

Primary Care Service Framework: Support for Self Care 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.

Primary Care Service Framework: Support for Self Care in Primary Care

- 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 support for self care for patients in primary care.
 - as a means of improving patient's health and quality of life by providing patient-centred, systematic and on-going support.

- 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**

The 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, community and voluntary sector, the independent sector or other alternative providers.

This service is targeted at all individuals who would benefit from some form of self care support. A proportion of these individuals may or may not have been diagnosed as having a long term condition, including mental health problems, and whose health may already be looked after by a recognised disease management programme or under a case management approach.

This Primary Care Service Framework 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 agreed enhanced service.

- 4. Parties to the agreement**

Insert names of any accountable individuals and organisation details.

- 5. Background**

Self care is part of daily living. It is the care and responsibility taken by individuals and carers towards their own health and well-being, and also includes the actions people take for themselves, their children, and their families and those they are caring for, to stay fit and maintain good physical and mental health; meet social and psychological needs; prevent illness or accidents; make better use of medicines; care for minor ailments and long-term conditions; and maintain health and wellbeing after an acute illness or discharge from hospital. In addition for people living with a long term condition, self care can become a more fundamental part of their everyday lives, to ensure independence, self worth and the ability to lead as near a normal life as is possible.

Providing support for self care is encapsulated in ensuring patients have the skills and education to take care of their illnesses and improve their health, up-to-date and easily accessible information about their health and condition, appropriate tools and devices to have better control over their lives and to assist them to live more independently, and access to local self care support networks.

Research evidence (www.dh.gov.uk/selfcare and www.kingsfund.org.uk) shows that supporting self care leads to improved patient health and quality of life, a rise in patient satisfaction and a significant impact on the use of services, including

- Visits to the GPs can reduce by up to 69%
- Outpatient visits can reduce by up to 76%
- A&E attendances can reduce by up to 54%
- Hospital admissions and number of days in hospital may be halved
- Medicines utilisation and compliance is improved
- Days off work can reduce by up to 50%.

One of the commitments in the White Paper (Our Health, Our Care, Our Say, 2006) states that at each stage of the professional education and regulatory process action should be taken to change the underlying dependency culture profoundly and encourage support for individuals' self care so that people are able to become more empowered and demonstrate health seeking behaviour. Additionally, the Public Health White Paper 'Choosing Health' underpins the approach to care of people with long term conditions. This will build on the public's growing desire for greater engagement in their own care by ensuring that the range of self care support is in place for them – particularly for people in disadvantaged groups and areas – to make healthier choices, such as about diet, physical activity and lifestyle.

Providing support for self care can help achieve local and national targets for the NHS. For instance the Public Service Agreement target to improve health outcomes for people with long term conditions by offering a personalised self care plan for vulnerable people most at risk, and reduce the number of emergency bed days by 5% by March 2008 through improved support for self 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.

Furthermore, self care is recognised as contributing towards the Workforce Reform Agenda (Department for Work and Pensions Green Paper) and subsequent Joint Health, Work and Well-Being Strategy.

6. Summary of Local Need

Commissioners should outline or reinforce a summary of local health and social care 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 support and empower patients to take an active role in their care
- To improve the ability of primary health care staff to provide support for self care
- To reduce the number of unscheduled hospital admissions
- To reduce patients length of stay in hospital
- To improve links with social care (tools and devices for self care)
- To release capacity in the Primary Health Care Team, particularly GP and practice nurse appointments
- To improve Public Health through more preventive self care and improvement in healthy choices
- To improve numbers on Pathways to Work programmes following fitness to work assessments
- To improve psycho-social health by being in work or increasing social support for individuals.

8. Service Outline

This Primary Care Service Framework will cover areas of provision which relate to the four main pillars for supporting self care - Skills and Education; Information; Tools and devices; Self Care support networks.

This specification is generic and should be tailored to suit the scale of provision at either practice or PCT level and could encompass statutory, independent, local community and voluntary sector providers. Specific clinical areas such as those in QOF may also be used to focus service provision. Once this scale and focus of provision is determined, providers are be required to:

1. Produce an annual, written, integrated self care support strategy and implementation plan should be understood and embraced by each practitioner involved in the service.
2. Nominate a clinical lead within the primary care team to oversee the service
3. Carry out population self care needs assessment to determine if a more detailed assessment is required for certain segments of the population For example, those with a clinical diagnosis, those who fall within the areas of greatest health inequalities (eg. areas of high deprivation), or those who are high users of NHS services (eg. those with 3 visits or more to walk-in/GP services/A&E)
4. Design individualised and integrated programme of support for self care for each patient including comprehensive advice.

5. Provide a self care plan for each patient including an information prescription (in different languages and different media where appropriate in line with any national information prescription requirement), signposting to other sources of information, and a fitness to work assessment and subsequent plan where appropriate
6. Provide access to equipment or devices to assist patients to live independently where appropriate, monitoring usage and equipment standard regularly
7. Referral to a self care support groups, networks or additional psycho-social support. For example, the local Expert Patient networks, e-learning packages or any other recognised, locally developed alternative
8. Referral to wider members of the primary health care team or other community-based services, for example
 - community pharmacy
 - optometrists
 - podiatrists
 - district nurses
 - cognitive behavioural therapy and electronic CBT
 - minor ailment services
 - community and voluntary sector groups
 - occupational health services or Pathways to Work programme - for those currently out of work and claiming benefit.
9. Ensure all members of the primary health care team are trained to provide support for self care through recognised in-house, on-line, or outsourced educational programmes
10. Ensure self care support is offered positively to ethnic minorities and disabled groups and to both genders.
11. Perform a recognised patient satisfaction survey tailored to elicit specific responses relating to the service

9. Location of Service

Commissioners should re-assure themselves that the service is provided from premises that are fit for purpose in a modern and integrated 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 – Providers should have a planned and regular programme of education as part of their self care support strategy. They may wish to access recognised competency based training programmes such as those provided by the Working in Partnership Programme (WiPP) or Occupational Health. Staff should be supported through any annual appraisal process, as part of the Knowledge and Skills Framework, or other disease-specific self care training as appropriate.

Similarly, education, skills training or support networks need to be made available to patients as part of their self care plan such as those offered by the Expert Patients Programme (www.expertpatients.nhs.uk), WiPP (www.wipp.nhs.uk) or the Health Foundation (www.health.org.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 strategy or practice 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

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. The following describe a selection of key quality requirements and measurable indicators which could be used to demonstrate service effectiveness and provider performance at the selected level.

- the number of people (in a specific clinical group as necessary) who have had an individualised self care plan designed for them in the last 12 months
- the number of people (in a specific clinical group as necessary) who have shown a clinical improvement in their condition in the last 12 months
- the number of people referred to self care skills training programmes such as the Expert Patients Programme, WiPP courses or equivalent (and attrition rates) in the last 12 months
- the frequency of attendance or contacts at practice/service location in the last 12 months (attendance at A&E, Out of Hours services, or unplanned admissions could also be included)
- the number of Primary Health Care Team consultations decreased in the last 12 months
- the number of people referred to Return to Work programmes or Occupational Health services in the last 12 months
- the number and destination of referrals to wider Primary Health Care Team in the last 12 months
- the number of sick note certificates issued in the last 12 months

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

- The reduction in all service use (cost and number), including attendances, admissions and re-admissions in the last 12 months
- The reduction of length of stay in the last 12 months

There will also need to be a further demonstration of

- Improvement in patient experience/satisfaction with services in the last 12 months
- Improvement in patient-professional relationships in the last 12 months
- Improvement in patient well-being in the last 12 months

- Number of professionals receiving training in supporting self care.

12. Service Monitoring and Evaluation

Individual service providers will need to demonstrate the effectiveness of their service (or aspect of the wider 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 interested stakeholders such as patients. Service evaluation should cover, as a minimum, the following areas:

Service activity – Volume of work against 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; evidence of personal self care plans for patients

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. 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 both parties as those accountable for the agreement

Additional supportive notes to assist the implementation of the Primary Care Service Framework: Support for Self Care in Primary care

Commissioning 'business case' and Value for Money

- Commissioning this Primary Care Service should have a significant impact on the availability of commissioning resources locally. Evidence for additional investment in the promotion of and support for self care is continuing to emerge but early analysis within the Department of Health suggests it could deliver significant healthcare savings. It has been estimated that the weighted average cost per user in a community is around £100 to £150 for self care support such as NHS Direct, self care skills training via courses available through the Expert Patients Programme and the Working in Partnership Programme, self care support networks, information materials and advice, assistive equipment and devices such as for blood pressure monitoring. However, potential savings per user are in the region of £200 which would be achieved through reduction in use of services or use of more appropriate primary care services, A&E services, better use of medicines, and self care of long-term conditions. There are additional benefits which are less quantifiable and have not been included in the figure of £200. These include better communication between patients and professionals; better use of information; improvement in clinical outcomes, such as reduction in pain, reduction in disabilities; greater independence, better self care of symptoms; increase in self confidence; reduction in anxiety and depression; reduction in days off work; significant improvement in quality of life; increase in life expectancy; increase in social capital.
- Importantly, the benefits described above will only be realised through a more integrated approach to support for self care, providing a combined package of support including information, self care skills training, devices and equipment, self care support networks, and greater involvement of care professionals such as community pharmacists.
- 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 (July, 2006) 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.

Self Care Support Continuum

- There are opportunities for supporting self care each time the patient comes into contact with a health/social care professional. Individuals will need information, signposting and support so they can take control and make informed choices about their care and treatment. Self Care can cover a whole spectrum of care that ranges from 100% self care (eg brushing teeth regularly) to 100% professional care (eg in-hospital care). It is for commissioners and providers to determine the scope of provision along care pathways.

100% self care					100% professional care				
The Self Care Support Continuum									
<i>Daily routine</i>	<i>Lifestyle</i>	<i>Self care of minor ailments</i>	<i>Self care of long term conditions</i>	<i>Self care of acute illness</i>	<i>Shared care of minor ailments</i>	<i>Shared care of long term conditions</i>	<i>Acute illness</i>	<i>Severe mental illness</i>	<i>Major trauma</i>
HEALTHY LIVING AND SELF CARE				MINOR AILMENTS CARE		LONG TERM CONDITIONS CARE		IN-HOSPITAL CARE	

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 there will be greater opportunities to develop a wider skill mix among staff in the local community. Local specialists and other roles will develop throughout the primary health care team including pharmacists, health advisers, and the community and voluntary sectors offering outreach and support services. New targeted roles are beginning to develop to provide services to more vulnerable groups and extended roles for professionals such as Health Care Assistants are becoming more widespread.
- Social Care alliances will be fundamental in the development of this service. In particular, joint initiatives to provide tools and devices to support independent living wherever possible and the delivery of shared treatment goals through the support for patients' self care.

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.
-