Wolverhampton City NHS
Primary Care Trust

Wolverhampton City PCT Long Term Conditions Management

Commissioning Strategy 2009-2012

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1.Executive Summary

The aim of this strategy document is to detail Wolverhampton PCT's commissioning approach to the management of Long Term Conditions . This executive summary provides an overview of the philosophy underpinning the strategy, further detail is provided in subsequent chapters. Long Term Conditions (LTC) also referred to as chronic diseases, are those conditions that cannot, at present, be cured but can be controlled by medication and other therapies. [1]

It has been estimated that 15.4 million adults in England may be living with a long term condition and therefore health and social care organisations face a huge challenge in responding to the needs of this population to limit the impact these conditions have on individuals everyday lives.

- **It is likely that three-quarters of these 15.4 million adults over 75yrs are suffering chronic illness of which 45% have more than one condition.**
- **This group accounts for 52% of all G.P appointments, 65% of Outpatient appointments and 72% of all inpatient bed days.**
- **The Department of Health has estimated that the treatment and care of those with LTC's account for 69% of the total health and social care spend in England or almost £ 7 in every £10 spent.**

The scope of this strategy includes coronary heart disease, diabetes, asthma, chronic obstructive pulmonary disease

[1] Raising the Profile of Long Term Conditions Care A Compendium of Information DOH 2008

(COPD) , and arthritis . This strategy does not stand alone, it is developed to be part of a wider framework of strategies such as those addressing mental health long term conditions, neurological long term conditions and the preventative Public Health Agenda . It also compliments other broader strategies such as the Strategic Services Delivery plan which provides the direction for changing patterns of care to be as close to home as possible.[2]

- **This Long Term Commissioning Strategy is informed by National Initiatives which have been tailored to address local needs.**
- **It is underpinned by the principle of moving away from reactive episodic care based in acute setting towards a more systematic person centred approach.**
- **This systematic patient care is rooted in the primary care setting but underpinned by improved communications and partnerships across health, social and third sector providers.**
- **Improved communications can be facilitated through utilisation of advances in information technology**
- **Central to systematic LTC management is the introduction of a personalised assessment and care planning process which allows individuals with long term conditions to make choices in partnership with their healthcare professionals.**
- **The Strategy advocates commissioning of a wide range of services to enable choice to be a reality**

[2] Wolverhampton PCT Strategic Plan 2005-2008

Wolverhampton PCT recognises the important role that all our partners have in the management of Long Term Conditions to achieve this transformation from reactive to targeted proactive care in a community setting. These partners include colleagues from Primary Care Provider arm, Royal Wolverhampton Acute Trust, Local Authority Staff, Third Sector Providers and importantly individuals with Long Term Conditions and their carers.

The strategy can be considered under five main themes.

Involving Individuals with Long Term Conditions

This strategy supports the concept that individuals with Long Term Conditions need more proactive support from health/social care providers to empower themselves to self manage the medical and social impact on their condition in addition to avoiding further complications and unnecessary progression of their disease.[3] The strategy therefore aims to place priority on this area and will require commissioned services to address this issue of increasing capacity for self management. This means that in service specifications the area of supporting self management should be addressed and in relation to integrated governance providers should include in their plans strategies to assist their workforce in adopting an empowering approach. There is strong evidence that this is what individuals with LTC want, [4] [5].

The strategy also supports the concept that carers need to be given access to advice, support and information.

[3] Wagner EH Chronic Disease Management; what will it take to improve care for chronic illness? Effective Clinical Practice 1998; 1 (1): 2-4
[4] Your health, your care, your say; Research report Opinion Leader Research for DH Jan 2006
[5] DH MORI Survey Public Attitudes to Self Care baseline Survey February 2005

Communication

Communication across the whole system is vital for success. Through the use of an long term conditions strategy steering group the philosophy , principles and required actions will be shared and discussed with our key stakeholders. In recognition of the importance of involving individuals with long term conditions as one of these stakeholders ,a hierarchical developmental approach will be adopted in relation to facilitating their involvement in the commissioning process.

It is acknowledged that individuals with long term conditions experience difficulties as a direct result from one condition , as a result of the interaction of two or more long term conditions and as a consequence of un related conditions or psychosocial factors . Therefore the strategy advocates the use of personalised care plans which can act as a bridge between disease specific pathways and generic workstreams to deliver care in different ways and where appropriate different locations, taking into account choice and active patient engagement. The roll out of electronic notes will serve as a tool to enable these personalised plans as they will support, develop and formalise links between different aspects of long term condition management. In this way communication between everyone involved will be enhanced.

Personalised care plans can assist carers in understanding how they can be involved in supporting individuals with long term conditions. Lord Darzi has pledged that personalised care plan should be offered to people with long term conditions by 2011.[6]

Case Finding and Targeting

The commissioning of services for long term conditions will be based around the concept of population stratification as detailed in the NHS Model for Heath and Social Care[7]. This enables services to be targeted and matched to needs at varying stages of the progression of illness and disability. For those at the lower end of the risk stratification the key concept is supported self care and timely access to information. Additional services and intervention will be required if/ when individuals require support to maintain their independence within their own homes .

The utilisation of predictive risk stratification tools and disease based registers in General Practice offer the opportunity for a radical new approach with proactive planning of services not reactionary responses to crisis. The SHA has commissioned Bupa Health Dialogue in conjunction with CBSA to provide a risk stratification tool .This will enable both high intensity users and those individuals with LTC who have emerging risk to be identified and services targeted to meet need. In this way issues around equitable access to services can be addressed because this predictive data adds a further detailed layer of knowledge. This targeted approach may identify unmet need and gaps in commissioned services

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[6] High Quality Care for All Operating Framework Department of Health 2008

[7] Supporting People with Long Term Conditions An NHS and Social Care Model to support local innovation and integration Department of Health 2005.

especially in relation to access for disadvantaged groups. To successfully do this the Trust will need to procure a G.P data extraction tool and secure agreement from G.P's in relation to data extraction.

Provider services will need to demonstrate that they have adequate governance arrangements in place and provide service specifications in order that services can be matched according to needs as identified above.

Service Redesign

Wolverhampton PCT has committed itself to service redesign within it's Care Closer to Home strategy and it's transfer of care plans within the Strategic Services Development Plan. In order for Wolverhampton PCT to deliver on the choice agenda it is necessary to ensure a range of options for management of long term conditions are available locally[8]. This means evaluating current service provision and where necessary looking to commission different services. The Government has discussed that they expect commissioners to be the catalyst for service transformation and health improvement locally, making best use of the levers available to them, including competition, choice and new contracts [9] . Integral to this drive to commission care to be delivered in different ways in new locations for the benefits of individuals with Long Term Conditions is a commitment to ensure the best use of resources and to challenge inefficiencies and service overlap . Therefore existing good practice needs to be recognised and supported to develop further and where necessary action shall be taken to redesign services . An example of recognising good practice is the community

[8] Generic Choice Model for Long Term Conditions Department of Health 2007
[9] The NHS in England: the Operating Framework for 2008/09 Department of Health 2007

management of COPD by a joint Health/ Social Care team (including rehabilitation) in conjunction with secondary care input which could be supported to develop by innovative approaches such as information prescriptions, third sector provision and assistive technology such as telecare and telehealth. The key development required is ensuring that services are co-ordinated so individuals with long term conditions experience seamless care regardless of provider.

Lord Darzi in his Next stage Review has stated that individual health budgets may be piloted post April 2009 and Wolverhampton intends to bid to become a pilot site initially around neurological conditions but with a potential for end of life care for other long term conditions

Ensuring Impact and Value for Money

Models of care for long term conditions are relatively new in the British health care system but there are emerging studies which are starting to form the evidence base for long term conditions.

Commissioners are tasked with the accountability to monitor and performance manage service providers to ensure expected health care outcomes are achieved. One of these outcomes will be around how individuals with long term conditions are engaged both in choices about their condition and in providing feedback on services provided. The ways in which other outcomes are measured and prioritised will be informed by national policy and the strategy implementation group. These outcomes should reflect both quantitative and qualitative measures.

A key issue in monitoring and measuring health outcomes is that information services are generally under developed and this may require addressing prior to establishing performance management system for community services. Correlation

between a community intervention and an avoided secondary care intervention is not necessarily straightforward both because of a time delay between the two and the complexity of the services involved in LTC.

Summary

Given the predicted rise in Long Term Conditions the risk of not achieving the changed approach advocated by this strategy is that individuals with Long Term Conditions will not experience an improvement in their quality of life , they will not be as supported in the management of their condition as they could be and may suffer greater ill health and adverse psycho/ social consequences. Alongside this duplications in service will continue, costs will continue to rise and emergency admissions will continue to rise. Therefore it is imperative that the vision described and discussed in this strategy document is realized. This vision is far more than simply changing the location where care is delivered and requires a significant whole system change involving behavioural changes of both individuals with long term conditions and service providers in order to deliver sustainable improvements.

To achieve this an implementation plan with detailed outcomes is required. This plan is provided in full in section 5 of this document, and summarized as key recommendations below in section 1.1. To assist in conveying the themes of this strategy five subareas are highlighted but the strategy implementation of each of these will run concurrently.

1.1 Key Recommendations

- Vision and leadership are central to success of this strategy and therefore it is imperative to identify a Long Term Conditions Programme Lead with responsibility for achieving formal links/ integration between all elements of this strategy and wider SHA LTC strategy developments.
- LTC steering group with responsibility for monitoring progress towards achievement of implementation plan.
- Commission provision of services to meet proposed model through identified service specifications with monitored outcomes via contracts monitoring team.

Involving Individuals with Long Term Conditions

- Secure involvement of individuals with LTC in the commissioning process
- Ensure provider services actively seek the views and opinions of individuals with long term conditions in relation to both service provision and development
- Actively seek the views of hard to reach groups/ communities
- Individuals with long term conditions known to Wolverhampton PCT will be offered a personalized plan of care
- Ensure individuals with Long Term Conditions identified in top 25% of risk stratification have key contact
- Ensure carers have access to information, advice and support.

Communication

- Develop and implement a communication plan re management of Long Term Conditions Strategy and commissioning for LTC.
- Ensure varied channels and methods of communication between PCT and all partners throughout the life span of the strategy
- Ensure links are established with Single Point of Access and Single Assessment Process to maximize communication in relation to multi-agency service provision
- Ensure progress reports and outcomes of commissioned services are shared across the whole system and wider health/ social care communities

Case Finding and Targeting

- Commissioning of a predictive modeling tool to risk stratify patients to target need , both of those at highest risk and those with emerging risk to avoid reactionary crisis management
- Utilize available data to improve the health outcomes of individuals with long term conditions and narrow health inequalities among these individuals by ensuring services are targeted to meet the needs of disadvantaged groups
- Ensure coordinated use of data by multiagency service providers to enable systematic delivery of targeted care.

Service Redesign

- Accelerate the development of a patient centred approach to the delivery of services for individuals with Long term Conditions through the use of care pathways
- Scope potential for changes/ commissioning of services for supported self care
- Support the development and evaluation of the virtual ward model of care across appropriate nursing teams
- Support the development of a workforce with appropriate skill mix to deliver on changed ways of working including training to address supporting self care
- Implement stage two of telehealth initiative

Ensuring Impact and Value For Money

- Undertake an audit to identify the analytical capacity of staff, and IT infrastructure across acute, primary and social care to monitor outcomes
- Persue potential business modeling potential of risk stratification tools
- Evaluate the potential to decrease admissions for ambulatory sensitive conditions through transfer of care initiatives.
- Development of a set of outcome metrics to ensure impact and value for money of commissioned services and ensure these metrics are integral to appropriate service specifications.

2.Ensuring Impact and Value for Money

Commissioning is a key driver for service transformation[10]. It should be used as a set of functions that ensure that services funded by the PCT, on behalf of the public are used to meet the needs of individuals fairly, efficiently and effectively.

Effective commissioning is about care that adds maximum value for patients in a system that promotes fairness, inclusion and respect from all sections of society. By redesigning care around the patient so that we reliably provide all the right care first time , we improve clinical quality, avoid costly readmissions, improve patient and staff satisfaction and therefore release savings that can be invested in other services……..seek to reinforce a virtuous circle of service redesign around the patient[11]

In relation to this long term condition strategy , is vital to examine what is needed locally, what is effective and how this provision can be reviewed and monitored . Each of these are considered within this strategy **(Sections 4.2 2.4 and 2.3 respectively)**

[10] The NHS in England: the Operating Framework for 2008/09 Department of Health 2007
[11] Commissioning Framework Department of Health 2006

It is also important that the local commissioning contributes to and benefits from the SHA wide LTC commissioning strategy as part of sharing in best practice. In order to ensure impact and value for money it is necessary to plan for measurable outcomes.

2.1 Commissioning Services in Partnership

The aim of this strategy is to drive forward the concept that quality care of individuals with long term conditions cannot be achieved without effective contributions from all of our partners including those individuals who live with long term conditions on a daily basis. Wolverhampton PCT recognises the importance of social care in achieving the goal of maintaining individual's independence within their own homes and is committed to future further integration with Social services.

The partnership arrangements with both statutory and voluntary organizations which have been the bedrock of the PCTs development in Wolverhampton are planned to increase in the coming year. The formulation of a legally binding partnership arrangement with the Local Authority is one example of this [12]. The Local Government and Public Involvement in Health Act (2007) places a duty on upper tier local authorities and PCT's to undertake Joint Strategic Needs Assessment (JSNA)[13] JSNA is a process that will identify the current and future health and well being needs of a

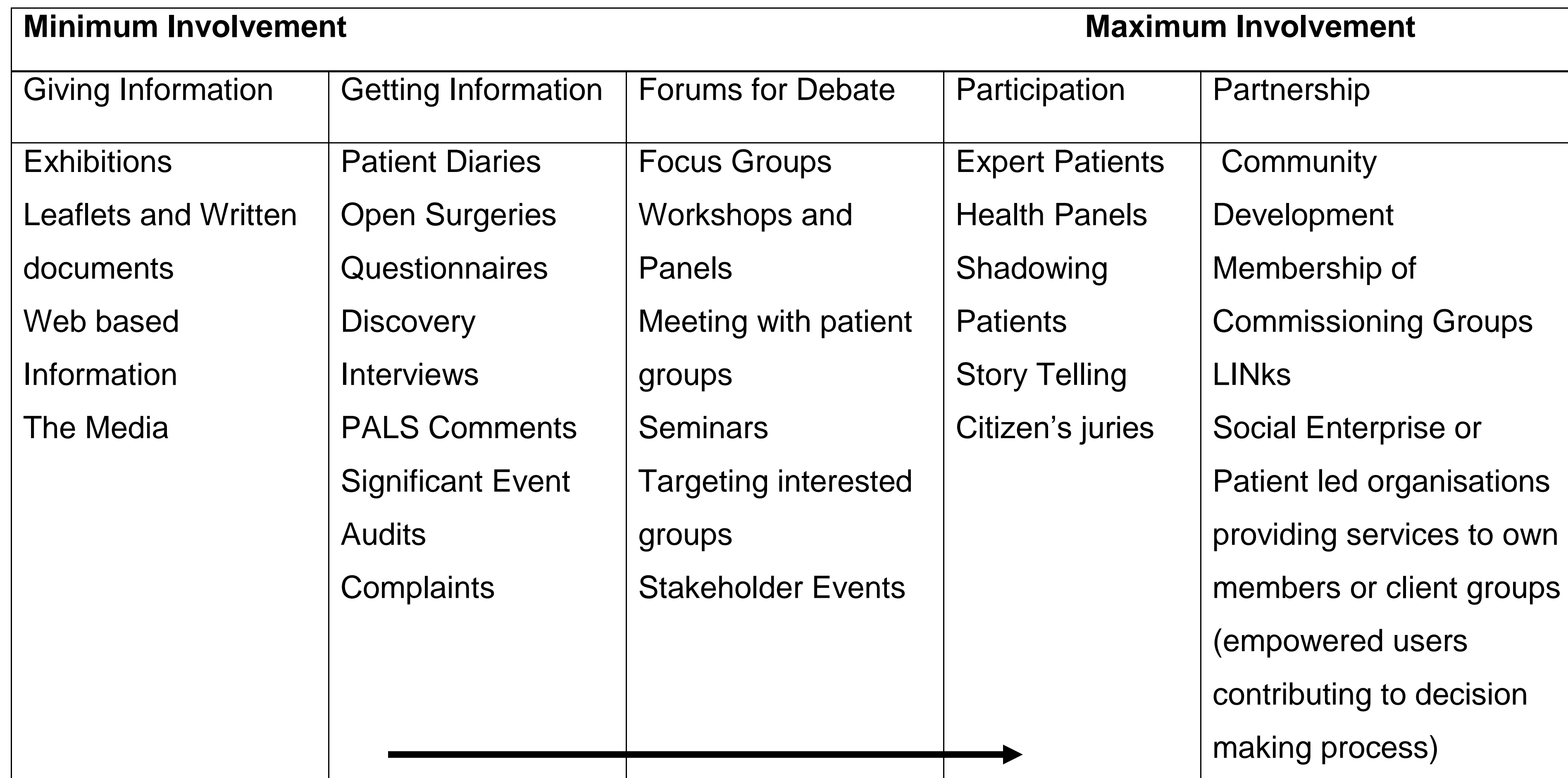
[12] Wolverhampton City PCT Business Plan 2008
[13] Guidance on Joint Strategic Needs Assessment Department of Health 2007

local population, informing the priorities and targets set by Local Area Agreements and leading to agreed commissioning priorities that will improve outcomes and reduce health inequalities.

Our priorities have to be linked to partner priorities (and ours to theirs) as it is unlikely that any one organisation can completely achieve strategic objectives by themselves. . Through engagement in JSNA , it is envisaged that joint working will be systematically adopted..

On an operational level the formation of the Long Term Strategy Implementation Group will serve as a catalyst for partnership working. It is important that individuals with long term conditions as one of our partners are included in this group. To enable this representation to be meaningful , a decision has been taken to adopt a hierarchical approach to recruitment of representation. Further details are provided in the following section.

2.2 Involving Users in Commissioning



Minimum Involvement				**Maximum Involvement**
Giving Information	Getting Information	Forums for Debate	Participation	Partnership
Exhibitions Leaflets and Written documents Web based Information The Media	Patient Diaries Open Surgeries Questionnaires Discovery Interviews PALS Comments Significant Event Audits Complaints	Focus Groups Workshops and Panels Meeting with patient groups Seminars Targeting interested groups Stakeholder Events	Expert Patients Health Panels Shadowing Patients Story Telling Citizen's juries	Community Development Membership of Commissioning Groups LINks Social Enterprise or Patient led organisations providing services to own members or client groups (empowered users contributing to decision making process)

This table above details the various level of user involvement [14]

[14] Practice Based Commissioning Bulletin 6 Patients and the Public Primary Care Contracting August 2006

It is recognised that for some individuals with long term conditions without direct experience of healthcare , it may be a large leap to be involved with a strategy implementation group. Therefore it is proposed that a staged approach is adopted. Individuals with long term conditions from across all three stages of the pyramid (Refer 3.3) being invited to participate in a structured telephone interview . Following this a stakeholder event is planned to further seek opinions. It is anticipated that from this individuals will feel able to volunteer for involvement in the implementation strategy group.

2.3 World Class Commissioning

World class commissioning will deliver better health and well-being for all

- People will live healthier and longer lives
- Health inequalities will be dramatically reduced

It will deliver better care for all

- Services will be evidence-based and of the best quality
- People will have choice and control over the services that they use, so they become more personalised

It will deliver better value for all

- Investment decisions will be made in an informed and considered way, ensuring that improvements are delivered within available resources
- PCTs will work with others to optimise effective care

11 World Class Commissioning Competencies

- locally lead the NHS
- work with community partners
- engage with public and patients
- collaborate with clinicians
- manage knowledge and assess needs
- prioritise investment
- stimulate the market
- promote improvement and innovation
- secure procurement skills
- manage the local health system
- make sound financial investments

The complexity of the task is enormous. Health & social care professional and individuals with long term conditions and their carers need to buy into this change. The NHS is not about policies and strategies- it is about the myriad of individual conversations and service provision that takes place up and down the country on a daily basis.

It is envisaged that that the implementation strategy group , with the involvement of individuals with long term conditions will contribute to the agenda for the selection of outcomes as Wolverhampton PCT is keen to listen to and respond to the views of those individuals who use their services.

There are given outcomes that must be achieved such as the targets which come from policy development. Policies affecting long term conditions are considered in section 3.2. In addition to these generic targets, there are ongoing disease specific targets within the Quality and Outcome Frameworks which form part of the practice based commissioning agenda. These disease specific targets relate to National Service Frameworks and NICE guidance.

National metrics relate to reduction in service utilization such as emergency bed days, emergency unplanned admissions and outpatients attendances. Potential outcome metrics may relate to clinical indicators e.g Achievement of HbA1c targets BP within guidelines, or may be patient centered such as increased sense of control, improved experience of care , increased feelings of psychological well being.

2.4 Evidence Base (Taken from NHS Next stage Review)

Self care and Supported Self Management

- Exercise based cardiac rehabilitation combined with self management advice reduces mortality[15]
- Pulmonary rehabilitation programmes produce clinically important reductions in breathlessness and fatigue in patients with chronic obstructive pulmonary disease[16]

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[15] Joliffe JA et al Self Management, education and regular review for patients with Asthma Cochrane database Syst rev2002 (3) CD 001117

- Self management improves psychological health, empowers people and enhances self efficacy. This is turn leads to behavioural changes and improved clinical outcomes[17]
- A review of the impact of skills –based self management information and psychological interventions on psychosocial outcomes in adults with diabetes suggested that self management improves psychological health.[18]
- Structured patient education that meets NICE criteria is a key component of diabetes management[19]
- The 6 week heart manual programme uses patient empowered model for 6 week rehabilitation after a cardiac event. Over a year , the programme improved psychological adjustment, especially in participants with high anxiety and depression scores at baseline, and it reduced visits to general practitioners and readmission.[20]
- Evidence from the Expert Patient programme (RCT) suggests a 50% reduction in use of hospital services and a 70% probability that expert patient is cost effective.
- Of nearly 1,000 participants at the National Citizen's Summit 86% of people thought that professionals in their local GP practice should provide more support to help than take care of their own health and well being.[21]

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[16] Lacasee Y Goldstein R Lasserson TJ Martin S   Pulmonary rehab for COPD Cochrne database Syst review 2006 (4) CD 003793
[17] Skinner CS et al How Effective is tailored print communication ? Annals of Behavioural Medicine 1999:21:290-8
[18] Norris SL et al Increasing diabetes self management education in community settings   A systematic review American Journal of Preventative medicine.
[19] Steed L Cooke D Newman S A systematic review of psychosocial outcomes following education, self management and psychological interventions in diabetes mellitus patient education and Counselling 2003 51 5-15
[20] Structured patient Education in Diabetes DH 2005 NICE TA60 Guidance on the use of patient education models for diabetes.
[21] Your health, your care, your say; Research report Opinion Leader Research for DH Jan 2006

- At the above summit, half of all people with LTCs were not aware of treatment options and did not have a clear plan that lays out what they can do for themselves to manage their condition better .as a consequence a significant proportion of all medicine are not taken as directed.
- In a DOH MORI survey some 82% of those with a LTC say they already play an active role in their care but they want to do more self care[22]
- More then 75% say that if they had guidance/support from a professional or peer they would feel more confident about taking care of health

3. National Overview

- It has been estimated that 15.4 million adults in England may be living with a chronic illness and therefore health and social care organisations face a huge challenge in responding to the needs of this population. [23]
- The prevalence of Long Term Conditions increases with age, by age 60 over half of people have at least one Long Term Conditions.[24]

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[22] DH MORI Survey Public Attitudes to Self Care baseline Survey February 2005
[23] Raising the Profile of Long term Conditions Care A Compendium of Information Department of Health 2008
[24] General Household Survey 2005

- Individuals with Long Term Conditions are high users of all services, including those for emergencies. They account for 55% of G.P appointments, 68% of outpatient and A & E appointments and 77% of inpatient bed days[25]
- Only about 50% of medicines are taken as prescribed. [26]
- According to GP Quality and Outcome Frameworks (QOF) almost one in eight people in England are being treated or monitored for hypertension and one in seventeen people are being treated/monitored for asthma.[27]

3.1 Patterns and Trends

- Nationally the differences in incomes between those on means tested benefits and those with other sources of income are a major determinant of health inequalities. Self reported illness is correlated with income deprivation.[28]
- People with Long Term Conditions are less likely to work and the gap in the employment rate grows with age [29].
- It has also been found that people with long term conditions have higher health risk factors and make more risky life style choices[30]

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[25] Ibid
[26] Our Health ,Our Care , Our Say Department of Health 2006
[27] Quality and Outcomes Framework 2005-2006 Health and Social Care Information Centre
[28] Health Profile of England 2007 Association of Public Health Observations.
[29] Labour Force Survey 2006

- National Service Framework guidance for Diabetes recommends that patients with diabetes should agree to a care plan to manage their conditions however nationally less than 50% of people have an agreed care plan.[31]

3.2 Policy Directives (Relating To Service Provision)

NHS Plan	2000	Described the challenge that faced the NHS in managing Chronic Disease and the need for change in how services are delivered. Commitment to bridging the gap between health and social care which it acknowledged had been characterised by variability in the quality of co-operation between agencies
Expert Patient: A New Approach	2001	This discussed the need for a fundamental shift in the way chronic diseases and long term conditions are managed- a shift that will empower and liberate patients to play a central role in decisions about their illness
GMS Contract	2004	Financial incentives for General practitioners and their practice staff in managing singular chronic conditions according to specific indicators. Conditions included are heart disease, diabetes, hypertension and asthma.

[30] Health Survey for England 2005
[31] HealthCare Commissions: Survey of People with Diabetes 2006

Choosing Health	2004	Emphasis on the importance of self care to enable people to make informed decisions about how to maintain their health
NHS Improvement Plan	2004	Set out the Governments Priority to improve care for people with Long term conditions by moving away from reactive care in an acute setting towards a systematic patient centred approach
NHS and Social Care Model	2005	Re-enforces the message of the NHS Improvement Plan and also refers to the PSA target discussed below. Strategic aim of the model is to embed into local health and social care communities an effective and systematic approach to the care and management of patients with a long term conditions and increase the provision of care in a primary, community or home environment.
Liberating the Talents of Nurses	2005	Re-emphasises the principles of whole population stratification and the development of nursing roles, especially Community Matrons.
Our Health, Our Care, Our Say, A new direction for Community Services	2006	This key white paper sets out a new direction for the whole of the health and social care system. The goals are • Better prevention and early intervention for improved health, independence and well being • More choice and a stronger voice for individuals and communities • Tackling inequalities and improving access to services • Increasing support for people with long term needs • Moving Care closer to home

The philosophy of the management of Long term conditions is that where possible care should be provided closer to home. This includes managing exacerbations of illnesses like COPD and heart failure at home when it is clinically appropriate to do so.

In order to meet this objective it is necessary to only send people to hospital as an emergency when there is no clinically appropriate alternative setting for them to receive the treatment and care they need. Personalised care plans aim to break the cycle of deterioration and rescue which is detrimental to maintaining independence at home and places carers and those with long term conditions under stress. The white paper " Our Health , Our Care , Our Say " (2006 DOH) also recognized this and included the following targets to be met by 2008.

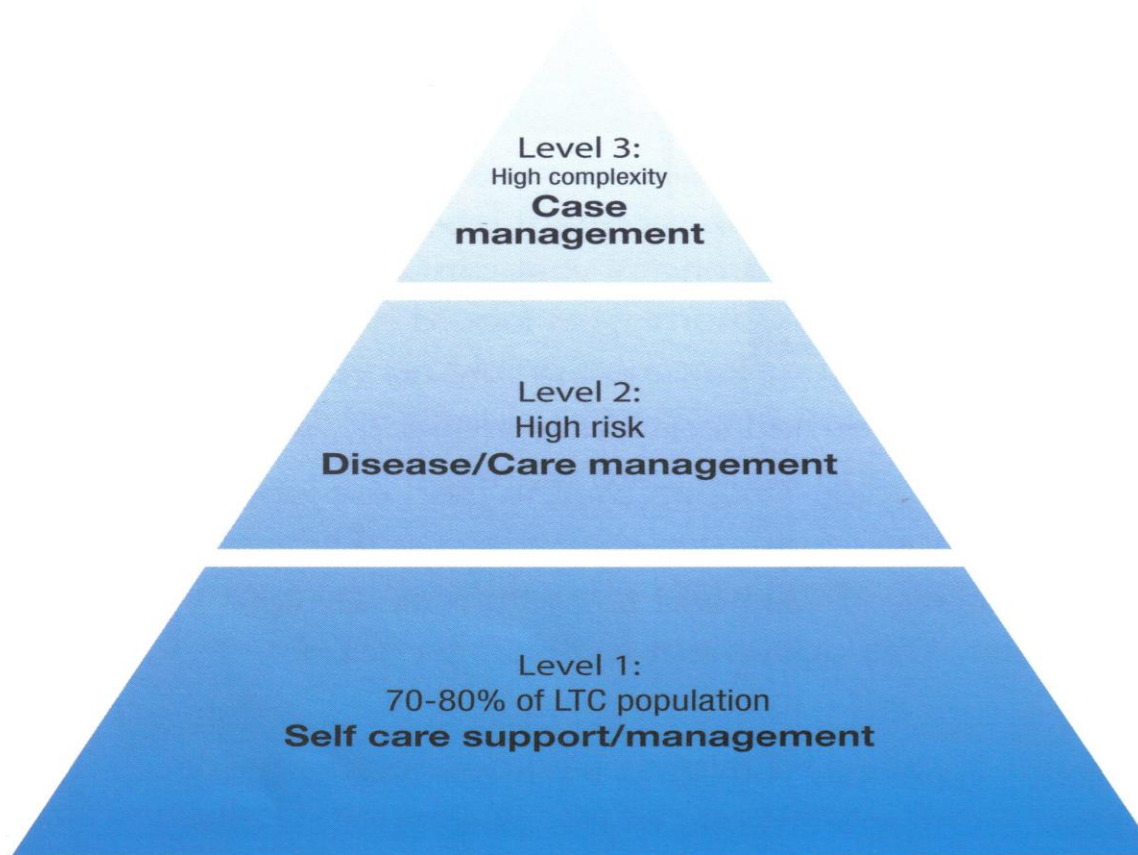
- Information prescriptions for all those with Long Term or Social Care needs
- Establish an information service/ helpline for carers or delegate this responsibility to a voluntary organization
- Personal Health and Social Care plans for those with both social needs and long term conditions (2008-2010)
- Establishment of joint working / joint teams between health/social care

This target for personalized care plans is also reinforced within the Operating Framework High Quality Care For All (DOH Dec 2008) section 36.

Over the next two years, to ensure that those living with a long term condition receive a high quality service and help to manage their condition, everyone with a long term condition should be offered a personalized care plan

3.3 The NHS and Social Care Model

The NHS and Social Care Long Term Conditions Model (DOH 2005) builds on the wealth of local and international experiences and innovations to improve the health and quality of life of those with long term conditions. It aims to achieve:



- Earlier detection
- Good control to minimize effects of disease and reduce complications
- More effective medicines management
- Reduction in the number of crisis

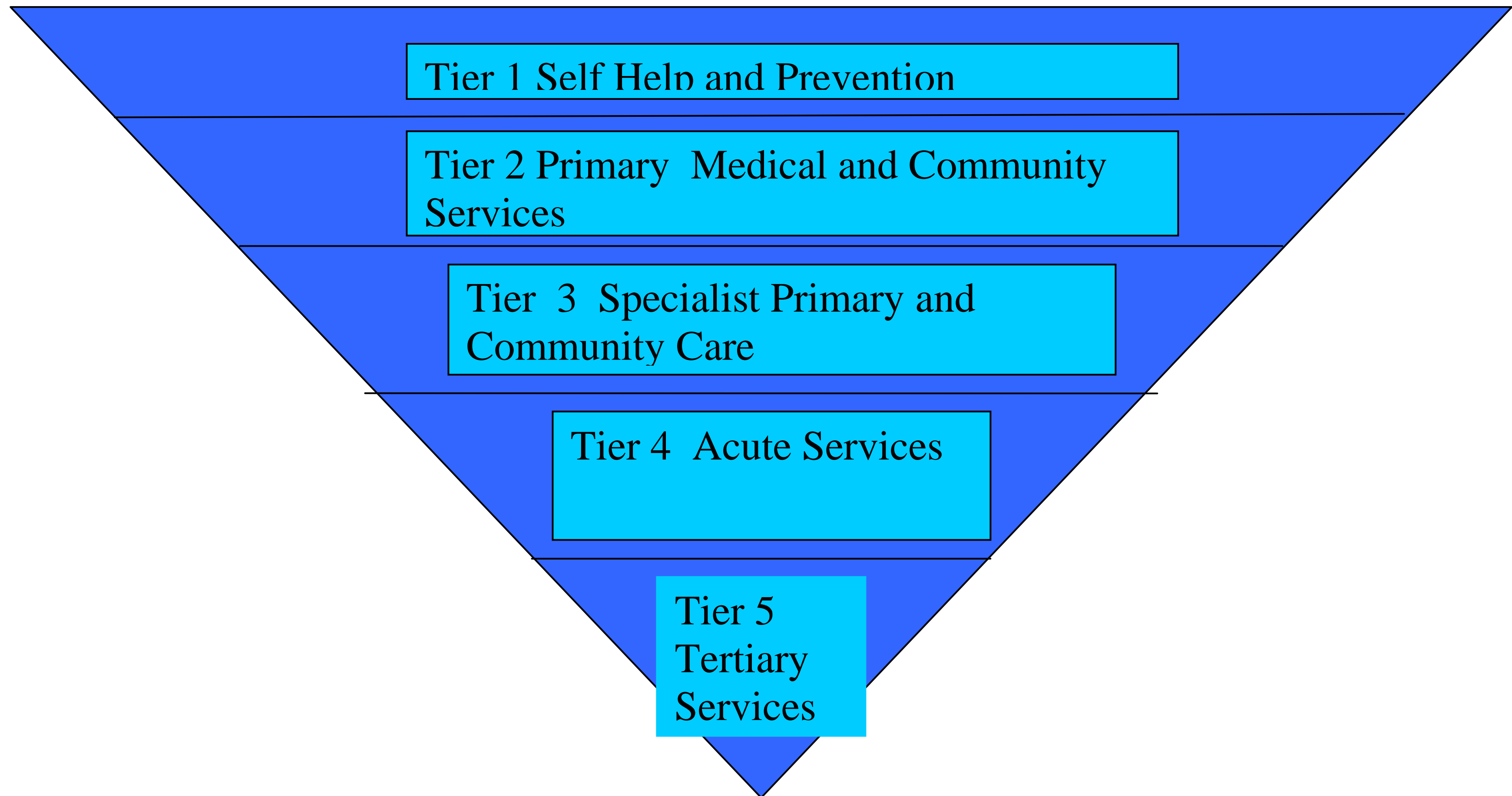
The NHS and Social Care Model
Department of Health 2005

Level 1 Supported Self Care ; **Collaboratively helping individuals and their carers to develop the knowledge, skills and confidence to care for themselves and their condition effectively .**

Level 2 Disease Specific Care Management ; **This involves providing people who have a complex single need or multiple conditions with responsive specialist services using multidisciplinary team and disease specific protocols and pathways, such as the National Service Frameworks and Quality and Outcomes Frameworks**

Level 3 Case Management : **This requires the identification of the very high intensity users of unplanned secondary care. Care for these patients is to be managed using a community matron or other professional using a case management approach, to anticipate, co-ordinate and join up health and social care.**

As part of the Darzi review a West Midlands model of care has been formulated to articulate the idea that there are levels of services that need to be considered in relation to the management of each of the clinical pathways including the Long Term Conditions Pathway. This is mapped to Wolverhamptons' model in section 4.3 .



4. Wolverhampton and Long Term Conditions

4.1 Local Patterns and Trends

Wolverhampton is a Spearhead Authority (joint Wolverhampton City Council and Wolverhampton Primary Care Trust) as it is in the bottom fifth of areas for life expectancy and deprivation indicators.[32] This is important given that we know that the prevalence of long term illness is much more strongly linked to social class than the prevalence of acute illness[33]

The following provides an overview of the health profile[34]

- Wolverhampton has high levels of income deprivation and child poverty with 20% of residents living in low income households
- There is evidence of low physical activity from the Sport England survey
- Death rates from major causes are higher than the England average
- Rates of recorded and self reported ill health are higher than the regional and national average
- Male and female life expectancy has increased over the last decade, although both remain below the regional and England averages.

[32] Wolverhampton Public Health Annual Report 2007 Dr Adrian Phillips
[33] Chapter Five West Midlands Strategic Health Authority 2007
[34] Wolverhampton Health Profile 2007 Association of Public Health Observatories Department of Health

Evaluating Wolverhampton's Performance

The DMIT (disease management information toolkit) is a voluntary toolkit which covers nine long term conditions and examines which conditions are contributing to high numbers of secondary care beds. It has a ranking system based on the number of emergency beds per 100 on relevant QOF register. The ranking of 1 indicates fewer emergency admissions compared to other PCTs. Wolverhampton is

Condition	July 2007 Data	July 2008
Asthma	129 out of 152	115 out of 152
COPD	49 out of 152	49 out of 152
CHD	49 out of 152	60 out of 152
Heart Failure	47 out of 152	52 out of 152
Diabetes		5 out of 152

Savings Potential

An external audit by K.P.M.G has identified, using an improvement investigation tool developed by the Audit Commission , areas for potential release of resources that could be disinvested from the acute sector into primary and preventative services. The tool compared PCT actual admissions to an expected admissions for an average comparable PCT which has a similar index of multiple deprivation. A calculation of the financial effect of reducing emergency admissions down to a comparable average is done using a relevant Payment by results tariff. It is important to note that any financial effect is

not a clear saving to the PCT , as the PCT will have to invest in local community and primary care services to prevent emergency admissions. The results show that the potential resource for re-investment is £ 850,000, based on average tariff, calculated on 2005/06 data. The main conditions were acute upper respiratory infection (£ 595,000) and a further £ 220,000 to heart disease.

4.2 Strategic Fit

Within Wolverhampton PCT's Business Plan 2007- 2008 (Trust Board May 1st 2007) it was identified that a strategy and implementation plan for Long Term Conditions be formulated in order to work towards in conjunction with other actions the strategic priority of "**Improving the Management of Chronic Illness and Vulnerability".** The strategic outcome of this priority is

> **We will see improvements in the management of people with long term clinical conditions. Most care will be given closer to home. An integrated, holistic model of support will be provided to vulnerable people in partnership with other agencies."**

This long term conditions management strategy is fully aligned with these principles and the principles expressed within Wolverhampton Strategic Plan 2008-2013 in relation to delivering personalized care that is
Fair; equally available to all, taking full account of personal circumstances and diversity

Personalised : tailored to the needs and wants of the individual, especially the most vulnerable and those in greatest need, providing access to services at the time and place of their choice.

Effective ; Focused on delivering outcomes that are among the best in the world

Safe; as safe as it possibly can be, giving patients and the public confidence in the care they receive

Locally accountable: so that staff are empowered to lead change and innovate locally, ensuring that this is based on the best clinical evidence, meets local needs and is the product of engagement with patients and the public.

In addition to this the principles from the Darzi Clinical Care Pathway group for Long Term Conditions are reflected throughout this document

Wolverhampton's LTC strategy is in alignment with NHS West Midlands Strategic Framework Investing for Health and the seven key challenges..

Challenge 1 – Reducing Inequalities

Despite improvements in overall health status, inequalities in health have widened. The SHA can demonstrate improvements in overall health status but when the data is examined in detail there are huge inequalities in the strategic management of patients with long term conditions in terms of access to the full range of services available for any single condition. Long term illness is also strongly linked to social class and so action to improve care for this population is a key element in tackling health inequalities.

Challenge 2 - Prevention

We are not investing enough in prevention. It is acknowledged that prevention is the key to reducing long term conditions in the future, yet commissioners and providers are still to a great extent concentrating on dealing with the here and now. Primary prevention will reduce those becoming ill in the first place, secondary prevention will keep those with LTC well for longer, and prevent them becoming worse more quickly.

Challenge 3 – Best Standard of Care

There remains an unjustifiable variability in the quality and safety of services and individual care, and a significant number of complaints are about standards of fundamental care. This area relates to challenge 1 and to some degree is dictated by where you live and individuals knowledge about where and how to access services.

Challenge 4 – Cost Effective

The rate of cost pressures arising from doing "more of the same" with an aging population, a rising tide of long term conditions and an accelerating pace of technological development in providing responses to illness outstrips any conceivable rate of increased funding. Increased prevention could reduce the rising tide of long term conditions, and quality of outcomes improved if learnt from what works. Also there are numerous technological developments which could assist this population, including Assistive Technology, but variability in cost and proven positive outcomes. There needs to be a clear sense of direction in making the most of technological advances within a value for money environment

Challenge 5 – Improve Public Confidence

The public, “our customers” have little confidence that their local NHS will get better. This is particularly important with long term conditions, patients and their carers need to have trust in the system that is there to support them to manage their condition within their individual lifestyle and preferences.

Challenge 6 – Evidence Based Healthcare

We continue to spend substantial amounts of resources on clinical activities where the evidence suggests there is little or no return on the investment in terms of improved health or where the evidence shows that there are other, better and more cost-effective alternatives. There is a vast array of evidence outlining the benefits of different types of interventions, and ideal models for delivery, however there is no one clear solution. This is one of the challenges to grasp when planning services in individual localities that meet patient need.

Challenge 7 – Joined Up Care

Patients expect services to be joined up and to have co-ordination across teams caring for them and yet the fact is that at present patients and public often struggle to understand how services work. It is clearly difficult to navigate the system and co-ordinate services to provide the best care possible. For patients with long term conditions, co-ordinated services are even more critical. It is clear therefore that there are many elements of system change that need to be addressed to improve the care pathway for people with LTC..

4.3 Wolverhampton Phased Approach/ Adaptation of National Model

Wolverhampton PCT has agreed the following draft model of care via it's implementation steering group. This model of care is both physical and psychosocial in it's philosophy in recognition of the complimentary and interacting roles these factors have in the management of Long Term Conditions.

Aims of Model ;

- **Work collaboratively with all the LTC population to promote Self Care and empowerment as the building blocks of LTC management**
- **Through proactive and pre-emptive interventions from a range of multiagency services, work collaboratively to reduce unnecessary hospital admissions and outpatient attendances**
- **Proactively utilize data to stratify LTC population in order to target service provision**
- **Demonstrate the impact and benefit realization in terms of health improvement, improved quality of life and financial cost savings through the use of whole systems integrated care.**

The Wolverhampton approach takes the three levels from the national model and discusses service provision for level one and then service provision for level two and three collectively.

Level One 75% **Levels Two and Three 25%**

Level One; Self Care

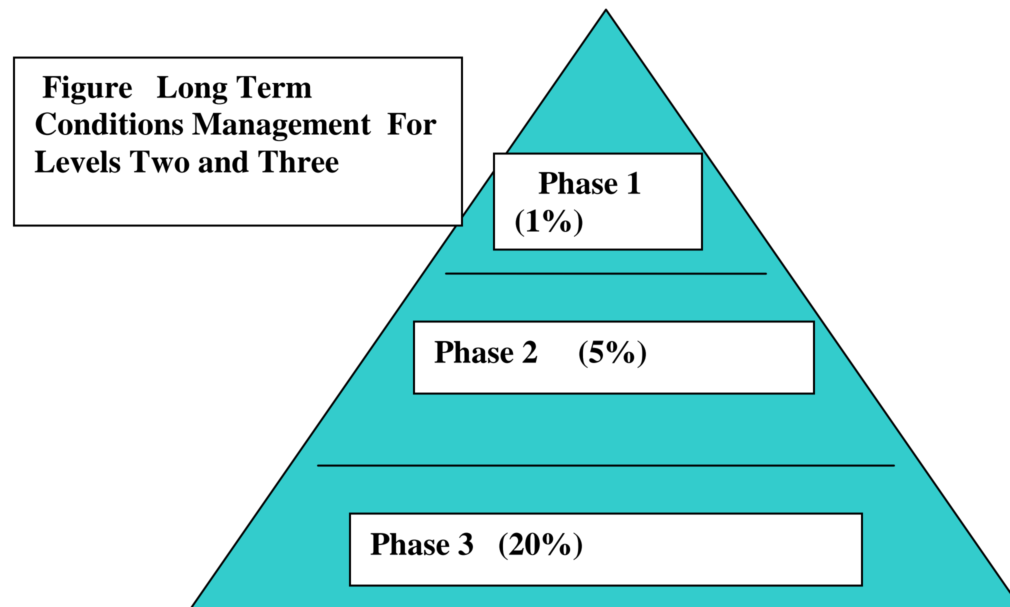
This group of patients are stratified as being at near equal risk to the total population in relation to utilisation of hospital services and the limitations on their everyday living is minimal. However it is vital that information is given to support this group to maintain them at this level of risk for the maximum amount of time. There is also scope within this group for preventative monitoring and lifestyle advice.

The expert patient programme aims to educate people with long term conditions about management skills for their conditions. It aims to equip people with the knowledge and skills to have more productive relationships with healthcare providers and to minimise effects of symptoms on their everyday lives. The course is delivered by volunteer tutors but does receive support from PCT and this shall continue.

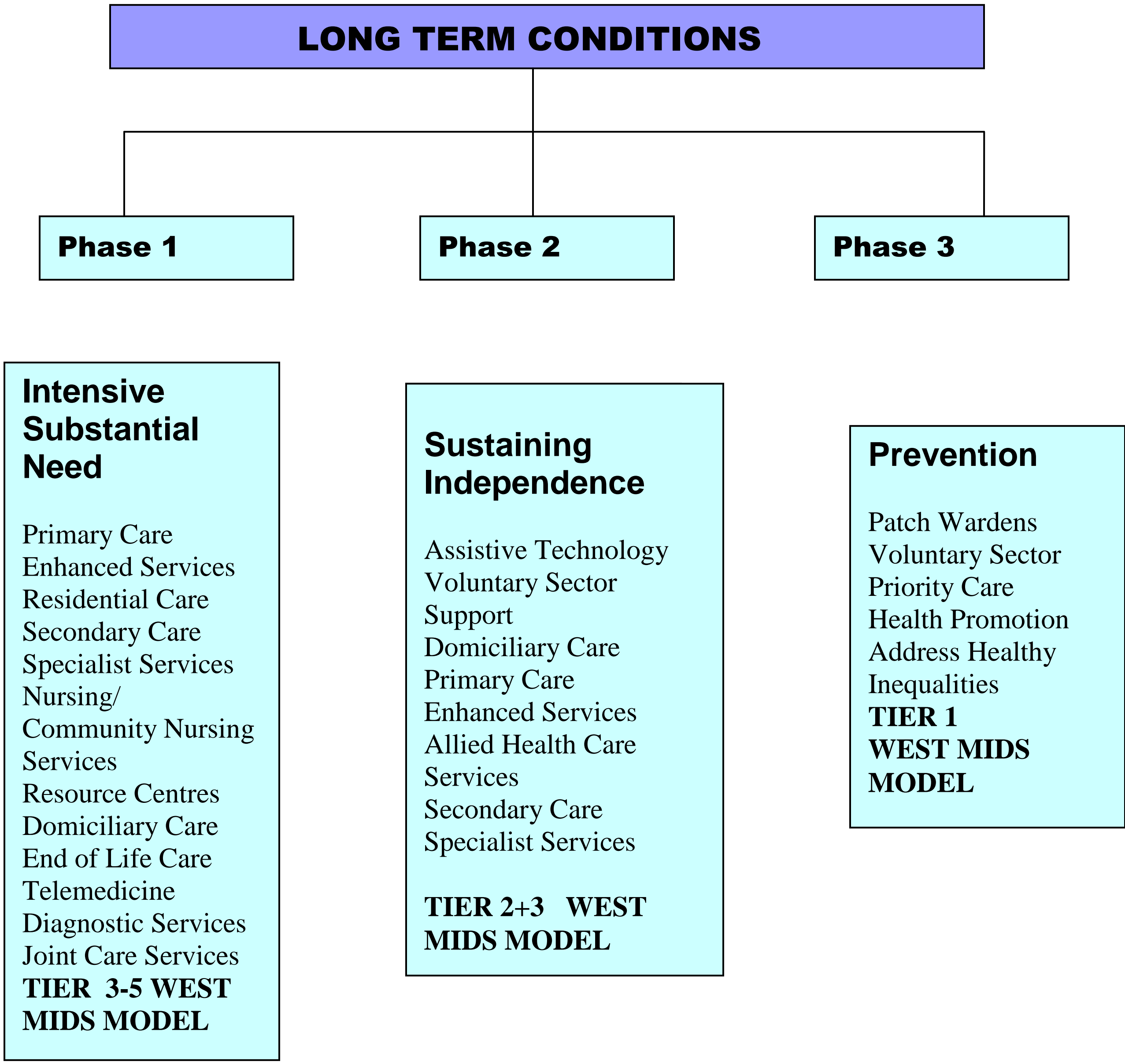
Currently there is no systematic targeted self care within Wolverhampton PCT. Providers do provide information and support on an adhoc basis but this needs to be formalized. It is also necessary to think about marketing and targeting self care especially in relation to hard to reach communities/ groups for whom traditional methods of promotion may be inappropriate or not culturally competent.

Level Two and Three

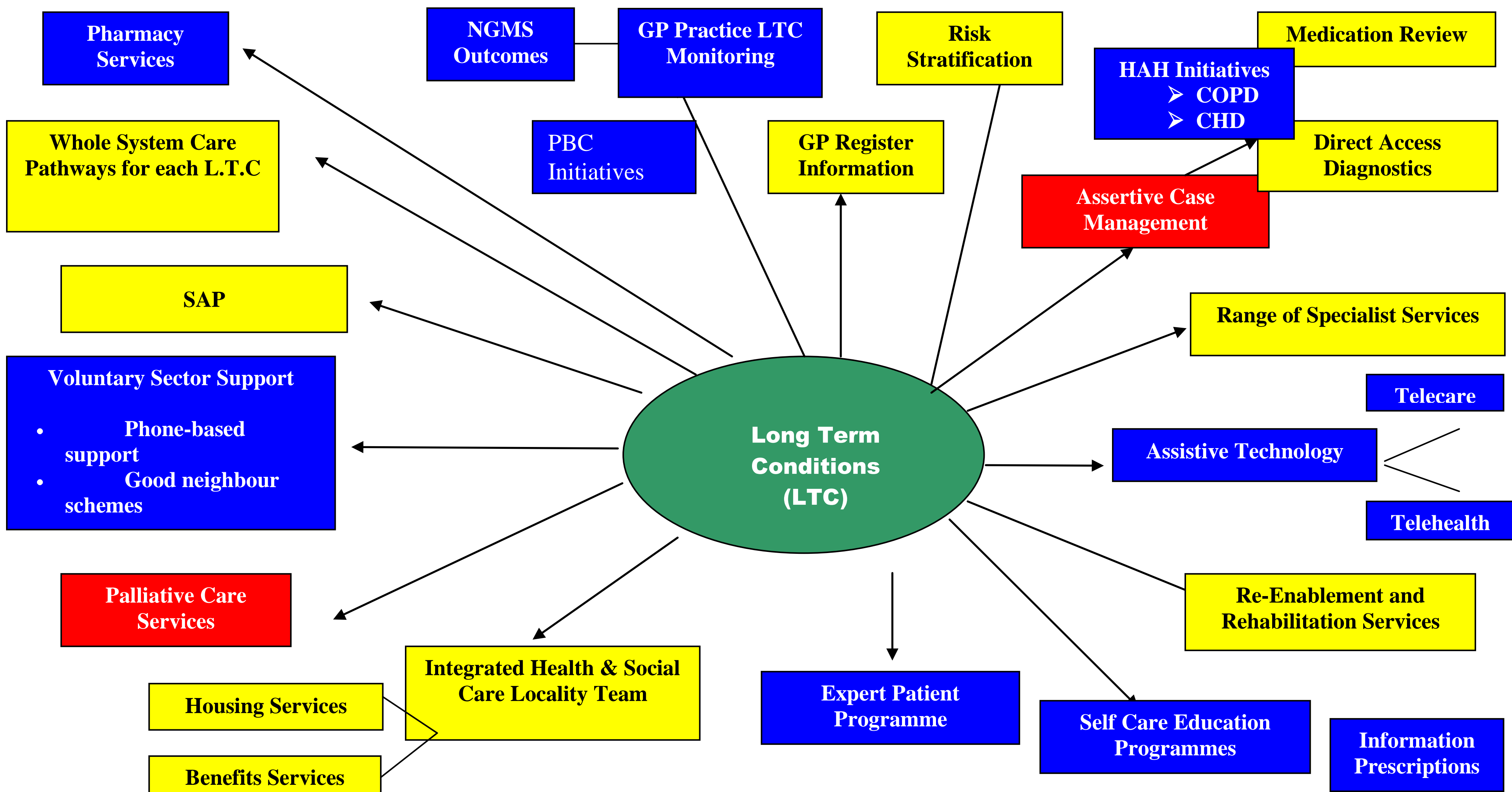
This approximates to the top 25 % of patients identified through risk stratification and the care of these two levels is considered under a Phase approach (Refer Figure below)



Whilst the services described under Level One can still be utilised by these groups, additional service inputs are required.


LONG TERM CONDITIONS
Phase 1
Phase 2
Phase 3
Intensive Substantial Need
Primary Care
Enhanced Services
Residential Care
Secondary Care
Specialist Services
Nursing/ Community Nursing Services
Resource Centres
Domiciliary Care
End of Life Care
Telemedicine
Diagnostic Services
Joint Care Services
TIER 3-5 WEST MIDS MODEL
Sustaining Independence
Assistive Technology
Voluntary Sector Support
Domiciliary Care
Primary Care
Enhanced Services
Allied Health Care Services
Secondary Care
Specialist Services
TIER 2+3 WEST MIDS MODEL
Prevention
Patch Wardens
Voluntary Sector
Priority Care
Health Promotion
Address Healthy Inequalities
TIER 1 WEST MIDS MODEL

FRAMEWORK FOR DELIVERY OF INTEGRATED CARE PATHWAYS FOR LONG TERM CONDITIONS



Collectively all of the services detailed in this framework are working to achieve the aims of the philosophy. Individual services will be required to complete service specifications and a template will be formed to assist this process. The following detail expected service dimensions that will be required in each of the phases within levels two and three.

Preventative / Health Promotion

- Providers will have an awareness of the health needs and the health inequalities in the locality through close working with the Public Health Practitioners and utilisation of the Locality Health Profile.
- In relation to key indicators for health all provider staff be able to provide the following basic advice (or signposting to that advice) in relation to
    - Healthy diet
    - Exercise and activity
    - Smoking cessation
    - Lifestyle factors
- Appropriately trained / qualified practitioners will be able to easily and speedily access community equipment in order to support individuals to maintain independence within their own home
- All providers will have the knowledge of locality based schemes and initiatives relating to improving the health of the population, how to access them and the ability to signposts individuals and families to these services.
- All healthcare providers will have or work towards establishing links with community networks and organisations. (i.e. Priority Care Project; Heantun Housing; Age Concern; St Leonard's link line) Local area network arrangements (LANA) and locality health panels.

- Provider services will be actively involved in relevant strategy development and implementation with relevant Partner agencies through Professional leads
- Healthcare provider services will work with partner agencies to reduce health inequalities in a coordinated approach dealing with the wider determinants of health including
    - Education
    - Employment
    - Poverty
    - Housing
    - Transport
    - Police

N.B Partner Agencies includes Statutory and Voluntary

Voluntary Sector Involvement

The main partners in the voluntary sector are currently Age Concern, Link Line and Heantun Care

Age Concern provides a wide variety of services including hospital discharge transport, shopping services, will writing and befriending. These services are available to all older residents.

Link line provides telephone based support and Heantun care provide a good neighbour service. This service aims to address the social isolation often experienced by those with long term conditions . This service has been subject to an external evaluation by Wolverhampton University and the results of this will inform subsequent commissioning.

Resource Centres

There are currently three resource centres, one located in each locality in the City. They provide respite services as well as a rehabilitation unit. This rehabilitation unit is staffed by physiotherapists, occupational therapists and rehabilitation assistants who will work together to formulate rehabilitation plans. Patients with long term conditions may utilise these facilities after a fall or acute illness when they need an extra period of time to regain the confidence and skills needed for them to return to independent living in the community. These existing centres will be relocated into new builds as part of the new primary care centres and will have an increased role as information points, provision of respite beds, intermediate care beds and other services such as chiropody. This will result in more co-ordinated services for individuals with long term conditions.

Services for avoidance of acute hospital admission

- Management of COPD exacerbation
- DVT management following diagnosis
- IV antibiotic therapy for individuals with identified systemic infection.
- Re-hydration Therapy
- Crisis intervention for exacerbation of chronic disease and falls that affects functional ability.

Alternative Referral & Support Pathway (West Midlands Ambulance)

Through Ambulance Service - for individuals requiring community based support & treatment to prevent acute hospital admission, following an episode or diagnosis of the following:-

- Falls
- Urinary Tract infection
- Chest infection
- Palliative Care crisis
- These services are expected to be utilised to support individuals with long term conditions whose admissions are often related to these episodes in addition to acute exacerbations.

In-reach Discharge facility

- A community based discharge link service that supports acute hospital discharges for individuals with complex needs.

'Carer replacement' Support .

- Provide support when an individual's sole carer suddenly and unexpectedly requires admission to hospital.

Management of Hypertension

This service is important in terms of prevention of other disabling long term conditions such as Cerebral vascular Accidents (CVA) and Myocardial Infarctions (MI). The commissioning of this service will involve both practice nurses and community based nursing teams both to offer choice and to target housebound individuals. The range of this service will cover

- Monitoring and recording of Blood Pressure as per agreed guidelines (British Hypertension Society Guidelines) and NICE guidance
- Reporting of results to G.P practice
- Venepuncture to monitor biochemistry profile
- Advice to individuals and families re healthy lifestyle
- Diet
- Exercise
- Smoking cessation
- Environment issues
- Stress management
- Support and advice re medication and side effects
- Referral and signposting to relevant supportive agencies

There will also be proactive engagement of individuals not accessing GP practice based delivered care . Good quality data will facilitate this .

Management of Diabetes

This service will be commissioned to be provided by practice based staff, specialist diabetic nurses or community nursing staff (for housebound patients). It is expected that providers to this group of individuals would liaise with each other in respect of an individual's treatment. The adoption of integrated care pathways is a tool to facilitate this.

- Support to newly diagnosed diabetics to teach self care and promote independence in relation to self medication and control (To include support and advice to those in level one)
- The administration of insulin to housebound individuals where independent care is not possible
- The annual review of monitoring for the complications of diabetes to include full screening as per agreed care pathway to include facilitating access to retinal screening
- To provide screening information back to GP practice and input into diabetic register
- Liaise with GP practice re HBA1c
- To provide advice re preventions of complications of diabetes
    - Healthy diet
    - Exercise
    - Lifestyle issues
    - Foot care
    - Medication compliance
- To signpost individuals to appropriate agencies/initiatives to support their diabetic care
- To provide expert diabetic knowledge in the form of diabetic specialist nurses to GP practice and community locality teams enabling improved glycaemic control, initiating insulin and its adjustment and monitoring as necessary and management of diabetic emergencies aiming to reduce need for an acute admission

Proactive engagement of individuals not accessing GP practice delivered care

Management of Respiratory Problems

The scope of commissioned services should provide

- Support and advice in relation to the range of symptoms present on assessment aiming to reduce the impact on quality of life.
- Monitoring effects of treatment on symptoms particularly pain management
- Support to G.P practice in the achievement of the GMS contract
- Education and support to individuals on the use of inhalers & oxygen therapy
- Ensure regular peak flow tests and access to spirometry.
- Monitoring condition of individuals who are exhibiting symptoms of exacerbation of respiratory illness offering support and advice re
    - Lifestyle
    - Positioning
    - Breathing techniques
    - Administration of medication
- Liaison with GP or Respiratory team concerning patient condition and progress in relation to respiratory observations
    - Pulse
    - Blood pressure
    - Respiration rate

    - Pulse oximetry
- Referral to O.T or physiotherapy /community matron as appropriate
- Provision of relevant aids and adaptations to support the individual in their own home
- Provision of advice and education re oxygen therapy and administration
- Proactive use of telehealth capability as appropriate
- Community Pulmonary Rehabilitation

CVD/Heart Failure   Housebound Patients

The effective management of CVD/ Heart Failure has been identified as an area where reinvestment potential and increased quality of life for individuals with Long Term Conditions exists.

Each individual with this diagnosis will have an appropriately skilled Key Worker identified whose responsibilities include the co-ordination of care.

- Liaise closely with the GP practice to offer the provision of an annual CVD check to offering lifestyle advice/support (below) aimed at reducing the risks of further myocardial infarctions:-
    - Smoking cessation
    - Diet
    - Exercise
- Stress management

- Identifications of abnormalities relating to cardiac function as per agreed care pathway and referral to GP where appropriate or liaison with Cardiac Rehab or the Rapid Angina Team/ Heart failure team at RWHT
- Review of medication (in conjunction with the trust pharmacist) to maximise efficacy of treatment
- Monitoring of vital signs to detect abnormalities and reporting back to GP practice
- Signposting individuals to relevant services as a preventative measure
- Proactive engagement of individuals not accessing GP practice delivered care
- Supporting GP practices with heart failure specialist nurses
- Proactively use telehealth capability as appropriate

For those individuals with high intensity needs

- Identified appropriately trained nursing staff to take continuing responsibility for high risk individuals with complex holistic needs (fulfilling role of community matron within the NHS Health and Social Care Model)
- Above staff to complete of an initial clinical assessment to provide access to required range of integrated community services: utilising evidence based approach.
- Appropriately coordination and monitoring of the provision of services to maximise personal independence and well being
- Proactive management of individuals identified as VHIU (Very High Intensity Users) on the caseload: utilising systematic physical examination skills in order to recognise early symptoms of disease exacerbation, acute illness and injuries.

- Respond to changes in clinical status through the use of independent prescribing skills.
- Anticipate and respond to functional and cognitive decline in abilities due to acute illness or exacerbation of existing chronic illness.
- Develop, implement and review programmes of care for individual patients, ensuring preventative and proactive actions within the programme, reduce the need for or prevent inappropriate hospital admission.
- Implement personalized care plans for 95% of individuals on their caseload by 2010
- Support and engage individuals and carers in achieving and maintaining their individual potential.
- Ensure appropriate and timely transfer/discharge to other key workers.

Palliative Care

Whilst palliative care is commissioned within it's own strategy it is important that providers of these services identify how they will engage with individuals who have long term conditions. The identification of the final phase of long term conditions needs to be systematically embedded into care pathways for long term conditions in order that individuals have access to the full range of palliative care services.

Nursing Home Care

- Assessment of Registered Nursing Contribution to Care (RNCC) by appropriately trained Community Nurses, in order to determine the level of care to be provided by the nursing home and the financial contribution from the NHS
- Review of assessments at regular intervals (after first 3 months and then annually)
- Assessment and provision of continence supplies to nursing home

The following services are not directly commissioned by Wolverhampton PCT but are expected to be complimentary to this strategy.

Health through Warmth

This is a scheme aimed at helping vulnerable people to increase the energy efficiency of their homes, saving money on heating bills and helping to reduce the impact of cold related illnesses.

Energy watch can also be used by individuals with long term conditions by ensuring they are on a priority register.

Kick-Start

A service provided by the City council designed to help owner occupiers through a loan against their property to maintain their homes in order to work towards the Government Decent Homes Standard. These loans enable people with long term conditions to ensure that their health is not adversely affected by their living conditions...

Sheltered Housing

There are seven very sheltered housing schemes within Wolverhampton which are run by various housing associations and charities under contract to Social Services.

These sheltered accommodations provide self contained flats with a care team within the scheme providing round the clock personal care and support for individual tenants. Social club facilities are also available allowing people to keep fit and follow their hobbies

Graisely Community Healthy Living Centre

This provides a wide range of activities for the general community as well as providing the base for commissioning classes for pulmonary rehabilitation/ cardiac rehab. It also serves as a base for the innovative walking for health service commissioned by the PCT. The centre functions as a information source through leaflets for conditions like diabetes and smoking cessation.

4.4 Proposals For Future Development of Model

In relation to self care , future commissioned services at this level are concerned with enabling empowered individuals to self care and manage their condition through information provided through a variety of resources (e.g. information prescriptions, GPs and other health professionals, condition specific self help groups). Wolverhampton PCT is committed to using every lever at it's disposal to support self management , including this commissioning strategy and associated provider workforce development plans. Leadership is key to ensuring the cultural change that is needed to empower individuals to participate in supported self management and providers of care at all levels should clearly demonstrate they have considered this factor.

Nationally work has been undertaken to seek the views of individuals with long term conditions in relation to self management. The results were that individuals with long term conditions thought;

- There needed to be an increase in healthcare professional skills to support self management
- There needed to be an increased provision of information and signposting
- There needed to be greater flexibility of services to fit in with patient's other commitments

Locally an engagement and communication exercise in relation to this Strategy supported these national views.[35]

[35] Jones T Communication and Engagement on LTC Strategy Oct2008-Jan 2009 available athttp://www.wolvespct.nhs.uk/Publications/publications.asp

It is acknowledged that no one single approach will be suitable for all individuals. Indeed not everyone may want to be involved in self management and that informed choice should be respected. Those who wish to be involved may need different methods of support and may be involved in different levels of self care.

Information prescriptions may be particularly useful at the time of diagnosis or as there is progression within an illness.

The government has made a commitment to improving access to appropriate services

> *We propose that services give all people with long term health and social care needs and their carers an information prescription.*[36]

Information prescriptions will be required to guide people to relevant and reliable sources of information to allow them to feel more in control and better able to manage their condition and maintain their independence

Information prescriptions will be nationally recognised as a source of key information on services and care that is seamlessly and formally integrated into the care process. The principle is access to the right information at the right time. The type of information may be a series of links and signposts to guide people to finding out about health conditions, treatments, care services, benefits advice and support groups. They may also provide information about networks, addresses and telephone numbers of support groups.

[36] Our health, Our care Our say Department of Health 2006

This area of information prescriptions and signposting is a new service for commissioners and scoping of what is currently being provided is recommended.

In relation to future developments within **levels two and three** within the phased approach , the following requires consideration

- It is aimed that through the use of predictive data all patients with a diagnosis of hypertension, diabetes or respiratory difficulties in levels two and three will have an identified key worker. This area of co-ordination is vital to achieve changes in the way care is experienced by individuals.
- All services need to have an enabling culture which supports individuals to fulfil their potential to engage in supported self care .
- In order to achieve this consideration to the skills of the provider workforce should be given in relation to Cognitive Behavioural Therapy techniques as these have been shown to be successful in assisting individuals to change their behaviour patterns.
- It is expected that for all long term conditions a comprehensive assessment of the physical, social, psychological and environmental needs of the individual utilising the integrated care pathway will take place.
- The single assessment document will be used to complete the above for those with health and social needs
- To enable timely access to services , a single point of access will be used to ease referral pathways
- Personalised plans of care need to be integral to care pathways
- Workforces need to demonstrate their ability to provide competent care that meets desired outcomes
- Alternative providers will be considered as well as changes to the roles of existing staff e.g pharmacists

4.5 Risk Stratification

Case finding is essential for effective long term condition management. Currently the PCT uses PARR ++ which focuses on triggered admissions for specific reference conditions for which management can often prevent future hospital admissions. However Parr ++ only targets those individuals who have had a hospital admission and therefore does not constitute a whole population risk stratification tools.

Commissioners need to have high quality and accurate information to identify and understand the composition of their entire Long Term Condition population to support the design , commissioning and implementation of an overall long term conditions strategy , including :

- Those at risk of developing a long term condition who may benefit from prevention and wellness promotion (for Public Health Intervention)
- Those who have a long term condition who may benefit from supported self care
- Those who have one or more long term condition who may benefit from proactive disease management
- Those at immediate or future risk of high utilization of secondary care services who may benefit from intensive case management services

- And those whose needs are unrecognized or who may be at risk of developing substantial health and social care needs in the future

It is important that the tool chosen for whole population risk stratification can identify those who can most benefit from outreach and targeted interventions with a high degree of accuracy to ensure that there is a match between intervention intensity and risk. Wolverhampton PCT will work closely with the SHA to ensure that Bupa Health Dialogue understands the local needs of Wolverhampton

.4.6 Clinical Governance Requirements Of Service Providers

Provider services will need to take into account the National Policy Directives detailed under 3.2. Any services commissioned must meet all national standards of service quality and clinical governance including those set out in Standards For Better Health [37]. These core and developmental standards of provision are designed to cover the full spectrum of health care as defined in the Health and Social Care (Community Health and Standards) Act 2003. The seven domains are safety, clinical and cost effectiveness, governance, patient focus, accessible and responsive care, the care environment and public health. Clinical Governance arrangements must be proportionate to the service provided. The following integrated governance arrangements are adapted from National guidance[38]

[37] Standards for Better Health Updated April 2006 Department of Health
[38] Primary Care Service Framework :Management of Long Term Conditions in Primary Care Primary Care Contracting Jan 2007

Professional Competency, Education and Training: Service Providers need to be able to demonstrate that their staff are competent to deliver the service. This may include where appropriate professional eligibility. Service providers will be required to demonstrate that they have addressed the workforce requirements of the service they are providing including identifying training needs and the means to achieve these needs. A competency based approach may be adopted by providers to demonstrate their ability to achieve this governance specification. It is expected that service providers conduct annual staff appraisals.

They will need to demonstrate that that they are able to deliver culturally competent care and also that they adopt strategies which promote choice and self empowerment for individuals with long term conditions. Equally providers will be required to ensure safe staffing capacity and appropriate caseloads are encouraged at all times. Staff should be able to demonstrate that they have participated in organisational mandatory and update training , for example infection control, manual handling risk assessment as appropriate to their areas of intervention.

Patient, Public and Staff Safety ; Providers will be required to demonstrate that evidence based clinical guidelines are being used. This will include Nice Guidance and National Service Frameworks

Relevant NICE Guidance include:

- CG 5 Chronic Heart Failure 2003
- CG12 Chronic Obstructive Pulmonary Disease 2004
- CG 21 Falls 2004
- CG34 Hypertension 2005
- CG 15 Type 1 Diabetes 2004
- G Type 2 Diabetes 2002
- CG10 Type 2 Diabetes Diabetic Footcare 2004
- H Type 2 Diabetes Management of Blood Pressure and Blood Lipids
- F Type 2 Diabetes Renal Disease 2002
- E Type 2 Diabetes Retinopathy 2002

National Service Frameworks pertinent to Long Term Conditions include

Diabetes (1999)
Coronary Heart Disease (2000)
Older People (2001)
The National Service Framework for Long Term Conditions (2005)

There is a NSF planned for Chronic Obstructive Pulmonary Disease in 2009

Providers will be required to ensure that they have appropriate health and safety and risk management systems and that premises where care is provided are safe and where appropriate young person friendly. They should ensure that any risk assessments and significant events are both documented and audited regularly and outcomes of these implemented.

There are national requirements for recording, reporting , investigation and implementation of learning from incidents. It is expected that providers will adhere these.

Clinical audit and review ; Providers will be required to demonstrate their co-ordination of and involvement in regular interprofessional and interagency meetings and regular clinical audit of service. This audit process should also be used to demonstrate achievement of identified outcome measures.

Information Management : It is considered paramount that procedures are put in place to safeguard confidential information .Where information sharing is in the interests of individuals with long term conditions , an information sharing protocol should be designed and individuals made aware. Principles of Caldicott Guardianship should be adhered to. This was an area that locally Wolverhampton residents felt strongly about.[39]

Patient and Public Involvement : This strategy is committed to ensuring a change in approach to patient and public involvement. All provider services will be required to demonstrate active engagement with patients and local communities in developing services, self care plans or in assisting/ supporting individuals to take up self care opportunities

Equality : Wolverhampton PCT is committed to reducing health inequalities and providers should demonstrate they have considered Health Inequality Impact Assessments (EqIA) . This strategy has been subject to an EqIA and the outcome has been that the need to record equality data should be considered at the contract setting stage.

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[39] Jones T Communication and Engagement on LTC Strategy Oct2008-Jan 2009 available athttp://www.wolvespct.nhs.uk/Publications/publications.asp

Managing Complaints; Providers should have responsive protocols and procedures in place for managing complaints .Regular reviews should be undertaken into complaints and learning from these shared.

Continuous Quality Improvement ; Providers are required to develop a set of indicators to inform commissioners of the key quality outputs of their service and how it uses these and other measures to ensure the quality of the service is continually improved.

4.7 Clinical Engagement / Communication Flows

In order to achieve the transformational changes in the management of long term conditions described in this strategy , the issue of clinical engagement and communication flows needs to be addressed. Within an internal review the PCT using the EFQM framework (European Foundation for Quality Management) were informed that staff want them to be clear who their customers are, what their needs and expectations are and to design services around those needs. They want clear messages regarding vision, values and objectives and want to see their work linked to those objectives. They also welcome clear objectives, priorities and targets which they can be measured against to see that they are making a difference. A recent staff survey re-emphasised the need for the PCT to have a clear sense of direction which is clearly

communicated through the organisation.[40] This strategy has identified that communication is a prime area for consideration and action.

4.8 Links To Other Strategies

The incidence of long term conditions increases with age, many older people have more than one long condition and face the dual challenges of medical and social problems .Therefore strategies written in relation to older people will have links to this strategy. Other strategies specifically identified are

- Information and informatics Strategies
- Palliative Care Strategies
- Unscheduled Care Strategies
- Population Wide Prevention Measures
- Carer Support Strategy

[40] Wolverhampton City PCT Strategic Plan 2005-2007

REF + Status	Recommendation	Actions	Date for Achievement	Resources	Identified Lead for Action
K1	**Ensure Vision and Leadership**	Identification of Long Term Conditions Programme Lead	August 08	Completed OCT 08	
K2		Secure PEC approval Secure Trust Board approval	Sept 08 Oct 08	Completed	
K3	**Commission service provision to meet proposed model through identified service specifications with monitored outcomes**	• Develop portfolio of current commissioning services • Ensure commissioned services have appropriate service specifications through analysis of provided information • Liaison with service leads if further development needed on service specifications • Disseminate and monitor developed outcome metrics	ongoing Begin review April 09 Post April 09 April 10	Contracts Management Team Commissioning In conjunction with appropriate Commissioning Lead	
5.1		**Involving Individuals with Long Term Conditions**			
INV 1	**Secure involvement of individuals with LTC in the commissioning process**	• Design telephone based short survey • Identify potential candidates (30) from Parr data • Email invite circulation of staff to identify potential lower level LTC population • Conduct telephone survey • Invite self selected individual to meeting/forum re strategy • Individuals to attend strategy group	April 09 May 09 June 09 July 09	Programme Lead	
INV 2	**Ensure provider services actively**	• Communicate the requirement to actively seek the views and opinions of	April 09 onwards	Contract setting and	

	seek the views and opinions of individuals with LTC in relation to both service development	individuals with LTC as part of service specifications to service leads • Communicate when this data will be collected and how results will be used and shared (bi yearly Aug and Feb		monitoring team in conjunction with appropriate commissioning lead	
INV 3	**Actively seek the views of hard to reach groups**	• Explore potential of partners in third sector to engage hard to reach groups • LINKED Action CF 1 re predictive modeling tool to utilise whole systems data provided to identify and then target wider range of individuals • LINKED Scope potential to adapt marketing strategies from Public Health Initiatives'	April 09 Dec 09 May 09		
INV 4	**Individuals with LTC known to Wolverhampton PCT will be offered a personalised plan of care**	• Utilise Parr to identify VHIU (very high intensity Users) • Community matrons to lead on co-ordination of personalised plans for VHIU • Utilise Media / website to publicise personalised care plans and encourage individuals with LTC's to request one from healthcare providers • LINKED Action SR 1 Implementation of care pathways to include personalised plan • LINKED Action COM 1 + COM 2	current Feb 09 April 10 April 10	Existing resources: Community Matrons Website Manager	Marcelle Rollings

		Communication strategy to inform all healthcare professionals re strategy and therefore need to have personalised plans of care • LINKED Action COM 3 Single Assessment and Single Point of Access to communicate personalised plans		Existing Resources SPA Co-ordinator SAP Manager	
INV 5	**Ensure individuals with LTC identified in top 25% of risk stratification have key contact**	• LINKED Action INV 4 re VHIU and community matrons • Community matrons to act as co-ordinator across virtual ward nursing team and practice nurses • LINKED Action CF 1 Predictive Data tool • Scope potential of single point of access in relation to management of key contact	Awaiting outcome of Community nursing review	Existing Resources Community Matrons	Marcelle Rollins
INV 6	**Ensure carers feel supported by providing access to information and advice**	• Linked to previous actions including information prescriptions and key contacts		Existing Resources	

5.2		Communication			
COM 1	**Develop and implement a communication plan re LTC strategy and commissioning for LTC**	• Secure approval of draft strategy • Review group membership to ensure cross representation • LTC identified lead to develop communication plan within LTC strategy group • Strategy to be disseminated via channels below and as a key responsibility of long term strategy group members	Completed 08 Oct 08	Programme Lead Existing Resources as per group membership	
COM 2	**Ensure varied channels and methods of communication between PCT and all partners throughout the lifespan of the strategy**	• Identify current channels of communication and gaps • Ensure all methods of communication/ media considered • Actively seek stakeholders views and preferences on methods of communication • Ensure identified route for feedback from stakeholders to LTC strategy group • Examine routes of communication re strategy to wider population not just those working or with LTC • Identify and implement systems for collection and feedback on service performance re service specifications	Sept 08 ↓ April 09	LTC Programme Lead) Band 2 Admin support (re- assignment of existing resources short term)	

COM 3	**Ensure links are established with Single Point of Access and Single Assessment Processes to maximize communication in relation to multi-agency service provision**	• Ensure cross working group representation via identified individual as per key recommendation • As a PCT support the commissioning of workstreams to support Single Point of Access and Single Assessment Process	Ongoing post Oct 08	Cross reference to SPA and SAP costings	
COM 4	**Ensure progress reports and outcomes of commissioned services are shared across the whole system and wider health/ social care**	• LINKED To be part of wider communication strategy as per COM 2 • Identify potential forums for information sharing • Identify opportunities for paper presentation/ journal articles to share best practice and learning experiences	Sept 08 ongoing	Existing Resources	
5.3		**Case Finding and Targeting**			
CF 1	**Commission predictive tool to risk stratify patients to target need, both of those at highest risk and those with emerging risk to avoid reactionary crisis management**	• Continue to use PARR 1 + 2 as interim tool • Identified lead to register as member of predictive risk development network to share in best practice • Work collaboratively with West Midlands Strategic Health Authority and CBSA to commission alternative tool	Oct 08 April 09	? contribution to CBSA	

CF 2	**Utilize available data to improve the health outcomes of individuals with LTC and narrow health inequalities among these individuals by ensuring services are targeted to meet the needs of disadvantaged groups**	• Undertake analysis of available data sources (NHS Comparators, NHS Institute for Improvement • Opportunities Locator , Self Care Connect) • Undertake analysis of data from tool in CF1 to gain information • Support the sharing of information across the wider community • Ensure that this information is shared with practice based commissioning leads • Ensure targeting of services incorporating information gathered from INV 1-3	May 09 July 09	Programme Lead PBC Project Managers	
CF 3	**Ensure coordinated use of data by multiagency service providers to enable systematic delivery of targeted care**	• Develop forum/ method for data sharing • Ensure adherence to information sharing protocols • Develop further partnership working with social care providers	Post CF1		
5.4		**Service Redesign**			
SR 1	**Accelerate the development of a patient centered approach to the delivery of services**	• Identify priority conditions • Support the identification of a key healthcare clinician per priority condition • Support this identified clinician to work in conjunction with care pathway and		Input of Consultant Nurse Care Closer To Home	

	for individuals with LTC through the use of care pathways	service redesign facilitators to agree care pathways informed by evidence based guidance and user involvement. • Ensure variance reporting from pathways is integral to outcome measures • Ensure systems in place for ongoing review and evaluation of impact of pathways on experience of care • Explore potential of information technology , specifically electronic notes to provide a framework for information sharing within pathway.		Clinical Lead Community Matron Input of Care pathways Facilitators	
SR 2	**Evaluate the potential to decrease admissions for ambulatory sensitive conditions through transfer of care initiatives**	• Ensure identified link with care closer to home strategy • LINKED VAL 1		As Above	
SR 3	**Scope potential for changes/ commissioning of services for supported self care**	• Identify, analyse and evaluate available evidence base • Network with other PCT's commissioning new ways of supported self care • Conduct baseline audit of current provision re self care	June 09	LTC Programme Lead	

		• Identify gaps in provision • Identify means of delivering these gaps taking into account INV 1-3	Dec 08		
SR 4	**Support the development and the evaluation of the virtual ward model of care across appropriate nursing teams**	• Maintain two way communications between commissioners and the providers developing the virtual model approach to ensure virtual model is informed by philosophy of this long term conditions management strategy • Ensure outcome metrics of changed ways of working have been clearly identified • Support commissioning of facilitator roles to assist provider staff with change management in service redesign		Input General Manager Community services Costs dependent upon tendering	
SR 5	**Support the development of a workforce with appropriate skill mix to deliver on changed ways of working including training to address supported self care**	• Communicate the requirement to consider skill mix to providers • Continue to work with West Midlands deanery re workforce development and training requirements • Commission necessary training		Costs dependent on training needs identified	
SR 6	**Implement stage two of telehealth initiative**	• Focus intervention on COPD and Heart Failure • Agree expected outcomes • Monitor and report on interventions	Feb 09	Existing resources Community matrons and CICT	Marcelle Rollins

5.5		**Ensuring Impact and Value For Money**			
VAL 1	**Undertake an audit to identify the analytical capacity of staff and IT infrastructure across acute, primary and social care to monitor outcomes**	• Communicate requirement to IT lead • Following audit , needs re structure, systems and training to be feedback to commissioners	Oct 08	Costing as per IT strategy	
VAL 2	**Persue potential business modeling potential of risk stratification tools**	• LINKED to CF 1		Programme Lead	
VAL 3	**Development of a set of outcome metrics to ensure impact and value for money of commissioned services and ensure these metrics are integral to appropriate service specifications**	• Identify and evaluate available metrics • Feedback re metrics to LTC strategy group • Discuss and agree metrics with service leads • Ensure metrics included in service specifications • Monitor outcomes and provide feedback to providers			