

# Multiple Long Term Conditions

## Co-design and engagement

### Introduction & project overview

One of the most significant challenges facing the NHS over coming decades will be meeting the needs of the growing number of people with multiple health conditions. One in four people live with at least two health conditions<sup>i</sup>. People with long term conditions account for around half of GP appointments and two thirds of outpatient appointments and hospital bed days<sup>ii</sup>. Within North Central London (NCL) we anticipate that the population of people living with one or more respiratory disease (like COPD or asthma) or metabolic disease (such as diabetes or cardiovascular disease) is expected to increase by 8%, around 24,000 people, by 2030<sup>iii</sup>.

Groups who represent patients with Long Term Conditions (LTCs) value careful coordination, shared decision making, prioritisation and a longer-term perspective<sup>iv</sup>. But, too often, what they find is that services are still characterised by siloed ways of working, a focus on acuity and a lack of forward planning<sup>v</sup>.

The NCL Health Alliance is the 'all in' provider alliance that covers all NHS healthcare providers in North Central London across acute, mental health, community and primary care services. The Health Alliance is running a Long-Term Conditions programme aims to design and test an improved model of care which responds to this feedback.

We will **develop and trial models of care designed to improve the experience, outcomes and efficiency of care for people with several long-term conditions or complexity in management of their long-term conditions**. This will generate learning and insight about how professionals and the organisations they work in respond to the challenge of complexity and multi-morbidity in an ageing population, with application both within NCL and more widely. The intention is to have two test early implementer sites running over the next twelve months each of which will operate as a trial of different ways of working that aim to reduce fragmentation and lack of prioritisation in care.

Engagement with people who have long term conditions in designing the new models of care is fundamental and a key element of learning will be how best to ensure that patients and carers can participate meaningfully in their care. **This expression of interest seeks a provider with significant experience of leading patient participation ideally with people who have a number of health conditions**. We are looking for an organisation/partnership of organisations that have established relationships with our diverse communities and particularly those who are under-served by health services, to plan and deliver this participatory approach. The patient

participation work will use a multi-method approach to reach most people and is expected to be co-designed with patient groups. It aims to trial:

- Ways of ensuring that patients/residents with multiple long-term conditions are meaningfully influencing their treatment, test and learning approaches as part of our early implementer sites
- Methods for ensuring that people whose circumstances make participation difficult (e.g. due to language barriers, poor health or mental health, time constraints) are supported so that they can input meaningfully into planning their care
- Ways of building trust and confidence in healthcare services for people who have had negative experiences or hold negative views about providers or their own ability to influence their health
- Ways to ensure a feedback loop so that themes and trends emerging from patient involvement inform this programme and future programmes of work

### **Aims and objectives of the engagement**

We hope that an engagement partner will help the programme team to plan and to carry out patient engagement. This will involve:

- a) Designing a methodology to support participation and activation of people with multiple health conditions to ensure that what matters to them is at the centre of their care
- b) Helping to support the design of any surveys, questionnaires or outreach approaches that are used to collect views of patients and residents
- c) Carrying out and enabling patient/carer participation at an individual patient level with patients/carers to understand experiences, views and priorities and to feed this into the care planning process
- d) Supporting the meaningful engagement of patients at an individual level, including people whose circumstances make engagement difficult (e.g. due to language barriers, poor health or mental health, time constraints)
- e) Designing and delivering information to patients and carers within the early implementer sites, about the work to ensure that patients/carers have an opportunity to be input and be involved at the level they feel is appropriate

### **Target Communities plus geographic areas**

We are going to start by working specifically within two Primary Care Networks (PCNs) within NCL as our early adopter sites. These networks will be based around GP populations of between 30,000 and 75,000 patients and will be in an area where there is a high incidence of deprivation

or high numbers of people with more than one LTC. Once these sites are up and running, we will upscale across other PCNs to develop borough wide delivery.

## Reporting

We hope that the engagement partner will be able to report on:

- Their planning process: The development of a plan for how people with LTCs are meaningfully involved in their care planning process, both in the design of the pathway improvements and at an individual patient level
- Progress on implementation on a weekly basis
- Delivery of participation and ability to report on activity numbers
- A mechanism to ensure that conversations and feedback from patients are informing care planning and that there is continuous learning about this approach to steer implementation A full written end of programme report that outlines the methodology both for co-production and patient engagement, what was done and the learning

Reporting in the form of:

- A planned implementation approach [4 weeks in August]
- Case studies/testimonies
- Qualitative and quantitative analysis and charts
- Thematic summary report of activities, research and outcomes

Reporting structure e.g.

- Monthly update meetings between July (or commencement of engagement and December/January)
- Partner organisation would participate in all relevant programme meetings (likely to be a monthly steering group and weekly programme team meeting).
- A final report at the end of the project that sets out the above learning and thematic analysis.

## Timeframe:

20 <sup>th</sup> June	Expression of interest shared
4 <sup>th</sup> July and 8 <sup>th</sup> July	Meeting with potential providers
29 <sup>th</sup> July	Deadline for submission of expression of interest
5 <sup>th</sup> August	Feedback to providers and commencement of work
August	Planning and setup
September	Initial contacts with patients and refining of approach
October	Individual level patient engagement
Nov – March	Participation work begins within test sites

## Budget:

£2,500	Planning for participation and patient activation [August and September]
--------	--

£8,500	Delivery of engagement work with individual patients within test sites between November 24 and April 25
£2,000	Write-up of work and learning
£2,000	Materials including catering, translation, travel, venue and additional staff/volunteer time
Total - £15,000	

### Proposal submission:

Please submit an Expression of Interest on how you will deliver the above brief. Please include how you will meet the above brief and the experience that you will draw on.

### Contact Details:

Naomi Tonkin [naomi.tonkin@uclpartners.com](mailto:naomi.tonkin@uclpartners.com)

---

<sup>i</sup> The Health Foundation (2018). [Understanding the health care needs of people with multiple health conditions - The Health Foundation](#)

<sup>ii</sup> Department of Health (2012). <https://www.gov.uk/government/publications/long-term-conditions-compendium-of-information-third-edition>

<sup>iii</sup> North Central London ICB *NCL population forecast 2024 and 2030 and the Long Term Condition LCS cohort* unpublished data

<sup>iv</sup> Richmond Group of Charities (2018) [trg\\_one\\_in\\_four.pdf \(richmondgroupofcharities.org.uk\)](#)

<sup>v</sup> Richmond Group of Charities (2018) [trg\\_one\\_in\\_four.pdf \(richmondgroupofcharities.org.uk\)](#)