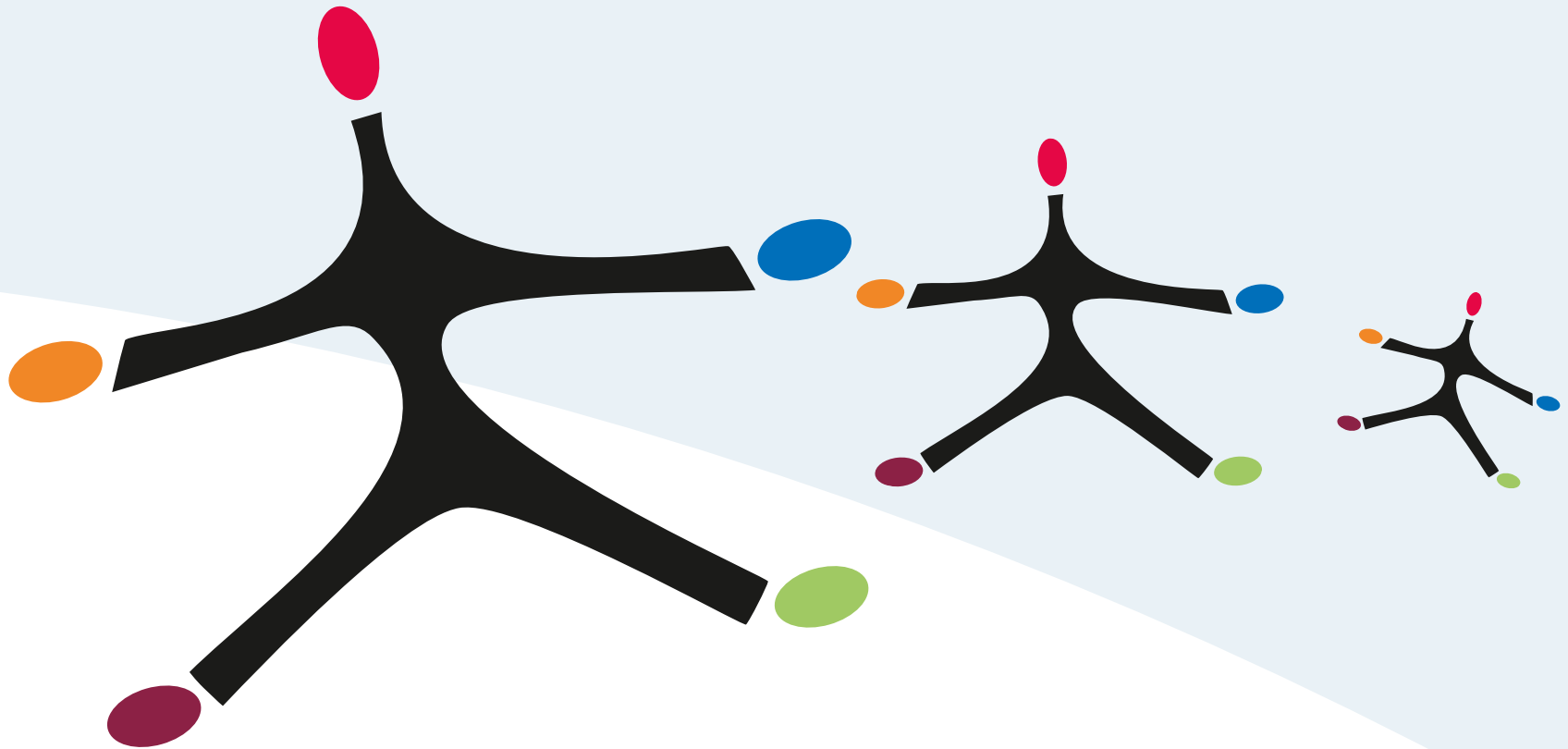


Improving the health and well-being of people with long term conditions

World class services for people with long term conditions –
information tool for commissioners



DH INFORMATION READER BOX

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Foreword



The Department of Health's strategy for long term conditions aims to put people with long term conditions at the centre of decision making about their own care. In this way, they will personalise the services they need so that they are truly supported to live life as they want. This should result in care being delivered in the most appropriate setting for the person's needs. In many cases, this will be as close to home as possible and mainly in a primary care setting.

Delivering health and well-being improvements for people with long term conditions is challenging: it isn't just about treating illness, it's about delivering personalised, responsive, holistic care in the full context of how people want to live their lives. There are huge benefits for everyone in getting it right – for the NHS, local authorities, the third sector and, most of all, for those people whose lives can be transformed by being given the support that's right for them and proportionate to their needs. It is therefore crucial to plan accordingly, ensuring an efficient use of health and social care resources.

Improving the health and well-being of people with long term conditions is intended to be a resource for reflection, challenge and practice change. The tool has been developed to provide information and recommend actions for commissioners and local partners to consider when developing commissioning strategies to meet the needs of people with long term conditions.

A handwritten signature in black ink that reads "Ann Keen". The signature is fluid and cursive, with the first name and last name clearly distinguishable.

Ann Keen

Parliamentary Under Secretary of State for Health Services

Executive summary

If better management of long term conditions (LTCs) is to be achieved, then transformational change is required – both within the system and, this is perhaps more challenging, to the culture and behaviours of the workforce, people with LTCs and the public. The personalisation aims of LTCs policy have long been talked about, but change is not happening fast enough and fundamental barriers persist. Local health and social care systems need to work together to identify what works well and to promulgate good practice to reduce variation.

This document has been co-designed with the NHS and social care to provide information that will help local partners to commission world class services for people with LTCs. The main aim throughout the development of this document has been to share a common vision of what a good service looks like for people with LTCs (including children and young people), their carers and families, and to provide some practical suggestions for commissioners to help them achieve that vision. It sets out some appropriate actions for commissioners to consider at each stage of the commissioning cycle, to support implementation of personalised care planning and self care support for people with LTCs.

A number of 'roadblocks' to achieving world class commissioning have been identified and set out in Annex A. In each case, examples of how commissioners have dealt with those 'roadblocks' have been provided, and 10 'Top Tips' have been developed to help commissioners achieve a good service model.

The information in this document has been developed through interviews with people with LTCs, professionals and managers from health and social care provider organisations, local authorities, primary care trusts (PCTs) and practice-based commissioning (PBC) groups.

Section 1: Purpose of this document

Context

A long term condition is one that cannot currently be cured but can be controlled with the use of medication and/or other therapies.

There are currently 15.4 million people in England with an LTC. Due to an ageing population, it is estimated that by 2025 there will be 42% more people in England aged 65 or over. This will mean that the number of people with at least one LTC will rise by 3 million to 18 million.

People with LTCs account for a significant and growing proportion of health and social care resources. The Department of Health's best estimate is that the treatment and care of people with LTCs account for 70% of the total health and social care spend in England, or almost £7 in every £10 spent.

Social care expenditure, too, is focused on those with LTCs and will be put under pressure by the ageing population. By 2022:

- the proportion of those aged 65 and over will increase by 37% to 10.8 million

- the number of people aged 65 and over with some disability will increase by 40% to 3.3 million
- the number of disabled older people receiving informal care (in households) will rise by 39% to 2.4 million
- the number of people in residential care homes will increase by 40% to 280,000
- the number of people in nursing homes will increase by 42% to 170,000.

This need for social care will mean that by 2022:

- public expenditure on long term care will rise by 94% to £15.9 billion
- total long term care expenditure is forecast to rise by 29% to £26.4 billion. This is equivalent to a rise from 1.4% to 1.8% of GDP.

The 15.4 million people in England with LTCs (around 30% of the population) account for more than 50% of all GP appointments, 65% of all outpatient appointments and over 70% of all inpatient bed days.



The Government's aim is to put people at the centre of decision making about the care they receive. This fits with the overall drive to embed personalisation across all public services. As part of this drive, personal health budgets are being piloted across the country, giving people more say and control over how the money for their healthcare is spent. Supporting people to take a more active role in decisions about their health and well-being means that the NHS has to change fundamentally the way in which it both delivers and commissions services for people with LTCs.

Commissioners must also understand how better management of LTCs can fully support them in achieving the aims of the Quality and Productivity Challenge. In the current economic climate, delivering more of the same is not an option and this is particularly relevant to long term conditions. We know that more proactive, preventive and personalised approaches can improve patient experience and reduce unscheduled use of hospital care. There are potential huge wins to be made, but they require transformational change, an innovative approach with strong, dynamic leadership to drive this forward. Better management of LTCs can support commissioners to achieve the challenge of quality and productivity in the following ways.

- **Quality** of services will be improved by people with LTCs having more proactive, planned care and services that meet their wider holistic needs with a focus on overall health and well-being. People will then feel better supported to be independent and in control of their condition.
- **Innovation** will be stimulated through a genuine discussion with people with an LTC that can open up wider choices to meet holistic needs – such as assistive technologies, exercise on prescription, holistic weight management programmes, access to psychological therapies or even therapies such as acupuncture and massage. This should motivate current providers to innovate, and stimulate new providers.
- **Productivity:** there are productivity gains to be had at the interfaces across sectors and services, and made through people with LTCs having their wider needs met, self caring, and having better-planned, proactive care. The 2008/09 GP patient survey found that GP practices performing well on care planning had fewer emergency admissions and outpatient appointments and slightly more elective care.
- **Prevention:** developing proactive care planning (which includes provision of information and support for self care) supports prevention in a number of ways, including slowing progression of disease and preventing emergency admissions.

Section 2: What is a good service?

A number of public consultations such as *Independence, Well-being and Choice* and *Your Health, Your Care, Your Say* have provided consistent messages from people with long term conditions (LTCs) about what is important to them. Overall, people say they want services that support them to remain as independent and healthy as possible. They want increased choice, with information to help them make choices and to understand and manage their conditions better. They want far more services delivered safely and effectively in the community or at home, with more seamless, proactive and integrated services that are personalised to them and their needs.

We know that people with LTCs are frequent users of health and social care services, including community services, urgent and emergency care and acute services. More needs to be done to support people with LTCs so that they can take a more active role in decisions about their health and well-being. Implementing personalised care planning will enable people with LTCs to plan their care, have strategies in place to cope with any exacerbations of their condition, and be in possession of all the relevant information they need to make decisions. They will be supported to self care,

have more confidence and control over their condition and understand the impact it will have on their lives. There will be a genuine shift towards addressing a person's full range of needs, including psychological and emotional support, rather than simply focusing on a medical model. Personal health budgets, whereby people are given more control of how money is spent, take this one step further.

There is evidence for the benefits of certain elements of the care planning process, e.g. self care and self management reducing GP and outpatient appointments. Most people with LTCs are keen to take responsibility for their health. Over 90% of people with LTCs say they are interested in being more active self carers, and over 75% would feel more confident about self caring if they had help from a healthcare professional or peer. Despite this, many people with LTCs have limited knowledge of, or influence over, their care.

Personalised care planning and self care support work together as part of one process of care delivery that promotes patient empowerment and choice, supporting people to be more independent and in control of their

conditions and to become more actively engaged. Personalised care planning and self care support the wider goals, embedding personalisation across health and social care services and underpinning excellent management of LTCs. Implementing these policies will help to achieve a gold standard vision for personalised care and to standardise this across the country. It is important, however, that they are not seen in isolation and that commissioning services and providers understand how they are aligned.

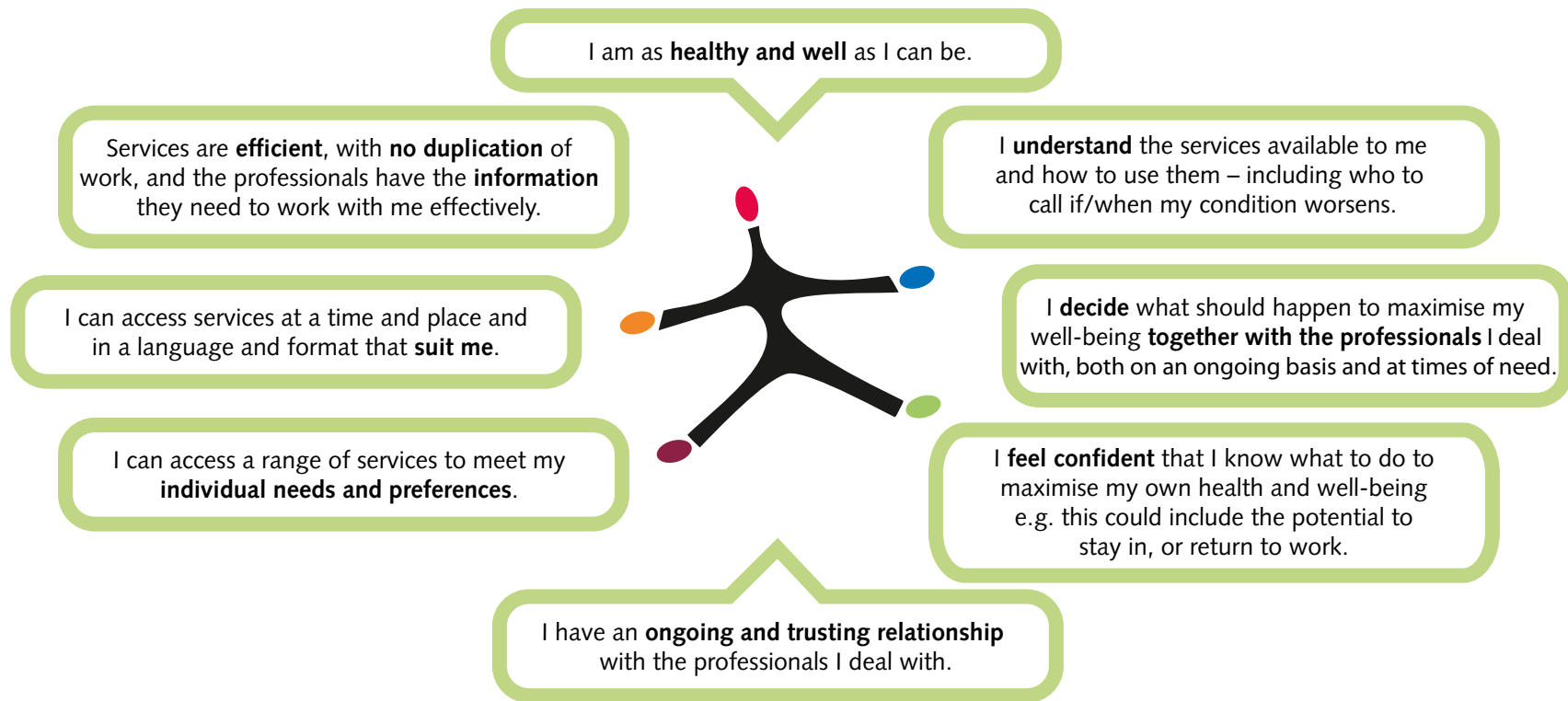
Personalised care planning underpins excellent management of LTCs and end of life care, and completely supports the key themes described in *Commissioning for Health and Well-being*, our vision for world class commissioning, *Putting People First* and *High Quality Care for All*, including:

- more individualised services
- more focus on prevention of disease and complications
- greater choice – including supporting people to make healthier and more informed choices
- reducing health inequalities
- providing care closer to home.

Genuine choices made through personalised care planning should lead to better-informed needs assessments. Collecting and aggregating data from care plans, including services people are requesting that could be beneficial and affordable but that are currently not available (unmet need), will help commissioners deliver the services that people actually want, and will have a positive impact on their overall health and well-being. This could mean decommissioning services that are neither wanted nor having any positive impact on the needs of people with LTCs. Commissioners in areas where personal health budgets are being offered will be able to get an even better understanding of what people want, as they will be able to consider what services people procure with their budgets – these may be outside traditional NHS services.

This section provides an outline of a vision for a good service from the perspective of people with LTCs, their carers and families, professionals and commissioners.

* What a good service looks like for people with long term conditions, their carers and families



What does good look like for people with long term conditions, their carers and families?

Good outcomes and experiences for people with LTCs include maximum health and well-being; control over what happens to them; confidence in managing their own condition and in using the services available; good relationships with professionals; and access to convenient, efficient services that meet individual needs and preferences. Successful outcomes for people with LTCs require a partnership between engaged, empowered individuals and a proactive, responsive and integrated system.

What does good look like for professionals?

To deliver high-quality services for people with LTCs, it is vital that the workforce has the right skills, approaches and behaviours.

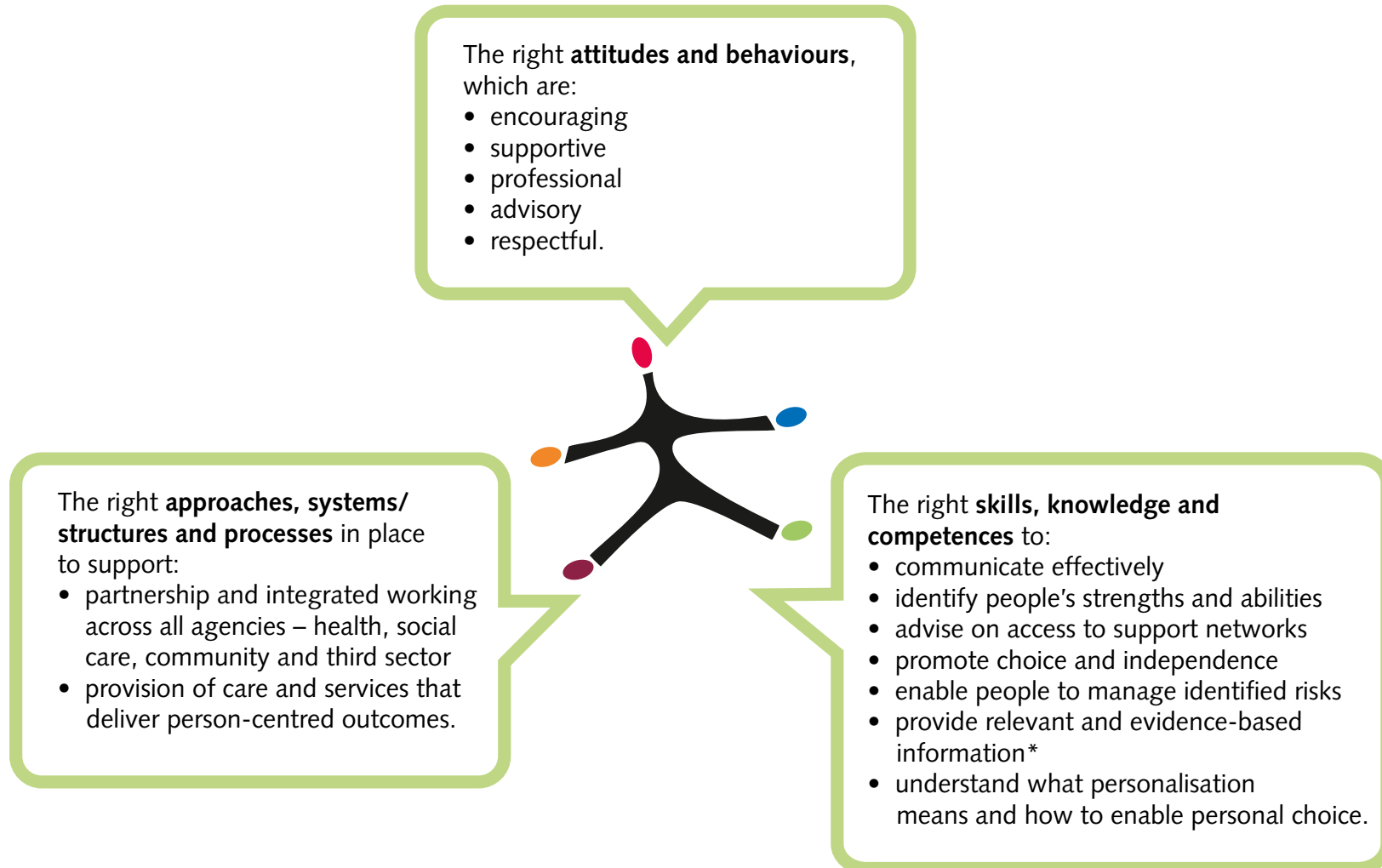
Effective LTC management depends on more than just providing information to individuals and their families. It requires a supported process whereby people who live with LTCs work to appraise their current lifestyle choices, think about important goals for them as individuals and work towards gaining the confidence to attain these

goals. A multidisciplinary team of health and social care professionals may be involved in this process, depending on the complexity of the individual's need.

The ability of individuals to take control will depend to some extent on what stage of their 'healthcare journey' they have reached. Someone who has just been diagnosed with an LTC will have very different needs to someone who understands and has accepted their condition, or someone requiring end of life support.

Effective LTCs management will enable individuals to become experts about their condition and their care. There will also need to be a recognition that an individual is as important within an integrated system as any clinician.

* What a good service looks like for professionals



* For more information see *Common Core Principles to Support Self Care* (Department of Health, 2008).

It is important that the expectations of the workforce become part of the contract discussions between providers and commissioners of services for people with LTCs.

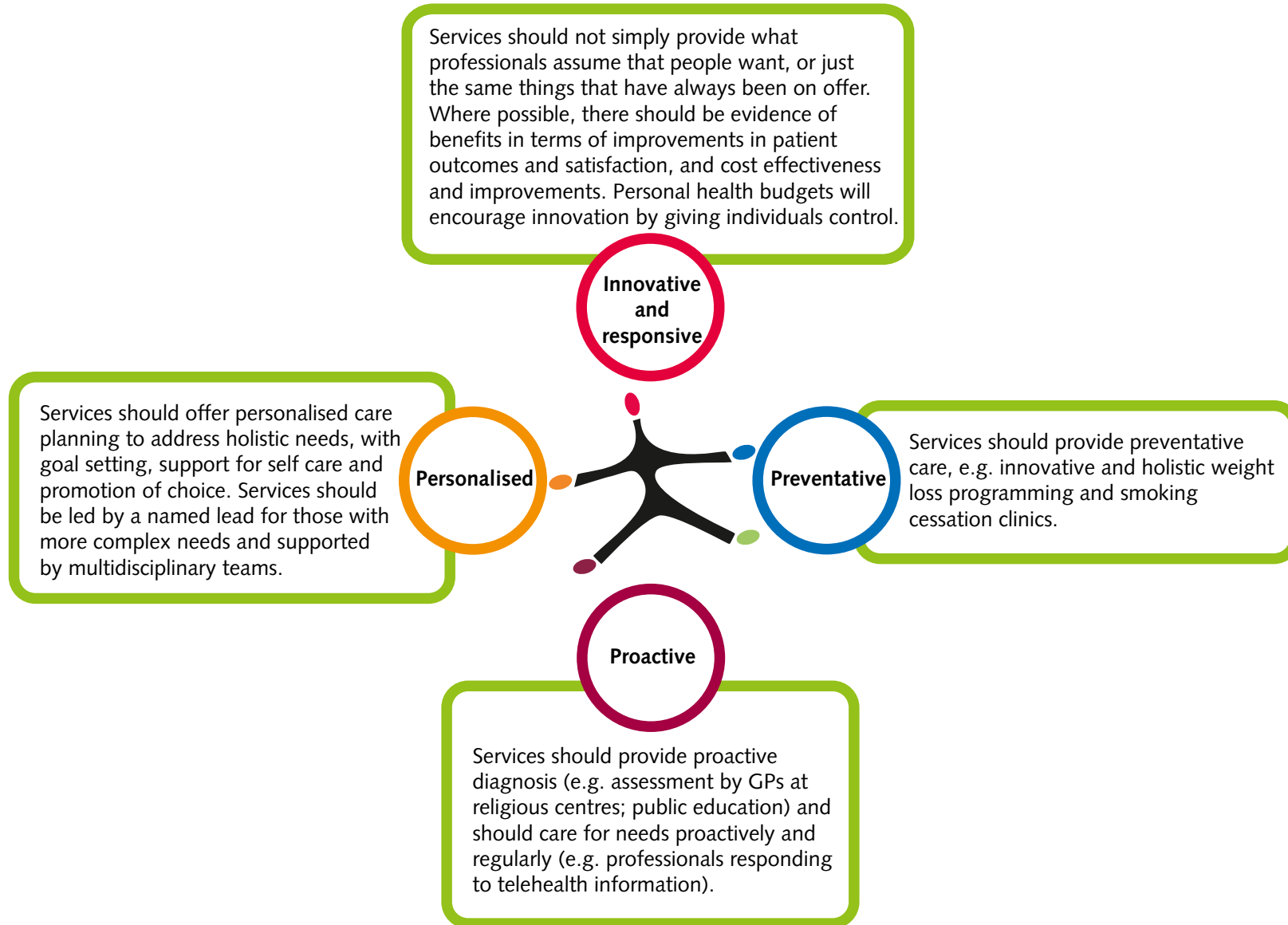
What does good look like for commissioners?

Good outcomes, value for money and experiences for people with LTCs must be at the heart of commissioning. The outcomes and experience that people with LTCs want determine how services need to be delivered, which in turn determines what service providers need to do; all of this then determines what the commissioner must do.

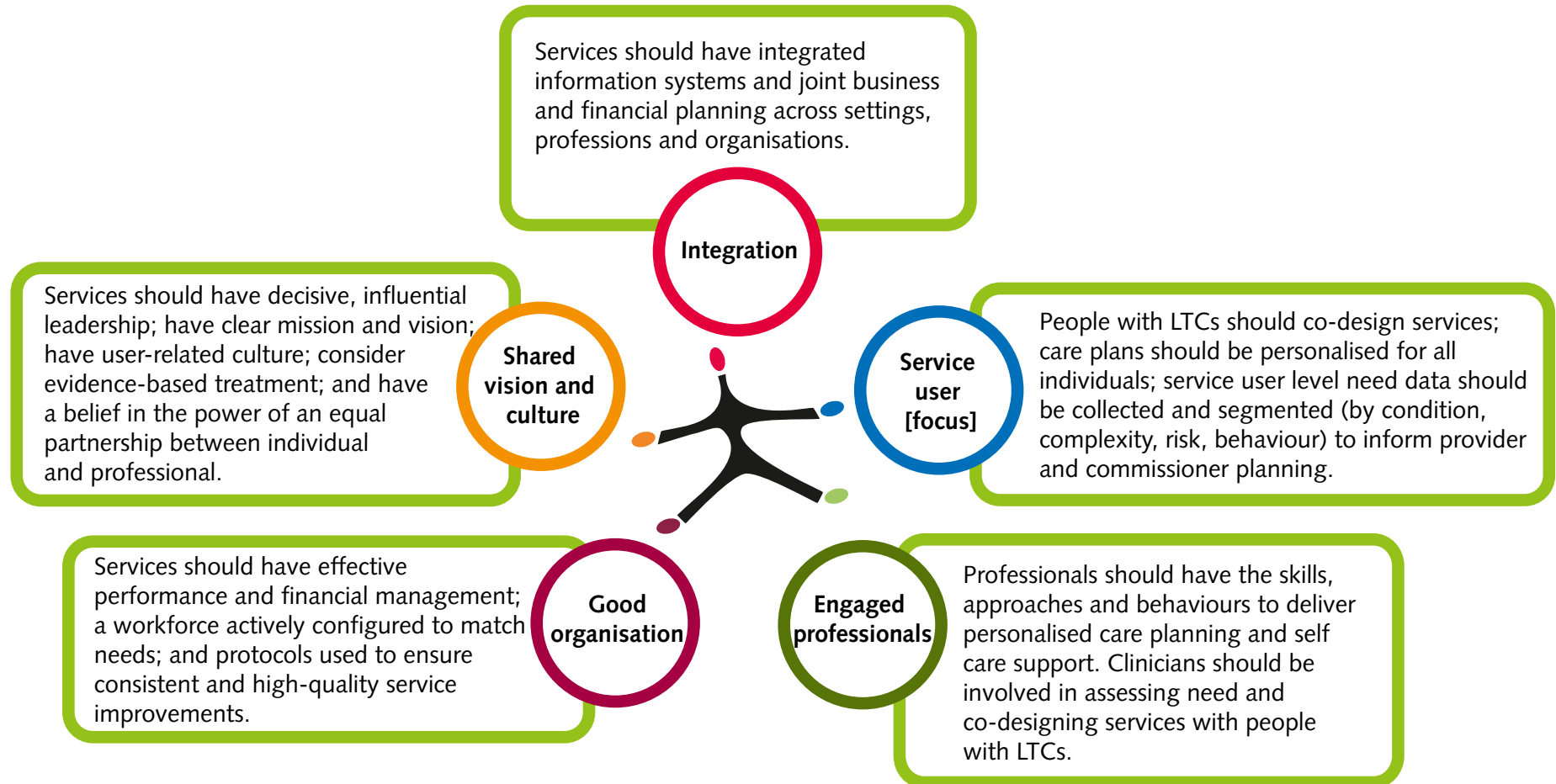
Setting a high bar for outcomes and experiences, therefore, sets an equally high bar for commissioning. The following diagrams illustrate the key areas commissioners need to consider when commissioning a good service for people with LTCs, and also highlight the key elements of how a good service should be provided.



*** Characteristics to aim for in order to commission a good service**



*** Qualities that demonstrate a good service**



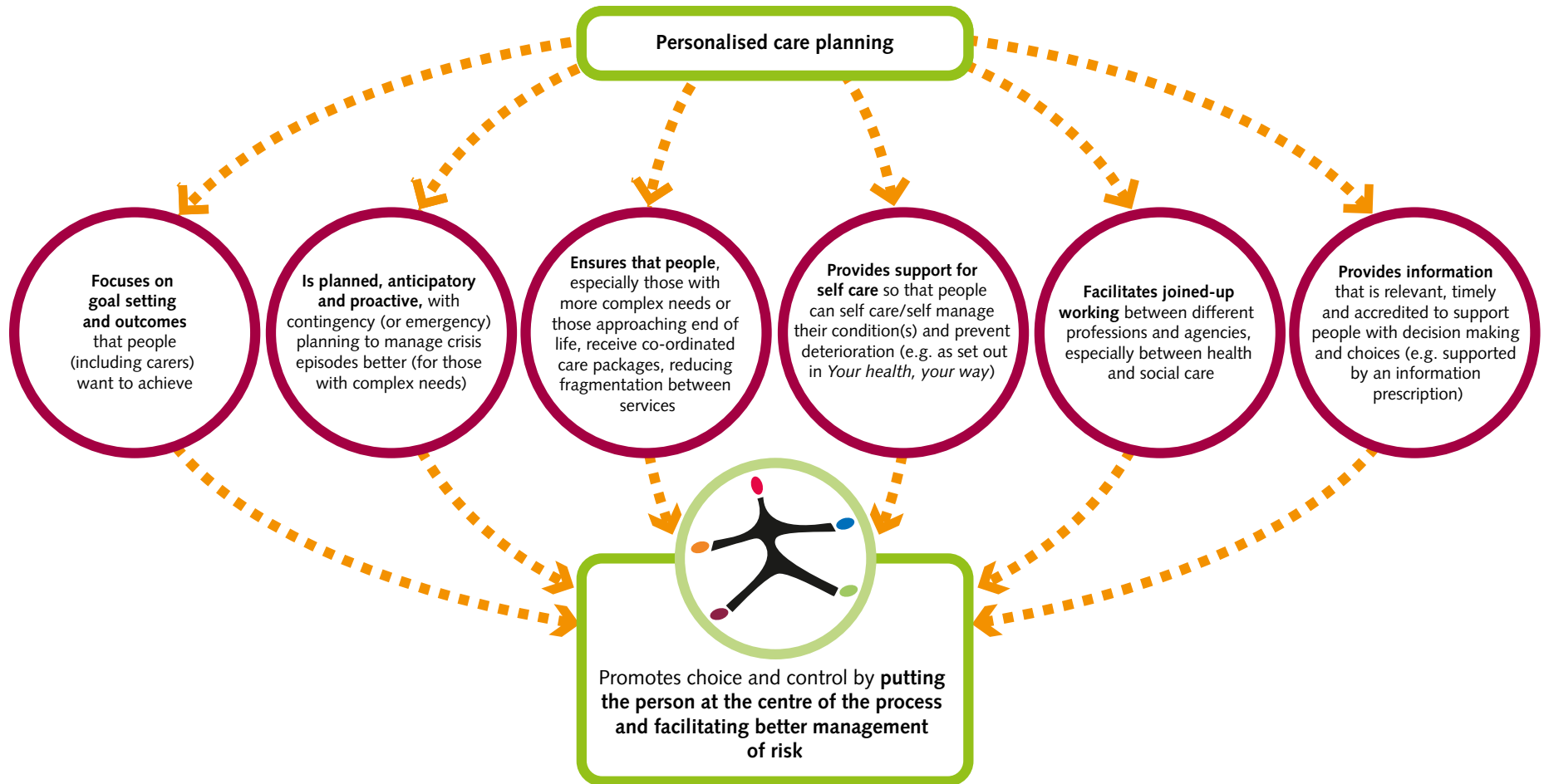
Achieving these outcomes and experiences require services which are proactive, preventive and personalised, which support self care and which moderate the level of case management to the need and risk of the individual.

Delivering such services requires a range of different service providers offering innovative solutions and interventions. Providers need to understand the drive for personalisation and choice and should offer personalised care planning (and joint assessment of need for those with more complex health and social care needs) as a routine part of the care pathway. Providers need to integrate across organisations, professions and settings of care; to involve people with LTCs; to engage their professionals; to have a person-centred culture; and to reinforce all of this with robust management systems and protocols.

Commissioning for these outcomes, experiences and services is a very complex task. The Top Tips in Annex A set out some practical suggestions that commissioners can follow to tackle the challenges it raises. They have been developed using real examples of what commissioners have done and are offered as suggestions for improving local services.



* Underpinning good services



Section 3: Commissioning a world class long term conditions service

This section illustrates the appropriate action at each stage of the commissioning cycle to secure a world class service for people living with long term conditions (LTCs). It highlights a suggested approach in terms of the actions commissioners should consider when implementing personalised care planning and self care support strategies. The Top Tips in Annex A aim to help commissioners identify what will help them become world class and secure a service that will fit with the needs of people living with one or more LTCs.

A world class service for people with LTCs will ensure that, through care planning, there can be a real dialogue and shared decision making between professionals and people with LTCs about the full range of choices available to suit the person's needs and lifestyle. It will focus on wider, holistic needs to support health and well-being, not just a medical model that focuses only on treating illness.

Commissioning is the process by which PCTs and other public sector commissioners secure best value and deliver improvements in health and care services, to meet the needs of the populations they serve. World class commissioning is a national programme that aims to develop world class commissioners of NHS-funded services, leading to improved health outcomes and reduction in health inequalities, adding life to years and years to life. World class commissioners constantly search for ways to refine and improve what they do, engaging with patients, public, other commissioners, clinicians and providers to work out how best to deliver the services that meet current health needs as well as the challenges of the future.

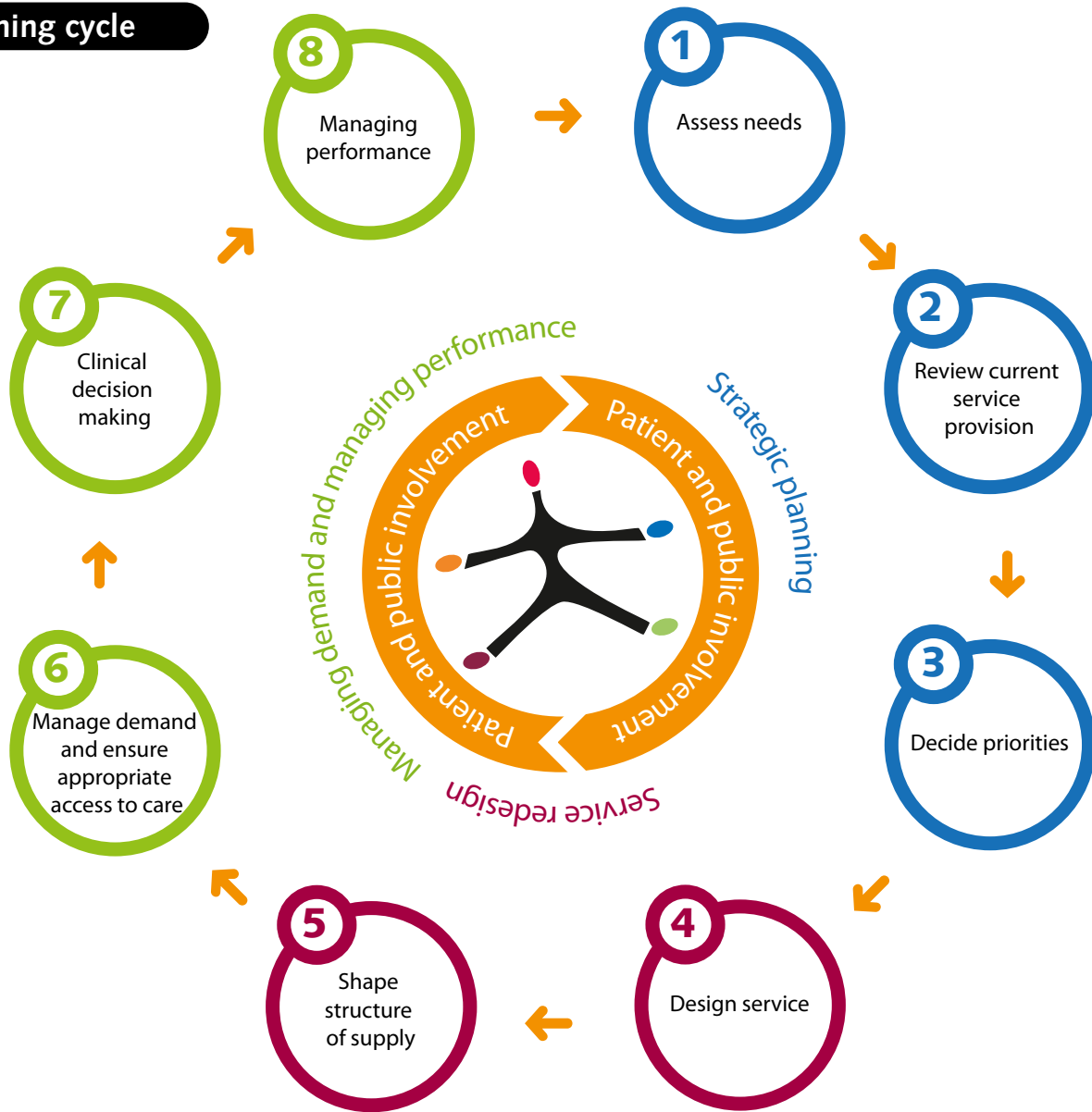
The NHS Vision is, with social care and third sector partners, to deliver a health and care system that is fair, personalised, effective and safe. World class commissioning will be one of the most important vehicles for delivering this vision. It will have a direct impact on population health and will significantly reduce inequalities between the areas with the worst health and population as a whole.

Reference: *World Class Commissioning: Vision* (Department of Health, December 2007)

The commissioning cycle illustrates the process commissioners will work through to secure services for their population. It provides a clear understanding of the steps commissioners take during any commissioning transaction. Yet it also clearly demonstrates that commissioning is essentially a transformational approach, which requires strategic decisions on needs, service design and shaping the structure of supply. It also outlines the need for transactional management through contracting and procurement, all of which is linked to patient needs and outcomes.



*** Commissioning cycle**



Commissioning personalised care planning and self care support

The following points suggest the appropriate actions at each stage of the commissioning cycle to support implementation of personalised care planning and self care support. This will help secure a world class service for people living with LTCs.

Commissioning a service based upon the principles of personalisation and supporting self care will help drive improvements in service quality for people with LTCs. This in turn will support the delivery of the productivity improvements needed to really drive forward the changes that need to be achieved in the coming years. Improving the quality and productivity of services for people with LTCs will also mean taking appropriate action to de-commission ineffective treatments and replace them with evidence based care which minimises unplanned and often unnecessary hospital care.

1. Assess needs of long term conditions population

Aim: Jointly with social care partners, understand your local LTC population in terms of (i) disease prevalence, demographics, deprivation levels, socio-economic make-up and mortality rates and (ii) services that people with LTCs want based on their feedback and views.

Recommended actions:

- Work with local authority partners to undertake a Joint Strategic Needs Assessment (JSNA), making use of Local Strategic Partnerships, Joint Commissioning Boards and Local Area Agreements.
- Use systematic and proven risk stratification tools and/or techniques such as the Combined Predictive Model to stratify risk for the whole LTC population.
- Work with providers to develop a feedback loop to gather and aggregate information about choices people are making through personalised care planning. This should also include monitoring services requested that are currently not available.
- Develop mechanisms for routine and systematic feedback from LTC patient group representatives such as the National Association for Patient Participation (NAPP),

Local Involvement Networks (LINks) and Patient Advice and Liaison Service (PALS) about services people with LTCs want.

- Find out if there are services that people don't want or interventions that are ineffective, for example through NICE guidelines, PROMS data and feedback from patient representatives groups and the third sector.
- Develop LTC-specific patient surveys for further feedback.
- Gather information from choices made through personal health budgets.
- Use social marketing techniques to gather insights into drivers of behaviour for groups of people with LTCs, to enable more sophisticated targeting of interventions to drive behaviour change.
- In areas offering personal health budgets, commissioners need to consider the services people are buying, which may be non-traditional services.
- To obtain a better understanding of the different needs of local communities, work with local partners to produce an EqIA to inform the development of LTCs strategies.

Applying these actions when implementing personalised care planning will help demonstrate meeting World Class Commissioning Competency 3 – Engage with public and patients, and 5 – Manage knowledge and assess needs. The essence of care planning is about truly engaging with people, encouraging their input and views about their care and finding out what can really make a difference to support them to achieve optimal health and well-being. This means that 'micro level' engagement is taking place across the whole population of people with LTCs who take up the offer of care planning. This could be considered one of the most effective ways to engage with people whose voice would otherwise not be heard.

Applying these actions when implementing a self care support strategy will help demonstrate meeting World Class Commissioning Competency 3 – Engage with public and patients, and 5 – Manage knowledge and assess needs. Local *Your health, your way* information is one way of establishing local needs and requirements through data collection when implementing the Care Planning process.



2. Review current service provision

Aim: Find out the range of services already available to meet the identified needs of those with LTCs and consider how these services match the identified needs.

Recommended actions:

- Use outcomes and activity data to benchmark against best practice evidence, i.e. use activity data and patient feedback to understand which services are the least popular or the most ineffective.
- Identify gaps in current services.
- Consider the services available to support self care, information and education – is there sufficient choice and capacity?
- Look at whether there are innovative services and interventions or any new services that are proven or have potential to be effective.
- Look at the provider mix – i.e. NHS, private, third sector, local authority, education.
- Consider which services may need to be decommissioned as a result of commissioning of any new services.
- In areas offering personal health budgets, consider what services budget holders buy.

- Work with providers to develop a feedback loop to gather and aggregate information about choices people are making through personalised care planning. This should also include monitoring services requested that are currently not available.

Applying these actions when implementing personalised care planning will help demonstrate meeting World Class Commissioning Competency 2 – Work with community partners, 5 – Manage knowledge and assess needs, and 8 – Promote improvement and innovation.

Developing fully integrated care planning promotes partnership working among health and social care providers, local government, and the third sector at both strategic and individual levels.

Applying these actions when implementing a self care support strategy will help demonstrate meeting World Class Commissioning Competency 2 – Work with community partners, 5 – Manage knowledge and assess needs, and 8 – Promote improvement and innovation. Implementing *Your health, your way* will provide opportunities to work closely with partners from local government, healthcare providers and third sector organisations.

3. Decide priorities

Aim: Good needs assessment will highlight at least one LTC that will be chosen as a priority. Many commissioners will also make improved health and well-being for the LTC population a priority, and may choose to do this by offering personalised care planning.

Recommended actions:

- Identify priorities, using needs assessment, understanding of the LTC population, demographics and prevalence of conditions, e.g. look at what your equality and diversity impact assessment tells you about your population and their relative need.
- Determine priorities against different financial scenarios, while considering technical and allocative efficiency [technical – is this the best thing to do for LTC?; allocative – priority of doing this versus other priorities such as urgent and emergency care].
- Use data from risk prediction tools to assess where to prioritise and target early interventions.
- Make better use of analytical skills, reports and analysis of the LTC population, and invest in these areas if under-resourced.

- Give priority to early interventions, services to support self care, and innovative and proven new interventions.
- Ensure resources are in the right place to support personalised care planning and support for self care.
- Look at evidence-based interventions or develop a local evidence base if there is nothing available nationally.

Applying these actions when implementing personalised care planning will help demonstrate meeting World Class Commissioning Competency 4 – Collaborate with clinicians, 5 – Manage knowledge and assess needs, and 8 – Promote improvement and innovation. The essence of care planning is about truly engaging with people, encouraging their input and views about their care and finding out what can really make a difference to support them to achieve optimal health and well-being. This means that 'micro level' engagement is taking place across the whole population of people with LTCs who take up the offer of care planning. This could be considered one of the most effective ways to engage with people whose voice would otherwise not be heard.

Applying these actions when implementing a self care support strategy will help demonstrate meeting World Class Commissioning Competency 4 – Collaborate with clinicians, 5 – Manage knowledge and assess needs, and 8 – Promote improvement and innovation.

Working with the local community will help shape the *Your health, your way* information into a product that wholeheartedly meets their needs.

4. Design service

Aim: Services are designed to meet the wider, holistic needs of people with LTCs with an emphasis on services to support people to self care.

Recommended actions:

- Ensure that services are designed with input from LTC patient representatives.
- Ensure that offering personalised care planning and personal health budgets in areas where these are available are part of the care pathway.
- Move away from the traditional linear, inflexible care pathway towards the Year of Care concept of a menu of choices.

- Develop integrated care pathway approaches to service delivery.
- Incorporate services to support self care and structured patient education into local pathways as routine.
- Ensure that access to generic self care services, such as generic skills training, is part of service design.
- Stimulate and support improvement in provider innovation.
- Consider established effective models that drive integrated working, personalisation, quality, innovation and efficiency, such as managed care networks and virtual wards.
- Establish information sharing protocols and consensus, e.g. providers getting consent from individuals to share their information with social care direct care givers.
- Develop information systems to support systematic sharing of information.
- Work with providers, in particular GP practices, to gather rich information from care plans; ideally this should record unmet needs.
- Promote the benefits of information sharing to people with LTCs and the public, encouraging early determination of who should have access to information about them.
- Include patient representatives in service design.

Applying these actions when implementing personalised care planning will help demonstrate meeting World Class Commissioning Competency 2 – Work with community partners, 3 – Engage with public and patients, 4 – Collaborate with clinicians, 6 – Prioritise investment, 7 – Stimulate the market, and 8 – Promote improvement and innovation. Allowing the patient voice to feed into decision making through localised implementation of personalised care planning will result in better quality service driven by the needs of the local population.

Applying these actions when implementing a self care support strategy will help demonstrate meeting World Class Commissioning Competency 2 – Work with community partners, 3 – Engage with public and patients, 4 – Collaborate with clinicians, 6 – Prioritise investment, 7 – Stimulate the market, and 8 – Promote improvement and innovation. Localised *Your health, your way* information will result in the delivery of quality local services driven by the needs of the local population.

5. Shape structure of supply

Aim: To ensure that there are providers who are able to offer the broad range of services to meet holistic needs of people with LTCs, stimulating innovation.

Recommended actions:

- Proactively seek out innovation and create a culture within the organisation that promotes innovation.
- Based on needs and priorities identified, actively seek providers of services that offer potentially different services. This may mean innovative, new approaches such as virtual wards, exercise on prescription, different, holistic approaches to support weight management and access to psychological therapies such as Cognitive Behavioural Therapy (CBT). The Department of Health is issuing guidance in the form of a revised PCT support guide, which offers further guidance on how to procure healthcare services, including ways to seek innovation.
- Allocate time for the PCT Board to specifically consider new and innovative offers of services from providers new to the market.
- Stimulate the market for providers of self care services.
- Look at workforce development plans. Assess the skill mix of the workforce and whether it meets the



needs of more personalised care, e.g. are there enough allied health professionals (AHPs), specialist nurses or community matrons? Can more staff such as health trainers be commissioned?

- Find out what is offered in other PCTs and gather evidence of effectiveness. Share learning on effective interventions and good providers of services.
- Improve local shared provider agreements.
- Consider how to use contracts with service providers as a mechanism for delivering personalised services for people with LTCs.

Applying these actions when implementing personalised care planning will help demonstrate meeting World Class Commissioning Competency 1 – Locally lead the NHS, 6 – Prioritise investment, 7 – Stimulate the market, 8 – Promote improvement and innovation, 9 – Secure procurement skills, and 10 – Manage the local health system. Care planning tailored to individual need is a way of establishing local needs and requirements through aggregated data collection from individual care plans. It also has the ability to provide granular information that can identify health inequalities and unmet need.

Applying these actions when implementing a self care support strategy will help demonstrate meeting World Class Commissioning Competency 1 – Locally lead the NHS, 6 – Prioritise investment, 7 – Stimulate the market, 8 – Promote improvement and innovation, 9 – Secure procurement skills, and 10 – Manage the local health system. Local *Your health, your way* information is one way of establishing local needs and requirements through data collection when implementing the Care Planning process.

6. Manage demand and ensure appropriate access to care

Aim: With more personalised services, people with LTCs should expect wider choice but within a framework of clinical cost effectiveness. This will require strategies for demand management.

Recommended actions:

- Ensure people with LTCs and the public are aware of the choices available.
- Set up a PCT directory of services, particularly self care and education programmes, for people with LTCs. This should be indicative if people with LTCs (through

personal health budgets) want something that is not on 'the list'. It should be considered on a case-by-case basis.

- Develop communications lines with people with LTCs and the public about what they can and cannot expect from personalisation and choice.
- Consider working with other PCT commissioners (or practice-based commissioners to pool resources to meet identified needs. Where there is a low demand and no service available, this could be based on the model for specialist commissioning of services.
- Make use of funding flexibilities set out in *Practice Based Commissioning – budget setting refinements and clarification of health funding, flexibilities, incentive schemes and governance* to encourage practice-based commissioners to set aside part of their budget to use flexibly in-year to meet variation in local demand, which should be stimulated by personalised care planning and *Your health, your way*.
- Ensures people with LTCs can easily navigate services available to them (e.g. that they are aware of the choices of provider, setting and treatment, and know what to do if/when their condition worsens or if they are dissatisfied).

Applying these actions when implementing personalised care planning will help demonstrate meeting World Class Commissioning Competency 1 – Locally lead the NHS, 3 – Engage with public and patients, 6 – Prioritise investment, 8 – Promote improvement and innovation, and 11 – Make sound financial investments. Personalised care planning can be a vehicle to understanding where local need is most needed and determine where investment priorities lie. It can also reveal services that are less popular, which can support decommissioning.

Applying these actions when implementing a self care support strategy will help demonstrate meeting World Class Commissioning Competency 1 – Locally lead the NHS, 3 – Engage with public and patients, 6 – Prioritise investment, 8 – Promote improvement and innovation, and 11 – Make sound financial investments. Local *Your health, your way* information can be a vehicle to understanding where local need is most needed and determine where investment priorities lie.

7. Clinical decision making

Aim: To ensure that clinical expertise is fully utilised by fully involving clinicians in decisions about LTC services.

Recommended actions:

- Take a leadership role in assessing need and designing and performance managing services.
- Support clinicians to co-create services with people with LTCs and support self care.
- Create and support an environment of user-centred collaboration and leadership across professions.
- Disseminate user outcome and experience information to inform professional decision making.
- Ensure clinicians have baselined and benchmarked data and information about LTC management.

Applying these tips when implementing personalised care planning will help demonstrate meeting World Class Commissioning Competency 4 – Collaborate with clinicians, and 5 – Manage knowledge and assess needs.

Working with a wide range of local clinicians such as GPs, nurses, AHPs and specialist consultants to implement care planning and feeding information from care planning into commissioning decisions will ensure that services commissioned as part of the process are based on local knowledge and need.

Applying these tips when implementing self care support strategy will help demonstrate meeting World Class Commissioning Competency 4 – Collaborate with clinicians, and 5 – Manage knowledge and assess needs.

Working with a wide range of local clinicians in the process of implementing local *Your health, your way* information will ensure that the services commissioned as part of the process are based on local knowledge and need.

8. Managing performance (quality performance outcomes)

Aim: To ensure that the right metrics are put in place in contracts with providers. Measures should relate specifically to the national and local vision for LTCs.

Recommended actions:

- Consider the national and local objectives when setting measures.
- Specify measures of outcome and experience – use short term proxies where true outcome metrics are lacking.
- Invest in cleaning up data and making data such as Hospital Episode Statistics (HES) more timely.

- Invest in analytical, programming and IT support to gather meaningful data and present this in usable formats for commissioners, senior managers and clinicians.

Applying these tips when implementing personalised care planning will help demonstrate meeting World Class Commissioning Competency 10 – Manage the local health system. Personalised care planning, together with *Your health, your way* should stimulate provision of a wider range of services by a plurality of providers to meet holistic needs. This should drive choice, continuous improvement and innovation by stimulating new services together with information to support decommissioning.

Applying these tips when implementing a self care support strategy will help demonstrate meeting World Class Commissioning Competency 10 – Manage the local health system. *Your health, your way* information allows plurality of providers to meet the information, health and care needs locally, which will drive choice, continuous improvement and innovation.

An Outline Service Specification (OSS) for personalised care planning has been co-designed by the Department of Health and Primary Care Contracting. The purpose of the OSS is to assist commissioners to put in place appropriate arrangements to ensure people with long term conditions have informed choice of, and access to, services that best enable them to manage their condition. The OSS aims to help PCTs to develop their local thinking and approach, and to work with providers to change existing ways of working, rather than commission additional services.

Conclusion

Factors such as an ageing population and the lifestyle choices that people make mean that the prevalence of LTCs will continue to rise. It is imperative, therefore, that there is a focus now on improved LTC management. Achieving this should involve more proactive, preventive, planned and personalised services that support people to be independent and in control of their condition and to have increased choice. Personalised care planning and supporting people to develop confidence and competence to self care can go a long way towards achieving these aims.

To support commissioners, this document has illustrated what 'good' looks like from the perspective of people with LTCs, their carers and families, professionals and commissioners. It sets out the key areas for commissioners to consider when commissioning LTC services locally. It has also highlighted a suggested approach in terms of actions to consider when implementing personalised care planning and self care support strategies. Considering these actions will enable commissioners to commission world class services where people with LTCs, their carers and families are given access to convenient, efficient services that meet individual needs and preferences.

The Top Tips in Annex A have been developed through interviews with people with LTCs, professionals and managers from health and social care provider organisations, local authorities, PCTs and practice-based commissioning groups. They aim to help commissioners identify what will help them become world class and secure a service that will fit with the needs of people living with one or more LTCs, and provide practical suggestions to help navigate through each one. The Top Tips outline and draw conclusions from good practice seen in some selected areas across the country.

The Top Tips are specific issues that commissioners have identified when trying to commission services for people with LTCs. Practical suggestions are provided to help navigate through each of the Top Tips. These have been developed to support commissioners when they are developing LTCs commissioning strategies.



Annex A: Top Tips in detail, including examples of overcoming barriers to delivery



*** Top Tips**

- 1** Proactively create a user-centred, can-do culture

 - Create a simple, user-centred vision for the whole system.
 - Promote it using executive and professional champions/role models, user stories, user-led training, etc.
- 2** One vision, strategy, priorities/targets shared by all commissioners

 - Invest in a close working relationship with other commissioners focused on a single vision.
 - Set joint strategy and priorities to meet the needs of all commissioners.
 - Set up clear joint working arrangements, whether or not commissioning teams are jointly appointed.
- 3** Stimulate and support provider innovation to improve care

 - Encourage integration into teams of services not specific to any disease, e.g. community nursing, physiotherapy, occupational therapy, social care.
 - Support frontline co-working of integrated teams, e.g. team development, professional champions/role models, making populations coterminous.
 - Expose providers to ideas from elsewhere.
 - Fund pilots or use primary care trust (PCT) capacity and capabilities to support them.
 - Move away from care pathway to Year of Care 'care packages'.
 - Seek to use individual budgets.
- 4** Assess risk using stratification techniques that will utilise hospital and primary care data, such as the Combined Model

 - Specify use of the Combined Predictive Model plus professional judgement or, failing that, a simpler method, e.g. Whiteboard System.
 - Make simple assessments by telephone.
- 5** Use existing ways to support individuals with LTCs and carers to self care

 - Support motivational interviewing and staff training.
 - Commission telephone health coaching for people with LTCs.
 - Commission disease or segment-specific courses, booklets/diaries and local information fairs.
 - Promote user support courses, engage GPs to refer and use sales and marketing techniques.
 - Use expert individuals and carers.
 - Consider investing in staff such as health trainers.
- 6** Develop the key outcomes and experience measures, which are relevant and meaningful

 - Provide a single specification and contract for jointly-commissioned services.
 - Specify integrated care and only a few of the most pertinent metrics.
 - Use shorter-term proxies where true outcome metrics are lacking.
- 7** Clear and professional responsibility for the well-being of specific individuals

 - Specify one key worker for each individual to co-ordinate and integrate across services and professionals.
 - Ensure those with the most complex needs have a key worker.
- 8** Identify quick wins and small steps forward in IT (instead of trying to reach a big vision all in one go)

 - Encourage remote read-only access.
 - Encourage transfer of paper records to one of the existing IT systems.
 - Support development/purchase of new IT for a workable subset of providers.
- 9** Establish information sharing protocols and consensus

 - Agree a local information sharing protocol.
 - Ask providers to get user consent to share information with the other local professionals who support them.
 - Encourage use of pseudo-anonymised reports to share.
 - Involve and engage professionals; make information sharing optional for GPs initially.
 - Promote information sharing protocols between health and social care professionals.
- 10** Engage and upskill primary and community care providers

 - Bring GPs with you in all developments.
 - Create or specify roles responsible for improving a defined skill set in a defined provider set, e.g. practice staff's ability to treat diabetes.

Using the Top Tips examples to overcome barriers to delivery

* 1 Proactively create a user-centred, can-do culture

Aspect of good commissioning: Ensure user-centred care

Roadblock to achieving this aspect of 'good' commissioning

- A lack of a user-centred culture.

How commissioners have overcome that roadblock

- Establish a clear, simple, 'sticky' **vision** to focus everyone on the service user
- Recruit executive and professional **champions**
- Clearly **communicate expectations** of workforce.

Examples

Torbay

- Commissioner and Chief Executive began talking about a fictional 85-year-old requiring support from different health and social care professionals, '**Mrs Smith**'. She was adopted by the full PCT Board, local authority Chief Executive, and key professionals and politicians – and, as a result, by the entire staff body.

Devon

- **Real-life people with LTCs and carer stories** from around the patch, highlighting the outcome for the user, carer and staff, are communicated via www.mylifemychoiceindevon.org.uk, in newsletters, team building, presentations
- 'Learning to Involve' **training** for health and social care staff is **designed and delivered by service users and carers** (www.exetercvs.org.uk/projects/learning/learning-to-involve.php).

Central Bedfordshire

- Using **imaginary people with LTCs** (e.g. an old man and his granddaughter, with description of their situation) to run 'what would our services do now' and 'what should our services do' **scenarios** focused on user outcomes and experience.

Using the Top Tips examples to overcome barriers to delivery



One vision, strategy and priorities shared by all commissioners

Aspect of good commissioning: effective joint working with other commissioners on LTCs

Roadblock to achieving this aspect of 'good' commissioning

- Co-working **not always supported by senior leadership** in the area
- Commissioner leaders see co-working as **financial burden**, not as a way to overcome financial challenges
- **Duplicated roles** across health and social care – difficult to get these working well together.

How commissioners have overcome that roadblock

- Establish a co-working mindset:
 - Ensure **senior commissioner leaders buy into and explicitly support joint working**
 - Unite all partners around a **shared vision and strategy**
 - Find **initiatives which 'tick every organisation's boxes'**, i.e. targets and strategic priorities, and make benefits to each explicit in business cases
 - Invest in building close, **trust-based relationships**.

Examples

Devon

- PCT and local authority have developed a single joint high-level strategy for community-based health and social care called The Way Ahead (www.devonpct.nhs.uk/)
- Business cases **make explicit the benefit to both** local authority and PCTs
- A **single, joint commissioning team** appointed by local authority and PCT for Mental Health, Learning Disabilities, Older People, Physical Disabilities and support of carers is jointly accountable to local authority Director of Adult Social Services and PCT Director of Strategic Commissioning
- Rapid response initiative pilot was governed by the Urgent Care Board (includes jointly-appointed commissioning, health and social care providers, PBC and is jointly chaired by PCT Director of Commissioning and local authority Director of Adult Social Care)
- Got **sign-off for new models of service delivery** (complex care teams) **at the highest level** (County Council Executive Committee, PCT Board) before rolling out.

Tower Hamlets

- PCT and local authority wrote a **joint primary and community care long term vision**. There is a working group on LTCs which includes commissioners from both the local authority and PCT. This reports into an integrated care board with executive level representatives from the PCT, local authority and local acute trust.

Using the Top Tips examples to overcome barriers to delivery

* 2 One vision, strategy and priorities shared by all commissioners

Aspect of good commissioning: effective joint working with other commissioners on LTCs

Roadblock to achieving this aspect of 'good' commissioning

- Governance structures for joint responsibilities **unclear, insufficient or absent**
- Lack of **shared vision**
- Different **strategic priorities**.

How commissioners have overcome that roadblock

- Support with systems and structures:
 - Establish **clear joint working arrangements** including detailed planning across commissioners with oversight by executives and boards
 - Create **one team** with joint responsibility for commissioning LTC services across health and social care – whether through joint appointments or co-location
 - Pooled budgets can help but are not necessarily the answer.

Examples

Derbyshire

- PCT and local authority conduct **joint strategic planning**, demonstrated in the local area agreement, joint commissioning strategies for individual service areas (e.g. older people), and an agreement between the PCT Director of Commissioning and local authority Director of Adult Services on the priorities for the year
- **Joint LTC Commissioning Board** as a sub-committee of both local authority and PCT Boards
- Appointing a **joint post** for the support of carers.

Torbay

- Progression of **individual budgets** for healthcare allows closer joint working of PCT with local authority
- Made a clear **economic case for joint working based on objective returns on investment for both organisations**.

Leeds

- **Leaders** across health and social care **signed off** an integrated care approach
- Leodis practice-based commissioning (PBC) group is **investing time to build relationships** with social services frontline staff, managers, executives and politicians
- **Integrated Care Board** reports to both local authority and PCT Boards.

Using the Top Tips examples to overcome barriers to delivery

* 3 Stimulate and support provider innovation to improve care

Aspect of good commissioning: Ensure the best possible services are available

Roadblock to achieving this aspect of 'good' commissioning

- Care pathways are traditionally designed around one-off episodes and specific diseases.

How commissioners have overcome that roadblock

- Leave **disease-specific services in place** and encourage **integration of non-disease-specific services** (district nursing, social services, occupational therapy, physiotherapy and potentially also mental health and pharmacy) in integrated, multidisciplinary teams centred on a defined population (ideally coterminous with GP practices).

Examples

Torbay's integrated health and social care Zone Teams:

- **One per GP practice** and responsible for that local population
- Including specialists in most-common LTCs, nurses, social workers, occupational therapists, physiotherapists and a lay co-ordinator who is the single point of contact
- **Pooled budgets** for use by that team
- **Single assessment process**
- **One phone number** for GP and/or service user to call
- **Co-ordinator** either deals with the problem (e.g. equipment, domiciliary care, meals on wheels) or arranges care from the appropriate professional within the team
- Team can **input remotely via the internet into the GP practice records**.

Devon's Complex Care Teams:

- One or two teams in each of 16 'clusters', each with designated GP practices
- Including social workers, occupational therapists, physiotherapists, community health workers, community matron and older people's mental health workers plus administrative staff
- In some cases includes a domiciliary pharmacist
- **Single assessment process** to identify individuals with complex needs and one or more LTCs
- Designed to meet the needs of older people.

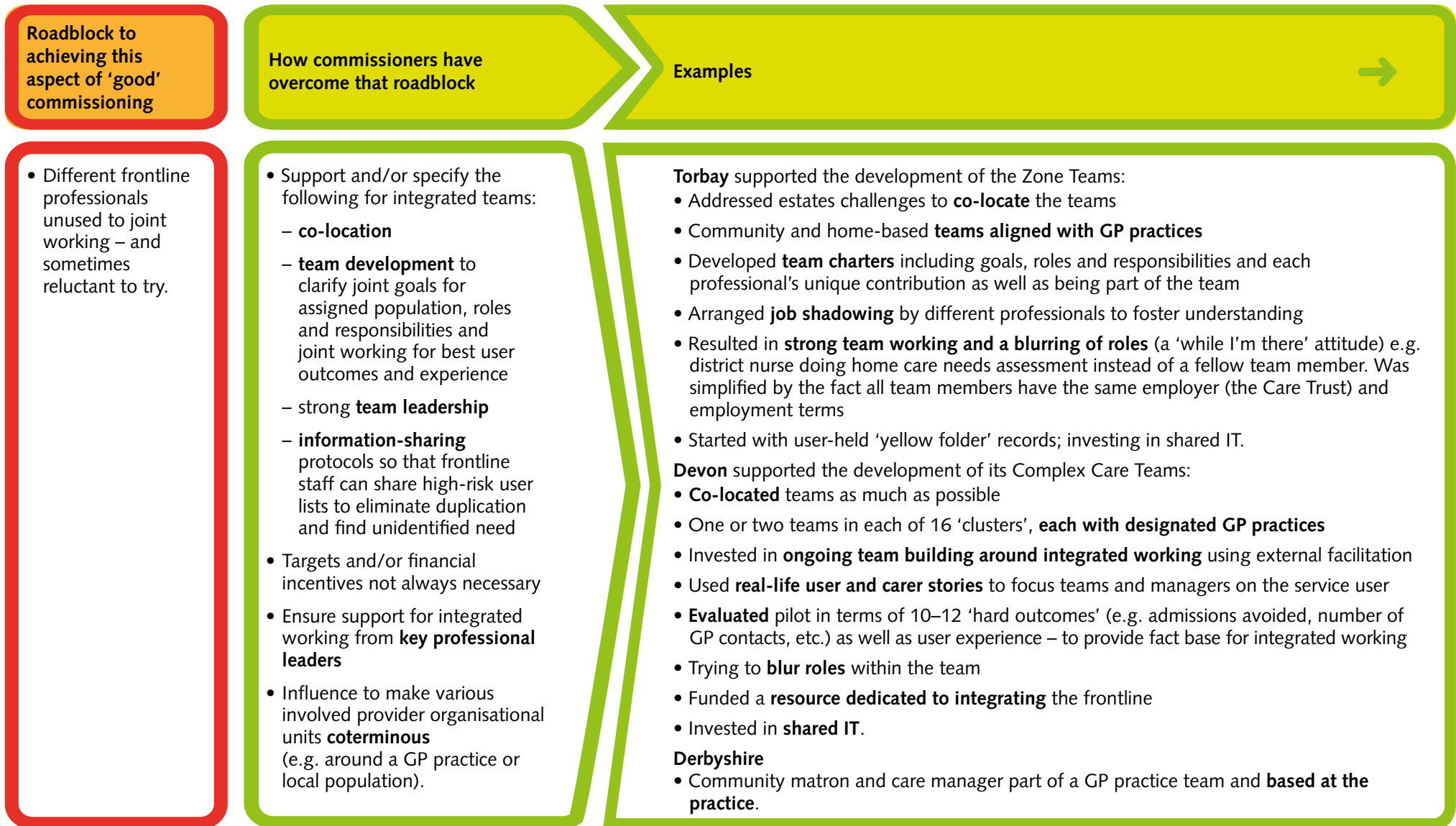
Derbyshire's 'Shires Joined Care':

- Community matron and care manager **part of a GP practice team**
- **Single assessment:** either community matron or care manager (or a delegate) assesses need of a high-risk individual for both health and social care.

Using the Top Tips examples to overcome barriers to delivery

* 3 Stimulate and support provider innovation to improve care

Aspect of good commissioning: Ensure the best possible services are available



Using the Top Tips examples to overcome barriers to delivery

* 3 Stimulate and support provider innovation to improve care

Aspect of good commissioning: Ensure the best possible services are available

Roadblock to achieving this aspect of 'good' commissioning

- Lack of home-grown innovation among providers.

How commissioners have overcome that roadblock

- Facilitate providers being **influenced and inspired by ideas from other areas**
- **Co-create** ideas together with providers, lead professionals, etc.
- **Pilot** innovations in parts of patch to prove concept, evaluate success and decide whether to roll-out, refine or drop
- Use an eager PBC group as a test bed for new ideas.

Examples

Devon

- Virtual Ward (as piloted in Croydon) and use of the Combined Predictive Model started by GP after attending a King's Fund presentation about it
- Piloted rapid response team in one area to test effectiveness and efficiency.

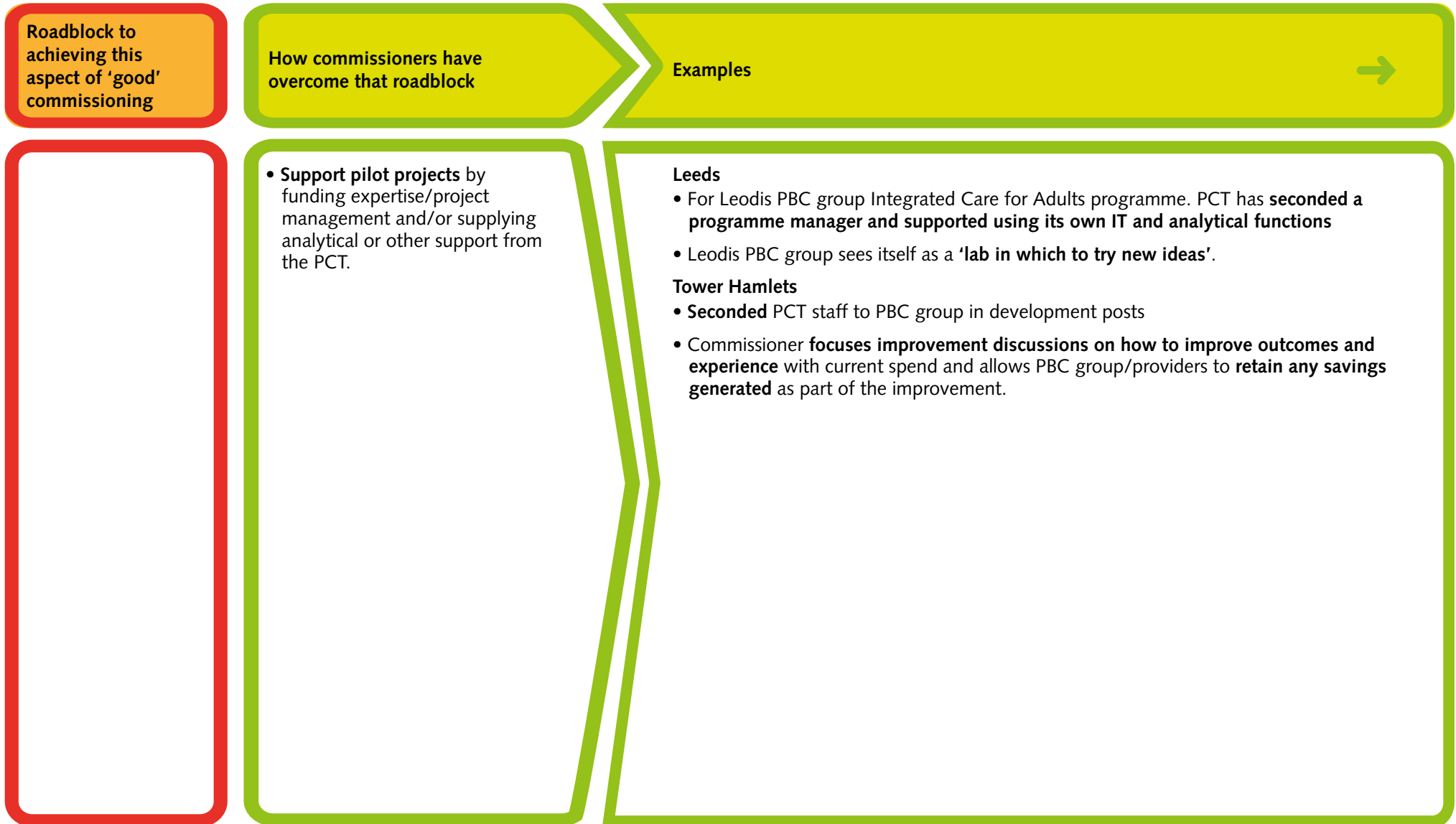
Derbyshire

- A PBC group set up an effective angina management programme after being funded by PBC to attend a **presentation by the Health Improvement Foundation**, resulting in anecdotal significant improvement in well-being of participants
- **Castlefields joint care model** adapted and piloted in Shires
- Commissioner **brought cardiac professionals to see successful rehab models** in other areas
- Commissioner **co-developed several new service ideas** with the proposing professional, e.g. Heart Failure Hospital at Home
- PBC group **provided project manager** for 'Shires Joined Care' team pilot
- Commissioner **hosted meetings** to discuss potential improvements, including all relevant professionals, resulting in such changes as palpitations direct access from GPs to event recorders.

Using the Top Tips examples to overcome barriers to delivery

* 3 Stimulate and support provider innovation to improve care

Aspect of good commissioning: Ensure the best possible services are available



Using the Top Tips examples to overcome barriers to delivery

* 3 Stimulate and support provider innovation to improve care

Aspect of good commissioning: Ensure the best possible services are available

Roadblock to achieving this aspect of 'good' commissioning	How commissioners have overcome that roadblock	Examples
<ul style="list-style-type: none">• Overly-prescriptive service specifications can stifle innovation• Care pathways address conditions, not people• No individual budgets for healthcare.	<ul style="list-style-type: none">• Specify few outcome and experience measures; support providers to design the service to deliver them• Design and commission care packages – holistic – not just components of it• Find opportunities to individualise commissioning decisions.	<ul style="list-style-type: none">• [See Top Tip 6]• Diabetes Year of Care (www.diabetes.nhs.uk/our_work_areas/year_of_care). <p>Torbay</p> <ul style="list-style-type: none">• Participating in <i>Staying in Control</i> and Department of Health Individual Budgets pilot. Using 'service user trusts' to allow people with LTCs/carers to manage their own care, resulting in several individuals being able to stay at home who otherwise would need to be in hospital• Care Trust funding three personalisation practitioners• Excellence in Care training made mandatory for Care Trust workforce to promote the required cultural change.

Using the Top Tips examples to overcome barriers to delivery

* 4 Assess risk using stratification techniques that will utilise hospital and primary care data, such as the Combined Model

Aspect of good commissioning: Ensure service users' holistic needs are identified and addressed

Roadblock to achieving this aspect of 'good' commissioning

- Process or algorithms to segment users by risk level not in place
- Or existing algorithms use only retrospective data

- Less complex assessments are completed face to face, which is more resource-intensive.

How commissioners have overcome that roadblock

- Adopt available algorithms to segment users by risk of admission, making use of primary care data

- Complete simple assessments and referrals by telephone.

Examples

Devon

- Using King's Fund **Combined Predictive Model** algorithm (www.networks.nhs.uk/177) to determine risk of admission (traffic light rating) – and apply professional judgement to upgrade or downgrade.

Tower Hamlets

- **Professional algorithm** including consideration of eye or kidney problems and restricted access used for users with diabetes to determine suitability for community care.

Derbyshire

- **Emergency Admission Risk Likelihood Index (EARLI) tool** (www.improvementfoundation.org) combined with the Combined Predictive Model
- Heart Failure Hospital at Home Service: People arriving in hospital Professional Decision Unit with heart failure are jointly **assessed using a professional algorithm by a heart failure nurse and consultants for suitability for treatment in the community** rather than admission.

Devon

- 'My Devon' is a Devon-wide **phone service** for local authority services, including Care Direct for older people, vulnerable adults and their carers
- 70% of calls to Care Direct require information and signposting and are **dealt with in call**; 30% are referred to Care Direct Plus
- 70% of Care Direct Plus callers are **assessed on the phone** and information, advice and service are provided then and there or arranged; the remaining **30% are referred to complex care teams** for assessment.

Using the Top Tips examples to overcome barriers to delivery

* 5 Use existing ways to support individuals with LTCs and carers to self care

Aspect of good commissioning: Maximise self care

Roadblock to achieving this aspect of 'good' commissioning

- Low take-up of education courses.

How commissioners have overcome that roadblock

- Engage GPs to increase referrals
- Understand the needs and preferences of the service user population and design a 'menu of services' that cater to them.

Examples

Tower Hamlets

- A small **Local Enhanced Service payment to GPs per attending patient**. Diabetes project manager got local medical council support and **visited every practice** to discuss self care course available. This resulted in a large increase in number of newly-diagnosed users referred, with some GPs calling during a consultation to facilitate the patient booking on to a course.

Derbyshire

- Commissioner shared comparative data on GP referral to user education courses, resulting in significantly increased referrals.

Tower Hamlets

- **Researched needs and preferences of certain segments** through research publications and talking to professionals, community groups and individuals with LTCs
- 53% of people with diabetes in Tower Hamlets are Bengali and 8% Somali, and **courses were tailored to reflect differences in language** (Bengali courses, investment in Somali LINks groups), time preferences (Bengali service users often woke and slept later, making morning courses unsuitable), **location** (>40 locations) and **cultural sensitivities** (e.g. women-only courses and courses where men and women were separated by a screen).

Birmingham

- Birmingham OwnHealth programme includes English, Punjabi, Urdu and Gujarati.

Using the Top Tips examples to overcome barriers to delivery

* 5 Use existing ways to support individuals with LTCs and carers to self care

Aspect of good commissioning: Maximise self care

Roadblock to achieving this aspect of 'good' commissioning

- Individuals with an LTC aren't motivated to self care because they are accustomed to paternalistic care.

How commissioners have overcome that roadblock

- Motivational interview and co-creation training and cultural change for practice staff
- Motivational counselling/health coaching service.

Examples

Barnsley and Derbyshire

- **Motivational interview training** for professionals so that they can encourage users to self care.

Humana

- 'Personal Nurse' provides **telephone-based health coaching** (information and care navigation, motivational counselling, ongoing personal relationship) to empower individuals with LTCs and support self care (www.humana.com/members/health/personal_nurse.asp).

Birmingham

- Birmingham OwnHealth programme provides proactive **telephone-based coaching** to residents with LTCs in the most deprived communities. Care Managers take a holistic, not just disease-based, approach to care and are supported by bespoke software that is adapted to incorporate local guidelines and pathways. Covers diabetes, cardiovascular disease, heart failure and chronic obstructive pulmonary disease (COPD) (www.pfizerhealthsolutions.co.uk/Pages/BirminghamOwnHealth.aspx).

East Surrey

- CareCall – telephone-based service run by health coaches who are highly-trained nurses with specific skills to support people to stay healthy and in their own home for as long as possible, reduce the need for hospital stays, and help them achieve their own health goals. After three months, 44% of participants said they had greater ability to talk to their GP after speaking to a health coach and 94% of them said they would recommend the service to a friend (www.mycarecall.net).

Health Foundation

- **Co-creating health programme** uses three enablers (agenda setting for patient/professional interactions, goal setting and goal follow-up)
- **Diabetes Year of Care** (www.diabetes.nhs.uk/our_work_areas/year_of_care).

Using the Top Tips examples to overcome barriers to delivery

* 5 Use existing ways to support individuals with LTCs and carers to self care

Aspect of good commissioning: Maximise self care

Roadblock to achieving this aspect of 'good' commissioning

- Low take-up of education courses.

How commissioners have overcome that roadblock

- Use marketing techniques to increase take-up and attendance rates.

Examples

Tower Hamlets

- Used **marketing team and technology to encourage referral** to diabetes courses to improve DNA rates from <50% to <5%. 7,500 people completed courses over six months
- **Used GP registers** (in line with data protection rules) to write to each patient on behalf of GP practice, with menu of available courses and advising they would receive a call
- Phone call within five working days to arrange a **suitable education course based on patient's lifestyle, location and choice** and also to address any questions or concerns. Confirmation letter sent two days later
- Promotional stands and events at local markets combined with media **advertising campaign to promote self-referral**
- Course tutors texted or called participants in the run-up to each session to **ensure attendance**. All DNAs were followed-up by the course tutor and, if necessary, the programme team. Course attendance was actively tracked and discussed by the team
- At courses, staff encouraged users to attend a follow-on course and made a **booking and supplied a confirmation letter at course**
- Programme has **dedicated project management resource** including direct marketing team of six full time equivalents and three administration staff.

Using the Top Tips examples to overcome barriers to delivery

* 5 Use existing ways to support individuals with LTCs and carers to self care

Aspect of good commissioning: Maximise self care

Roadblock to achieving this aspect of 'good' commissioning

- 'Formal' education programmes not always most effective

- Users have little control over their records

- Carers under-identified.

How commissioners have overcome that roadblock

- Use **expert users**
- Use or adapt disease- or user-segment-specific **courses or booklets**

- **Users can update their records** and allow selected professionals to view them

- Engage GPs to proactively 'case-find' carers.

Examples

Derbyshire

- Cardiac rehab '**buddy**' system of volunteers who have experienced coronary heart disease (CHD) who advise newly-diagnosed users, attending consultations helping them to absorb information, and assisting them in navigating their care
- **COPD booklet**, including symptom-remedy/action descriptions to assist self-diagnosis, self-medication and contact numbers for advice, providers and out-of-hours services.

Barnsley

- **Self-care telephone service** of care navigators for those self caring.

Devon

- 'Getting the most out of life' is a **web- and paper-based information source for older people**, based on the fields of information identified as important for the well-being of older people in the *Sure Start to Later Life* report of the Social Exclusion Unit, e.g. health and healthy living, finance, housing and home. There is an accompanying '**360 degree well-being check**' tool which **frontline staff have found very useful** in assessing older people's holistic information, as well as service, needs (www.devon.gov.uk/de/gtmool)
- Local **information fairs for over-50s and their families** very successful.

Expert Patient Programme

- **Free six-week course** for people with LTCs to help users manage their care and symptoms (www.expertpatients.nhs.uk).

Barnsley

- Doc@home enables service users to upload test results from home through a hand-held device and allows selected professionals to monitor their progress (www.barnsley.nhs.uk/default.aspx.locid-02tnew00v.html).

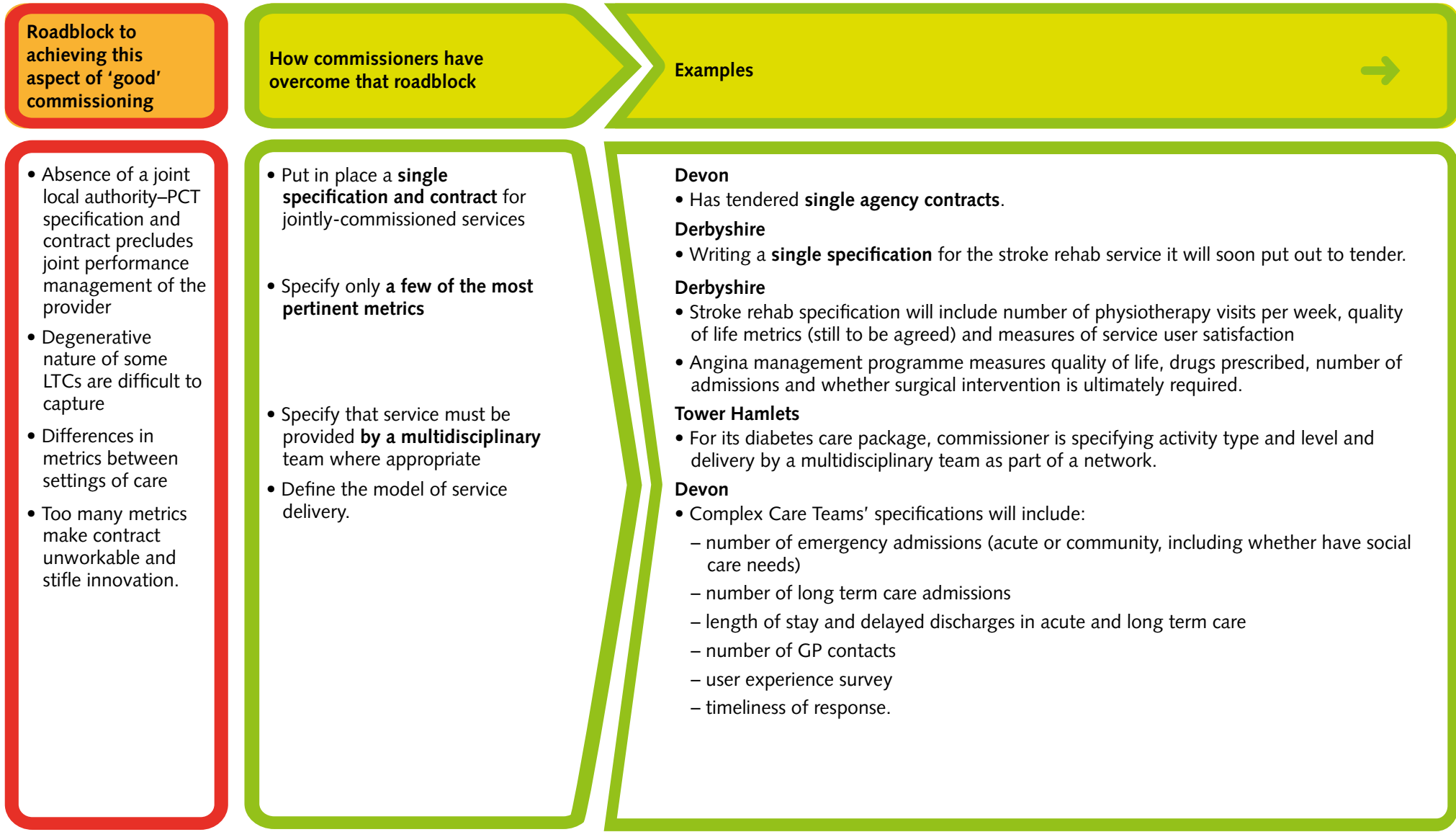
Devon

- Programme to encourage and support identification by GPs of carers has brought significant numbers of carers into the available supports.

Using the Top Tips examples to overcome barriers to delivery

* 6 Develop the key outcomes and experience measures, which are relevant and meaningful

Aspect of good commissioning: Use contracting to ensure the best possible services are available



Using the Top Tips examples to overcome barriers to delivery

* 6 Develop the key outcomes and experience measures, which are relevant and meaningful

Aspect of good commissioning: Use contracting to ensure the best possible services are available

Roadblock to achieving this aspect of 'good' commissioning	How commissioners have overcome that roadblock	Examples
<ul style="list-style-type: none"> • Shortage of true outcome metrics for LTCs – especially those which are measurable within a few years • Difficult to incentivise activities that are important but seen by a given provider as 'non-core'. 	<ul style="list-style-type: none"> • Use shorter-term proxies for longer-term outcomes, e.g. process metrics • Specify integration • Specify quality-of-life enhancing elements to the service • Specify case finding activities. 	<p>– care protocols, e.g. use of case-finding tools, how need will be assessed, source of information and how it should be recorded, skills required in the team, case management method, empowerment of user and carer, admissions avoidance, use of complementary services, existence of key strategies (falls, stroke, etc.).</p> <p>Various</p> <ul style="list-style-type: none"> • Time to assessment • Admissions • Length of stay. <p>Tower Hamlets</p> <ul style="list-style-type: none"> • Local authority retendered for lunch club stating clearly they wanted the provider to do more than just a meal (but without specifying what). This resulted in several innovative services being added including line dancing, ta'i chi, and sitting exercises for those unable to stand • Specified case finding and self care promotion activities from its providers of older people's social services • LinkAge provider should give each service user a card to take to the optometrist to complete and return to them to try to address a significant unidentified need for eye healthcare in the local older population • Various providers to signpost care, check home fire and other safety and seek to identify socially isolated people.

Using the Top Tips examples to overcome barriers to delivery

* 7 Clear and professional responsibility for well-being of specific users

Aspect of good commissioning: Encourage provider innovation to maximise user well-being

Roadblock to achieving this aspect of 'good' commissioning

- Lack of clear professional responsibility for the navigation and integration of care for individuals
- Providers don't proactively manage well-being of their users.

How commissioners have overcome that roadblock

- GP is 'key worker' for all people with LTCs not referred to a **Community Matron** or an integrated care team
- If referred to an **integrated care team**, ensure a 'key worker' is appointed within that team (i.e. one person who co-ordinates and integrates all service provision to a given individual)
- Consider use of **dedicated care navigators**
- Incentivise provider to analyse the population to identify the needs and risk of different groups within it and innovate to proactively **keep users well and out of hospital**.

Examples

Torbay

- Within integrated health and social care Zone Teams, a 'key worker' is assigned to each service user based on their **dominant care need**.

Devon

- Within the Complex Care Teams, there is always an **assigned 'case manager'** for each service user – the most suitable member of the team.

Barnsley

- Telephone care navigators.

Devon

- One GP has an **LTCs nurse and an admissions avoidance nurse based at the practice** to keep their people with LTCs well and avoid hospital admissions, funded by PBC group
- Complex Care Teams **responsible for the well-being and all needs of a defined high-risk segment** of the local population.

Torbay

- Integrated health and social care Zone Teams **responsible for the needs of a defined local population**.

Using the Top Tips examples to overcome barriers to delivery

* 8 Identify quick wins and small steps forward in IT (instead of trying to reach a big vision all in one go)

Aspect of good commissioning: Support integrated service provision

Roadblock to achieving this aspect of 'good' commissioning

- IT doesn't support information sharing – all providers on different systems and getting all on a single IT system is difficult, lengthy and costly.

How commissioners have overcome that roadblock

- Maintain existing IT systems but enable remote access
- Support the purchase of a new IT system for selected sets of providers
- Make 'quick-win' steps to unifying care providers' informatics.

Examples

Torbay

- Giving acute and GP practice staff **read-only access** via the internet to a summary of social care IT system service user records and giving district nurses remote read-and-write access via the internet to GP practice records.

Tower Hamlets

- Setting-up **GP remote access** to retinal screening service user records.

Torbay

- IT system to give GPs remote access via the internet to summaries of social care records.

Tower Hamlets

- Rolling out EMIS Web
 - Roll out first to GPs and community teams
 - Aim to roll out in **acute settings through disease-specific teams** within secondary providers to avoid challenges of 100% roll-out.

Torbay

- **Moving previously paper-based records and selected electronic records** onto one of the **pre-existing systems** (district nurse, occupational therapist and physiotherapist records onto existing social care IT system PARR).

Tower Hamlets

- Using FACE assessment tool as a **single holistic assessment** shared across case management (social services) and community matron (health services) teams.

Using the Top Tips examples to overcome barriers to delivery

* 9 Establish information sharing protocols and consensus

Aspect of good commissioning: Support integrated service provision

Roadblock to achieving this aspect of 'good' commissioning

- Limited information sharing.

How commissioners have overcome that roadblock

- Agree **information sharing protocol** between local authority and PCT and get **consent to share information from people with LTCs** as part of assessments
- In Integrated Care Organisations, frontline provider arm staff have the same employer which eliminates blocks to information sharing between them.

Examples

Torbay

- Agreed **information sharing protocol** before becoming an Integrated Care Organisation
- Being an **integrated organisation** has removed many information sharing barriers
- A well-respected **PEC Chair has facilitated discussions** around information sharing.

Leodis PBC group

- Invested time to **reassure practices and partners** that data would be anonymous.

Devon

- Dedicated **resource and push to drive** information sharing – resulted in information sharing protocol.

Tower Hamlets

- An informatics expert **GP chairs the committee** overseeing the drafting of protocols and procedures for information sharing in primary care.

Using the Top Tips examples to overcome barriers to delivery

* 10 Engage and upskill primary and community care providers

Aspect of good commissioning: Ensure the best possible services are available

Roadblock to achieving this aspect of 'good' commissioning

- Providers don't have the right skills to deliver the best possible services.

How commissioners have overcome that roadblock

- Appoint role(s) with responsibility for improving a defined skillset.

Examples

Tower Hamlets

- **Diabetes consultant and team**

- Role to **upskill** primary care workforce and **reduce acute referrals**
- Available to GP practices for advice by visits, phone or email. Will inform GPs on latest diabetes care, do '**rounds**' of current diabetes caseload and **see service users together with practice staff**
- Consultant **works at acute trust** to maintain skills and network
- Is **supported by Diabetes Centre specialist nurses** who are assigned to eight practices each and proactively engage them. They are performance managed in this regard by the lead nurse and supported by professional psychologist
- This team has reduced acute referrals from 20–30 to 6–7 per week

- **GP networks**

- Piloting '**networks**' of GPs, who share specialties and refer between each other, to care for more complex users in the community.

Derbyshire

- **Specialist diabetes nurses** upskill practices on basic diabetes care.

Annex B: Linked policies and initiatives with supporting information

(Listed in alphabetical order)

Care Programme Approach (CPA)

CPA was introduced in 1990 to provide a framework for effective mental health services for people with severe mental health problems. It places an emphasis on personalised care planning, ensuring that individuals and their carers are involved in decisions about their care. Effective co-ordination of services with a key worker taking the lead and a multidisciplinary approach are also key elements of CPA. More information can be found at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083650

Carers' strategy

The carers' strategy sets out the Government's short term agenda and long term vision for the future care and support of carers. A more integrated and personalised support service for carers will be offered through easily accessible information, targeted training for key professionals to support carers and pilots to examine how the NHS can better support carers. The strategy can be downloaded at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085345

Commissioning Framework for Health and Well-Being

This framework sets out the eight steps that health and social care should take in partnership to commission more effectively. It places an emphasis on personalisation of services, putting people at the centre of commissioning. The framework is aimed at commissioners and providers of services in health, social care and local authorities and is part of the White Paper *Our Health, Our Care, Our Say* implementation. The guidance can be downloaded at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_072604

Common Assessment Framework (CAF) for adults

The White Paper *Our Health, Our Care, Our Say* included a commitment to develop a common assessment framework (CAF) for adults which would:

1. improve outcomes for adults by ensuring a personalised and holistic assessment of need, focused on delivering individual outcomes;
2. support improved joint working between health and social services; and
3. increase efficiency through better information sharing.

The CAF will improve the sharing of information around assessment and care/support planning. It is a generic approach to assessing the health, social care and wider support needs of individual adults and supporting this with appropriate IT solutions and potential focus around Connecting for Health. It is a necessary part of *Putting People First's* vision for every locality having a single community-based support system focused on the health and well-being of the local population. The development of the CAF is expected to support personalisation and help underpin the wider agenda of the NHS Next Stage Review, in particular through supporting delivery of an integrated person-centred approach to assessing people's need for support from health and social care services and the support needs of their carers. More information can be found at: www.cpa.org.uk/sap/caf_more_about.html

Common Core Principles for Self Care

Skills for Health and Skills for Care have worked with key stakeholders, including people who use services and carers, to develop a set of common core principles to support self care. The principles capture best practice in order to support service reform and promote choice, control, independence and

participation of the people who use services. This guide can be downloaded at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084505

Confidentiality: NHS Code of Practice

The Code's purpose is to provide guidance to the NHS and NHS-related organisations on patient information confidentiality issues. The Code of Practice can be downloaded at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4069253

Dignity in Care

The Dignity in Care Campaign aims to eliminate tolerance of indignity in health and social care services through raising awareness and inspiring people to take action. More information can be found at: www.dh.gov.uk/en/SocialCare/Socialcarereform/Dignityincare/index.htm

End of Life Care

In July 2008 the Department of Health published a national End of Life Care Strategy for adults, this country's first. Implementation of the strategy will deliver increased choice



to all adult patients, regardless of their condition, about where they live and die. It will cover adult patients with all conditions; care given in all settings (home, hospital, care home and hospice); care given in the last year(s) of life; and patients, carers and families. It will help to take forward the commitments in the election manifesto and in the White Paper *Our Health, Our Care, Our Say*.

End of life care is also one of the eight pathways the strategic health authorities (SHAs) examined to produce the reports that helped shape the NHS Next Stage Review. As the strategy developed we shared its emerging findings with SHAs to inform the Review, and in turn we took account of this important local work in the development of the final version of the national strategy itself.

Good end of life care should attend to the needs of the whole person and those who are important to them. People approaching the end of life should reasonably expect that their care will be pre-planned wherever possible; well co-ordinated; equitable; and ethical with regard to preferences and personal beliefs. Involving the person and their carer in planning and agreeing a care plan and

identifying their needs and preferences for care at the end of life ensures that they remain in control. This is fundamental to retaining a person's dignity at a time when they are likely to be feeling at their most vulnerable. End of life care is also an area where there is input from a range of care providers, from health, social care and the third sector, and it is equally important to ensure that these services are well co-ordinated.

These issues are all addressed in the End of Life Care Strategy.

More information can be found at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_086277 and at: www.endoflifecare.nhs.uk

Generic Choice Model for Long Term Conditions

This generic model helps commissioners understand the process and range of services that need to be commissioned to improve and personalise services and support people with long term conditions (LTCs). The model, developed in conjunction with a number of patient organisations, provides

good practice examples and aims to reduce inequalities. The model can be downloaded at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081105

Health, Work and Well-being

Health, Work and Well-being – Caring for our Future is an ambitious strategy put together by the Department of Health, the Department for Work and Pensions and the Health and Safety Executive to improve the health and well-being of working age people. It places real responsibility not just in the hands of Government, but also with employers, individuals, the healthcare profession and stakeholders. The strategy can be downloaded at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4121756

Improving Access to Psychological Therapies

This initiative seeks to deliver on the Government's 2005 General Election manifesto commitment to provide improved access to psychological therapies for people who require the help of mental health services, and to offer a more personalised service based around their individual needs. The toolkit can be downloaded at:

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084065

Improving Quality in Primary Care

This is a practical guide to support PCTs as commissioners of primary care, in working with local clinicians and other stakeholders – including patients – to promote continuous quality and productivity improvement in primary care services. This guide can be downloaded at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_106594

Improving Stroke Services: a guide for commissioners

Improving Stroke Services promotes the benefits of taking an integrated approach across the whole of the stroke patient journey to ensure that opportunities for improving care and making more efficient use of resources are realised. It works through the commissioning cycle to set out how each stage may be applied to stroke. At the centre of the cycle is the role of patients and the public, to whom commissioners must be accountable for their commissioning decisions. The guidance can be found at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_063260

In Control

In Control is about changing the system of social care. It is for everybody who wants to control their support by ensuring that they know what they are entitled to. Service users can control their money through individual budgets as much as they want as part of their self directed support. More information can be found at: www.in-control.org.uk/

Independence, Choice and Risk: a guide to best practice in supported decision making

This best practice guide is for the use of everyone involved in supporting adults (18 and over) using health and social care within any setting, whether community or residential, in the public, independent or third sectors. This includes all NHS staff working in multidisciplinary or joint teams. The guide can be downloaded at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/dh_074773

Individual budgets

These will empower people needing social care support to take control and make decisions about the care they receive by bringing together a number of different funding streams and offering a transparent way of allocating resources to individuals.

Knowing the level of resources at their disposal can help individuals plan and control how their support needs will be met. More information about individual budgets can be found at: www.dhcarenetworks.org.uk/personalisation/index.cfm

Information prescription

Information prescription is designed 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. It will be nationally recognised as a source of key information on services and care that will be seamlessly and formally integrated into the care process. Further information can be found at: www.informationprescription.info/

Interim Evaluation of Partnerships for Older People Projects (POPPs)

A total of 29 local authority-led partnerships including health and third sector partners (voluntary, community and independent organisations) have been funded by the Department of Health to deliver and evaluate local, innovative schemes for older people. The Interim Evaluation Report published in October 2008 reveals a number of positive messages, including POPP pilot sites having a demonstrable

effect on reducing emergency bed days compared to non-POPP sites and patients reporting improved quality of life. The interim report concludes that POPP can lead to better investment and disinvestment decisions, faster development of joint commissioning involving voluntary and community groups and more local working to identify needs and inform commissioning. The October 2008 evaluation report can be found at: www.networks.csip.org.uk/_library/Evaluation_of_POPP_interim_report.pdf

Joint Strategic Needs Assessment

The Local Government and Public Involvement in Health Act 2007 requires PCTs and local authorities to produce a Joint Strategic Needs Assessment of the health and well-being of its local community. The guidance for Joint Strategic Needs Assessment provides tools for local partners undertaking a Joint Strategic Needs Assessment and describes the stages of the process, including stakeholder involvement, engaging with communities and recommendations on timing and linking with other strategic plans. The guidance can be found at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081097

National Service Frameworks

National Service Frameworks (NSFs) are long term strategies for improving specific areas of care. They set national standards, identify key interventions and put in place agreed timescales for implementation. A list of all the strategies and information about them can be found at: www.dh.gov.uk/en/Healthcare/Medicinespharmacyandindustry/DH_4000165

Outline Service Specification: Personalised Care Planning for People with Long Term Conditions

The Outline Service Specification has been developed to assist commissioners to put in place appropriate arrangements to ensure people with LTCs have informed choice of, and access to, services that best enable them to manage their condition. This specification can be downloaded at: www.pcc.nhs.uk/204

Person-centred Planning for Learning Disabilities

This is a method of supporting and working with people who have a learning disability. It helps to work out what the individual wants from life, how best to achieve it, the kind of support a person will need and how it would be best given. More information can be found at: www.publications.doh.gov.uk/learningdisabilities/planning.htm

Pharmacy White Paper

This sets out the Government's vision of the future role pharmacists can play in delivering world class pharmaceutical services. This includes pharmacists acting as centres within the community promoting and supporting healthy living and healthy lifestyle, providing advice and support on self care and offering new services to those with minor ailments and LTCs such as routine monitoring, vascular risk assessment and support for making best use of their medicines. The full edition of the White Paper be downloaded at: www.official-documents.gov.uk/document/cm73/7341/7341.asp

Putting People First

Across government, the shared ambition is to put people first through a radical reform of public services, enabling people to live their own lives as they wish, confident that services are of high quality, are safe and promote their own individual needs for independence, well-being and dignity.

This ministerial concordat establishes the collaboration between central and local government, the sector's professional leadership, providers and the regulator. It sets out the shared aims and values which will guide the transformation of adult social care, and recognises that the sector will work across agendas with users and carers to transform people's experience of local support and services. More information can be found at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081118

See also **Commissioning Personalisation, a Framework for Local Authority Commissioners** at: <http://networks.csip.org.uk/Personalisation/PersonalisationResources/Type/Resource/?cid=3241>; and the **Personalisation Network** – a place where people involved in changing the adult social care system can get guidance and examples from across the country at: www.dhcarenetworks.org.uk/personalisation/index.cfm

Raising the Profile of Long Term Conditions Care: A Compendium of Information

This document updates the first compendium of information on LTCs, published in May 2004. It will further inform all those who are involved in both commissioning and providing care and support services for people with LTCs. It focuses on the outcomes that people with LTCs say they want from services and describes how more effective management of LTCs in a number of areas is delivering high-quality, personalised care. More information can be found at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082069

Single Assessment Process

The Single Assessment Process (SAP) was developed following recognition that many older people have a wide range of health and social care needs, and that agencies need to work together to ensure that assessment and subsequent care planning are effective and co-ordinated. Care should be holistic and involve service users. More information about SAP can be found at: www.dh.gov.uk/en/SocialCare/Chargingandassessment/SingleAssessmentProcess/index.htm

Summary Care Record

The Summary Care Record is part of the NHS Care Records Service and is being implemented as part of the National Programme for IT in the NHS. Initially it will contain a small but important data set of current medication, allergies and adverse reactions, which will be uploaded from GP systems. The Summary Care Record will be available throughout England to those who need to access it to deliver care and who have the necessary security permissions. Consequently, it has the potential to bring major benefits to both patients and clinicians, especially when treatment is being delivered in settings where the patient's usual records are not

available. More information can be found at:
www.nhscarerecords.nhs.uk/

Supporting People with Long Term Conditions: Commissioning Personalised Care Planning – A guide for commissioners

This document sets out to provide commissioners of health and social care services with the information and support they need in order to fulfil their obligation to embed personalised care planning in their localities. It describes what personalised and integrated care planning is, what the benefits are and what this means for them as commissioners. It supports world class commissioning and the aims of *Putting People First: A shared vision and commitment to the transformation of adult social care* with a focus on truly personalised services, promoting health and well-being, and ensuring proactive, planned, co-ordinated and integrated services. This document can be downloaded at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093354

Transforming Services for People with LTCs

This best practice guide has a vital role to play in the delivery of the intentions for *High Quality Care for All: NHS Next Stage Review Final Report*. This document can be downloaded at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_101425

Whole System Demonstrators

The Whole System Demonstrators programme is exploring the exciting possibilities opened up by truly integrated health and social care working, supported by telehealth and telecare. The demonstrators will lead to a better understanding of the level of benefit associated with such innovative developments. The evaluation conducted by the programme assesses the impact of telehealth and telecare services on clinical outcomes, service cost effectiveness, individuals' and carers' quality of life and well-being, and professionals' lives. The demonstrators in Cornwall, Kent and Newham will also help to fast-track future change by addressing the key implementation barriers and providing solutions for the wider NHS and social care services.

More information about this programme can be found at: www.dh.gov.uk/en/Healthcare/Longtermconditions/wholesystemdemonstrators/index.htm and: www.wsdactionnetwork.org.uk/about_wsdan/index.html

World Class Commissioning

World class commissioning will transform the way health and care services are commissioned and will deliver a more strategic and long term approach to commissioning services, with a clear focus on delivering improved health outcomes. There are four key elements to the programme: a vision for world class commissioning; a set of world class commissioning competencies; an assurance system; and support and development guidance. More information can be found at: www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Worldclasscommissioning/index.htm

World Class Commissioning Assurance Handbook Year 2

This handbook provides a detailed explanation and practical guide to world class commissioning assurance Year 2. The handbook can be downloaded at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_105117

Year of Care

Year of Care helps people to exercise choice and be partners in decisions about their own care, and supports them to self care effectively. It makes routine consultations between clinicians and people with long term conditions truly collaborative, **through care planning**, and ensures that the local services people need and want to support this are identified and made available, **through commissioning**.

The first year of this three-year project used pilots as a 'test bed' for these ideas. The pilots have produced a detailed commissioning model for care planning in diabetes. A training programme for care planning is close to completion.

Further information can be found in the following services:

National Diabetes Support Team (2008) *Partners in Care: A guide to implementing a care planning approach to diabetes care*: www.diabetes.nhs.uk/document/php?0=75

Diabetes UK *Getting to Grips with the Year of Care:*
A practical Guide: www.diabetes.org.uk/upload/Professionals/Year%20of%20Care/Getting%20to%20Grips%20with%20the%20Year%20of%20Care%20A%20Practical%20Guide.pdf

Year of Care Programme: www.diabetes.nhs.uk/our_work_areas/year_of_care

Your Health, Your Way (formerly the Patients' Prospectus)

Launched on 2 November 2008 on NHS Choices website, *Your health, your way* will provide people with LTCs with the information they need about the choices which should be available to them locally to enable them to self care in partnership with health and social care professionals. For more information about *Your health, your way* visit the NHS choices website at: www.nhs.uk/yourhealth/Pages/Homepage.aspx

Annex C: Glossary

Care plan

A single overarching plan that records the outcome of discussion between the individual being cared for and the professional responsible. It may be electronically stored or written on paper. It should be accessible by the individual in whatever form is suitable for them.

Carer

An individual who provides or intends to provide practical and long term emotional support to someone with a long term condition. They may or may not live with the person cared for. Carers may be relatives, partners, friends or neighbours. They may be young people who find themselves in the position of needing to support an unwell person. A person may have more than one carer.

Commissioning

The means to secure the best care and the best value for local people. It is the process of translating aspirations and needs, through the specifying and procuring of services for the local population, into services which:

- deliver the best possible health and well-being outcomes, including promoting equality

- provide the best possible health and social care provision
- achieve this within the best use of available resources.

Complex

A term used to describe patients that have an intricate mix of health and social care needs. Because of their vulnerability, simple problems can make their condition deteriorate rapidly, putting them at high risk of unplanned hospital admissions or long term institutionalisation.

Holistic

In medical terms denotes a treatment or service which deals with the needs of the whole person, not just the injury or disease.

Long term condition

A condition that cannot at present be cured, but can be controlled by medication and other therapies.

Multidisciplinary team

A team made up of professionals across health, social care and the third sector who work together to address the holistic needs of their patients/clients so as to improve delivery of care and reduce fragmentation.

Patient-centred

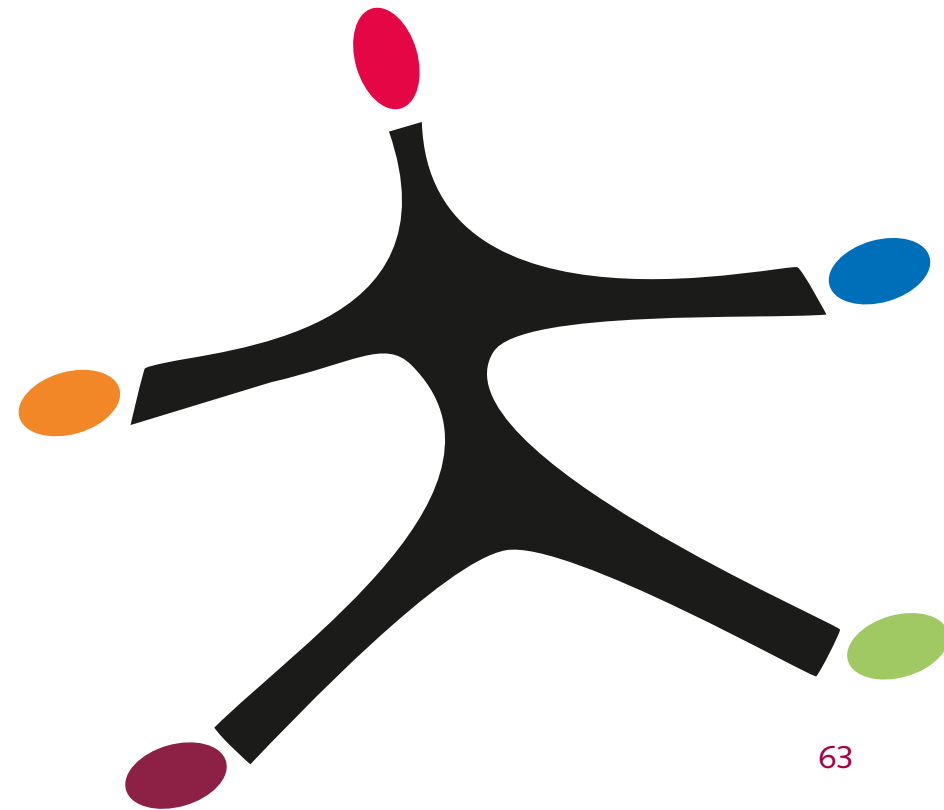
Denotes an organisation's provision to support personalised care delivery.

Personalised

Describes care and services that are individualised and tailored to the person receiving them.

Self care/self management

The principle of individuals being supported to take responsibility for their own health and well-being. This includes staying fit and healthy, both physically and mentally; taking action to prevent illness and accidents; the better use of medicines; treatment of minor ailments; and better care of long term conditions.







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