

Primary Care Service Framework: Management of Long Term Conditions in Primary Care

- This 'enhanced service' framework should be read in conjunction with the **supportive statements for commissioning** on the Primary Care Contracting website – www.pcc.nhs.uk – and the **additional supportive notes** at the end of this document to help commissioners, providers and other stakeholders with contextual planning and local service design and development. They offer further implementation pointers and have been developed with the help of those currently commissioning or providing primary care services.
- The document itself can be adapted and used as a basis for an enhanced service via a primary care contract or Service Level Agreement. This will hopefully avoid duplication of effort and speed up the commissioning process. It would be appropriate to adapt or include local information in the relevant sections. Legal advice or support for local contractual arrangements may need to be considered.
- NHS Primary Care Contracting kindly requests feedback from PCTs or Practice Based Commissioners following implementation of this Framework via the brief feedback questionnaire on their website – www.pcc.nhs.uk. This will assist in its on-going development and sharing of good practice across the NHS.
- The Department of Health and NHS Primary Care Contracting would like to thank all those individuals, departments and organisations who have contributed to the development of this Primary Care Service Framework as well as Steering Group members. Thanks also go to Dr Jeff Anderson of Primary Care Unlimited – www.primarycareunlimited.com – for coordinating the development of each Framework.

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- 1. Purpose of this Primary Care Service Framework**

The purpose of this Primary Care Service Framework is

 - to equip commissioners, providers and practitioners with the necessary background knowledge, service and implementation details to safely deliver the service for people with Long Term Conditions.
 - as a means of improving patient's health and quality of life by providing patient-centred, systematic and on-going support.
 - to reduce the reliance on secondary care services and increase the provision of care in a primary, community or home environment.

- 2. Period of Service**

This service will run for a period of twelve months from 1st April 2007 – 31st March 2008 (extended subject to satisfactory annual review).

- 3. Scope and Definition of service**

This service is open to male and female patients of all ages, including children and adolescents, and can be provided either at individual practice level, or on a locality or PCT basis. It is open to all types of providers and is not setting-specific. For example, GP practices, Community Pharmacists, community and specialist nurse-led services, voluntary or local authority sector, the independent sector or other alternative providers.

This primary care service should not be confused with (and sits outside of) essential and additional GMS or PMS services already provided, current Quality and Outcomes (QOF) indicators, and any other national or locally enhanced service.

- 4. Parties to the agreement**

Insert names of any accountable individuals and organisation details.

- 5. Background**

The Long Term Medical Conditions Alliance (LMCA) has described a long term condition as 'a condition of prolonged duration that may affect any aspect of any person's life. The symptoms may come and go, but usually there is no cure'. For example, living with physical disabilities, learning disabilities, enduring mental health problems and chronic conditions. Patients with a long term condition either have a single disease which may have existed for a long period of time or the individual may have complex co-morbidities which make the management of the patient's condition increasingly difficult.

Seventeen and a half million people in this country are reported to live with a long term condition, limiting their ability to cope with day-to-day activities. Just 5% of inpatients, many with a long term condition, account for 42% of all acute bed days. It is estimated that around 80 per cent of GP consultations relate to long-term conditions as well as over 60 per cent of hospital bed days. Furthermore, only about 50% of medicines are

taken as prescribed leading to further complications and often medical admissions.

In January 2005, the Department of Health published 'Supporting people with Long Term Conditions – an NHS and Social Care Model' which described three levels of appropriate long term care to help meet individual needs.

Level 3: Case management – Identifies the most vulnerable people, those with highly complex multiple long term conditions, and uses a case management approach to anticipate, co-ordinate and join up health and social care.

Level 2: Disease-specific care management – Involves providing people who have a complex single need or multiple conditions with responsive, specialist services using multi-disciplinary teams and disease-specific protocols and pathways, such as the National Service Frameworks and Quality and Outcomes Framework.

Level 1: Self care – Describes the care and responsibility taken by the majority of individuals towards their own health and well-being and the support provided to them. It includes the actions people take for themselves, their children, and their families to stay fit and maintain good physical and mental health in order to ensure independence, self worth and the ability to lead as near a normal life as is possible. It ensures people will have the necessary skills and education, information, tools and devices and support networks to manage their own health.

The National Service Framework for Long Term Conditions (2005) and the Public Health White Paper 'Choosing Health' underpins the entire long term condition approach. This approach responds to the growing need to ensure that self care support is in place so people – particularly those in disadvantaged groups or areas – to make healthier choices about diet, physical activity and lifestyle. Furthermore, the recent White Paper 'Our Health, Our Care, Our Say' has called for a more integrated health and social care system to deliver services that better meet the needs of the local population, closer to their homes.

National targets have focused the mind on achieving better services and better outcomes for patients with long term conditions. For instance, the Public Service Agreement target to improve health outcomes for people with long term conditions by *offering a personalised care plan for vulnerable people most at risk, and reduce the number of emergency bed days by 5% by March 2008 through improved care in primary and community settings* and the Older Persons target *to increase the number of people over 65 supported to live at home by 1% a year in 2007 and 2008.*

6. Summary of Local Need

Commissioners should outline or reinforce a summary of local health and social care or service need drawn from a Joint Strategic Needs Assessment, done with Local Authority partners. Suggested options to include here can be found in the additional notes below.

7. Service Objectives and Intended Health Outcomes

The following is a list of service objectives and intended health outcomes for the local population:

- To identify locally which long term condition clinical area(s) this service may be appropriate to focus on
- To develop a patient-centred approach to the delivery of services for patients with these long term conditions
- To improve the health outcomes of patients with these long term conditions and narrow health inequalities among these patients by ensuring services meet the needs of disadvantaged groups
- To reduce the number of unscheduled admissions and re-admissions to hospital
- To reduce hospital length of stay, and thus occupied bed days, by increasing throughput of patients
- To improve patient quality of life and feelings of well-being
- To improve integration of health and social care for patients with these long term conditions
- To improve access to services in primary care through referral to more integrated services, particularly for disadvantaged groups and areas
- To improve skill mix working across a more joined up primary health care team.
- To develop clinical networks as a basis on which to develop local condition-specific services
- To encourage a range of approaches for case-management
- To encourage greater participation in self-care through appropriate support mechanisms.
- To improve referral and signposting to appropriate services for patients, including voluntary agencies and community groups.

8. Service Outline

To encourage the early identification of individual patients, the scale of the problem locally, and on-going service provision in a more manageable way, it may be appropriate to agree with providers an approach to delivery which begins at the most basic level of patient identification. Patient assessment, screening, and treatment elements could be provided in addition to this basic level as a cumulative step.

Providers will be required to:

1. Name a clinical lead who will be fully responsible for this Primary Care Service and who will link formally with other recognised leads for long term conditions at other levels of the health service.
2. Identify all patients (from all primary or secondary care data sources) who are, or have the potential to be, very high intensity users of health care resources including those with palliative care needs and those in

residential or nursing care accommodation

3. Identify those patients currently in hospital beds who could, by pro-active management of their condition, be discharged back into primary care or home, including identifying needs arising from disadvantage, ethnicity, culture, belief, disability, low educational achievement and age
4. Name key worker(s) responsible for those identified as at risk or very high intensity users of resources
5. Risk stratify all patients (using predictive modelling techniques where appropriate) into the three levels of the long term conditions model (see additional supportive notes below)
6. Identify all patients (in the subjective opinion of local GPs involved in the service) who would be classified as highest risk and compare this to 3. above
7. Provide a comprehensive assessment of health and social care needs of all patients (building on the Single Assessment Process) including identifying any support for self care
8. Undertake a full medicines management analysis and on-going medication review for each patient
9. Where appropriate, ensure a vocational assessment is provided to determine fitness to work, to assist patients regaining or remaining in work
10. Develop and implement an integrated and personalised care plans covering both health and social care needs for all patients and a clear approach to supporting self care taking account of needs arising from disadvantage, ethnicity, culture, belief, disability, low educational achievement and age
11. Ensure appropriate patient care is organised in the most appropriate setting including local community facilities such as intermediate care, 'step-down' rehabilitation facilities, or the home
12. Provide up-to-date information, advice and support for self management or rehabilitation, and for carers of patients with long term conditions.
13. Provide patients with access to and/or advice about any assistive technology/equipment to support activities of daily living and more independent lifestyles
14. Provide (or refer to) a comprehensive range of palliative care services which provide appropriate symptom control, pain relief and meet the needs for personal, social, psychological and spiritual support in line with the Gold Standards Framework
15. Demonstrate multi-professional and integrated team working across the whole care pathway and between all those agencies delivering care including secondary care, ambulance trusts, primary care, social care, voluntary and community organisations

9. Location of Service

Commissioners will need to re-assure themselves that the service is provided from premises that are fit for purpose in a modern and way and address issues of service uptake, particularly in communities with poor health outcomes. Details should be included here.

10. Integrated Governance

Any commissioned service must meet all national standards of service quality and clinical governance including those set out in Standards for Better Health (updated April 2006 www.dh.gov.uk). These core and developmental standards of provision are designed to cover the full spectrum of health care as defined in the Health and Social Care (Community Health and Standards) Act 2003. The seven domains are safety, clinical and cost effectiveness, governance, patient focus, accessible and responsive care, the care environment and public health. Compliance with NICE guidance www.nice.org.uk is also required.

Clinical Governance arrangements must be proportionate to the service provided and comply with any local expectations or requirements of the commissioner.

Professional competency, education and training – All healthcare professions delivering the service will be required to demonstrate their professional eligibility, competence, and continuing professional development in order to remain up-to-date and deliver an effective service which is culturally appropriate. Staff appraisal on an annual basis and at an appropriate level will also be required. Commissioners will need to be reassured that practitioners have the required competencies at an appropriate level. For example, GPwSI, PhwSI, Community Matron, nurse specialist/practitioner, health and social care generic worker (see additional notes below).

Providers should ensure safe staffing capacity and appropriate caseloads should be encouraged at all times. Staff should be able to demonstrate that they have participated in organisational mandatory and update training, for example infection control, manual handling, risk assessment as required.

Patient, public and staff safety – Providers will be required to demonstrate that evidence based clinical guidelines are being used. Providers should have in place appropriate health and safety and risk management systems and that premises are safe and young person friendly. They should also ensure that any risk assessments and significant events are both documented and audited regularly and outcomes of these implemented. Services should comply with national requirements for recording, reporting, investigation and implementation of learning from incidents. Further details can be found on the National Patient Safety Agency website www.npsa.nhs.uk.

Clinical audit and review – Providers will be required to demonstrate their coordination of and involvement in regular inter-professional and inter-agency meetings and regular clinical audit of the service.

Information management – Any communications strategy or provision should be coherent with and follow local policies and the Department of Health Code of Confidentiality, local child and adult protection

procedures, and should outline the mechanisms to safeguard patient information when shared within an integrated service.

Patient and public involvement – Providers will be required to demonstrate active engagement with patients and local communities in developing services, self care plans or in supporting patients to utilise self care opportunities. Providers should demonstrate how systematic patient feedback is being used to shape and improve services.

Equality and human rights - Delivering good quality care will require organisations to demonstrate competence in identifying and taking action on inequality; and also needing to engage with communities that have not found accessing public services easy. Undertaking Equality Impact Assessments (EQIAs) is a specific legal obligation, and conducting EQIAs and using the evidence to create a meaningful dialogue with communities (especially seldom heard from groups) is central to effective commissioning and service provision. This will create an evidence-based approach. As a minimum, core standard C7e of *Standards for Better Health* stipulates “healthcare organisations should enable all members of the population to access services equally and offer choice in access to services and treatment equitably”.

Managing complaints – Responsive protocols and procedures should be in place for managing patient complaints. Complaints should be reviewed at regular intervals and learning from these shared and applied as appropriate to ensure that services are continually improved.

Continuous quality improvement – a set of indicators should be selected or developed and then agreed which defines the key quality requirements of the service. The service should also identify how it uses these measures and others to ensure that the quality of the service is continuously improved.

11. Information management/requirements

The following describe a selection of key information areas which providers could use to analyse in order to help demonstrate service quality, effectiveness and provider performance. Information needs may be different depending on the scale of service provision (PCT-wide or at individual practice level) or if provision is focused in specific clinical populations.

Analysis of clinical outcomes in the last 12 months for any selected disease-specific conditions will be required including:

- The number and percentage of patients identified in each risk category in the last 12 months
- The number and percentage of patients with an individualised management plan as a result of the single joint assessment between health and social care
- The number and percentage of each specific long term condition clinical area who have shown clinical improvement in their condition

Working with the PCT, other service providers and secondary care usage data, determine

- The reduction of bed days saved (cost and number) in the last 12 months
- The reduction of all admissions (cost and number), including re-admissions, in the last 12 months
- The reduction of length of stay in the last 12 months
- The reduction of A&E and Out of Hours service attendances (cost and number) in the last 12 months
- Analysis of prescribing and medicines management initiatives
- Analysis of patient referral to any alternative primary care services in relation to patient need
- Analysis of data relating to feedback from patients
- Analysis of health inequalities trends locally.

12. Service Monitoring and Evaluation

Service providers will need to demonstrate the effectiveness of the service to commissioners possibly at regular times during the year and, at the least, on an annual basis. This will need to be provided to the commissioners in an annual report, which will inform any annual review process or meeting. The process by which this evaluation is achieved can also be used to show the outcomes of the service to other key stakeholders such as patients. Service evaluation should cover, as a minimum, the following areas:

Service Activity – Volume of work against any agreed activity levels and distance from profile, capacity, needs and demand analyses, workforce arrangements, real time referral data to other care pathways or appropriate agencies

Clinical Outcomes – Regular analysis and interpretation of clinical outcomes data as well as regular analysis and interpretation of PPA data for prescribing

Quality and Governance – Quality criteria will need to be established (in agreement with commissioners) and measured with standards needing to be met on a continual basis. Results of clinical audits will be used to inform service provision during the year. EQIA data should be used to underpin local integrated service provision.

Patient Experience – Patients views on their experiences and satisfaction levels will need to be measured through an on-going, systematic process to test whether the service is engaging with patients in a way that supports them. This process should be stratified where possible to show any differential impact on disadvantaged groups (e.g. Black and Minority Ethnic groups, deprived groups, males, females etc) and any resultant service changes (planned or achieved) should be highlighted.

Value for Money – Cost effectiveness or ‘best value’ analyses of the primary service outcomes in relation to comparative costs of hospital activity or those services providing equivalent quality of care. Such measures

could include attendance rates, waiting times, length of stay. Other possible analyses include: - Prescribing costs; Quality Adjusted Life Years (QALYs); Savings due to reductions in days off work; benefits of increase in social capital and active citizenship; Staff and non-staff costs of running the service; Capital costs; Potential supplementary costs to patients eg time off work, travel and transport or other in-direct costs such as cost of loss of production to society

13. Funding

There will be no fixed or nationally agreed price for this service. Commissioners and providers should agree funding which is reflective of the level of service to be delivered locally and could include:

- Basic funding for achieving minimum requirements within the service specification
- Additional funding or financial incentive for delivering specific local patient outcomes
- Indication of national benchmark prices if available

Where the service is provided by general practice teams it is recognised that they may also gain additional reward for quality service provision relating to the clinical domains within the Quality and Outcomes Framework.

14. Contract Management

The name and contact point of the contract manager of both the commissioner and provider should be given here. Any specific local arrangements for contract management should also be stated.

15. Review, variation and re-commissioning process

A number of important contractual design and management issues will be followed throughout the period of the contract. In particular:

- Formal review of the service will be on-going and will inform the end of year service review process which will be used to determine if service is to be extended or de-commissioned.
- Any in-year contract variations will be discussed and agreed by both parties and will be included as additions to this Primary Care Service Framework.
- Following the review the commissioner will decide whether the service has been effective, including whether it is addressing the needs of disadvantaged groups with high needs. If not, the commissioner will discuss with the provider any formal escalation or recovery plan with realistic timeframes for delivery.
- Appropriate notice periods and termination procedures will be agreed by both parties.

Both parties may wish to seek legal advice before agreeing any formal contractual arrangements resulting from this Primary Care Service Framework.

16. Signatories

Signatures from all parties as those accountable for the agreement

Additional supportive notes to assist the implementation of the Primary Care Service Framework: Management of Long Term Conditions in Primary Care

Commissioning 'business case' and Value for Money

- Commissioning this Primary Care Service will have a significant impact on the availability of commissioning resources locally. Investment in managing long term conditions, re-designing services and developing new care pathways can deliver considerable healthcare savings, especially if a combined approach to case management, disease management, and self care is adopted. Clearly this is offset by the investment in new care pathways, workforce development, investment in new partnerships and new providers, and potential increases in prescribing but, overall, this would still be very good value for money for primary care.
- There would be significant savings made by managing patients to avoid unnecessary hospital admissions and thus freeing up expensive hospital beds. For instance:
 - ❖ Elective spell tariff (average cost £1541 of all procedures below £5000 tariff); Non-elective spell tariff (average cost £2662). These are minimum figures as they do not include any length of stay payments or top ups.
 - ❖ First Out Patient appointments and Follow Up appointments (£50 - £300)
 - ❖ A&E attendances (£71 - £99)
 - ❖ Reducing the average patient stay in hospitals also reduces the fees payable to Trusts
 - ❖ Freeing up GP capacity with support provided by appropriate, but potentially less expensive, workforce Eg. community nursing or community matron.
- Details of elective and non-elective national tariff and Payment by Results can be found at www.dh.gov.uk/paymentbyresults and examples of savings made through different approaches to managing Long Term Conditions can be found in recent publications from NHS Employers www.nhsemployers.org
- Commissioners should also be aware of the wider savings which would be realised through support for self care as described in a complementary Primary Care Service Framework. This can be found on the NHS Primary Care Contracting website www.pcc.nhs.uk

Practice Based Commissioning (PBC) sign off

- PCTs and Practice Based Commissioners should be aware that business case proposals for the provision of this Primary Care Service will need to meet the full requirements of any local service delivery plan and authorisation process. This may well be at PCT Board level or any delegated panel. For proposals that pertain to the provision of services for a wider population, consideration as to further engagement and sign off with the SHA may be necessary.
- The Commissioning Framework (Department of Health, July 2006) highlights how commissioners should follow EU best practice principles when considering competitive procurement of local services. This does not necessarily mean open tendering processes should be adopted in every case. The Department of Health would not normally expect tendering where practices currently under GMS/PMS contracts could provide services as a means of extending patient choice.

- PBC resources can be obtained from the Department of Health www.dh.gov.uk and NHS Primary Care Contracting www.pcc.nhs.uk. The recent PBC guidance can be found at www.dh.gov.uk/assetRoot/04/14/15/64/04141564.pdf

Contracting for the service

- This service should be considered as a 'locally enhanced service'. As such, the full range of providers and primary care contracting flexibilities should be considered, including GMS, PMS, PCTMS, APMS, and community and voluntary organisations. Once an appropriate provider has been selected, the appropriate contracting route should be adopted. Additionally, providers may wish to sub-contract part or all of the service provision. This should be made clear throughout the contract implementation process.
- NHS Primary Care Contracting has developed a simple guide for potential providers of services such as this Primary Care Service www.pcc.nhs.uk

Incentivising provision

- The recent Commissioning Framework publication www.dh.gov.uk/assetRoot/04/13/72/30/04137230.pdf emphasised the options open to commissioners to support new local providers of services by offering additional quality incentives or use of local primary care premises or pump-priming loans. However, the Kings Fund has described some of the considerations when developing local incentives. For instance, introducing new providers into the local health economy may improve service quality and efficiency but this may be at the expense of service responsiveness, provider collaboration and sustainability of services. Also care must be taken to develop better access to services without generating extra demand within the local health system which increases pressure on other services.

Summary of local need

- Local demographic information along with a broad public health profile may need to be considered and made explicit. Specific details of morbidity and mortality levels, other health and well being data and condition-specific data, health inequality data and ethnicity profile are also important and should be included if available. It is essential to clarify that this service is a priority identified in the Local Delivery Plan for either the PCT or the local PBC group.
- Additional relevant information should also be considered for inclusion such as recent service user feedback, current service staffing levels and competencies, local partnership arrangements, and any planned changes to local need.

Criteria for selection of 'at risk' patients and predictive modelling tools

- Castlefields Health Centre, in Runcorn selects patients for more intensive case management if they are over 65 and meet at least three of the following criteria:
 - ❖ Four or more active long term conditions; four or more medicines, prescribed for six months or more; two or more hospital admissions, not necessarily as an emergency, in the past 12 months; two or more A&E attendances in the past 12 months;

significant impairment in one or more major activity involved in daily living; significant impairment in one or more of the instrumental activities of living, particularly where no support systems are in place; older people in the top 3% of frequent visitors to the practice; older people who have had two or more outpatient appointments; older people whose total stay in hospital exceeded four weeks in a year; 1 older people whose social work contact exceeded four assessment visits in each three month period, and older people whose prescribing costs exceeded £100 per month.

- The Evercare pilots used any one of the following four criteria as reasons to nominate a person into the high-risk caseload:
 - ❖ Recent exacerbation or decompensation of chronic illness (within last 90 days); recent falls: >2 falls in 2 months; recently bereaved and at risk of medical decline (death of a spouse or family member in past 6 months), and cognitively impaired, living alone, medically unstable, and high intensity social service package.
- There are a number of useful pieces of software which can assist commissioners and providers in analysing patient data in terms of health profile and usage of health care resource. The software uses predictive modeling techniques to establish a list of patients who are or potentially would be very high intensity users of health and social care. Some examples of these include the Patients At Risk of Readmission (PARR) tool available from the Kings Fund www.kingsfund.org.uk. A further tool is currently being piloted by Imperial College in London using Ambulatory Care Groups as a key predictive metric. Other tools are available commercially including those from Dr Foster and United Healthcare Europe.

Involving patients and the public

- The White Paper 'Our Health, Our Care, Our Say' made it clear that patients and the public would be firmly placed at the centre of NHS and social care services, with a stronger local voice. Following this, the Department of Health has published a framework for creating stronger public engagement in the development of health and social care services www.dh.gov.uk/assetRoot/04/13/70/41/04137041.pdf. This will develop with patients and the public having more involvement in service planning processes where possible including design of individualised care plans and choice of services as well as involvement in decision-making processes and service evaluation mechanisms at both provider and commissioner level.

Skill mix and partnership opportunities

- Where there is a need to develop the GP with Special Interest role, it is important to be aware of new guidance and regulation procedures due to be published by the Department of Health at the end of 2006. This will mean greater adherence to any new special interest competency framework and more formal special interest accreditation of new practitioners.
- The White Paper has stated the government's desire to see more integrated health and social care services, based in the community. Through more integrated service delivery and the development of clinical networks, there will be greater opportunities to develop a wider skill mix among staff in the local community. Further evidence of successful approaches has been described in detail in 'Improving services for people with long term conditions through large scale workforce change' www.nhsemployers.org

- Additional educational resources can be found on the Department of Health website www.dh.gov.uk/longtermconditions such as the 'Case management competencies framework for the care of people with Long term Conditions'.
- Developing a close relationship with Local Authorities and Social Services Departments will be essential to ensure joint planning and commissioning for integrated care. This will be reinforced in the joint commissioning framework due to be published by the Department of Health at the end of 2006. In 2005, the Modernisation Agency published 'Good care planning for people with Long Term Conditions' which may assist in these developing collaborations.

Health Inequalities

- Reducing the gap in infant mortality across social groups, and raising life expectancy in the most disadvantaged areas (the Spearhead areas) faster than elsewhere are the focus for the 2010 health inequalities Public Service Agreement target. Effective, pro-active action to tackle health inequalities at local level by commissioners, providers, practitioners and other stakeholders will be key to meeting the target. To understand more about the Equalities and Human Rights agenda in the NHS, the Department of Health has recently published a useful guide for NHS Boards – www.dh.gov.uk/assetRoot/04/14/13/71/04141371.pdf.
- With any provision of service, consideration must be given up front to the impact on inequalities in health which may result from service outcomes. This Primary Care Service provides an opportunity to narrow the inequalities gap by providing services not only to the mainstream population but also those in disadvantaged groups with poor health outcomes. Provision of this Primary Care Service should consider, where possible, outreach services by practitioners which offer a more flexible approach to ensure all groups in the population have good access to services.
- The first Local Authority Health Profiles covering the whole of England have been produced by Public Health Observatories and will be updated every year. These profiles, which can be used by both local authorities and the health service, are designed to show where there are important problems with health or health inequalities to help target action to improve the health of local people. The profiles can be accessed at www.communityhealthprofiles.info/
- Commissioners may also wish to consider looking at the profile of their local population against the Health Poverty Index www.hpi-org or the inequalities reports compiled by the London Health Observatory www.lho.org to help them understand the impact this service may have on local population health.
- Further help in this area can be obtained from the National Support Team for Health Inequalities at the Department of Health.
- Links to Health Literacy through support for self care and using health as a useful means of educating local people.