Appendix A

Implementing the Long Term Conditions across the Lifecourse JSNA: **Delivery plan**

Update: **8th June 2016**

1. **Raising awareness of key findings from the JSNA**

Key Findings	Action Required/ Update	Ownership	Status
There are a substantial proportion of people with multiple LTCs in Cambridgeshire. Nearly 20% of people aged 18-64 years have more than one LTC and 70% of people over the age of 65 have more than one LTC. Levels of limitation are high in both groups.	Dissemination of findings across health system.	PH CCC	**Ongoing**
The co-occurrence of mental health conditions and LTCs is marked and has clear commissioning and service implications.	Ensuring finding is communicated with C&P CCG colleagues and other relevant stakeholders	PH CCC	**Ongoing and embedded in communications plan**
Those with multimorbidity are often at higher risk of escalation of health and social care. Those with multimorbidity and significant levels of limitation, pain and mental health conditions are at even higher risk of poorer health and social outcomes.	Primary care + community care - Early intervention and support for people with multiple LTCs - Support for carers	PH CCC	**Multimorbidity as a key cross cutting theme identified in the Proactive Care & Prevention workstream in the Sustainability & Transformation Programme**
LTCs and specifically multimorbidity are heavily socioeconomically patterned. People living in deprived areas may present up to 15 years earlier with multimorbidity. This emphasises a need for the development of targeted interventions to address health outcomes in the most vulnerable groups.	Targeted interventions in Cambridgeshire to include early identification of LTCs - Promotion of health checks in targeted areas - Other interventions?	LTCs working group for BCF Healthy Ageing and Prevention within CEPB programme	**Ongoing PH programmes to address health inequalities, particularly in the north of the County including workplace and community-based health checks by lifestyle services provider**

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Key Findings	Action Required/ Update	Ownership	Status
There is clear fragmentation in service design across levels with an urgent need to join up around the person and engage differently to achieve real integration of care and demonstrable improvement in health and care outcomes for patients, their families and communities.	Input into CCG system transformation programme, and into Cambridgeshire Executive Partnership Board (responsible for oversight of the Better Care Fund)	PH CCC	**In progress – the JSNA has provided key intelligence used for the CCG STP work and Better Care Fund programmes addressing both multimorbidity and key long term conditions including cardiovascular disease, chronic obstructive pulmonary disease, and diatbetes**
A person-centred focus and services that are built together with and in response to the citizen voice are fundamental to achieve both integration and improved outcomes. A culture of effective communication and co-production between levels of care, and between people and the health and social care staff they interact with would support this.	Co-production and design of services for people with LTCs – system wide approach - Can HWB take action to particularly support this?	LTCs working group for BCF Healthy Ageing and Prevention project within CEPB programme	**To be developed further**
The impact of self-management approaches need to be addressed within a local context. An integrated service designed around optimal self-management and self-care could prove more effective than current patterns of use.	Self-management as key theme within health system planning – ongoing evidence updates	LTCs working group for BCF Healthy Ageing and Prevention project within CEPB programme	**In progress through working groups and through Sustainability & Transformation Programme**
A lifecourse approach provides a framework from which to design preventative interventions that address physical and social risk factors as well as the wider determinants of health.	CEPB workstream on healthy ageing and prevention will take and emphasise a lifecourse approach, with recognition of wider determinants of health	PH CCC; BCF Healthy Ageing and Prevention for CEPB	**Wider PH workstreams including Public Health Reference Group and BCF Healthy Ageing & Prevention Programme all emphasising a lifecourse approach**
A stronger emphasis and implementation of evidence-based models and interventions to support appropriate hospital and care admissions avoidance should be at the core of all LTC agendas	'JSNA implications' within the standard CCC report templates	PH CCC	**Actioned**

2. **Further development steps as identified in the JSNA - PH CCC**

Proposed steps	**Action Required/ Update**	**Status**
Further analysis of the quantitative data to seek patterns that might further inform targeting approaches.	PHI analyst to collaborate with CCG and other colleagues to support	**Ongoing**
Exploration of innovative models for providing services to people with multiple LTCs including visits to areas of good practice.	Identifying areas of good practice (e.g. South Somerset)	**Ongoing**
Cross-system join-up across sectors.	Emphasis within CEPB, CCG Transformation Plans and specifically the HEAP programme	**Ongoing**

3. **Additional actions arising from Cambridgeshire Health and Wellbeing Board (2nd July 2015)**

Action Required/ Update	**Status**
Establishing a thorough communications plan for the JSNA	**Completed**
Noting from the minutes of the Health and Wellbeing Board *'because of the scope for the strategic use of the JSNA, all providing services across the county should acknowledge its importance'* – ensure contact with all key providers is included within the communications plan	**Completed**
Report back to Cambridgeshire Health and Wellbeing Board on progress on the delivery plan	**7th July 2016**