessional working in primary and community care for older people with multiple health and social care needs.
http://www.netscc.ac.uk/hsdr/files/project/SDO_FR_08-1819-216_V01.pdf
Associated documentation: http://www.netscc.ac.uk/hsdr/projdetails.php?ref=08-1819-216

NHS Confederation. Mental Health Network
Investing in emotional and psychological wellbeing for patients with long-term conditions and medically unexplained symptoms.
London : NHS Confederation, 2012 *Web publication*
For many patients, several physical illnesses will coexist at any one time, and for some a mental health disorder will also be present. In the face of such multi-morbidity and need, focus on the patient journey across the lifespan and across the care system will maximise effective service design and delivery. The collation of evidence and emerging economic analysis, together with examples of service design and delivery in this guide, will assist commissioners, clinicians and managers in primary care, secondary care and mental health in designing services, improving productivity and learning across disease-specific groups.
http://www.nhsconfed.org/Publications/Documents/Investing%20in%20emotional%20and%20psychological%20wellbeing%20for%20patients%20with%20long-term%20condtions%2016%20April%20final%20for%20website.pdf
Associated briefing:
http://www.nhsconfed.org/Publications/Documents/Long_Term_Health_Gains_Briefing.pdf

Diabetes UK and NHS Diabetes
Implementing local diabetes networks.
London : Diabetes UK, 2012 *Web publication*
This report is aimed at commissioners of diabetes networks. It provides guidance and support to create local diabetes networks that deliver high-quality, cost-effective care through the effective commissioning, delivery and monitoring of services.
http://www.diabetes.org.uk/Documents/Reports/implementing-local-diabetes-networks-0113.pdf

ISBN: 9780215049803
Hodge, Margaret, chair
Great Britain. Parliament. House of Commons. Committee of Public Accounts
Department of Health : the management of adult diabetes services in the NHS : seventeenth report of session 2012-13 : report together with formal minutes, oral and written evidence.
House of Commons papers. Session 2012-2013 ; HC 289
London : Stationery Office, 2012 *Web publication*
http://www.publications.parliament.uk/pa/cm201213/cmselect/cmpubacc/289/289.pdf

Nolte, Ellen
RAND Europe
Evaluating disease management programmes : learning from diverse approaches across Europe.
Project REsource
Cambridge : RAND Europe, 2012 *Web publication*
The DISMEVAL consortium examined approaches to chronic disease management and its evaluation in 13 countries across Europe. The project identified and validated evaluation methods that can be used in situations where randomisation is not possible.
http://www.rand.org/content/dam/rand/pubs/research_briefs/2012/RAND_RB9687.pdf

Nolte, Ellen, et al.
RAND Europe
Preventing emergency readmissions to hospital : a scoping review.
Technical report ; TR-1198-DH
Cambridge : RAND Europe, 2012 *Web publication*
This report reviews the evidence and potential for use of 'emergency readmissions within 28 days of discharge from hospital' as an indicator within the NHS Outcomes Framework. It draws on a rapid review of systematic reviews, complemented by a synopsis of work in four countries designed to better understand current patterns of readmissions and the interpretation of observed patterns.
http://www.rand.org/content/dam/rand/pubs/technical_reports/2012/RAND_TR1198. pdf

Melzer, David, et al.
University of Exeter. Peninsula College of Medicine and Dentistry. Ageing Research Group
Health care quality for an active later life : improving quality of prevention and treatment through information : England 2005 to 2012.
Exeter : University of Exeter, 2012 *Web publication*
This report brings together recent scientific data to look at how successfully disease and disability has been prevented in later life in England. It examines the current state of health of the older population and explores the evidence on how the NHS is meeting the needs of the older population.
http://www.exeter.ac.uk/media/universityofexeter/medicalschool/pdfs/Health_Care_Quality_for_an_Active_Later_Life_2012.pdf

Great Britain. Department of Health
An outcomes strategy for people with chronic obstructive pulmonary disease (COPD) and asthma in England.
London : DH, 2011 *Web publication*
This strategy sets out six shared objectives to improve outcomes for COPD and asthma through high-quality prevention, detection and treatment and care services.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/151852/dh_128428.pdf.pdf
Associated documentation:
https://www.gov.uk/government/publications/an-outcomes-strategy-for-people-with-chronic-obstructive-pulmonary-disease-copd-and-asthma-in-england

Burton, Chris
Great Britain. Department of Health. Health Inequalities National Support Team
Assessment of services to reduce diabetes-related mortality.
London : DH, 2011 *Web publication*
This workbook was developed by the Health Inequalities National Support Teams (HINST) with 70 local authorities covering populations in England. Local areas could use this approach when analysing whether a population level improvements could be achieved from a set of best-practice and established interventions.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/147329/dh_126336.pdf.pdf

Martin, Stephen, et al.
The Health Foundation
Do quality improvements in primary care reduce secondary care costs? : primary research into the impact of the Quality and Outcomes Framework on hospital costs and mortality.
London : Health Foundation, 2011 *Web publication*
This study shows an association between achievement of the Quality and Outcomes Framework (QOF) indicators and a reduction in hospital costs and lives saved, particularly for stroke care. The primary research, which analyses newly available data to establish the impact of QOF on hospital costs and mortality, finds that a single point increase in the QOF stroke score, across England, could lead to 2,385 fewer deaths in a year.
http://pelorous.totallyplc.com/media_manager/public/75/QOFnew.pdf
Summary: http://pelorous.totallyplc.com/media_manager/public/75/QOFsummary.pdf

Ipsos MORI
Long term health conditions 2011 : research study conducted for the Department of Health.
London : Ipsos MORI, 2011 *Web publication*
This study by Ipsos MORI for the Department of Health explores attitudes towards 'self-care' and the public's perceptions and behaviour with regard to both their own health and the NHS generally. It aims to capture the attitudes and behaviour of those people with a long term condition regarding the self management of their condition and their use of healthcare services.
https://www.gov.uk/government/publications/long-term-health-conditions-2011-research-study

ISBN: 9781857176308
Ross, Shilpa, et al.
The King's Fund
Case management : what it is and how it can best be implemented.
London : The King's Fund, 2011 *HIBO (Kin)*
Case management is a well-established way of integrating services around the complex needs of people with long-term conditions. It is a targeted, community-based and pro-active approach that identifies individuals at high risk of hospital admission, assesses their needs, produces a personal care plan, and ensures co-ordination of that plan. However, evidence to date suggests that case management is not always implemented in a cost-effective way or to the benefit of patients and carers.
http://www.kingsfund.org.uk/publications/case-management

Imison, Candace, et al.
The King's Fund
Transforming our health care system : ten priorities for commissioners.
London : King's Fund, 2011 *HOHCC (Kin)*
Health care commissioners will need to deliver a sustainable system in the face of the most challenging financial and organisational environment seen in decades. They must shift the current emphasis on acute and episodic care towards prevention, self-care and integrated and well co-ordinated care to cope with an aging population and increased prevalence of chronic diseases. And they will need to direct resources to the patients with greatest need and redress the 'inverse care law' by which those who need the most care often receive the least. This document sets out ten priorities for action to help commissioners transform the health care system.
http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/transforming-health-care-system-ten-priorities-commissioners-may11.pdf

ISBN: 9781857176155
Thistlethwaite, Peter
The King's Fund
Integrating health and social care in Torbay : improving care for Mrs Smith.
London : King's Fund, 2011 *HPPP (Kin)*
Integration of health and social care is a core policy aim of the new coalition government in England. It has several benefits for patients, particularly older people and those with long-term conditions. But how does integration work in practice? This paper sets out how one particular area – Torbay – created an integrated care system that aimed to improve care for 'Mrs Smith', a fictitious user of health and social care services.
http://www.kingsfund.org.uk/publications/integrating-health-and-social-care-torbay

ISBN: 9780857027504
Lloyd, Cathy E. and Heller, Tom, editors
Long-term conditions : challenges in health and social care.
London : SAGE, 2011 *HPPP (Llo)*

NHS Improvement
Improving earlier diagnosis and the long term management of COPD : testing the case for change.
Leicester : NHS Improvement, 2011 *Web publication*
This publication, which is aimed at healthcare professionals, commissioners and other stakeholders involved in respiratory health, highlights the work undertaken by NHS Improvement to develop services that deliver efficient and high quality care and support for patients suspected to have COPD or living with the disease.
http://system.improvement.nhs.uk/ImprovementSystem/ViewDocument.aspx?path=Lung%2fNational%2fwebsite%2fEarlier_diagnosis%2fEarly%20Diagnosis%20Case%20for%20Change.pdf

Lewis, Geraint, et al.
Nuffield Trust
Choosing a predictive risk model : a guide for commissioners in England.
London : The Nuffield Trust, 2011 *Web publication*
Following the government's decision not to upgrade existing predictive risk models, this guide aims to help commissioners now tasked with choosing risk tools from an open market.
http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/choosing_predictive_risk_model_guide_for_commissioners_nov11.pdf
Associated documentation:
http://www.nuffieldtrust.org.uk/publications/choosing-predictive-risk-model-guide-commissioners-england

Parsons, Suzanne, et al.
Picker Institute and University of London
Self management support amongst older adults : the availability, impact and potential of locally based services and resources.
SDO Project ; 08/1715/161
Leeds : NIHR SDO, 2011 *Web publication*
The purpose of the study is to investigate the self-management experiences and expectations of older adults, and to examine the relationship between these and the availability of locally based support services and resources.
http://www.netscc.ac.uk/hsdr/files/project/SDO_FR_08-1715-161_V01.pdf
Associated documentation: http://www.netscc.ac.uk/hsdr/projdetails.php?ref=08-1715-161

Mathers, Nigel, chair
Royal College of General Practitioners. Clinical Innovation and Research Centre.
Care planning : improving the lives of people with long term conditions.
[London] : RCGP, 2011 *Web publication*
This report focuses on people with long term physical health problems and provides guidance to help GPs and their teams better support such patients in gaining more control over their health and improving the quality of their lives.
http://www.rcgp.org.uk/clinical-and-research/clinical-resources/~/media/Files/CIRC/Cancer/Improving%20the%20Lives%20of%20people%20with%20LTC%20-%202012%2005%2009.ashx
Associated documentation:
http://www.rcgp.org.uk/clinical-and-research/clinical-resources/care-planning.aspx

Social Care Institute for Excellence
The King's Fund
Social care and clinical commissioning for people with long-term conditions.
At a glance ; 45 (September 2011)
London : SCIE, 2011 *Web publication*
In caring for an ageing population, with rising numbers of people living with long-term conditions (LTCs), more integrated working between the NHS and social care is crucial to achieve good outcomes and make best use of resources.
http://www.scie.org.uk/publications/ataglance/ataglance45.pdf

Dusheiko, Mark, et al.
University of York. Centre for Health Economics
Does better disease management in primary care reduce hospital costs?
CHE research paper ; 65
York : CHE, 2011 *Web publication*
We apply cross-sectional and panel data methods to a database of five million patients in 8,000 English general practices to examine whether better primary care management of ten chronic diseases is associated with reduced hospital costs.
http://www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP65_Disease_management_in_PC_reduce_hospital_costs.pdf

ISBN: 9781907815270
Sultan, Nadiya
2020 Public Services Trust
Payment-by-outcome in long-term condition management.
Case study ; 3 (January 2011)
London : 2020 Public Services Trust, 2011 *Web publication*
This case study seeks to identify tools that commissioners can use to ensure that payment-by-outcome effectively delivers desired outcomes from public services. Although payment-by-outcome has not been implemented in long-term condition management, commissioners have experimented with paying providers for the completion of certain processes, and the impact on patient health of certain programmes has been monitored.
http://clients.squareeye.net/uploads/2020/documents/LTCM%20case%20study.pdf

JOURNAL ARTICLES

Lewis, Geraint, et al.
Integrating care for high-risk patients in England using the virtual ward model : lessons in the process of care integration from three case sites.
International Journal of Integrated Care 2013; 13 (October 2013)
BACKGROUND: Patients at high risk of emergency hospitalisation are particularly likely to experience fragmentation in care. The virtual ward model attempts to integrate health and social care by offering multidisciplinary case management to people at high predicted risk of unplanned hospitalisation. OBJECTIVE: To describe the care practice in three virtual ward sites in England and to explore how well each site had achieved meaningful integration. METHOD: Case studies conducted in Croydon, Devon and Wandsworth during 2011-2012, consisting of semi-structured interviews, workshops, and site visits. RESULTS: Different versions of the virtual wards intervention had been implemented in each site. In Croydon, multidisciplinary care had reverted back to one-to-one case management. CONCLUSIONS: To integrate successfully, virtual ward projects should safeguard the multidisciplinary nature of the intervention, ensure the active involvement of general practitioners, and establish feedback processes to monitor performance such as the number of professions represented at each team meeting. [Abstract]
http://www.ijic.org/index.php/ijic/article/view/URN%3ANBN%3ANL%3AUI%3A10-1-114754/2197

Bower, Peter, et al.
Multimorbidity and delivery of care for long-term conditions in the English National Health Service : baseline data from a cohort study.
Journal of Health Services Research and Policy 2013; 18 (2): 29-37 (October 2013 Suppl.)
OBJECTIVES: Many patients with long-term conditions have multiple conditions. Current delivery of care is not designed around their needs and they may face barriers to effective self-management. This study assessed the relationships between multimorbidity, the delivery of care, and self-management. METHODS: We surveyed 2439 patients with long-term conditions concerning their experience of the delivery of care and self-management in England in 2011. We assessed multimorbidity in terms of a count of long-term conditions and the presence of 'probable depression'. We explored the relationships between multimorbidity, patient experience of the delivery of care, and self-management. RESULTS: Neither measure of multimorbidity was a significant predictor of patients' experience of the delivery of care. Patients with multimorbidity reported higher levels of self-management behaviour, while the presence of depression was associated with less positive attitudes towards self-management. CONCLUSIONS: The current data do not demonstrate a consistent impact of multimorbidity on patients' experience of care or on self-management. Further research is required to assess those types of multimorbidity that are associated with significant deficits, or to identify other aspects of care that might be problematic in the context of multiple conditions. [Abstract]

Charlton, Judith, et al.

Impact of deprivation on occurrence, outcomes and health care costs of people with multiple morbidity.

Journal of Health Services Research and Policy 2013; 18 (4): 215-233 (October 2013)

OBJECTIVE: This study aimed to estimate the impact of deprivation on the occurrence, health outcomes and health care costs of people with multiple morbidity in England. METHODS: Cohort study in the UK Clinical Practice Research Datalink, using deprivation quintile (IMD2010) at individual postcode level. Incidence and mortality from diabetes mellitus, coronary heart disease, stroke and colorectal cancer, and prevalence of depression, were used to define multidisease states. Costs of health care use were estimated for each state from a two-part model. RESULTS: Data were analysed for 141,535 men and 141,352 women aged â‰¥30 years, with 33,862 disease incidence events, and 13,933 deaths. Among incidences of single conditions, 22 per cent were in the most deprived quintile and 19 per cent in the least deprived; dual conditions, most deprived 26 per cent, least deprived 16 per cent and triple conditions, most deprived 29 per cent, least deprived 14 per cent. Deaths in participants without disease were distributed most deprived 22 per cent, least deprived 19 per cent; in participants with single conditions, most deprived 24 per cent, least deprived 18 per cent; dual conditions, most deprived 27 per cent, least deprived 15 per cent, and triple conditions, most deprived 33 per cent, least deprived 17 per cent. The relative rate of depression in most deprived participants with triple conditions, compared with least deprived and no disease, was 2.48 (1.74 to 3.54). Costs of health care use were associated with increasing deprivation and level of morbidity. CONCLUSIONS: The higher incidence of disease, associated with deprivation, channels deprived populations into categories of multiple morbidity with a greater prevalence of depression, higher mortality and higher costs. This has implications for the way that resources are allocated in England's National Health Service. [Abstract]

Porter, Zoe and Simpson, Bernadette

Preparing to introduce personal health budgets.

Nursing Management 2013; 20 (6): 18-23 (October 2013)

A large-scale study (Forder et al 2012) piloting personal health budgets for people with long-term conditions found that they improved patients' quality of life and psychological wellbeing. They were cost-effective and reduced the use of other healthcare services. From April next year [2014], people receiving NHS continuing healthcare funding will have the right to ask for personal health budgets. Some clinical commissioning groups are also introducing them for mental health service users and patients with other long-term conditions. This article outlines the benefits and challenges of introducing personal health budgets, and suggests how nursing managers can begin to consider their role in implementing them. [Abstract]

Shaw, Sara E., et al.

The work of commissioning : a multisite case study of healthcare commissioning in England's NHS.

BMJ Open 2013; 3 (9): (5 September 2013)

OBJECTIVE: To examine the work of commissioning care for people with long-term conditions and the factors inhibiting or facilitating commissioners making service change. DESIGN: Multisite mixed methods case study research, combining qualitative analysis of interviews, documents and observation of meetings. PARTICIPANTS: Primary care trust managers and clinicians, general practice-based commissioners, National Health Service trust and foundation trust senior managers and clinicians, voluntary sector and local government representatives. SETTING: Three ‘commissioning communities’ (areas covered by a primary care trust) in England, 2010-2012. RESULTS: Commissioning services for people with long-term conditions was a long drawn-out process involving a range of activities and partners. Only some of the activities undertaken by commissioners, such as assessment of local health needs, coordination of healthcare planning and service specification, appeared in the official â€˜commissioning cycle’ promoted by the Department of Health. Commissioners undertook a significant range of additional activities focused on reviewing and redesigning services and providing support for implementation of new services. These activities often involved partnership working with providers and other stakeholders and appeared to be largely divorced from contracting and financial negotiations. At least for long-term condition services, the time and effort involved in such work appeared to be disproportionate to the anticipated or likely service gains. Commissioners adopting an incremental approach to service change in defined and manageable areas of work appeared to be more successful in terms of delivering planned changes in service delivery than those attempting to bring about wide-scale change across complex systems. CONCLUSIONS: Commissioning for long-term condition services challenges the conventional distinction between commissioners and providers with a significant amount of work focused on redesigning services in partnership with providers. Such work is labour-intensive and potentially unsustainable at a time of reduced finances. New clinical commissioning groups will need to determine how best to balance the relational and transactional elements of commissioning. [Abstract]

http://bmjopen.bmj.com/content/3/9/e003341.full

Tavabie, Jacqueline and Tavabie, Marianne

The patient liaison officer : a new role in UK general practice.

Quality in Primary Care 2013; 21 (5): 303-313

BACKGROUND: The population health needs of an ageing population, with increasing demands and opportunities for intervention, mean that the National Health Service (NHS) in the United Kingdom (UK) faces inevitable change. Maintaining traditional boundaries and professional roles is placing an unmanageable burden on the NHS and its workforce. Redesigning roles and developing capacity for integrated working across traditional boundaries of primary and secondary may provide ways of sustaining the health service whilst involving patients and carers in a community care model. AIMS: This project explores development of a patient liaison officer (PLO) in general practice to support delivery of integrated community care for patients with complex health needs and long-term conditions. It seeks to improve communication and administrative functions between different care providers, and incorporate patient and carer voices in care planning and delivery. It supports the UK national agenda for increasing care in the community and identifies learning needs for this new workforce. It provides career development opportunities for existing medical receptionists with potential to reduce administrative work for general practitioners (GPs). METHOD: A new role in general practice was developed through discussion and formal training based on identified key competencies of a liaison officer. Based in Bromley Clinical Commissioning Group (CCG) in South London, UK, 39 of 46 possible practices were involved. Outcome measures included: the development of a new role; the design and implementation of training, and evaluation of the participant; and teacher and observer feedback, including post-training focus groups, using thematic analysis. RESULTS AND CONCLUSIONS: Positive uptake and feedback indicated significant potential for developing this role. Investment in implementation may facilitate the achievement of improvements in healthcare and new Quality and Outcomes Framework (QOF) targets through better co-ordinated care. Future evaluation will include patient surveys and measures of impact on avoidable hospitalisation for vulnerable patients, and GP feedback on whether time has been released for new clinical work through reduction in administration carried out by PLOs. [Abstract]

Chew-Graham, Carolyn, et al.

How QOF is shaping primary care review consultations : a longitudinal qualitative study.

BMC Family Practice 2013; 14 (103): (21 July 2013)

BACKGROUND: Long-term conditions (LTCs) are increasingly important determinants of quality of life and healthcare costs in populations worldwide. The Chronic Care Model and the NHS and Social Care Long Term Conditions Model highlight the use of consultations where patients are invited to attend a consultation with a primary care clinician (practice nurse or GP) to complete a review of the management of the LTC. We report a qualitative study in which we focus on the ways in which QOF (Quality and Outcomes Framework) shapes routine review consultations, and highlight the tensions exposed between patient-centred consulting and QOF-informed LTC management. METHODS: A longitudinal qualitative study. We audio-recorded consultations of primary care practitioners with patients with LTCs. We then interviewed both patients and practitioners using tape-assisted recall. Patient participants were followed for three months during which the research team made weekly contact and invited them to complete weekly logs about their health service use. A second interview at three months was conducted with patients. Analysis of the data sets used an integrative framework approach. RESULTS: Practitioners view consultations as a means of â€˜surveillance' of patients. Patients present themselves, often passively, to the practitioner for scrutiny, but leave the consultation with unmet biomedical, informational and emotional needs. Patients perceived review consultations as insignificant and irrelevant to the daily management of their LTC and future healthcare needs. Two deviant cases, where the requirements of the â€˜review' were subsumed to meet the patient's needs, focused on cancer and bereavement. CONCLUSIONS: Routine review consultations in primary care focus on the biomedical agenda set by QOF where the practitioner is the expert, and the patient agenda unheard. Review consultations shape patients' expectations of future care and socialize patients into becoming passive subjects of â€˜surveillance'. Patient needs outside the narrow protocol of the review are made invisible by the process of review except in extreme cases such as anticipating death and bereavement. We suggest how these constraints might be overcome. [Abstract]

http://www.biomedcentral.com/1471-2296/14/103

Rijkin, Mieke, et al.
Icare4eu : improving care for people with multiple chronic conditions in Europe.
Eurohealth 2013; 19 (3): 29-31
Currently, an estimated 50 million people in the European Union live with multiple chronic diseases, which deeply impacts on their quality of life. Innovation in chronic illness care is urgently called for. First, most current care delivery models are disease-specific and therefore are not adapted to the needs of the growing number of people with multi-morbidity. Second, chronic illness care places a high burden on financial and human resources. The ICARE4EU project, a major new European initiative co-funded by the Health Programme of the European Union, wants to improve care for people living with multiple chronic conditions by identifying, analysing and disseminating innovative patient-centred multidisciplinary care programmes to address multi-morbidity. [Summary]
http://www.euro.who.int/__data/assets/pdf_file/0006/216843/Eurohealth_v19-n3.pdf

Kennedy, Anne, et al.
Implementation of self management support for long term conditions in routine primary care settings : cluster randomised controlled trial.
BMJ 2013; 346 (7913): 14 (22 June 2013)
This is a summary of a paper that was published on bmj.com as BMJ2013;346:f2882
OBJECTIVE: To determine the effectiveness of an intervention to enhance self management support for patients with chronic conditions in UK primary care. DESIGN: Pragmatic, two arm, cluster randomised controlled trial. SETTING: General practices, serving a population in northwest England with high levels of deprivation. PARTICIPANTS: 5599 patients with a diagnosis of diabetes (n=2546), chronic obstructive pulmonary disease (n=1634), and irritable bowel syndrome (n=1419) from 43 practices (19 intervention and 22 control practices). INTERVENTION: Practice level training in a whole systems approach to self management support. Practices were trained to use a range of resources: a tool to assess the support needs of patients, guidebooks on self management, and a web based directory of local self management resources. Training facilitators were employed by the health management organisation. MAIN OUTCOME MEASURES: Primary outcomes were shared decision making, self efficacy, and generic health related quality of life measured at 12 months. Secondary outcomes were general health, social or role limitations, energy and vitality, psychological wellbeing, self care activity, and enablement. RESULTS: We randomised 44 practices and recruited 5599 patients, representing 43 per cent of the eligible population on the practice lists. 4533 patients (81.0 per cent) completed the six month follow-up and 4076 (72.8 per cent) the 12 month follow-up. No statistically significant differences were found between patients attending trained practices and those attending control practices on any of the primary or secondary outcomes. All effect size estimates were well below the pre-specified threshold of clinically important difference. CONCLUSIONS: An intervention to enhance self management support in routine primary care did not add noticeable value to existing care for long term conditions. The active components required for effective self management support need to be better understood, both within primary care and in patients everyday lives. [Abstract]
http://www.bmj.com/content/346/bmj.f2882

Maresso, Anna
The quality and outcomes framework in England.
Eurohealth 2013; 19 (2): 9-10
The Quality and Outcomes Framework (QOF) is a pay-for-performance scheme that rewards general practitioner (GP) practices with financial incentives for meeting quality targets measured against specific indicators, many of which are clinical and related to disease management. The scheme was introduced to improve the quality of primary care, and to stimulate an improvement in chronic disease management. Overall, the evidence base for the impact of the QOF remains patchy and inconclusive. Major challenges include the financial sustainability of the QOF and ensuring it represents value for money for the National Health Service; vigilance against potential gaming; and ensuring that non-incentivised disease areas are not neglected by GP practices. [Summary]
http://www.euro.who.int/__data/assets/pdf_file/0019/191008/EuroHealth-v19-n2.pdf

Mooney. Helen
Shining a light on coordinated care.
Health Service Journal 2013; 123 (6347): 26-27 (19 April 2013)
US Firm Beacon Health Strategies spots the most expensive patients and creates tailored care plans. President Tim Murphy tells Helen Mooney the NHS could benefit from the same approach. [Introduction]

Brilleman, Samuel

Implications of comorbidity for primary care costs in the UK : a retrospective observational study.

British Journal of General Practice 2013; 63 (609): 195-196 (April 2013)

BACKGROUND: Comorbidity is increasingly common in primary care. The cost implications for patient care and budgetary management are unclear. AIM: To investigate whether caring for patients with specific disease combinations increases or decreases primary care costs compared with treating separate patients with one condition each. DESIGN: Retrospective observational study using data on 86 100 patients in the General Practice Research Database. METHOD: Annual primary care cost was estimated for each patient including consultations, medication, and investigations. Patients with comorbidity were defined as those with a current diagnosis of more than one chronic condition in the Quality and Outcomes Framework. Multiple regression modelling was used to identify, for three age groups, disease combinations that increase (cost-increasing) or decrease (cost-limiting) cost compared with treating each condition separately. RESULTS: Twenty per cent of patients had at least two chronic conditions. All conditions were found to be both cost-increasing and cost-limiting when co-occurring with other conditions except dementia, which is only cost-limiting. Depression is the most important cost-increasing condition when co-occurring with a range of conditions. Hypertension is cost-limiting, particularly when co-occurring with other cardiovascular conditions. CONCLUSION: Three categories of comorbidity emerge, those that are: cost-increasing, mainly due to a combination of depression with physical comorbidity; cost-limiting because treatment for the conditions overlap; and cost-limiting for no apparent reason but possibly because of inadequate care. These results can contribute to efficient and effective management of chronic conditions in primary care. [Abstract]

Elissen, Arianne, et al.

Is Europe putting theory into practice? : a qualitative study of the level of self-management support in chronic care management approaches.

BMC Health Services Research 2013; 13 (117): (26 March 2013)

BACKGROUND: Self-management support is a key component of effective chronic care management, yet in practice appears to be the least implemented and most challenging. This study explores whether and how self-management support is integrated into chronic care approaches in 13 European countries. In addition, it investigates the level of and barriers to implementation of support strategies in health care practice. METHODS: We conducted a review among the 13 participating countries, based on a common data template informed by the Chronic Care Model. Key informants presented a sample of representative chronic care approaches and related self-management support strategies. The cross-country review was complemented by a Dutch case study of health professionalsâ€™ views on the implementation of self-management support in practice. RESULTS: Self-management support for chronically ill patients remains relatively underdeveloped in Europe. Similarities between countries exist mostly in involved providers (nurses) and settings (primary care). Differences prevail in mode and format of support, and materials used. Support activities focus primarily on patientsâ€™ medical and behavioral management, and less on emotional management. According to Dutch providers, self-management support is not (yet) an integral part of daily practice; implementation is hampered by barriers related to, among others, funding, IT and medical culture. CONCLUSIONS: Although collaborative care for chronic conditions is becoming more important in European health systems, adequate self-management support for patients with chronic disease is far from accomplished in most countries. There is a need for better understanding of how we can encourage both patients and health care providers to engage in productive interactions in daily chronic care practice, which can improve health and social outcomes. [Abstract]

http://www.biomedcentral.com/1472-6963/13/117

Henderson, Catherine, et al.

Cost effectiveness of telehealth for patients with long term conditions (Whole Systems Demonstrator telehealth questionnaire study) : nested economic evaluation in a pragmatic, cluster randomised controlled trial.

BMJ 2013; 346:f1035 (22 March 2013)

OBJECTIVE: To examine the costs and cost effectiveness of telehealth in addition to standard support and treatment, compared with standard support and treatment. DESIGN: Economic evaluation nested in a pragmatic, cluster randomised controlled trial. SETTING: Community based telehealth intervention in three local authority areas in England. PARTICIPANTS: 3230 people with a long term condition (heart failure, chronic obstructive pulmonary disease, or diabetes) were recruited into the Whole Systems Demonstrator telehealth trial between May 2008 and December 2009. Of participants taking part in the Whole Systems Demonstrator telehealth questionnaire study examining acceptability, effectiveness, and cost effectiveness, 845 were randomised to telehealth and 728 to usual care. INTERVENTIONS: Intervention participants received a package of telehealth equipment and monitoring services for twelve months, in addition to the standard health and social care services available in their area. Controls received usual health and social care. MAIN OUTCOME MEASURE: Primary outcome for the cost effectiveness analysis was incremental cost per quality adjusted life year (QALY) gained. RESULTS: We undertook net benefit analyses of costs and outcomes for 965 patients (534 receiving telehealth; 431 usual care). The adjusted mean difference in QALY gain between groups at 12 months was 0.012. Total health and social care costs (including direct costs of the intervention) for the three months before 12 month interview were £1390 (€1610; $2150) and £1596 for the usual care and telehealth groups, respectively. Cost effectiveness acceptability curves were generated to examine decision uncertainty in the analysis surrounding the value of the cost effectiveness threshold. The incremental cost per QALY of telehealth when added to usual care was £92 000. With this amount, the probability of cost effectiveness was low (11% at willingness to pay threshold of £30 000; >50% only if the threshold exceeded about £90 000). In sensitivity analyses, telehealth costs remained slightly (non-significantly) higher than usual care costs, even after assuming that equipment prices fell by 80% or telehealth services operated at maximum capacity. However, the most optimistic scenario (combining reduced equipment prices with maximum operating capacity) eliminated this group difference (cost effectiveness ratio £12 000 per QALY). CONCLUSIONS: The QALY gain by patients using telehealth in addition to usual care was similar to that by patients receiving usual care only, and total costs associated with the telehealth intervention were higher. Telehealth does not seem to be a cost effective addition to standard support and treatment. [Abstract]

http://www.bmj.com/content/346/bmj.f1035

Drinkwater, Jessica, et al.

Operationalising unscheduled care policy : a qualitative study of healthcare professionals' perspectives.

British Journal of General Practice 2013; 63 (608): 135-136 (March 2013)

BACKGROUND: UK health policy aims to reduce the use of unscheduled care, by increasing proactive and preventative management of patients with long-term conditions in primary care. AIM: The study explored healthcare professionals' understanding of why patients with long-term conditions use unscheduled care, and the healthcare professionals' understanding of their role in relation to reducing the use of unscheduled care. DESIGN AND SETTING: Qualitative study interviewing different types of healthcare professionals providing primary care or unscheduled care services in northwest England. METHOD: Semi-structured interviews were conducted with 29 healthcare professionals (six GPs; five out-of-hours GPs; four emergency department doctors; two practice nurses; three specialist nurses; two district nurses; seven active case managers). Data were analysed using framework analysis. RESULTS: Healthcare professionals viewed the use of unscheduled care as a necessary component of care for patients with long-term conditions. Those whose roles involved working to targets to reduce the use of unscheduled care described a tension between this and delivering optimum patient care. Three approaches to reducing unscheduled care were described: optimising the system; negotiating the system; and optimising the patient. CONCLUSION: Current policy to reduce the use of unscheduled care does not take account of the perceptions of the healthcare professionals who are expected to implement them. Lipsky's theory of street-level bureaucrats provides a framework to understand how healthcare professionals respond to imposed policies. Healthcare professionals did not see the use of unscheduled care as a problem and there was limited commitment to the policy targets. Therefore, policy should aim for whole-system change rather than reliance on individual healthcare professionals to make changes in their practice. [Abstract]

Hoult, James and Matheson, Hailey

Spot future patients to find tomorrow's savings.

Health Service Journal 2013; 123 (6340): 26-28 (21 February 2013)

A risk stratification tool used by GP practices in Leeds helped to identify where early intervention would benefit patients with long-term conditions- and lead to cash savings, as James Hoult and Hailey Matheson explain. [Introduction]

Guthrie, Bruce, et al.

Adapting clinical guidelines to take account of multimorbidity.

BMJ 2012; 345 (7878): 22-24 (13 October 2012)

Most people with a chronic condition have multimorbidity, but clinical guidelines almost entirely focus on single conditions. It will never be possible to have good evidence for every possible combination of conditions, but guidelines could be made more useful for people with multimorbidity if they were delivered in a format that brought together relevant recommendations for different chronic conditions and identified synergies, cautions, and outright contradictions. We highlight the problem that multimorbidity poses to clinicians and patients using guidelines for single conditions and propose ways of making them more useful for people with multimorbidity. [Introduction]

Brusamento, Serena, et al.

Assessing the effectiveness of strategies to implement clinical guidelines for the management of chronic diseases at primary care level in EU Member States : a systematic review.

Health Policy 2012; 107 (2-3): 168-183 (October 2012)

PURPOSE AND SETTING: This review aimed to evaluate the effectiveness of strategies to implement clinical guidelines for chronic disease management in primary care in EU Member States. METHODS: We conducted a systematic review of interventional studies assessing the implementation of clinical guidelines. We searched five databases (EMBASE, MEDLINE, CENTRAL, Eppi-Centre and Clinicaltrials.gov) following a strict Cochrane methodology. We included studies focusing on the management of chronic diseases in adults in primary care. RESULTS: A total of 21 studies were found. The implementation strategy was fully effective in only four (19 per cent), partially effective in eight (38 per cent), and not effective in nine (43 per cent). The probability that an intervention would be effective was only slightly higher with multifaceted strategies, compared to single interventions. However, effect size varied across studies; therefore it was not possible to determine the most successful strategy. Only eight studies evaluated the impact on patients' health and only two of those showed significant improvement, while in five there was an improvement in the process of care which did not translate into an improvement in health outcomes. Only four studies reported any data on the cost of the implementation but none undertook a cost-effectiveness analysis. Only one study presented data on the barriers to the implementation of guidelines, noting a lack of awareness and agreement about clinical guidelines. CONCLUSION: Our results reveal that there are only a few rigorous studies which assess the effectiveness of a strategy to implement clinical guidelines in Europe. Moreover, the results are not consistent in showing which strategy is the most appropriate to facilitate their implementation. Therefore, further research is needed to develop more rigorous studies to evaluate health outcomes associated with the implementation of clinical guidelines; to assess the cost-effectiveness of implementing clinical guidelines; and to investigate the perspective of service users and health service staff. [Abstract]

Gornall, Jonathan

Does telemedicine deserve the green light?

BMJ 2012; 345 (7865): 20-23 (14 July 2012)

The government is enthusiastically promoting telehealth as a way to cut NHS costs and improve care, but the evidence emerging from a large NHS trial seems much more equivocal, Jonathan Gornall reports. [Introduction]

Steventon, Adam, et al.

Effect of telehealth on use of secondary care and mortality : findings from the Whole System Demonstrator cluster randomised trial

BMJ 2012 345 (7865): 16 (14 July 2012)

OBJECTIVE: To assess the effect of home based telehealth interventions on the use of secondary healthcare and mortality. DESIGN: Pragmatic, multisite, cluster randomised trial comparing telehealth with usual care, using data from routine administrative datasets. General practice was the unit of randomisation. We allocated practices using a minimisation algorithm, and did analyses by intention to treat. SETTING: 179 general practices in three areas in England. PARTICIPANTS: 3230 people with diabetes, chronic obstructive pulmonary disease, or heart failure recruited from practices between May 2008 and November 2009. INTERVENTIONS: Telehealth involved remote exchange of data between patients and healthcare professionals as part of patients' diagnosis and management. Usual care reflected the range of services available in the trial sites, excluding telehealth. MAIN OUTCOME MEASURES: Proportion of patients admitted to hospital during 12 month trial period. RESULTS: Patient characteristics were similar at baseline. Compared with controls, the intervention group had a lower admission proportion within 12 month follow-up (odds ratio 0.82, 95 per cent confidence interval 0.70 to 0.97, P=0.017). Mortality at 12 months was also lower for intervention patients than for controls (4.6 per cent v 8.3 per cent; odds ratio 0.54, 0.39 to 0.75, P<0.001). These differences in admissions and mortality remained significant after adjustment. The mean number of emergency admissions per head also differed between groups (crude rates, intervention 0.54 v control 0.68); these changes were significant in unadjusted comparisons (incidence rate ratio 0.81, 0.65 to 1.00, P=0.046) and after adjusting for a predictive risk score, but not after adjusting for baseline characteristics. Length of hospital stay was shorter for intervention patients than for controls (mean bed days per head 4.87 v 5.68; geometric mean difference −0.64 days, −1.14 to −0.10, P=0.023, which remained significant after adjustment). Observed differences in other forms of hospital use, including notional costs, were not significant in general. Differences in emergency admissions were greatest at the beginning of the trial, during which we observed a particularly large increase for the control group. CONCLUSIONS: Telehealth is associated with lower mortality and emergency admission rates. The reasons for the short term increases in admissions for the control group are not clear, but the trial recruitment processes could have had an effect. [Abstract]

http://www.bmj.com/content/344/bmj.e3874

Roland, Martin, et al.

Case management for at-risk elderly patients in the English integrated care pilots : observational study of staff and patient experience and secondary care utilisation.

International Journal of Integrated Care 2012; 12 (July 2012)

INTRODUCTION: In 2009, the English Department of Health appointed 16 integrated care pilots which aimed to provide better integrated care. We report the quantitative results from a multi-method evaluation of six of the demonstration projects which used risk profiling tools to identify older people at risk of emergency hospital admission, combined with intensive case management for people identified as at risk. The interventions focused mainly on delivery system redesign and improved clinical information systems, two key elements of Wagner's Chronic Care Model. METHODS: Questionnaires to staff and patients. Difference-in-differences analysis of secondary care utilisation using data on 3646 patients and 17,311 matched controls, and changes in overall secondary care utilisation. RESULTS: Most staff thought that care for their patients had improved. More patients reported having a care plan but they found it significantly harder to see a doctor or nurse of their choice and felt less involved in decisions about their care. Case management interventions were associated with a nine per cent increase in emergency admissions. We found some evidence of imbalance between cases and controls which could have biased this estimate, but simulations of the possible effect of unobserved confounders showed that it was very unlikely that the sites achieved their goal of reducing emergency admissions. However, we found significant reductions of 21 per cent and 22 per cent in elective admissions and outpatient attendance in the six months following an intervention, and overall inpatient and outpatient costs were significantly reduced by nine per cent during this period. Area level analyses of whole practice populations suggested that overall outpatient attendances were significantly reduced by 5 per cent two years after the start of the case management schemes. CONCLUSION: Case management may result in improvements in some aspects of care and has the potential to reduce secondary care costs. However, to improve patient experience, case management approaches need to be introduced in a way which respects patients' wishes, for example the ability to see a familiar doctor or nurse. [Abstract]

http://www.ijic.org/index.php/ijic/article/view/850/1771

Dean, Erin

From heart failure to success.

Nursing Standard 2012; 26 (40): 16-17 (6 June 2012)

A cardiovascular disease service in Merseyside is keeping patients out of hospital and providing them with faster and more effective care. The key to the service's success is the integration of formerly fragmented services. The model is popular with nurses, who no longer work in isolation and are supported to provide holistic care. [Abstract]

Blunt, Ian

Take the risk out of risk modelling.

Health Service Journal 2012; 122 (6308): 35 (31 May 2012)

Predictive risk tools are more efficient and accurate than clinicians at targeting at-risk patients groups - so CCGs should not shy away from them, says Ian Blunt. [Introduction]

O'Donnell, Catherine, et al.

Delivering a national programme of anticipatory care in primary care : a qualitative study.

British Journal of General Practice 2012; 62 (597): 200-201 (April 2012)

BACKGROUND: Primary prevention often occurs against a background of inequalities in health and health care. Addressing this requires practitioners and systems to acknowledge the contribution of health-related and social determinants and to deal with the lack of interconnectedness between health and social service providers. Recognising this, the Scottish Government has implemented a national programme of anticipatory care targeting individuals aged 45-64 years living in areas of socioeconomic deprivation and at high risk of cardiovascular disease. This programme is called Keep Well. AIM: To explore the issues and tensions underpinning the implementation of a national programme of anticipatory care. DESIGN AND SETTING: A qualitative study in five Wave 1 Keep Well pilot sites, located in urban areas of Scotland, and involving 79 general practices. METHOD: Annual semi-structured interviews were conducted with 74 key stakeholders operating at national government level, local pilot level and within general practices, resulting in 118 interviews. Interview transcripts were analysed using the framework approach. RESULTS: Four underlying tensions were identified. First, those between a patient-focused general-practice approach versus a population-level health-improvement approach, linking disparate health and social services; secondly, medical approaches versus wider social approaches; thirdly, a population-wide approach versus individual targeting; and finally, reactive versus anticipatory care. CONCLUSION: Implementing an anticipatory care programme to address inequalities in cardiovascular disease identified several tensions, which need to be understood and resolved in order to inform the development of such approaches in general practice and to develop systems that reduce the degree of fragmentation across health and social services. [Abstract]

Mayes, Rick and Oliver, Thomas R.

Chronic disease and the shifting focus of public health : is prevention still a political lightweight?

Journal of Health Politics, Policy and Law 2012; 37 (2): 181-200 (April 2012)

Why is it so politically difficult to obtain government investment in public health initiatives that are aimed at addressing chronic disease? This article examines the structural disadvantage faced by those who advocate for public health policies and practices to reduce chronic disease related to people's unhealthy lifestyles and physical environments. It identifies common features that make it difficult to establish and maintain initiatives to prevent or reduce costly illness and physical suffering: (1) public health benefits are generally dispersed and delayed; (2) benefactors of public health are generally unknown and taken for granted; (3) the costs of many public health initiatives are concentrated and generate opposition from those who would pay them; and (4) public health often clashes with moral values or social norms. The article concludes by discussing the importance of a new paradigm, "health in all policies," that targets the enormous health and economic burdens associated with chronic conditions and asserts a need for new policies, practices, and participation beyond the confines of traditional public health agencies and services. [Abstract]

Hattrick, Gemma and Bentham, Ceri

Using ambulatory A&E care to cut admissions.

Nursing Times 2012; 108 (14): 14-15 (3 April 2012)

Evidence shows many conditions can be effectively managed out of hospital, with greater patient satisfaction and fewer hospital admissions. South Tyneside Foundation Trust ran a pilot project in which an ambulatory emergency care (AEC) department saw patients admitted to hospital via their GP, producing the benefits stated above. [Abstract]

Dixon, Anna and Khachatryan, Artak

Socioeconomic differences in case finding among general practices in England : analysis of secondary data.

Journal of Health Services Research & Policy 2012; 17 (2): 18-22 (April 2012)

OBJECTIVES: To determine how levels of case finding differ between general practices in England by level of population socio-economic deprivation. METHOD: Observational analysis of data from the Quality and Outcome Framework in England for 2005/06. It covered 8339 primary care practices. Reported prevalence and estimated prevalence for coronary heart disease, chronic obstructive pulmonary disease, stroke and hypertension were compared. RESULTS: The gap between estimated and reported prevalence increased with population deprivation and was higher among practices in more deprived areas (defined as Spearhead areas) for all four conditions after adjustment for practice level variables. CONCLUSIONS: There is some evidence of unmet need in areas of social deprivation. Existing financial incentives in the Quality and Outcome Framework may be insufficient to promote active case finding by practices serving deprived populations. [Abstract]

Burt, Jenni, et al.

Prevalence and benefits of care plans and care planning for people with long-term conditions in England.

Journal of Health Services Research and Policy 2012; 17 (1): 55-63 (January 2012)

OBJECTIVES: Among patients with long-term conditions, to determine the prevalence and benefits of care planning discussions and of care plans. METHODS: Data from the 2009/10 General Practice Patient Survey, a cross sectional survey of 5.5 million patients in England. Outcomes were patient reports of: care planning discussions; perceived benefit from care planning discussions and resultant care plans. Patient and practice variables were included in multilevel logistic regression to investigate predictors of each outcome. RESULTS: Half the respondents (49 per cent) reported a long-term condition and were eligible to answer the care planning questions. Of these, 84 per cent reported having a care planning discussion during the last twelve months and most reported some benefit. Only twelve per cent who reported a care planning discussion also reported being told they had a care plan. Patients who reported having a care plan were more likely to report benefits from care planning discussions. Several factors predicted the reporting of care planning and care plans of which the most important was patients' reports of the quality of interpersonal care. CONCLUSIONS: There is a gap between policy and current practice which might reflect uncertainty as to the benefits of care plans. There is, therefore, a need for rigorous evaluation of care plans. [Abstract]

Soljak, Michael, et al.

Does higher quality primary health care reduce stroke admissions? : a national cross-sectional study.

British Journal of General Practice 2011; 61 (593): 731-732 (December 2011)

BACKGROUND: Hospital admission rates for stroke are strongly associated with population factors. The supply and quality of primary care services may also affect admission rates, but there is little previous research. AIM: To determine if the hospital admission rate for stroke is reduced by effective primary and secondary prevention in primary care. DESIGN AND SETTING: National cross-sectional study in an English population (52 763 586 patients registered with 7969 general practices in 152 primary care trusts). METHOD: A combination of data on hospital admissions for 2006-2009, primary healthcare staffing, practice clinical quality and access indicators, census sources, and prevalence estimates was used. The main outcome measure was indirectly standardised hospital admission rates for stroke, for each practice population. RESULTS: Mean (3 years) annual stroke admission rates per 100 000 population varied from zero to 476.5 at practice level. In a practice-level multivariable Poisson regression, observed stroke prevalence, deprivation, smoking prevalence, and GPs/100 000 population were all risk factors for hospital admission. Protective healthcare factors included the percentage of stroke or transient ischaemic attack patients whose last measured total cholesterol was ≤5 mmol/l ($P<0.001$), and ability to book an appointment with a GP ($P<0.003$). All effect sizes were relatively small. CONCLUSION: Associations of stroke admission rates with deprivation and smoking highlight the need for smoking-cessation services. Of the stroke and hypertension clinical quality indicators examined, only reaching a total cholesterol target was associated with reduced admission rates. Patient experience of access to primary care may also be clinically important. In countries with well-developed primary healthcare systems, the potential to reduce hospital admissions by further improving the clinical quality of primary healthcare may be limited. [Abstract]

Von Korff, Michael, et al.

Functional outcomes of multi-condition collaborative care and successful ageing : results of randomised trial.

BMJ 2011; 343 (7833): 1083 (26 November 2011)

The print version is a summary of a paper that was published on bmj.com as bmj 2011; 343:d6612

OBJECTIVES: To evaluate the effectiveness of integrated care for chronic physical diseases and depression in reducing disability and improving quality of life. DESIGN: A randomised controlled trial of multi-condition collaborative care for depression and poorly controlled diabetes and/or risk factors for coronary heart disease compared with usual care among middle aged and elderly people. SETTING: Fourteen primary care clinics in Seattle, Washington. PARTICIPANTS: Patients with diabetes or coronary heart disease, or both, and blood pressure above 140/90 mm Hg, low density lipoprotein concentration >3.37 mmol/L, or glycated haemoglobin 8.5 per cent or higher, and PHQ-9 depression scores of ≥10. INTERVENTION: A twelve month intervention to improve depression, glycaemic control, blood pressure, and lipid control by integrating a “treat to target” programme for diabetes and risk factors for coronary heart disease with collaborative care for depression. The intervention combined self management support, monitoring of disease control, and pharmacotherapy to control depression, hyperglycaemia, hypertension, and hyperlipidaemia. MAIN OUTCOME MEASURES: Social role disability (Sheehan disability scale), global quality of life rating, and World Health Organization disability assessment schedule (WHODAS-2) scales to measure disabilities in activities of daily living (mobility, self care, household maintenance). RESULTS: Of 214 patients enrolled (106 intervention and 108 usual care), disability and quality of life measures were obtained for 97 intervention patients at six months (92 per cent) and 92 at 2 twelve months (87 per cent), and for 96 usual care patients at six months (89 per cent) and 92 at 12 months (85 per cent). Improvements from baseline on the Sheehan disability scale (−0.9, 95 per cent confidence interval −1.5 to −0.2; P=0.006) and global quality of life rating (0.7, 0.2 to 1.2; P=0.005) were significantly greater at six and 12 months in patients in the intervention group. There was a trend toward greater improvement in disabilities in activities of daily living (−1.5, −3.3 to 0.4; P=0.10). CONCLUSIONS: Integrated care that covers chronic physical disease and comorbid depression can reduce social role disability and enhance global quality of life. [Abstract]

http://www.bmj.com/content/343/bmj.d6612

Dusheiko, Mark, et al.

Does better disease management in primary care reduce hospital costs? : evidence from English primary care.

Journal of Health Economics 2011; 30 (5): 919-932 (September 2011)

We apply cross-sectional and panel data methods to a database of 5 million patients in 8000 English general practices to examine whether better primary care management of ten chronic diseases is associated with reduced hospital costs. We find that only primary care performance in stroke care is associated with lower hospital costs. Our results suggest that the ten per cent improvement in the general practice quality of stroke care between 2004/5 and 2007/8 reduced 2007/8 hospital expenditure by about £130 million in England. The cost savings are due mainly to reductions in emergency admissions and outpatient visits, rather than to lower costs for patients treated in hospital or to reductions in elective admissions. [Abstract]

de Bruin, Simone, et al.

Impact of disease management programs on healthcare expenditures for patients with diabetes, depression, heart failure or chronic obstructive pulmonary disease : a systematic review of the literature.

Health Policy 2011; 101 (2): 105-121 (July 2011)

OBJECTIVE: Evaluating the impact of disease management programs on healthcare expenditures for patients with diabetes, depression, heart failure or COPD. METHODS: Systematic Pubmed search for studies reporting the impact of disease management programs on healthcare expenditures. Included were studies that contained two or more components of Wagner's chronic care model and were published between January 2007 and December 2009. RESULTS: Thirty-one papers were selected, describing disease management programs for patients with diabetes (n=14), depression (n=4), heart failure (n=8), and COPD (n=5). Twenty-one studies reported incremental healthcare costs per patient per year, of which 13 showed cost-savings. Incremental costs ranged between -$16,996 and $3305 per patient per year. Substantial variation was found between studies in terms of study design, number and combination of components of disease management programs, interventions within components, and characteristics of economic evaluations. CONCLUSION: Although it is widely believed that disease management programs reduce healthcare expenditures, the present study shows that evidence for this claim is still inconclusive. Nevertheless disease management programs are increasingly implemented in healthcare systems worldwide. To support well-considered decision-making in this field, well-designed economic evaluations should be stimulated. [Abstract]

McDonald, Julie, et al.

Collaboration across private and public sector primary health care services : benefits, costs and policy implications.

Journal of Interprofessional Care 2011; 25 (4): 258-264 (July 2011)

Ongoing care for chronic conditions is best provided by interprofessional teams. There are challenges in achieving this where teams cross organisational boundaries. This article explores the influence of organisational factors on collaboration between private and public sector primary and community health services involved in diabetes care. It involved a case study using qualitative methods. Forty-five participants from 20 organisations were purposively recruited. Data were collected through semi-structured interviews and from content analysis of documents. Thematic analysis was used employing a two-level coding system and cross case comparisons. The patterns of collaborative patient care were influenced by a combination of factors relating to the benefits and costs of collaboration and the influence of support mechanisms. Benefits lay in achieving common or complementary health or organisational goals. Costs were incurred in bridging differences in organisational size, structure, complexity and culture. Collaboration was easier between private sector organisations than between private and public sectors. Financial incentives were not sufficient to overcome organisational barriers. To achieve more coordinated primary and community health care structural changes are also needed to better align funding mechanisms, priorities and accountabilities of the different organisations. [Abstract]

Reilly, Siobhan, et al.

Case management for people with long-term conditions : impact upon emergency admissions and associated length of stay.

Primary Health Care Research and Development 2011; 12 (3): 223-236 (July 2011)

AIM: This paper describes findings from a study that evaluated the implementation and impact of case management for long-term conditions (CMLTC) in 10 primary care trusts (PCTs). BACKGROUND: Patients who have long-term conditions and complex health and social needs may require case management to deliver and coordinate their care from a range of agencies. METHODS: A cross-sectional postal survey of managers with lead responsibility for CMLTC in each PCT is adopted to describe the implementation of services. A retrospective cohort analysis of longitudinal routinely collected admission data for patients enrolled within the CMLTC service (nine months before and nine months after the entry; n = 867) is used to measure their impact.FindingsThe organisation of case management varied between PCTs in some aspects despite a high level of coordination across the geographical area. Mean emergency admissions and associated length of stay (LOS) for patients reduced significantly in the nine months after the service entry. There were a number of fairly robust positive and negative influences on these outcome measures in the regression analysis. Most patients with a history of emergency admissions experienced a marked improvement over time. However, most of those without any or with few admissions experienced an increase in admissions and corresponding LOS. Furthermore, a proportion of frequent service users with particular diagnoses also experienced an increase or remained at a high level. A very modest effect was shown with regard to the features of case management arrangements. For each day spent in hospital before service entry, patients are predicted to experience a reduction of nearly one day after. The main contributor explaining increases in LOS for emergency admissions was the number of primary and secondary diagnoses. Each added diagnosis is associated with a 2.4-day increase in LOS, everything else being equal. [Abstract]

WEB RESOURCES

Commissioning for long term conditions
NHS Networks
http://www.networks.nhs.uk/nhs-networks/commissioning-for-long-term-conditions

Improving quality of life for people with long term conditions
Department of Health policy page
https://www.gov.uk/government/policies/improving-quality-of-life-for-people-with-long-term-conditions

Integrated care and support exchange (ICASE).
http://www.icase.org.uk

National Voices
http://www.nationalvoices.org.uk/

NHS Improving Quality (NHS IQ)
NHS England
http://www.england.nhs.uk/ourwork/qual-clin-lead/nhsiq/

NHS Information Centre for Health & Social Care - Data Collections
http://www.hscic.gov.uk/searchcatalogue

Office for National Statistics - Health and Social Care
http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Health+and+Social+Care

People Powered Health
NESTA
http://www.nesta.org.uk/project/people-powered-health

Preventing Chronic Disease : public health research, practice and policy.
- a U.S. peer-reviewed electronic journal with free access full-text articles and research study results.
http://www.cdc.gov/pcd/index.htm

World Health Organization. Regional Office for Europe
- Non-communicable diseases
  http://www.euro.who.int/en/what-we-do/health-topics/noncommunicable-diseases
- Communicable diseases
  http://www.euro.who.int/en/health-topics/communicable-diseases

WISE - Whole System Informing Self-Management Engagement approach
http://www.medicine.manchester.ac.uk/wise/