Transforming Community Services & World Class Commissioning:

Resource Pack for Commissioners of Community Services.

DH INFORMATION

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For Recipient's Use	

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Contents

Foreword

High Quality Care for All defines quality as spanning three areas: patient safety, patient experience and the effectiveness of care. This requires transformational change – by clinicians and other front-line staff, by the organisations providing community services and by commissioners.

As PCTs pursue the health outcomes for their communities that mean most in their local context, they will want to identify the best means possible to achieve them. The community services commissioning portfolio and the work that many are engaged in to commission jointly with their Local Authorities, together present enormous scope to improve health and wellbeing and reduce inequalities.

The NHS investment alone in community services is some £10billion a year and, with Local Authority expenditure, such a substantial sum of money must continually seek to drive up quality, promote personalised care outside of hospital, offer choice and provide modern services.

A more rigorous approach to commissioning using the World Class Commissioning competencies, when combined with the huge value patients place on those who often care for them in their own home and at critical stages in their lives, has enormous potential for a step change.

This Resource Pack draws heavily on some of the excellent application of the world class commissioning approach by PCTs and their Local Authority partners to a wealth of health and social care challenges and we hope it will support and encourage future work.

The Commissioners, including Practice Based Commissioners, have been innovative, determined and impressive in improving quality for local people.

I commend this Resource Pack to Commissioners,

Mark Britnell

Director – General,

Commissioning & System Management

Executive Summary

- The Next Stage Review Primary and Community Care Strategy set out the vision for modern, responsive, high quality community services that give patients greater choice and personalisation and improve access to an integrated range of services. The Transforming Community Services Programme has been set up to help deliver this vision by supporting clinicians and staff to increase their skills and knowledge to innovate, deliver high quality care and lead transformational change. More effective commissioning will also be crucial to transforming community services - World Class Commissioning is the vehicle for delivering this. The Resource Pack (which is part of a suite of WCC products) is intended to help commissioners to secure transformational change in community services.
- The Resource Pack sets out basic principles for commissioning effective and responsive community services. It raises awareness of the challenges and provides examples of good practice in each of the six core service areas themed in the Transforming Community Services Programme: promoting health and well-being and reducing inequalities, services for children and families, long term conditions, acute services closer to home, rehabilitation and long term neurological conditions, end of life care. It includes a route map to help guide commissioners through the process by building on three main foundations: the world class commissioning cycle, competences and effective health and care pathways and concludes with a detailed bibliography to signpost additional information.

Chapter 1

Context

The objectives of this resource pack

The core objectives of this resource pack are as follows:

- To set out the principles of good practice when commissioning Community Services
- To raise awareness of what constitutes good practice
- To showcase existing good practice
- To share lessons learnt and encourage shared learning
- To demonstrate innovation in service development
- To signpost commissioners to the most pertinent and relevant information
- To provide information which will allow commissioners to be better informed about what services to purchase for local communities and how to commission them
- The Bibliography found in Chapter 10 signposts the reader to a number of technical resources associated with the 6 core Transforming Community Services Programme service areas and around World Class Commissioning and Procurement

What this resource pack does not provide is:

- Clinical advice associated with the delivery of Community Services
- Technical advice on how to commission specific services.

Who is this document for?

- Commissioners of Community Services within PCTs including practice based commissioning
- Commissioners in Local Authorities

Any queries relating to the document should be addressed to:

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How has this resource pack been developed?

- The resource pack has been developed drawing on the good practice put forward by PCTs and Local Authorities (LAs)
- All PCTs have been given the opportunity to contribute to the document. It is recognised that there will be examples of good practice not included in the resource pack
- The case studies have been scored against the good practice criteria agreed by the Department of Health
- The scores attributed have been based solely on the information provided by PCTs and LAs during this project
- The scores attributed should not be used for the World Class Commissioning assurance process or any other assurance, audit, award or funding process
- Due to the short timeframe the information included has not been validated with individual PCTs or LAs
- It is recognised that commissioners of Community Services are currently on a journey to improve the way that they commission services for the communities they serve
- The development of this resource pack is therefore an iterative process and the resource pack and case studies will be updated over time. Further information on how the resource pack will be updated will be provided by the Department of Health in due course
- The case studies included have been selected based on information provided by the PCT/LA
- The case studies included have demonstrated good practice against most of the principles of the 3 core foundations set out in this document
- Going forward the case studies will be expected to meet all the good practice criteria to gain entry into future iterations of the resource pack

Setting the Scene for Transforming Community Services

> The Transforming Community Services Programme is designed to improve service provision and drive up quality and overall performance in the services delivered to local communities

The core values of the programme are based around:

> Delivering Excellence for Users

> Enabling Staff

> Empowering Communities

To achieve this the programme will focus on delivering improvements in 6 core service areas:

> Promoting Health and Well Being and Reducing Inequalities

> Services for Children and Families

> Acute Services Closer to Home

> Long Term Conditions

> Rehabilitation and Long Term Neurological Conditions

> End of Life Care

The development of this good practice resource pack for commissioners of Community Services is a key component of the programme

> The core elements of the programme include:

Taken together these practical resources should help re-shape how commissioners of Community Services commission services for the local communities they serve

Chapter 2

The Foundation of Good Practice in Community Service

Chapter 2:
The Foundations of Good Practice in Community Services

What does good practice mean?

> This resource pack sets out the foundations for good practice for commissioners of Community Services

> The 3 foundations of good practice are as follows:

- foundation 1: World Class Commissioning Competencies
- foundation 2: The Commissioning Cycle
- foundation 3: Effective Health and Care Pathways

> The details of each foundation are set out in turn on the following pages

> Taken together the 3 foundations should help commissioners improve the way they commission services for the local communities they serve

> To be considered good practice commissioners must be able to demonstrate and evidence that they have achieved the following:

> Each service change can demonstrate it has, or will seek, to achieve a level 3 or above in at least 5 of the 11 WCC competencies

> The ability to demonstrate and evidence that the service change has followed each of the 6 steps of the commissioning cycle

> The service change needs to have an appropriate and robust business case to justify investment

> Any service change or new service is based on effective health and care pathways

> Effective health and care pathways are proactively rather than reactively pursued

> Any service promotes integrated care

> Services are not bound by organisational or professional boundaries

> Services must be able to demonstrate they are following the effective health and care pathway tiers

Good Practice Foundation 1: World Class Commissioning

Context

> Launched in December 2007, the World Class Commissioning programme aims to drive up the commissioning capability of local NHS commissioners. The World Class Commissioning (WCC) framework was introduced by the Department of Health to assist PCTs on their journey to become world class commissioners of health and care services. The emphasis of this framework is 'to add years to life and life to years.'

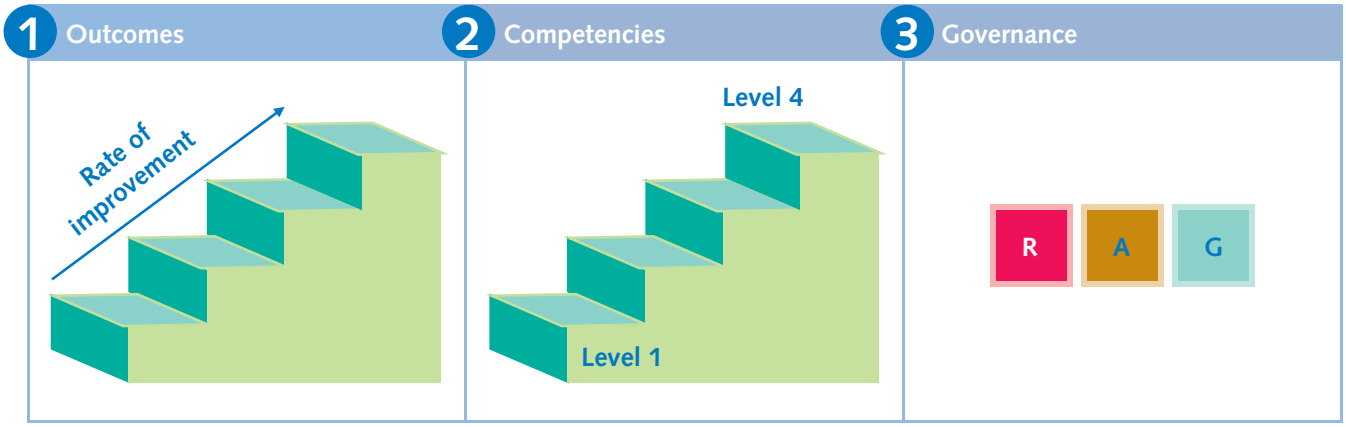
> This is the first year of the framework and as such an assurance process has been set up to establish where PCTs are in relation to WCC. There is recognition that this is a developmental process which involves a rigorous assessment in the first year which becomes the baseline against which future progress is measured. The assessment process can be broken down into 3 component parts:

- **outcomes:** For the purposes of the commissioning assurance PCTs will have up to 10 outcomes for assessment and review. To ensure a degree of national consistency, and because they are core to the business of all commissioners, two of these outcomes, life expectancy and health inequalities will be included by all PCTs.
- **competencies:** There are 11 competencies against which the PCT will be measured. In the first year the PCT has to undertake a self assessment of its progress against the competency framework. The 11 competencies are as follows:

	Level 1	Level 2	Level 3	Level 4
Recognised as the leader of the local NHS				
Working collaboratively with the community partners to commission services that optimise health gains and reduce health inequalities				
Proactively build continuous and meaningful engagement with the public and users to shape services and improve health				
Lead continuous and meaningful engagement of all clinicians to inform strategy and drive quality, service design and resource utilisation				
Manage knowledge and undertake robust and regular needs assessment and establish a full understanding of current and future local health needs and requirements				
Prioritise investment according to local needs, service requirements and values of the NHS				
Effectively stimulate the market to meet demand and secure required clinical and health and wellbeing outcomes				
Promote and specify continuous improvements in quality and outcomes through clinical and provider innovation and configuration				
Secure procurement skills that ensure robust and viable contracts				
Effectively manage systems and work in partnerships with providers to ensure contract compliance and continuous improvement on quality and outcomes and value for money				
World class commissioners make sound financial investment to ensure sustainable development and value for money				

Good Practice Foundation 1: World Class Commissioning

- Each PCT will score themselves against 3 measures within each competency and the outcome of this will be fed into an organisational development plan which will address the actions the PCT needs to take to enable it to continue on its journey to becoming a world class commissioner.
- Governance: this will establish Board grip and will review:
  - strategy – Is there a coherent strategy in place that will deliver improved quality and health outcomes?
  - finance – Is the strategy underpinned by a robust long term financial plan? Is there a sustainable financial position?
  - board – Is the Board aligned? Has the board ensured that the organisation is geared to success? Does the organisation have controls in place to know what is going on?
- The challenge will be conducted via a panel of experts that will test out Board executives and non-executives through an interview process. The questions and areas of review will be based on information provided by the PCT as part of the assessment process and data analysis undertaken by an analyst as part of the panel team. The basis of the assessment is based on the following:



- The feedback will set out the potential for improvement, provides a commentary on the PCT status and current direction of travel and its development needs, focussing on organisational health issues.

How WCC has been used to develop good practice examples included within the resource pack

- We have used the WCC competencies to review all the good examples we have received and inclusion is based on:
  - a score of 3 or above in a least 5 of the WCC competencies. The following diagram sets out the criterion against which case studies have been assessed
  - demonstrate they are on a journey towards world class commissioning
  - progression is sought across all the competencies and there is an expectation that performance will improve prior to next year's assurance process
  - the material and evidence required to demonstrate the locally lead the NHS competency was not available for case-studies and was therefore not tested in this version of the resource pack.

Good Practice Foundation 1: World Class Commissioning

		Level 1	Level 2	Level 3	Level 4
1	**Locally lead the NHS**	• Not tested in this process	• Not tested in this process	• Not tested in this process	• Not tested in this process
2	**Work with community partners**	• Does not meet level 2	• Membership on local strategic partnership boards	• Establish joint commissioning arrangements	• Establish joint commissioning posts, a joint unit and pooled budgets with a clear remit and governance arrangements
3	**Engage with public and users**	• Does not meet level 2	• The PCT actively listens to, understands and responds to public and users	• The PCT formally involves users and public in review of services	• The PCT demonstrates that they know the impact of their involvement and engagement process and how effective it is through evaluation that demonstrates improvement in people's health and experience of services
4	**Collaborate with clinicians**	• Does not meet level 2	• The PCT seeks views of a broad range of clinical groups.	• PCT engagement includes clinicians that represent all healthcare and well-being delivery methods	• Involvement of multi-disciplinary clinicians throughout the commissioning process
5	**Manage knowledge and access needs**	• Does not meet level 2	• A consistent methodology is used to identify gaps in care and drivers of performance	• The PCT analyses progress towards reducing gaps and identifies the key causes of variance from expectations	• The PCT analyses progress and any gaps, identifies the key drivers of variance from expectation and develops solutions
6	**Prioritise investment**	• Does not meet level 2	• Investment proposals contains predicted improvements in health outcomes and impacts on Health Inequalities	• The PCT actively monitors what has happened as a result of past investment	• The PCT understands the returns on investments and compares this to best practice. This is used to inform future investment.
7	**Stimulate the market**	• Does not meet level 2	• The PCT regularly reviews the healthcare provision marketplace and identifies potential providers	• The PCT uses user experience data to develop specification of services and choices available	• The PCT has clear investment and disinvestment processes which lead to a mix of providers based on clinically defined cost/ quality trade-off
8	**Promote improvement and innovation**	• Does not meet level 2	• The PCT benchmarks their current performance against best practice utilising regional and national definitions of best practice through the next stage review and SHA clinical visions	• The PCT and providers review and agree clinical pathways and engage on opportunities for improvement and innovation	• The PCT and providers regularly review and agree clinical pathways and engage on opportunities for improvement and innovation
9	**Secure procurement skills**	• Does not meet level 2	• There is clear identification of defined negotiation variables e.g. cost, quality , clinical indicators and service targets	• The PCT works with providers to develop outcome based service specification	• Negotiation has successfully delivered changes to variables and significant improvements in service quality and value for money.
10	**Manage the local health system**	• Does not meet level 2	• Data collected supports key performance indicators defined in contracts	• There is near real time monitoring on measures where the PCT could have influenced and ensure actions to address problems as they arise	• Data is proactively discussed with providers to drive fact-based continuous improvement in quality and outcomes
11	**Make sound financial investments**	• Does not meet level 2	• Business case to support financial investment	• Develop project and performance process to ensure investments achieve the required outcomes	• Teams need to work together throughout the commissioning cycle. This includes finance, commissioning, contracting, procurement, public health and information analysis.

Good Practice Foundation 2: The Commissioning Cycle

- The second foundation of good practice when commissioning Community Services is to ensure that when re-designing and purchasing services for local communities commissioners carry out a robust commissioning cycle
- Commissioners need to demonstrate and evidence that they have followed the 6 key stages of the commissioning cycle
- To become a world class commissioning organisation PCTs will need to demonstrate compliance with each stage of the commissioning cycle
- A suggested good practice guide model for commissioning Community Services is set out in the following diagram which demonstrates the core objectives and steps commissioners should undertake when commissioning Community Services to ensure that the services to be purchased:
  - meet a priority local need
  - deliver service improvements and improved outcomes for users and
  - offer value for money
- Progress against the stages of the commissioning cycle are indicated at the end of each case study.

The Six Phases of the Commissioning Cycle

Stages	Objectives	Steps
Prioritise Need	• Develop a clear view of priorities (Partner / PCT / user) • Identify clear outcome targets to drive re-design	Horizon Scanning → Analyse data (eg Population) → Prioritise commissioning activity
Plan	• Defining approach and governance • Planning scope and milestone for project	Agreed project plan → Assign Resources
Review current state	• Understanding of current pathway (consult users / partners) • Undertake financial and activity modelling of current pathway • Gain agreement of current pathway	Gather and analyse data → Map current pathway → Model financial and activity data
Design future state	• Design Future Pathway (Clinical and patient involvement) • Perform Financial modelling of future pathway • Agreement of Future Pathway and assumptions with Stakeholders	Understanding Best Practice → Initial design of future pathway → Modelling of future pathway
Implement Service Change	• Develop implementation plan • Review current commissioning approach • Identify supply market and capability • Develop and commercial and procurement strategy	Identify commercial approach → Plan implementation → Implement service change (Procure)
Transition and Monitor	• Transition new service • Monitor and track benefits • Perform corrective action and continually improve service • Review cyclically to ensure delivery and changing needs	Transition service → Monitor and track benefits → Review Pathway

Good Practice Foundation 3: Effective Health & Care Pathway

Good practice within Community Services should focus on maximising well-being, effective prevention and promotion of health, case management and high quality care in ill-health and at the end of life

Effective health and care pathways should be characterised by the following:

- A proactive, risk management approach
- Stratifies local communities by disease risk
- Raises awareness and personal responsibility for one's own health
- Aims to maximise health and minimise disease progression
- Targets skills, expertise and resources at regular risk assessment, early detection and proactive care management
- Aims to get individuals back to/maintain a good standard of well-being
- Flexes intensity of specialist clinical expertise to match the severity and complexity of the condition
- High quality care when people are ill and at the end of life
- Avoids organisational and professional boundaries

Effective Health and Care Pathway	0	1	2	3	4
Focuses on effective prevention, management, maintenance of well-being and promotion of health	Staying Healthy	Risk Assessment and Diagnosis	Self and Early condition management and support	Intervention and crisis management and stabilisation	Specialist intervention and treatment

- Each case study in the document must demonstrate that service provision is being considered in an effective health and care pathway. This starts with work to encourage people to stay healthy
- The focus of an individual case study is reflected in the diagram at the end of each case study.

Chapter 3

Using the Document: Route Map

Chapter 3: Using the Document: Route Map

Individuals using the resource pack should use it in the following way

> Chapters 4-9 represent a specific Transforming Community Service programme core service group (e.g. Chapter 4 covers all Promoting Health and Well Being and Reducing Inequalities case studies)

> These chapters will have a brief introduction setting out the context for this service area

> Case studies are indexed against the effective health and care pathway

> The case studies set out:
  - whether the case study is at the planning (P), Implement (I) or delivered (D) stage (indicated by a box in the top right of the page)

  - a strap line for the case study
  - why the service change was introduced
  - what the change involved
  - what it achieved (or is expected to achieve)
  - the core lessons learnt from undertaking the change
  - the key strengths of the case study in relation to the good practice foundations
  - contact details
  - good practice table outlining how it was scored against (see below):
    - WCC competencies
    - Commissioning Cycle
    - Effective health and care pathway

WCC Competencies	1	2	3	4	5	6	7	8	9	10	11

Commissioning cycle steps	1	2	3	4	5	6

Effective Health and Care Pathway	0	1	2	3	4

> The ratings given to case studies for all 3 assessment criteria do not constitute part of any assurance process and are based purely on information provided during the development of this resource pack

> PCTs wanting further information on the case studies should use the contact details provided for the case study

> Chapter 10 includes a bibliography of key documents for each of the 6 core service areas and for World Class Commissioning

Chapter 3: Using the Document: Route Map (continued)

The following table, which has been developed for the Department of Health by KPMG LLP[1], provides a summary of the case studies by service area and provides an indication of progress against the effective health and care pathway and whether the project is in the planning, implementation or delivered stage

Service Area	PCT/LA	Case study name	Strap-line of case study	Location on Health and Care Pathway	Project Stage (PID)
Promoting Health and Well Being and Reducing Inequalities					
Case Study 1	• NHS County Durham	• Commissioning Strategy for People with Learning Disabilities	• A whole systems approach to commissioning healthcare that are inclusive of the needs of the learning disabled population	0 1 2 3 4	P
Case Study 2	• Northamptonshire PCT	• Sex Workers Around Northamptonshire (SWAN): Improving life opportunities for sex workers and local communities	• To improve the health and life chances of sex workers in order to assist women to exit the sex industry and reduce crime and anti-social behaviour within the communities they currently work	0 1 2 3 4	D
Case Study 3	• Halton and St Helens PCT	• Go! Men's Health Campaign	• The Go Campaign – a men's health programme launched in 2008 to encourage men to take better care of their health and to make more use of available health services	0 1 2 3 4	D
Case Study 4	• Doncaster PCT	• Early Detection and Prevention of Lung Cancer	• A social marketing approach to increase the rate of early detection and prevention of lung cancer	0 1 2 3 4	D
Case Study 5	• Wiltshire PCT	• Neighbourhood teams	• Neighbourhood teams: A vision to provide equitable services to the population encompassing urgent, managed, rehabilitation, long term conditions and end of life care	0 1 2 3 4	I

[1]KPMG LLP, a UK limited liability partnership, is a member of KPMG International, a Swiss cooperative

Service Area	PCT/LA	Case study name	Strap-line of case study	Location on Health and Care Pathway	Project Stage (PID)
Services for Children and Families					
Case Study 1	• Stockport PCT	• The Children and Young People's Disability Partnership (CYPDisP)	• A Whole Systems approach to supporting children and young people with disabilities and their families	0 1 2 3 4	I
Case Study 2	• Oxford-shire County Council	• Joint Commissioning of Primary Child and Adolescent Mental Health Services	• Joint Commissioning of Primary Child and Adolescent Mental Health Services • PCAMHS won the prestigious Health Service Journal Award in 2007 for Mental Health Innovation and the MJ Award in 2008 for partnership between health and local government	0 1 2 3 4	D
Case Study 3	• Luton PCT	• Redesign of services for children with complex disabilities	• Redesign of services for children with complex disabilities using a multi-disciplinary approach using a performance improvement process that has resulted in parents feeling more supported, empowered and satisfied with service delivery	0 1 2 3 4	D

Service Area	PCT/LA	Case study name	Strap-line of case study	Location on Health and Care Pathway	Project Stage (PID)
Acute Services Closer to Home					
Case Study 1	• Oldham Council	• Personalised Care	• Development of personalisation to enable users and cares to take more control of their care if they wish based on an individual budget	0 1 2 3 4	D
Case Study 2	• Salford PCT and Council	• Rapid response	• Joint health and social care approach that providers users and carers with a crisis response which has avoided emergency admissions and attendance at A&E and enabled both the PCT and Social Care to achieve savings	0 1 2 3 4	D
Case Study 3	• West Sussex PCT	• Virtual Ward	• Currently implementing an integrated Primary and Community Care strategy across the county which has reduced admissions and resulted in a 20% improvement in productivity within community hospitals	0 1 2 3 4	I
Case Study 4	• Surrey PCT	• Procurement of a GP led health centre	• Procurement of a GP led health centre to improve health outcomes for a poorly doctored area.	0 1 2 3 4	I
Case Study 5	• Surrey PCT	• Integrated heart failure in the community	• Developed a integrated heart failure service which resulted in the establishment of a community focused service that operated effectively across the community and acute sector	0 1 2 3 4	D

Service Area	PCT/LA	Case study name	Strap-line of case study	Location on Health and Care Pathway	Project Stage (PID)
Acute Services Closer to Home					
Case Study 6	• Stockport PCT	• Assessment, diagnostic and referral point for ambulatory care sensitive conditions	• An assessment, diagnostic and referral point which will deliver Enhanced Primary Care in a community setting for ambulatory care sensitive conditions	0 1 2 3 4	P
Case Study 7	• Sheffield PCT	• PBC – Enhanced local service to nursing care homes	• PBC project within the nursing home sector which has improved GP access and management whilst reducing needs for hospital admission	0 1 2 3 4	D

Service Area	PCT/LA	Case study name	Strap-line of case study	Location on Health and Care Pathway	Project Stage (PID)
Rehabilitation and Long Term Neurological Conditions					
Case Study 1	• Stockport PCT	• Community Falls Service	• A Community Falls Service that provides assessment and rehabilitation of older people at risk	0 1 2 3 4	P
Case Study 2	• Berkshire West PCT	• Pulmonary Rehabilitation Programme	• Pulmonary Rehabilitation programme: To optimise individuals physical and social performance and autonomy	0 1 2 3 4	D
Case Study 3	• Salford PCT	• Cardiac rehabilitation	• Redesigned the cardiac rehabilitation service to ensure it better meets the needs of the patient through a menu type approach. This means that the solution is individualised to meet the patient need and is able to offer life long access to affordable leisure facilities.	0 1 2 3 4	D
Case Study 4	• Berkshire West PCT	• An early discharge support service for Stroke	• An early supported discharge and rehabilitation service for people who have suffered a stroke	0 1 2 3 4	I
Case Study 5	• Surrey PCT/ LA	• Health and Social Care Rehabilitation Service	• A joint service drawing together both Surrey County Council and Surrey Primary Care Trust to provide a fully integrated service in east surrey that best meet population needs	0 1 2 3 4	D
Case Study 6	• Greenwich PCT	• COPD Support and Rehabilitation service	• Greenwich COPD Clinical Service Framework which includes Pulmonary Rehabilitation programme	0 1 2 3 4	D

Service Area	PCT/LA	Case study name	Strap-line of case study	Location on Health and Care Pathway	Project Stage (PID)
Long term conditions					
Case Study 1	• Bournemouth and Poole PCT	• Poole Intermediate Care Service	• Poole Intermediate Care Services: An integrated health and social care service, delivered in the community and with single line management	0 1 2 3 4	I
Case Study 2	• Salford PCT	• Chronic Obstructive Pulmonary Disease (COPD) reconfiguration	• Improve the performance of this service which was high cost due to high number of admissions and longer length of stay against the national average.	0 1 2 3 4	I
Case Study 3	• Halton and St Helens PCT	• Chronic Obstructive Pulmonary Disease (COPD) Pathway Review: Introducing a new service delivery model	• To develop an integrated model of care for COPD across the Halton and St Helens PCT area to harmonise the services received by patients and reduce the number of admissions into the acute sector	0 1 2 3 4	I
Case Study 4	• Nottingham County PCT	• Chronic Obstructive Pulmonary Disease (COPD) – A condition management approach to commissioning services	• By knowing who is at risk and intervening early we can provide care for twice as many people, for less money – and reduce the number of attendances at A&E by 60%	0 1 2 3 4	I
Case Study 5	• Sheffield PCT	• Neurology reconfiguration	• Improve the performance of this service which is currently providing equitable service across the city and is not meeting user needs	0 1 2 3 4	I

Service Area	PCT/LA	Case study name	Strap-line of case study	Location on Health and Care Pathway	Project Stage (PID)
Long term conditions					
Case Study 6	• Manchester PCT	• Chronic Obstructive Pulmonary Disease (COPD) – Redesign and tender service	• Evaluation established that the service was focused mainly on the acute sector with significant gaps within the community . Developed a business case which resulted in two service specifications (Oxygen provision and Community clinic/ outreach service), tender the service, had five bidder shortlisted 3 who have been invited for interview	0 1 2 3 4	I

Service Area	PCT/LA	Case study name	Strap-line of case study	Location on Health and Care Pathway	Project Stage (PID)
End of Life Care					
Case Study 1	• Bournemouth and Poole PCT	• The Poole Palliative Care Service	• A 24/7 day nurse led community generalist palliative service that gives users the opportunity to remain in their home at the end of life	0 1 2 3 4	D
Case Study 2	• Berkshire West PCT	• Palliative Care Service	• Palliative care- where and when needed at the most appropriate setting	0 1 2 3 4	D
Case Study 3	• Hillingdon PCT	• Community Palliative Nurse led Clinic	• A management plan for all patients identified with a limited prognosis	0 1 2 3 4	I

Chapter 4

Promoting Health and Well Being and Reducing Inequalities

Chapter 4: Promoting Health and Well Being and Reducing Inequalities

Context

> Over the last 50 years, there have been impressive socio economic and health improvements in this country. Although life expectancy and quality of life has improved by leaps and bounds, even today, not everyone is able to share the benefits of these improvements

> Health inequalities are unacceptable in a modern, civilized society. They start early in life and persist not only into old age but subsequent generations. Tackling health inequalities is a top priority on the Health and Social Care agenda, and it is focused on narrowing the health gap between disadvantaged groups, communities and the rest of the country, and on improving health overall

> Tacking Health Inequalities: A Programme for Action was launched in July 2003 as the health inequalities cross government strategy. Backed by twelve departments, the Programme lays the foundation for meeting the government's targets to reduce the health gap on infant mortality and life expectancy by 2010

Specific Target

> The health inequalities PSA Target is by 2010 to reduce inequalities in health outcomes by 10 per cent as measured by infant mortality and life expectancy at birth

> The Secretary of State for Health announced the new comprehensive strategy for reducing health inequalities 'Health Inequalities Progress and Next Steps published in June 2008 which sets out the next phase of health inequalities work and commissioning. The new strategy challenges the NHS, as a key player, to live up to its founding and enduring values of universality and fairness addressing unjustified gaps in health status, fair access to NHS services for all and good outcomes for all

> Community Services are a vital component in reducing health inequalities. Commissioning (and providing) services that focus on achieving better health with everyone working together to promote inclusion and tackle health inequalities is a challenge

> The remainder of the chapter includes examples of 'Health Inequalities' good practice case studies

> Relevant policy documents and resources associated with the health inequalities can be found in the Chapter 10 the Bibliography. This also includes relevant documents associated with the World Class Commissioning agenda and procurement

Case Study 1

Commissioning Strategy for People with Learning Disabilities
NHS County Durham

P

A whole systems approach to commissioning healthcare that are inclusive of the needs of the learning disabled population

Why?

> Consultation with 200 service users and their carers on their experiences of accessing mainstream health services such as general practice and general hospitals

> Valuing People

> Sir Jonathon Michaels Independent Inquiry Report into access to healthcare

> NHS County Durham commissioning strategy for learning disability services

What?

> Service developments were intended to increase access into mainstream health service provision for service users and their carers. 3 new services have been planned underpinned by a common commissioning strategy across the local health economy:
  - a commissioning of a Health Facilitation Service
  - a primary care mental health support service to ensure access to mainstream community mental health services for people with a learning disability and concurrent mild mental health condition
  - commissioning of a primary care support service to work with GP practices to support the implementation of the DES and to ensure health screening is accessible to people with a learning disability

> Currently working on a joint commissioning strategy for learning disability with the Local Authority

> Working with Public Health on the provision of information in accessible forms

What we expect to achieve?

Improved health outcomes

> Improve access into mainstream health services for people with a learning disability

Quality

> Increasing independence and choice

> Raising the health agenda for learning disability services

Performance improvement

> New services underpinned by national guidance and targets

> Decommissioning of outdated service models

> Move away from specialist to mainstream service provisions

> Performance monitoring through new contracting arrangements

Value for money

> County wide strategy to ensure an increase in quality of service and seamless user experience

> Move towards mainstream health provision is not only inclusive but is likely to be better value for money than specialist services

> Increasing independence amongst service users will lessen the cost to the health economy and release savings for re-investment in learning disability services

Case Study 1 (continued)

Commissioning Strategy for People with Learning Disabilities
NHS County Durham

P

A whole systems approach to commissioning healthcare that are inclusive of the needs of the learning disabled population

Skill mix and Training

> Joint working arrangements with colleagues in the local authority and NHS Trusts will further enhance the available skill mix for the services

> Raising awareness of the learning disabled population, the development of new service areas and the move from specialist to mainstream health provision will all have to be supported by training for staff who may not have previously worked with the learning disabled population

> Development of web based training tools for health professionals working in acute services.

Lessons Learned

> Support from the learning disability community and health professionals has been hugely helpful in pushing forward the change agenda

> Importance of timely planning.

Key strengths

> Service developments are intended to increase access into mainstream health service provision for service users and their carers

> To make healthcare professionals more aware of the specific needs of their learning disabled population

> To increase access into preventative healthcare and health promotion programmes

> To provide specialist support to service users and carers and health professionals during admission and discharge from hospital

> To ensure that people with learning disability were given the opportunity to have a health action plan completed with the help of a health facilitator if required

> To raise general awareness of learning disability issues and provide a commissioning framework for the next 3 years to support investment

> To provide support to general practice in the implementation of the new directed enhanced service for learning disability and to link this to the health facilitation service

> To develop improved communication between mainstream and specialist health services

> To promote partnership working between agencies.

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Case Study 1 (continued)

Commissioning Strategy for People with Learning Disabilities
NHS County Durham

P

A whole systems approach to commissioning healthcare that are inclusive of the needs of the learning disabled population

Why is it included?

- The PCT has been able to demonstrate that they have achieved 3 or more in at least five of the WCC competencies
- The PCT has followed clear and logical steps in its commissioning approach for this new service
- This is a good example of a planned service working to provide care that supports high quality care across the effective health and care pathway

Good practice table

WCC Competencies	1	2	3	4	5	6	7	8	9	10	11

Commissioning steps	1	2	3	4	5	6

Effective Health and Care Pathway	0	1	2	3	4

Case Study 2

Sex Workers Around Northamptonshire (SWAN): Improving life opportunities for sex workers and local communities
Northamptonshire PCT

D

To improve the health and life chances of sex workers in order to assist women to exit the sex industry and reduce crime and anti-social behaviour within the communities they currently work.

Why?

- The SWAN programme was established following a community crime and anti-social behaviour initiative which found prostitution and drugs were the key issues affecting the Spring Borough part of Northampton
- A multiagency partnership (PCT, Drugs and Alcohol Team, Police, GP service, Probation, Housing, Borough and County Council) was established to provide a wide range of services to assist women to exit sex work
- The target clients have complex and chaotic lifestyles which mean that a multiagency approach is essential in order to provide a holistic service which offers a wide range of services, knowledge and skills

What did we do?

- The overall aim of the service is to provide safe, supported and sustainable opportunities for sex workers to exit from prostitution, thereby improving life chances for women, children and young people engaged in or affected by prostitution. The SWAN partnership also works towards improving the quality of life for the local community affected by prostitution and contributes to the reduction of crime caused by illegal drugs and antisocial behaviour
- SWAN services are provided through a variety of approaches and include:
  - evening outreach to street sex working areas
  - targeted outreach to indoor sex working establishments
  - one to one appointments (including enforceable criminal justice appointments)
  - dedicated drop in times
  - flexible contact at the dedicated centre
  - housing support and direct accommodation
  - probation support
  - fast drug treatment (48 hours turnover)
  - practical assistance (e.g. sexual health materials, showers, washing needle exchange)
- All services are delivered from a range of agencies (PCT, Drugs and Alcohol Team, GP service, Probation, Housing) within one friendly, approachable environment to ensure ease of access to the mix of services needed and offers the opportunity to develop existing relationships and activities

What we achieved?

- At the start of the programme 200 sex workers were working as street sex workers providing a 24 hour service. This has fallen to around 20 active street sex workers who only work at night
- Reduction in crime amongst within the local community
- Increase in the number of sex workers registered with a GP (90% now registered)
- Increased number of sex workers accessing substance treatment
- Increased number of sex workers in safe, sustainable housing
- Increased access to health screening
- Reduced instances of sexually transmitted infections and blood borne viruses
- Increasing number of sex workers retained on probation orders
- Decreasing levels of crime in sex working population (e.g. at start of programme £16 million drug use per annum in this small area which has fallen to £2.5 million per annum)
- Street sex working now contained within this borough within Northamptonshire

Case Study 2 (continued)

Sex Workers Around Northamptonshire (SWAN): Improving life opportunities for sex workers and local communities
Northamptonshire PCT

D

To improve the health and life chances of sex workers in order to assist women to exit the sex industry and reduce crime and anti-social behaviour within the communities they currently work.

Lessons Learned

> Need to simultaneously address the complex needs of clients and flex service to meet their needs

> Must ensure sustainable partnership working key to address complex issues facing clients

> Need to be clear what benefits each partner requires from the service

> To ensure that funding for posts are mainstreamed

> Need to work closely with police to tackle demand

Key strengths

> Strong and sustainable multi-agency partnership

> Holistic approach to service provision

Good practice table

WCC Competencies	1	2	3	4	5	6	7	8	9	10	11
		■	■	■	■		■				■

Commissioning steps	1	2	3	4	5	6
	■	■	■	■	■	■

Effective Health and Care Pathway	0	1	2	3	4
	■	■			

Why was it included?

> Example of successful multi-agency working

> The programme has demonstrated a score of 3 or above on at least 5 of the WCC competencies

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Case Study 3

Go – Men's Health Campaign
Halton and St Helens PCT

The Go Campaign – A men's health programme launched in 2008 to encourage men to take better care of their health and to make more use of available health services

Why?

> In response to poor male health statistics in Halton's more deprived neighbourhoods, a dedicated approach was developed to engage with men over 40 through the delivery of free health checks. The target audience consisted of men over 40 in Halton's most deprived wards. A thorough social marketing approach was employed, ensuring the programme was based on clear insights into the lives and attitudes of the target audience

What did we do?

> A dedicated service was built around the needs of local men – with flexible times for health checks, non-clinical settings and venues that were accessible. Motivating the target audience to attend the health checks in the first place was a key challenge – given that men in the most deprived areas are often disengaged from services and in some cases socially isolated. Provision of what they asked for – 'a service just for us' – provided an excellent motivational tool

Objectives/Behavioural Goals:

> To motivate the target audience to attend a free men's health check

> To engage attendees with additional programmes relevant to their health situation

> To promote simple ways of achieving healthier lifestyles on a one-to-one basis

What did we achieve?

> The approach increases access to a hard-to-reach group, exemplifies the social marketing concepts of exchange and competition, and is totally based on audience insight gained through meaningful consultation

> The evaluation of the programme is being carried out by the University of Liverpool. However a review of the marketing has been built into the booking process to enable ongoing refinement and adjustment

> Initial results surpassed all expectations with the first sessions being over-subscribed. To date the programme has continued to meet its challenging targets, and continued innovation has been seen in the flexibility to keep stimulating demand. 57% of attendees have since gone on to access further services – including diet and exercise interventions, smoking cessation and health trainer services – reflecting ongoing engagement that will drive genuine health improvements

The Go Campaign has built in the National Social Marketing Centre's key benchmark criteria throughout the whole process. However, this case study provides particularly strong examples of:

> Being insight-driven

> Utilising the exchange concept

> Using a mix of methods to get the message to the target audience

> This case study was recently presented at the World Social Marketing Conference

Case Study 3 (continued)

Go – Men's Health Campaign
Halton and St Helens PCT

I

The Go Campaign – A men's health programme launched in 2008 to encourage men to take better care of their health and to make more use of available health services

Lessons Learned

> The programme draws upon best practice and developed a social marketing approach, undertaking research with local men. A key element of the programme is a 'lessons learnt' approach with continuous consultation with men to encourage contributions from users to shape activities and wider delivery of the programme

Key strengths

> Clear focus on prevention and promotion of health and well being

> Funded by neighbourhood management in Halton

> Effective management of a live and dynamic campaign

> Success has led to the programme being rolled out to St Helen's

Why is it included?

> The PCT has been able to demonstrate that they have achieved 3 or more in at least five of the WCC competencies

> The PCT has followed clear and logical steps in its commissioning approach for this new service

> This is a good example of a service which impacts on major part of the effective health and care pathway

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Good practice table

WCC Competencies	1	2	3	4	5	6	7	8	9	10	11
	■	■	■		■	■		■		■	

Commissioning steps	1	2	3	4	5	6
	■	■	■	■	■	■

Effective Health and Care Pathway	0	1	2	3	4
	■	■			

Case Study 4

Early Detection and Prevention of Lung Cancer
Doncaster PCT

D

A Social Marketing Approach to increase the rate of early detection and prevention of lung cancer

Why?

> Doncaster has significantly higher-than-average death rates from cancer and chronic lung disease, particularly among more disadvantaged people. The awareness campaign was prioritised to reflect:
  - the overall PCT vision to 'promote public health and reduce inequalities: through the prevention, investment, partnerships and the commissioning of high quality, accessible services'
  - the 'Achieving Early Impact Programme' which focuses on initiatives which will have the greatest impact on improving the local life expectancy and particularly targets the most disadvantaged 20% of Doncaster's population
  - a social marketing scheme focusing on early diagnosis of lung cancer amongst the most deprived areas of Doncaster which is aligned with both of the objectives of promoting health and reducing inequalities

What did we do?

> The aim of this project was to use a Social Marketing approach to increase the rate of early detection of lung cancer in the Doncaster area. This project was a pilot with potential for a more significant roll-out if proven successful

> A social marketing approach was adopted to raise awareness and target the audience and their families to the need for awareness of early symptoms of lung cancer. The campaign also sought to change behaviour; the target audience needed to be encouraged and empowered to present their health concerns to their GPs and ask directly for a chest X-ray

> The insights from the initial research and the geo-demographic profiling allowed for extremely targeted media campaign. This included an integrated mix of media including local press, appropriate bus routes, beer mats in working men's clubs and pubs, and pharmacy bags. A uniquely impactful campaign was enhanced by 'coughing' bus shelters, where sound chips coughed repeatedly to draw attention to the creative message

> The training materials for GPs was also designed to reflect the creative idea & form an integrated part of the campaign

What we aim to achieve?

> The main aim of the project was to improve life expectancy and reduce health inequalities in the Doncaster area by focusing on the early identification of lung cancer in a primary target audience of adults aged over 50 from lower socio economic groups

> Positive changes are already evident in the target audience's behaviour. In the pilot area there has been an increase in propensity to visit a GP with a 'really bad' cough. There has also been a large increase in the pilot area for patients visiting with a 'really bad' cough to request a chest X-ray. There is also a measurable change in attitudes towards 3-week coughs from family members, and good evidence of campaign awareness

Case Study 4 (continued)

Early Detection and Prevention of Lung Cancer
Doncaster PCT

D

A Social Marketing Approach to increase the rate of early detection and prevention of lung cancer

Lessons Learned

- The project formed partnerships with advertising and media agencies to design and develop the awareness campaign which would target this audience. The insights that came from the segmentation process were crucial
- The awareness campaign approach combined elements of traditional advertising and also a strong PR element in order to attract the attention of both audiences
- Qualitative research was commissioned to ascertain consumer attitudes and behaviours around the broader issue of lung cancer and also issues which impacted on their likelihood to present early
- The depth of insight meant that media planning ensured the most appropriate media to reach the target audience was utilised
- The project commenced following the five step social marketing approach recommended by the NSMC (Scope, Develop, Implement, Evaluate and Follow-up). However, it became clear that a clearer focus regarding the precise nature of the project was required and this was reflected in the addition of a sixth stage: Define

Key strengths

- Championing a Social Marketing Approach within the NHS
- Placing Planning at the Heart of the Developmental Process
- An Integrated Approach to 'Consumer Push' and 'Service Pull' : The public awareness campaign focused on the 'consumer push': raising awareness of the symptoms of lung cancer and the benefits of early detection. However it was also necessary to ensure that the 'service pull' was targeted to make sure that patients successfully entered the service
- Challenging Social Marketing Best Practice
- A structured evaluation process; the framework of assessment was broken down into four distinct areas: reach; changing attitudes; response; and service with measurable outcomes for each.

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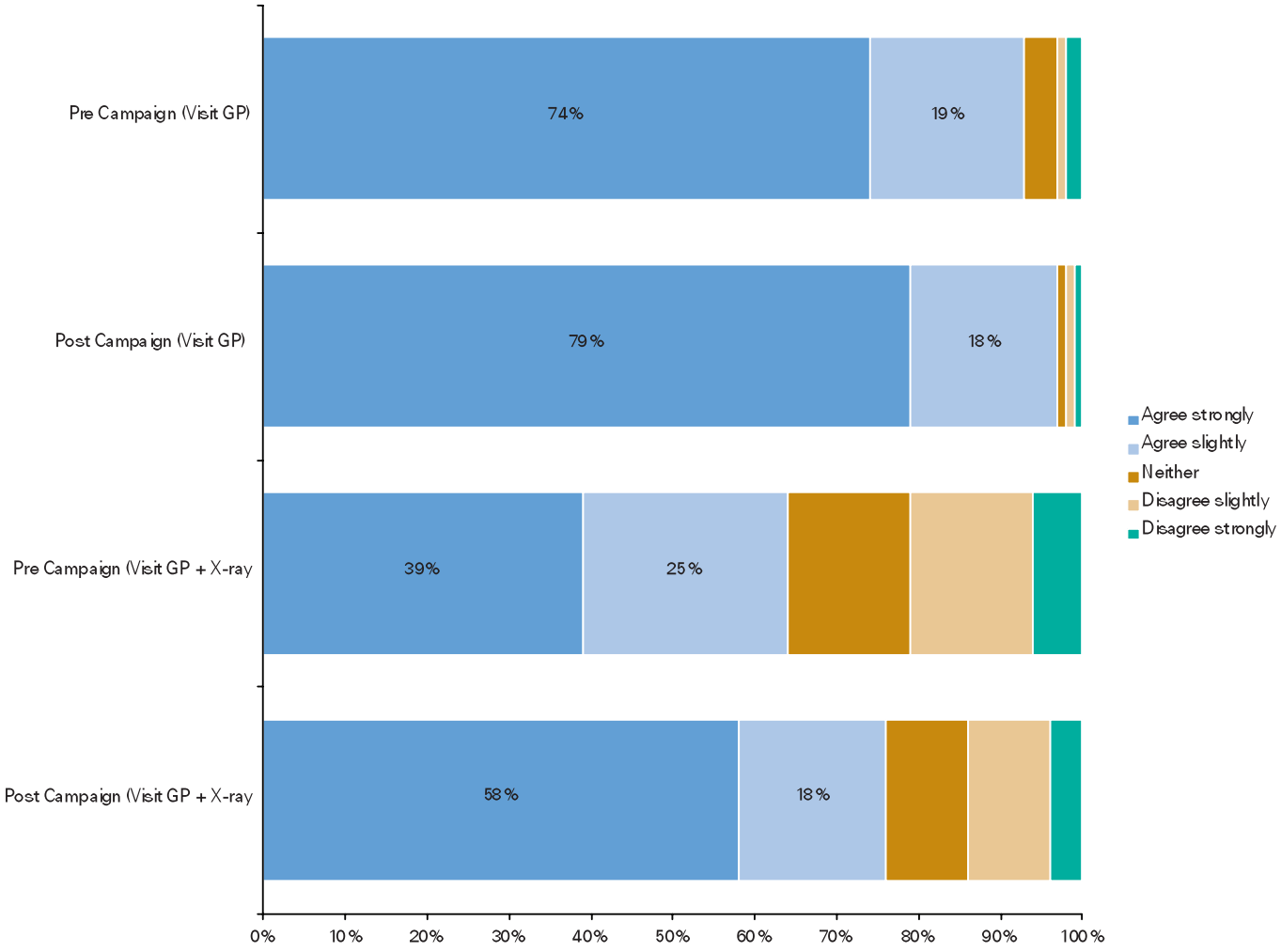
Case Study 4

Early Detection and Prevention of Lung Cancer
Doncaster PCT

D

A Social Marketing Approach to increase the rate of early detection and prevention of lung cancer



> Early results show that the proportion of targeted individuals that would visit their GP and ask for a Chest X Ray has increased from 39% to 58% for the proportion who stated they agree strongly with this statement

> The proportions for all agreeing shifted from 64% to 76%

> The PCT is currently waiting for data showing the numbers of presentations at each target surgery which will indicate whether intent translates to action

Case Study 4 (continued)

Early Detection and Prevention of Lung Cancer
Doncaster PCT

D

A Social Marketing Approach to increase the rate of early detection and prevention of lung cancer

> The level of change for each target surgery between the 'pre' and 'post' measures and contrasts with the control group area:

% Change: Pre Campaign to Post Campaign							
Statistically Significant positive change at 95% level	**Hyde Park** (n=118;n=119)	**Highfields** (n=63;n=85)	**Denaby Main** (n=116;n=103)	**Stainforth** (n=146;n=108)	**Clay Lane** (n=78;n=89)	**Toll Bar &** (n=81;n=96)	**Control (DN8 4)** (n=199;n=200)
Would visit GP if had a 'really bad' cough?	8	8	–	6	1	1	(3)
Would visit GP if had a 'really bad' cough and ask for an X-ray?	16	11	20	21	–	(6)	(3)
Very concerned if had a cough for more than 3 weeks	12	13	7	(7)	(9)	(1)	(1)
Would leave cough no more than 3 weeks before visiting GP	4	14	6	–	(2)	1	(5)
Would recommend to friend/ family not to leave cough any more than 3 weeks before visiting GP	9	11	7	1	7	4	–
Seen/read/heard anything relating to 3 week cough	13	9	7	21	17	(7)	7

> While the campaign has had a different result by location, the broad pattern between our test and control sites is clearly evident – awareness has forced a change in intent

Case Study 4

Early Detection and Prevention of Lung Cancer
Doncaster PCT

D

A Social Marketing Approach to increase the rate of early detection and prevention of lung cancer

Why is it included?

> The PCT has been able to demonstrate that they have achieved 3 or more in at least five of the WCC competencies

> The PCT has followed clear and logical steps in its commissioning approach for this new service

> This is a good example of a service at the front end which impacts across the effective health and care pathway

Good practice table

WCC Competencies	1	2	3	4	5	6	7	8	9	10	11

Commissioning steps	1	2	3	4	5	6

Effective Health and Care Pathway	0	1	2	3	4

Case Study 5

(but also falls under Rehabilitation and Long Term Neurological Conditions, Acute Care, Long Term Conditions and End of Life Care)

I

Neighbourhood teams
Wiltshire PCT

Neighbourhood teams: A vision to provide equitable services to the population encompassing urgent, managed, rehabilitation, long term conditions and end of life care

Why?

> Neighbourhood teams are multi disciplinary teams working closely with primary care, specialist services and social care to provide community based services for adults (with the exception of those services which are exclusively mental health and learning disability services) currently provided by Wiltshire NHS. The aim of this service was to provide equitable services to the PCT population and to provide care in the most clinically cost effective way and with maximum responsiveness, flexibility, support and access

What did we do?

> The service was visioned as a holistic, multi-disciplinary care in the community based on patients' need and working in collaboration with GP practices, specialist services, mental health, social care and other partner agencies. The teams consisting of nurses, OTs, Physiotherapists and support workers will support the GP populations for both urgent and managed care. Core service hours are 7 AM to 10 PM , seven days a week with a out of hours nursing needs service helpline to cover from 10 PM to 7AM. The team seeks alternatives to hospital admissions in order to avoid inappropriate use of hospital beds, prolonged and unnecessary stay in hospital or inappropriate admissions to long term care. For users for whom admission is unavoidable, the team facilitates timely return to their home through close liaison with the inpatient setting

Neighbourhood Teams would support four kinds of patients:

> Patients needing urgent care – the teams would provide a fast response service to patients requiring an urgent response to a health crisis. People requiring an 'urgent response' would be seen by the appropriate professional from the Neighbourhood Team, assessed and where appropriate be treated at home

> Patients needing support in managing their own care – the teams would support people who need a period of planned care to support them during active treatment, post hospital stay or post operatively-providing a range of Community Services monitoring and helping to maintain patients' health status. This service links closely with Community Matrons

> Patients who are elderly and frail and need some co-ordinated medical intervention – providing a range of services to assess and treat people quickly to avoid hospital admissions. Enabling and supporting people to manage their own chronic conditions such as diabetes, asthma, heart disease by regular monitoring through specialist multi-disciplinary clinics

> Patients needing palliative care – The neighbourhood teams would work alongside Dorothy House Hospice, Prospect Hospice, Macmillan Nurses and Marie Curie to provide support to patients nearing the end stages of life and to their carers; thereby offering more choice of palliative care to patients and support as their disease progresses

> The service is founded on the principles of evidence based with clear clinical pathways and a patient-led philosophy that enables and supports people and carers to manage their care themselves

What we aim to achieve?

> The aim of this programme is to:
  - increase the number of people receiving services in the community rather than in acute settings
  - increase the proportion of older people being supported to live in their own homes

Case Study 5 (continued)

(but also falls under Rehabilitation and Long Term Neurological Conditions, Acute Care, Long Term Conditions and End of Life Care)

I

Neighbourhood teams
Wiltshire PCT

Neighbourhood teams: A vision to provide equitable services to the population encompassing urgent, managed, rehabilitation, long term conditions and end of life care

- reduce number of admissions to hospitals, and length of inpatient stay
- no patient should be readmitted as a non-elective to inpatient care within 28 days of discharge from the neighbourhood team
- reduce emergency bed stays through improved care in primary care and community settings for people with long term conditions
- increasing in number of people dying in their place of choice

Lessons Learned

> Gain commitments from all agencies involved and agree a shared vision

> Moving away from a medical led and hospital based model of care was a challenge

> Establishing and working to clearly defined pathways and patient flows

> New ways of working

Key strengths

> Centred on clusters of GP Practices and would have one single point of access

> Strong links would exist between the Neighbourhood Teams and all GP practices to ensure good communication between the person's GP and the Neighbourhood Teams

> Each person being cared for by a Neighbourhood Team would have a plan of that care

> Two important groups of people who currently come into hospital but in future could be supported at home by Neighbourhood Teams are those who have a chest or urine infection and those who have fallen but do not have a serious injury, but are shaken and have lost their confidence

> Patients would receive the majority of their care from their GPs, as they do now – and in addition to that, they may receive care from Neighbourhood Teams which would replace some of the care they may traditionally have received from their community hospital

> The Neighbourhood Teams would provide a service for patients in a variety of settings, such as GP practices, Primary Care Centres, registered care homes as well as in the patient's own home. We envisage that each team would consist of 30 – 35 whole time equivalent staff, depending upon the size and the demography of the area.

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Case Study 5 (continued)

(but also falls under Rehabilitation and Long Term Neurological Conditions, Acute Care, Long Term Conditions and End of Life Care)

Neighbourhood teams

I

Neighbourhood teams: A vision to provide equitable services to the population encompassing urgent, managed, rehabilitation, long term conditions and end of life care

Why is it included?

- The PCT has been able to demonstrate that they have achieved 3 or more in at least five of the WCC competencies
- The PCT has followed clear and logical steps in its commissioning approach for this new service
- This is a good example of a service which impacts across the health and care pathway

Good practice table

WCC Competencies	1	2	3	4	5	6	7	8	9	10	11
	■	■	■	■		■	■	■			

Commissioning steps	1	2	3	4	5	6
	■	■	■	■	■	

Effective Health and Care Pathway	0	1	2	3	4
	■	■	■	■	■

Chapter 5

Services for Children and Families

Chapter 5: Services for Children and Families

Context

> Society has a duty to promote the welfare of children. The Children and Families Agenda is a partnership working amongst various agencies, including health, social service, education, voluntary sector organisations and with other local authorities, to ensure that children and their families are provided with the best service

> The Government's policy **Every Child Matters**, set out a new approach to the well-being of children and young people from birth to age 19. It described the Government's aim for every child, whatever their background or their circumstances, to have the support they need to
  - be healthy
  - stay safe
  - enjoy and achieve
  - make a positive contribution
  - achieve economic well being

> The Government is consulting on proposals to give Sure Start Children's Centres (SSCCs) a specific statutory legal basis, as part of the forthcoming Education and Skills Bill

> The health agenda is spearheaded by the **Children's National Service Framework** (NSF), which is a 10-year programme intended to stimulate long-term and sustained improvement in children's health. Setting eleven standards for health and social services for children, young people and pregnant women, the NSF aims to ensure fair, high quality and integrated health and social care from pregnancy, right through to adulthood

> The current commissioning guidelines set out the need for specific services to be designed and delivered around the needs of children and families

> The remainder of the chapter includes examples of 'children and families' good practice case studies

> Relevant policy documents and resources associated with the 'children and families' agenda can be found in the Chapter 10: Bibliography. This also includes relevant documents associated with the World Class Commissioning agenda and procurement.

Case Study 1

The Children and Young People's Disability Partnership (CYPDisP)
Stockport PCT

D

A Whole Systems approach to supporting children and young people with disabilities and their families

Why?

> The key driver for the initiative was to plan, design, provide and develop services that are joined up and are centred on children and young people with disabilities in Stockport so that they can achieve their highest potential

What did we do?

> The Children and Young People's Disability Partnership (CYPDisP) has been established bringing together staff from NHS Provider services, Stockport Primay Care Trust, Stepping Hill NHS Foundation trust and Local Authority

> There are 3 main strands to their work:
- Social Care Disability Service
- Special Educational Needs
- Additional/Continuing Health Care Needs

> Services are delivered within the local communities at children's centres and extended schools; however the partnership has a main base at Beckwith House in central Stockport. The Partnership includes the following services
- CYPDisP Social Care
- Speech and Language Therapy
- Occupational Therapy
- Community Equipment and Adaptations Service
- Special Educational Needs Service
- Autism Spectrum Disorder Project
- Portage Services
- Disability Database
- Community Learning Disability Team
- Dragon Fly – Palliative Care
- Inclusion Coordinators

What we achieved?

> The partnership aims to deliver services that offer:

- flexibility –Services will put the needs of the child at the centre of service delivery
- choice – where possible we will have a range of different services available with elements of choice for children and families
- accessibility – while some services provided by statutory agencies will be subject to assessment and threshold criteria, other services in the community will provide open access to children and families. Whether services are universal or subject to assessment the process for accessing them will be simple and clear and will avoid duplication.

Case Study 1 (continued)

The Children and Young People's Disability Partnership (CYPDisP)
Stockport PCT

D

A Whole Systems approach to supporting children and young people with disabilities and their families

> Transparency – where access to services is subject to assessment, these processes will be fair and transparent with the child and family participating fully and having access to all information recorded about them

> Multi-Agency support – Social Services, Education, Health, the voluntary sector and other agencies will work in partnership, together with parents to improve outcomes for disabled children with complex needs

> Inclusivity – Disabled children have the right to be included and to access services and activities within their local communities and promote participation of young people within their communities

> Value– services will promote self-esteem and self-reliance, value children and their families

> Holistic services – the provision of services will not focus exclusively on needs arising from disability, but will take note of other needs of children and their families

> Improved Outcomes– services will focus on improving outcomes and will be able to evidence improvement

Lessons Learned

> Quick wins – it was possible to make some simple effective changes just following on from sharing information in the office and discussing a few key issues, e.g. re-charging equipment to SMBC so VAT saved and money effectively pooled budgets although not actually pooled

> Outcomes are shared across all agencies and staff in the partnership changed philosophies and culture quite quickly in terms of funding, roles etc – this pace has tended to be faster sometimes than the strategic view

> The support needed from back office functions e.g. estates, IT, HR etc was underestimated resulting in difficulties in practical working arrangements which have been ongoing in nature due to lack of ring fenced time to support the partnership

> The amount of additional management time to create a true partnership was not calculated and has resulted in services trying to move forward in the partnership agendas whilst maintaining their own highly pressured services – it would have been beneficial to have some additional time in the first 2 years

Key strengths

> Enhanced therapy provision for children with Autism at special schools – primary aged. Improved diagnostic pathways for children on autistic spectrum disorders. Multi-agency team based at CDU/ CAMHS with standard screening tools have been developed and implemented. A standard awareness training has been developed

> A multi-agency equipment group has been set up to utilise funding for all equipment effectively and consistently across Stockport

> Published resources have been developed for nurseries/schools to use prior to re-referral ie Speech and language packages (Narrative framework) and Occupational Therapy (Motor Skills United)

> Joint Footsteps clinics run by Physiotherapy/podiatry has been established resulting in swift access to services in a 'one stop' shop for children with less complex difficulties

Case Study 1 (continued)

The Children and Young People's Disability Partnership (CYPDisP)
Stockport PCT

D

A Whole Systems approach to supporting children and young people with disabilities and their families

> Consultations with children and families have been carried out using differentiated methods ie signs, symbols, multi-media productions .eg. Aiming high consultation

> Transition planning – policies have been developed and use of personal passports are being developed to aid transition

> Single point of entry/common processes – this is currently being developed so families receive a package of care based around the child's need with the 'team around the child' model

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Why is it included?

> The PCT has been able to demonstrate that they have achieved 3 or more in at least five of the WCC competencies

> The PCT has followed clear and logical steps in its commissioning approach for this new service

> This is a good example of a service which works across the health and care pathway in a joint up approach to service delivery

Good practice table

WCC Competencies	1	2	3	4	5	6	7	8	9	10	11

Commissioning steps	1	2	3	4	5	6

Effective Health and Care Pathway	0	1	2	3	4

Case Study 2

Joint Commissioning of Primary Child and Adolescent Mental Health Services
Oxfordshire County Council

D

Joint Commissioning of Primary Child and Adolescent Mental Health Services
PCAMHS won the prestigious Health Service Journal Award in 2007 for Mental Health Innovation and the MJ Award in 2008 for partnership between health and local government

Why?

> PCAMHS was established to meet new government requirements under the Children's NSF (2004), and the Children's Act (2005) to provide a comprehensive mental health service for children. The government allocated hypothecated grants to the local authority and PCT's to support the joint commissioning of mental health services

What did we do?

> PCAMHS was jointly commissioned by the local authority and the PCT in Oxfordshire. It is a community based early intervention children's multi agency health service. It is commissioned to work with directly with 1200 children a year and to support children's agencies and professionals to respond to children with emotional and mental health concerns across the health economy including the voluntary sector

> Offers a direct intervention to individual children and young people

> Screens all referrals through to wider child mental health services through the management of a single referral and screening point (screen 3000 referrals annually)

> Develops the skills and expertise of the wider children's workforce to respond more effectively to children's emotional and mental health needs

> The service is multi professional and consists of social workers, counsellors, and teachers, psychiatric nurses, counselling psychologists, health visitors and nurses. It has been operational since October 2005

What we achieved?

Access

> PCAMHS has more than doubled the numbers of children in Oxfordshire receiving a mental health intervention from 2004-2007

Impact on tier 3

> A 30% fall in the numbers of children being seen by tier 3 CAMHS

> An eradication of waiting lists for specialist treatment

> A reduction of inappropriate referrals to Specialist Mental Health services

High satisfaction ratings with the service

> PCAMHS consistently receives excellent satisfaction scores from the children and families who it works with. These aggregate to average scores of;

- 88/100 for young children
- 91/100 for older children
- 90/100 for parents
- 86/100 for other stakeholders

Case Study 2 (continued)

Joint Commissioning of Primary Child and Adolescent Mental Health Services
Oxfordshire County Council

D

Joint Commissioning of Primary Child and Adolescent Mental Health Services
PCAMHS won the prestigious Health Service Journal Award in 2007 for Mental Health Innovation and the MJ Award in 2008 for partnership between health and local government

Lessons Learned

> It has implemented a single screening and referral process for children's mental health services (unique nationally)

> It has transformed access into children's mental health services. Before PCAMHS waiting lists were over a year for specialist mental health services. Now over 95% of children are given appointments within 4 weeks

> It has dismantled the medical model of the delivery of mental health services for children. Previously access to a child mental health service was through a GP, and then to a hospital based clinic. Now, any professional in children's services can refer a child mental health service through the completion of a simple form

> It has integrated the database for children who need safeguarding (protection) with those who require mental health services (unique nationally)

> It delivers a direct service to children and families with over 90/100 satisfaction ratings. The intervention is entirely community based, tailored around the needs of the child and delivered often in the child's home or school

> It has significantly helped to improve the skills and abilities of a range of professionals in children's services to work with children with emotional and mental health needs

Key strengths

> Improvement of access for all children into mental health services (From 2006/7- 2007/8 the numbers have nearly double from around 1200- 2400 children in Oxfordshire. This is well in excess of government targets to increase this population by 10% year on year)

> Very high satisfaction ratings with the service

> Implementation of a clear pathway for children who require mental health services

> A very tightly monitored and implemented multi- stakeholder management process

> Outcomes oriented performance management culture

> Transferable service model

> Value for Money (In terms of value for money PCAMHS delivers an intervention at a unit cost of £515 per child. This is extremely competitive when contrasted against other children's mental health teams)

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Case Study 2 (continued)

Joint Commissioning of Primary Child and Adolescent Mental Health Services
Oxfordshire County Council

D

Joint Commissioning of Primary Child and Adolescent Mental Health Services
PCAMHS won the prestigious Health Service Journal Award in 2007 for Mental Health Innovation and the MJ Award in 2008 for partnership between health and local government

Why is it included?

- The programme has demonstrated a score of 3 or above on at least 5 of the WCC competencies
- There is evidence to suggest that a logical and evidence based approach was followed in commissioning this service
- The PCAMHS is a project which has demonstrated how a well planned service in the front end of the effective health and care pathway can impact across all tiers on how users receive care

Good practice table

WCC Competencies	1	2	3	4	5	6	7	8	9	10	11

Commissioning steps	1	2	3	4	5	6

Effective Health and Care Pathway	0	1	2	3	4

Case Study 3

Redesign of Services for Children with Complex Disabilities
Luton PCT

D

Redesign of services for children with complex disabilities using a multi-disciplinary approach using a performance improvement process that has resulted in parents feeling more supported, empowered and satisfied with service delivery

Why?

- We chose to improve services for children with complex disabilities because all local organisations recognised that Luton had an increasing number of families where disability was a key issue. Referral rates to all agencies were increasing and agencies noted, in particular, that there was a high number of families from ethnic minority backgrounds that contained several children with complex disabilities within the same family
- In 2003, Luton teaching Primary Care Trust and Luton Borough Council had consulted with the parents of children with disabilities and identified the difficulties that parents experienced in getting good care for their children (Consultation Event Report, 2003). Parents reported that services were disjointed, poorly co-ordinated and difficult to access due to inter-agency barriers. All agencies were experiencing an increase in complaints and acknowledged that the parents of children with disabilities felt a general dissatisfaction with the services that they provided
- The launch of the Children's National Service Framework in late 2004, and the drive to meet the outcomes of Every Child Matters in Luton, coincided with this local recognition of the need to improve services for children with complex disabilities. The national drivers served to increase the feelings of need and commitment, by all agencies, to improve services for this group of patients
- The fundamental aims of the project were to develop, with the parents, a shared vision of service redesign and then to initiate improvements in key areas for children with disabilities in Luton
- The objectives of the project were identified as being to:
  - engage with parents and listen to their experiences
  - identify 'perfect care' by listening to the views and needs of parents
  - engage parents in the planning, delivery and evaluation of services
  - break down barriers to achieving good care
  - deliver improvements across agencies
  - create a seamless service for children with disabilities
  - work within available resources

What did we do?

- A steering group, comprising parents and professionals from all agencies, was established to progress the eleven key areas of 'perfect care' for children with disabilities. It met quarterly to oversee the work; sub-groups, each involving parents, were set up to progress the key areas of service improvement
- Parents on the groups consulted with other parents – informally or via meetings at schools, nurseries or other parent groups – bringing information and ideas back to the sub-groups. Some consulted directly with parents, others consulted local support groups such as the Down's Syndrome Group
- The sub-groups, led by key individuals from the steering group, began work in September 2005, starting with some areas of service improvement identified by parents. The plan is to continue the work until all areas have been addressed.

Case Study 3 (continued)

Redesign of Services for Children with Complex Disabilities
Luton PCT

D

Redesign of services for children with complex disabilities using a multi-disciplinary approach using a performance improvement process that has resulted in parents feeling more supported, empowered and satisfied with service delivery

What we achieved?

- Parent Booklet; we published an information booklet designed by parents for parents, available in schools, health centres and on the Children and Young People's website
- Improved multi-disciplinary assessment (MDA) process; we have a streamlined MDA and multi-agency care plan, shared with all professionals to improve communication. A family services plan is initiated pre-MDA and completed after assessment, a support worker allocated to the family before and after MDA. Every child has a named care co-ordinator/lead professional. There is an information leaflet for parents
- Shared care; we developed parent-held shared care folders to improve communication. Parents' expertise is recognised and they are involved in training new carers for their child, supported by nurses. We developed a shared database of competencies to raise the standards of carers
- Discharge planning; we developed a pathway for children with complex disabilities discharged from hospital, leading to more efficient discharges, fewer readmissions and allowing parents to feel supported. We improved the supply of specialist equipment via the joint equipment stores, so parents only have to deal with one agency and have faster access to repairs and replacements. We held discussions with wheelchair services to improve supply and provide appointments in schools
- Discharge planning following surgery; further 'goldfish bowl' sessions were held to identify 'perfect care' for children with disabilities needing surgical interventions. The sub-group is working on a care pathway
- Hospital facilities; we facilitated meetings between hospital staff and parents, identifying equipment and resources to improve child and family admissions. The hospital now has facilities in place for older children with disabilities
- Downs Syndrome; we developed a multi-agency care pathway for inter-agency care of children with Downs Syndrome

Success to date

- It is clear that through this Pursuing Perfection work, the group has successfully improved services for children with complex disabilities. However, to reach the goal of 'perfect care' will take continued commitment from all involved. Pursuing Perfection has created a positive culture amongst all agencies and has laid the foundations for the work to continue
- The focus of this work has encouraged all agencies to address the needs of children with disabilities, throughout their organisations. Many groups and services other than the Pursuing Perfection sub-groups are working to improve services for these children. Work includes multi-agency data collection of the true number of children with disability in Luton, and investment in Bedfordshire University research to understand the growing numbers of children with disability in the South Asian community
- The benefits to parents have been significant. Parents say they feel more supported, empowered and satisfied with service delivery
- Noreen Walsh, a parent from the steering group, summed it up at a national conference and told the audience "Pursuing Perfection has positively changed the way services are delivered to our children. Parents feel listened to and are more empowered to work with professionals to identify perfect care for their children".

Case Study 3 (continued)

Redesign of Services for Children with Complex Disabilities
Luton PCT

D

Redesign of services for children with complex disabilities using a multi-disciplinary approach using a performance improvement process that has resulted in parents feeling more supported, empowered and satisfied with service delivery

Lessons Learned

> A key outcome of our Pursuing Perfection project is the way that agencies and parents have begun to work together. A culture of shared ownership means that barriers are overcome because everybody is focusing on the child and finding solutions to problems. Working this way allows us all to deliver outcomes that are good for staff and service users

> We encourage parents who express dissatisfaction with services to join the group. They are the driving force behind work to change service delivery. Parents have developed a relationship of equals with professionals, able to voice their concerns without the fear of consequences and understanding the constraints that professionals work under. So we are able to work on joint solutions that can be provided from available resources

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Why is it included?

> Innovative project that has resulted in a service that better meets the needs of users and carers

> The programme has demonstrated a score of 3 or above on at least 5 of the WCC competencies

> There is evidence to suggest that a logical approach has been followed in commissioning this service

Good practice table

WCC Competencies	1	2	3	4	5	6	7	8	9	10	11
		■	■	■	■			■			

Commissioning steps	1	2	3	4	5	6
	■	■	■	■	■	■

Effective Health and Care Pathway	0	1	2	3	4
	■	■	■	■	■

Chapter 6

Acute Services Closer to Home

Chapter 6: Acute Services Closer to Home

Context

Our Health, Our Care, Our Say, White Paper set out a vision to provide people across all age ranges with high quality health services in the communities where they live. This vision has been reaffirmed by the expectation of a NHS that is fair, personalised, effective, and safe, expressed in **the NHS Next Stage Review, Our NHS, Our Future**. Implementing this policy will be at the forefront of commissioning decisions

In addition, the forthcoming **Child Health Strategy building on the National Service Framework for Children, Young People and Maternity Services and Every Child Matters** is likely to identify areas where further work is required for children and young people who have acute and on-going health care needs

This approach is reflected in **'Putting people first: a shared vision and commitment to the transformation of adult social care'**, the ministerial concordat launched in 2007

The NHS Institute's **Care Outside Hospital** programme has been established to explore the scope for bringing about shifts in care within the NHS. The programme has found that, if everyone were to perform as well as the top quartile do now, some 50 million attendances in hospital outpatients, emergency admissions and rehabilitation stays for major conditions could be shifted from the traditional hospital setting and into the community. The cost of delivering this activity is in excess of £2 billion and this funding could therefore be released to provide high quality services closer to home

The NHS Operating Framework for 2008/09 expects PCTs to plan and develop changes to allow care provision as close to people's homes as possible. The Framework suggests that central to the delivery of this change will be the development of rapid-response services and coordination centres. PCTs are expected to take ambitious steps toward making this happen

The remainder of the chapter includes examples of 'Acute Services Closer to Home' good practice case studies

Relevant policy documents and resources associated with the 'Acute Services Closer to Home' agenda can be found in the Chapter 10: Bibliography. This also includes relevant documents associated with the World Class Commissioning agenda and procurement.

Case Study 1

Personalised care
Oldham Council

D

Development of personalisation to enable users and cares to take more control of their care if they wish based on an individual budget

Why?

> Originally the social care service was zero rated and the new management team were committed to make the service more responsive to client needs, based on
  - Client expressed their wish to remain in the community as long as possible
  - Commitment to the citizen model thereby passing control to clients
  - Build on direct payments

What did we do?

> Major organisational development programme that:
  - modernised services to ensure that they were more responsive and better met the clients need:
    - 7 days a week day centre
    - in-house residential care provision based on short stay and intermediate care
    - 24 hour home care service
    - accredited autism service provided within the community
  - workforce modernisation to ensure they have the skills and expertise to respond to the new way of working:
    - care brokerage
    - planning for person centre care
    - self assessment and brokerage
    - development of a new support services model to support the personalisation agenda
    - stimulate the market to ensure that it is able to respond to user and carers needs

What we achieved?

> All clients who meet the council's criteria are given a budget (amount to spend) and are given 3 choices:
  - take control of their budget and arrange their own care package
  - continue with the traditional model whereby social care staff make the arrangements and continue to support the client
  - an amalgam of the two above whereby the client takes control of part of their budget

> Services that better meet the needs of the users and carers

> Greater focus on the preventative agenda across the council which included use of the third sector

> Improved satisfaction

> Changes within the assessment and care management team which led to the development of new brokerage model i.e. contracted within 3rd sector and self brokerage based on a web solution

Lessons Learned

> Need to develop support mechanisms for smaller providers that have developed as a consequence of the personalisation approach

> Need to engage early with providers to ensure they appreciate the impact of the change may have on their current provision model and encourage greater innovation to meet users needs.

Case Study 1 (continued)

Personalised care
Oldham Council

D

Development of personalisation to enable users and cares to take more control of their care if they wish based on an individual budget

Key strengths

> Efficiency improvements through the modernisation of provision and the development of leaner processes

> Cheaper models of care in most instances

> Users and carers have more control over their care

> Services that are more focused on meeting individual's needs and aspirations

Why is it included?

> Innovated project that has resulted in all new users being offered a budget for them to manage if they want

> The programme has demonstrated a score of 3 or above on at least 5 of the WCC competencies

> There is evidence to suggest that a logical approach has been followed in commissioning this service

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Good practice table

WCC Competencies	1	2	3	4	5	6	7	8	9	10	11
			■	■	■		■	■	■		

Commissioning steps	1	2	3	4	5	6
	■	■	■	■	■	■

Effective Health and Care Pathway	0	1	2	3	4
	■	■			

Case Study 2

Rapid response
Salford PCT and Council

D

Joint health and social care approach that providers users and carers with a crises response which has avoided emergency admissions and attendance at A&E and enabled both the PCT and Social Care to achieve savings

Why?

> Reduce inappropriate use and improve access:
  - 999 and Urgent Ambulances
  - Accident and Emergency
  - unplanned acute admissions
  - social emergency respite (residential/nursing home)

> Reduce confusion around which services to access from the community not only creates poor user pathways but costs time and money

What did we do?

> Used section 75 agreements for commissioning and provision:
  - rapid response/Admission Avoidance
  - supported discharge team
  - community rehabilitation team
  - transfer of care liaison team (joint discharge team)

> Reablement services included:
  - intermediate Home Care Team
  - 47 Nursing Beds
  - 26 Residential/Rehab Beds
  - furnished Tenancies
  - COPD Team
  - Community Geriatrics (2-weekly sessions with acute service)

> Investment included:
  - NHS £4.5 million
  - LA £3.0 million
  - Total £7.5 million

> How does it work:
  - Single entry point (SEP)
  - Assessment in persons own home, A&E or Emergency Assessment Unit within four hours
  - Tailored health, therapy +/ social package
  - Team work with the individual to manage the crisis and start return to previous independence
  - Links made to other Community Services to continue re-enablement as required.
  - Maximum length of stay 14 days, average 5

Case Study 2 (continued)

Rapid response
Salford PCT and Council

D

Joint health and social care approach that providers users and carers with a crises response which has avoided emergency admissions and attendance at A&E and enabled both the PCT and Social Care to achieve savings

What we achieved?

> People prefer to stay at home if at all possible and the Rapid Response Team are able to achieve this while avoiding unnecessary admissions and optimising their independence

> Rapid Response provides a better service for users and saves money

Lessons Learned

> Have a better marketing and communication strategy

> Set up a single line management structure with clearer lines of reporting from the offset

> Have an longer evaluation period to create a robust business case with measurable outcome

Key strengths

> Rapid responses team – last year 868 people were treated within team with an average of 5.6 hours intervention

> Of this, 340 clearly avoided services:
  - 307 avoided an Ambulance journey
  - 6 avoided an Accident and Emergency visit
  - 301 avoided an acute hospital admission
  - 39 avoided emergency respite care

> Services avoided
  - Social 6.0% 39
  - Health 94.0% 614

> Money saved
  - Social 35.5% (longer term)
  - Health 64.5% (shorter term)

Contact

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Case Study 2 (continued)

Rapid response
Salford PCT and Council

D

Joint health and social care approach that providers users and carers with a crises response which has avoided emergency admissions and attendance at A&E and enabled both the PCT and Social Care to achieve savings

Why is it included?

- The project has enabled users to avoid unnecessary admissions and optimising their independence
- The programme has demonstrated a score of 3 or above on at least 5 of the WCC competencies
- There is evidence to suggest that a logical approach has been followed in commissioning this service

Good Practice Table

WCC Competencies	1	2	3	4	5	6	7	8	9	10	11

Commissioning steps	1	2	3	4	5	6

Effective Health and Care Pathway	0	1	2	3	4

Case Study 3

Virtual ward
West Sussex PCT

Currently implementing an integrated Primary and Community Care strategy across the county which has reduced admissions and resulted in a 20% improvement in productivity within community hospitals

Why?

- Five very different PCTs merge into one, with a challenging £50 million FRP
- Fit For Future public consultation focused on acute trust services but required changes to delivery in primary and community care
- History of poor relationships with primary care in some areas
- PBC immature, with a culture that had been acute trust focussed
- Change of out of hours provider, Harmoni appointed in April 2008
- No overnight nursing services in the community across the county
- Working in a historically data free zone with no activity information
- Historical working practices resulting in poor and inconsistent productivity
- Different services working in silos, community matrons working in isolation
- Monday to Friday, 9am-5pm culture, with people falling through the gaps
- Lack of user transport, with contract inconsistencies around acute hospital flows and no rapid response transport service working past early evening

What did we do?

- Concept supported by all, including PCT Board, Practice Based Commissioning (PBC) leads, West Sussex Health and Overview Scrutiny Committee, West Sussex County Council, Acute Trusts and Voluntary Organisations
- Professional Executive Committee (PEC) championed the strategy
- Acute Trust colleagues and PBC leads supported the strategy
- Consultation paper developed and circulated widely
- Many large staff events held across the county
- External consultants ran focus groups with staff
- Staff side organisations fully involved in the consultation process
- Implementation commenced September 2007

What we achieved?

- Created 19 'virtual wards' across West Sussex, led by virtual ward managers with large teams of nurses, therapists, health and social care support workers – working 7am-7pm
- Morbidity and mortality data, national benchmarks and Croydon experience used to scope workforce required in each 'ward'

Case Study 3 (continued)

Virtual ward
West Sussex PCT

I

Currently implementing an integrated Primary and Community Care strategy across the county which has reduced admissions and resulted in a 20% improvement in productivity within community hospitals

- Created one 'virtual ward' urgent overnight nursing service
- Integrated community matrons back into 'virtual ward' teams
- Developing case manager role
- Developing Assistant Practitioner Role (Band 4)
- Integrating intermediate care into 'virtual ward' teams
- Working with GPs to develop 'virtual ward' rounds (unique care)

Success to date

- Overnight nursing service – 120 admissions avoided within first 3 months
- 20% increase in productivity seen already in our community hospitals
- CHAPS (single point of referral) already proving beneficial from 7am
- Partnerships for Older People (POPPS) received SHA 'Best of Health' Award, community partnership project with West Sussex County Council
- Unique Care pilot at Worthing GP practice – runner up in national award
- Recruitment boost – people wanting to work for West Sussex Health, plus significant percentage drop in staff leavers
- Professional development opportunities, e.g. Gemma Smith PHD, Sue Barrett MSC and electrician NVQ opportunities
- Partnerships – external organisations seeking partnership with West Sussex Health
- 82% GP Practices engaged in extended access to primary care services
- Culture change being brought about by working together to deliver streamlined patient-centred services

Case Study 3 (continued)

Virtual ward
West Sussex PCT

I

Currently implementing an integrated Primary and Community Care strategy across the county which has reduced admissions and resulted in a 20% improvement in productivity within community hospitals

Lessons Learned

> Need to ensure that the consultation involves all grades of staff

> Need to ensure that communication process provides information to all staff and it needs to effectively market the change

Why is it included?

> The project has avoided a number of admissions and enabled user to be supported in the community

> The programme has demonstrated a score of 3 or above on at least 5 of the WCC competencies

> There is evidence to suggest that a logical approach has been followed in commissioning this service

Contact

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Good Practice Table

WCC Competencies	1	2	3	4	5	6	7	8	9	10	11

Commissioning steps	1	2	3	4	5	6

Effective Health and Care Pathway	0	1	2	3	4

Case Study 4

Procurement of a GP led health centre
Surrey PCT

I

Procurement of a GP led health centre to improve health outcomes for a poorly doctored area

Why?

> The Lord Darzi interim report in October 2007 pledged new monies to develop new GP surgeries in the most under doctored areas, and a GP led health centre in all PCTs. These new services are to help increase access to primary medical care services for all patients, something that is still an issue nationally

> Combined with this was the publication of the results of a recent health needs assessment completed by the Surrey PCT public health directorate that clearly demonstrates that areas of the county are still facing significant challenges in improving our patients' health

> The assessment points to the area of Spelthorne as one with continuing and significant health inequalities. The PCT was able to use the opportunity of the allocation of this new funding, to develop a focussed and personalised service that we hope will address some of these health inequalities

What did we do?

> The GP led health centre communication and engagement process commenced in April and was completed in July, following a further extension after requests from various stakeholders. This process included:
  - production of a communication and engagement process strategy
  - production of a communication and engagement leaflet
  - stakeholders events
  - stakeholder briefings
  - regular attendance at stakeholder meetings
  - engagement with local MP
  - leaflet drops through local newspapers
  - radio interviews
  - press releases
  - feedback and Question and Answer mechanism
  - co-design meeting
  - attendance at Surrey County Council HOSC
  - attendance at public meeting of the Spelthorne Borough Council Performance and review committee

What we achieved?

> There are several key objectives in the procurement of the GP led health centre:

> Improving access and patient satisfaction

> Implementing a service of high clinical quality

> Implementing a value for money service

> Significantly reducing health inequalities across a wide range of factors; and

> Delivering improved cost efficiencies with the integration of the health centre with the walk in centre at Ashford Hospital

Case Study 4 (continued)

Procurement of a GP led health centre
Surrey PCT

I

Procurement of a GP led health centre to improve health outcomes for a poorly doctored area

It is yet to be proven whether the population of Spelthornes health improves with the implementation of the new GP led health centre. The service is due to commence summer 2009

Lessons Learned

> Several key issues presented themselves during the process and were a challenge to effectively manage:
  - Incorrect national and local media stories about the introduction of polyclinics and the removal of GP surgeries caused much misunderstanding and misconception
  - Local GPs encouraged the above incorrect view
  - As did the local MP
  - Limited visible support from the DH and SHA with regards to communication issues and
  - Misunderstanding about what we were 'consulting' on – not the location of the health centre, not whether the money could be better spent, but how the service could be best implemented for the good of the local population

> Whilst the process was challenging, it gave the PCT the opportunity to address many misconceptions that had been formed. Much of the feedback received pertained to the implementation of a polyclinic and, therefore, was not relevant. However, some constructive feedback was received about issues such as access, appointments system, services that would be welcomed. Much of the feedback challenged our thinking and encouraged us to cement in more detail the decisions that had previously been made

> Want to ensure more robust and aggressive communication to dispel myths and misconceptions quickly

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Case Study 4 (continued)

Procurement of a GP led health centre
Surrey PCT

I

Procurement of a GP led health centre to improve health outcomes for a poorly doctored area

Why is it included?

> Well managed process with involvement of all key stakeholders which will hopefully lead to health improvements in a under doctored area

> The programme has demonstrated a score of 3 or above on at least 5 of the WCC competencies

> There is evidence to suggest that a logical approach has been followed in commissioning this service

Good Practice Table

WCC Competencies	1	2	3	4	5	6	7	8	9	10	11
			■	■	■		■				

Commissioning steps	1	2	3	4	5	6
	■	■	■	■		

Effective Health and Care Pathway	0	1	2	3	4
	■	■			

Case Study 5

Integrated heart failure in the community
Surrey PCT

D

Developed a integrated heart failure service which resulted in the establishment of a community focused service that operated effectively across the community and acute sector

Why?

> There was an established heart failure service within the community but links with secondary care were not fully established. There was also a need to improve communication and the transfer of patient information between the organisations in order to improve patient management. The main objectives were to:

> Reduce admissions

> Reduce length of stay

> Increase referral to heart failure nurses

> Fully integrated heart failure services across all organisational boundaries

> Improved clinical management of heart failure patients

> End of life stage – improved access to palliative care and hospice services

> Improve communication of patient information across organisational boundaries with the use of IT

What did we do?

> With the use of IT the heart failure team within NW Surrey area of Surrey PCT and Ashford & St Peters Hospitals NHS Trust have developed a fully integrated Heart Failure service across organisational boundaries. In July 2007 the team recognised the need for improved communication between primary and secondary care and in particular direct access to a consultant opinion, test results and patients' medical information. The multidisciplinary project group set the aims and objectives of reducing heart failure admissions and attendances, length of stay, increased referral to HF nurses and improved communication of patient information across organisational boundaries with the use of IT resulting in improving the clinical management of heart failure patients with the direct communication between health care professionals. Service redesign methodology was used to establish a baseline and information and inform service improvement. The outcome of the project has been direct access to a consultant cardiologist via IT, the electronic transfer of patient information to inform clinical assessment, the use of portable ECG to assist in diagnosis, direct access to PACS, test results, discharge letters and access hospital appointments via IT. This has resulted in reduced hospital admissions/attendances, LOS, improved medicines management and patient satisfaction

What we achieved?

> The outcomes were:
- reduction in hospital admissions from 65 to 21 per month – data was collected for the 4th quarter of years 2006, 2007 and 2008 for comparison
- reduction in LOS fro average of 8.59 days to 4.5 – data captured as above
- improved medicines management through the use of home ECG monitoring – an audit of the ECG performed was undertaken
- reduction in GP contact, hospital admission – data from HF nurse activity database Nov 2007 – Jan 08
- potential saving of 24 inpatient bed days and 15 outpatient attendances for a 4 month period – consultant review audit
- high level of patient satisfaction with service – patient satisfaction audit Jan – march 2008
- new one stop consultant led Heart Failure clinic within acute trust
- generic protocols and patient information

Case Study 5 (continued)

Integrated heart failure in the community
Surrey PCT

D

Developed a integrated heart failure service which resulted in the establishment of a community focused service that operated effectively across the community and acute sector

Success to date

> There a various models of heart failure service across the country which span both primary and secondary care. However there are few, if any, in place where heart failure specialists out in the community have direct access to a consultant cardiologist via phone, fax and email for rapid response on clinical issues. The heart failure nurses and GPwSI also have direct access to the acute Trust IT to access images via PACS; test results, patient discharge letters, and can view patient's inpatient episodes and OPD appointment. The community staff have access to all clinical information via a shared network drive. This can also be accessed by the consultant. The nurses can also perform ECG's within the home and email directly to the consultant

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Lessons Learned

> Need a clinical champion to drive the change

> Need someone who is prepared to drive and make things happen e.g. getting access to the hospital information in the community and e-mail access across organisations

> A motivated team makes all the difference to making it happen

> Having access to a facilitator with a background in service improvement assisted in focusing the effort and driving the change

Why is it included?

> Innovated project that has resulted in access to a heart failure in the community which has reduce admissions and length of stay.

> The programme has demonstrated a score of 3 or above on at least 5 of the WCC competencies

> There is evidence to suggest that a logical approach has been followed in commissioning this service

Good Practice Table

WCC Competencies	1	2	3	4	5	6	7	8	9	10	11
		■	■	■	■			■			

Commissioning steps	1	2	3	4	5	6
	■	■	■	■	■	

Effective Health and Care Pathway	0	1	2	3	4
	■	■	■	■	

Case Study 6

Assessment, diagnostic and referral point for ambulatory care sensitive conditions
Stockport PCT

P

An assessment, diagnostic and referral point which will deliver Enhanced Primary Care in a community setting for ambulatory care sensitive conditions
(The programme is to be launched in February 2009 for a 2 year pilot)

Why?

> The PCT's Community Hospital bid recognised that there was a need to provide community based care for Ambulatory Care sensitive conditions especially Diagnostics. Stockport spent over £6 million in 06/07 on 4200 short stay admissions for patients within the list of 19 ACS conditions devised by the NHS Institute for Innovation and Improvement. With investment on an Enhanced Primary Care Service, the PCT could allow cost efficiencies to be reinvested in other areas in Health

What we will do?

> The main goal is to provide an Enhanced Primary Care Service in a Community setting. The EIS will provide assessment, diagnostics(X-ray and Pathology on site) and treatment for patients arriving after been directed from any other first contact – GP, DN, ACM, Intermediate Care etc. There will be a small team of staff but high calibre and a treatment area where patients can stay for up to 6-8 hours if required

> This service is aiming to see at least those patients who make up the 4200 less than 2 day LOS admissions presently. This number is expected to increase with other attendees from different groups who do not necessarily fit in the ACS19 .e.g. Blood Transfusions, repeat diagnostics

What we aim to achieve?

> Benefits
  - there are many benefits for the system, patients and staff in developing this service. As already discussed National and local targets will be performance monitored to ensure the success of the service is realised
  - reduction in Falls
  - care closer to home
  - 24/48 hour Access targets in Primary Care
  - reduction in readmission rates in the over 65's
  - reduce Emergency Admissions by up to 20% – 5% by 2008 (freeing up diagnostic time /bed days for utilisation in Elective work)
  - reduce A&E attendance by 15% (or 1 million nationally)

> Other knock on effects in the system should develop such as:
  - improved well being and health education
  - reduction in Hospital acquired infection
  - reduction in GP referrals to Acute Sector
  - reduction in Ambulance requests
  - improvements in chronic disease management
  - review and improved utilisation of PC services e.g. Heart Failure service

Case Study 6 (continued)

Assessment, diagnostic and referral point for ambulatory care sensitive conditions
Stockport PCT

P

An assessment, diagnostic and referral point which will deliver Enhanced Primary Care in a community setting for ambulatory care sensitive conditions
(The programme is to be launched in February 2009 for a 2 year pilot)

- Improved partnership working across all services
- Improved efficiency and utilisation of other services eg. COPD service
- Cost savings both in reduction of short stay admissions and DOH incentives for commissioners who reduce emergency admissions
- Development of clinical relationships between GP's and allied professionals and staff at EIS, allowing early prompt clinician interface to pre-empt clinical crisis

Lessons Learned

- Feedback has from professionals and users have had a positive effect on the development of the service
- Data analysis of the ACSC on short stay LOS (<3days) evidenced the appropriateness of an Enhanced Primary Care Service in the community
- External advisors, especially Professor Stephen Wilson from Australia has helped us learn other models and evidence on Ambulatory Care which has helped shape the service

Key strengths

- Partnership working within the health economy
- Recovery mode of care based in the community with appropriate signposting when required
- Extensive performance framework to monitor the National and Local KPI's
- Cost efficient
- Impact on other services and PROMS
- Development of workforce

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Case Study 6 (continued)

Assessment, diagnostic and referral point for ambulatory care sensitive conditions
Stockport PCT

P

An assessment, diagnostic and referral point which will deliver Enhanced Primary Care in a community setting for ambulatory care sensitive conditions
(The programme is to be launched in February 2009 for a 2 year pilot)

Why is it included?

- The planned project is a community based Enhanced Primary Care Service that impacts on the Ambulatory Care pathway on how patients are managed and care delivered
- The programme has demonstrated a score of 3 or above on at least 5 of the WCC competencies
- There is evidence to suggest that a logical and evidence based approach has been followed in commissioning this service

Good practice table

WCC Competencies	1	2	3	4	5	6	7	8	9	10	11

Commissioning steps	1	2	3	4	5	6

Effective Health and Care Pathway	0	1	2	3	4

Case Study 7

PBC – Enhanced Local service to nursing care homes
Sheffield PCT

D

PBC project within the nursing home sector which has improved GP access and management whilst reducing need for hospital admission

Contact

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Why?

> The Local enhanced service Care Homes project proposed seeks to improve health outcomes for residents by providing enhanced GP care to tackle the following:

- inefficient systems and poor communication, with many residents registered with multiple practices (practices currently visit between 1-7 homes)
- GPs not visiting
- lack of pro-active care in managing chronic disease and medicines
- lack of care planning, especially around discharge and end of life care
- over-reliance on OOH for crisis management

This LES excludes intermediate care beds, for which a separate specification has been developed.

What did we do?

> Set up a project group and charter for this, representatives included:

- Project Sponsor: Dr Richard Oliver, Parson Cross Consortium Chair and Joint Chair, Professional Executive Committee, NHS Sheffield
- Clinical Champion: Dr Alison Hobbs, with cover from Dr Andy McCoye, Parson Cross Consortium
- Project Lead: Agnes McAuley, Practice Based Commissioning Manager, NHS Sheffield
- Hilary Hull, Strategic Commissioning Manager, Adult Services, Sheffield City Council
- Suvira Madan, Consultant Geriatrician, Sheffield Teaching Hospitals Foundation Trust
- Paul Matthews, Locality District Nursing Manager, Sheffield PCT
- Kath Webb, Manager, Hartwells
- Jayne Taylor, Senior Finance Officer, NHS Sheffield
- Trudy Roberts, Manager, POPPS Team, Sheffield PCT
- Robina Okes-Voysey, Clinical Practice Pharmacist, NHS Sheffield
- Gill Pascott, Business Manager, NHS Sheffield
- Novenka Bex, Secretary for Parson Cross Consortium, NHS Sheffield
- To be emailed copies of papers of project team:
- Daniel Mason, Strategy and Specification Manager, Unscheduled Care, NHS Sheffield
- Margaret Gibson, Strategy and Specification Manager, Older People, Sheffield PCT
- Gill Greenwood, Manager, Sheffield Carers Centre

Case Study 7 (continued)

PBC – Enhanced Local service to nursing care homes
Sheffield PCT

D

PBC project within the nursing home sector which has improved GP access and management whilst reducing need for hospital admission

What we achieved?

> The LES has been provided since May 2008 so the limited data of its impact must be treated cautiously. In Q2 2008, emergency admissions were 9% less in the LES homes (Tables 2 and 3) than in Q2 2007

> Other achievements are:
  - each home aligned to one practice which accepts all residents who choose to register. Service agreement between home and practice. 1 or 2 named GPs provide proactive care
  - planned weekly surgery in the home
  - 6-monthly medication reviews. Managers/carers concerned resident can rely on GP practice and OOH
  - rapid access to named geriatrician
  - annual medical review organised between resident and carers to anticipate/plan for exacerbations and crisis, including EOL
  - care plan based on review and held in home
  - availability of plan flagged on OOH and YAS databases to alert them on call out
  - event form for all emergency admissions by care home manager/GP to share learning. Monthly practice review of emergency admissions

Lessons Learned

> Early agreement from all GP surgeries in the PBC Consortium. Speak to neighbouring practices that may be affected by the scheme

> Make sure that there is sufficient buy in from Care Home Managers

Why is it included?

> Innovated project that has been PBC led, it has improved GP access within the nursing homes and reduced emergency admissions

> The programme has demonstrated a score of 3 or above on at least 5 of the WCC competencies

> There is evidence to suggest that a logical approach has been followed in commissioning this service

Good Practice Table

WCC Competencies	1	2	3	4	5	6	7	8	9	10	11
		■	■	■	■	■		■			

Commissioning steps	1	2	3	4	5	6
	■	■	■	■	■	■

Effective Health and Care Pathway	0	1	2	3	4
	■	■	■		

Chapter 7

Rehabilitation and Long Term Neurological Conditions

Chapter 7: Rehabilitation and Long Term Neurological Conditions

Context

It is clear from national strategy and user participation events that wherever possible users and their carers want to remain as independent as possible, for as long as possible, within their current community. To facilitate this both community providers and commissioners have started to develop and implement service changes that achieve this goal.

Rehabilitation was originally addressed in the NHS Plan, Delivering the NHS Plan and the NHS Improvement Plan.

The National Service Framework (NSF) for long-term conditions (published March 2005) addresses in detail the issue of rehabilitation. A range of quality requirements is identified covering early and specialist rehabilitation, community rehabilitation and support, and vocational rehabilitation.

The White Paper 'Our Health, Our Care, Our Say' (2006) and the 2008/9 Operating Framework are about improving health and healthcare and sets out a direction that require fundamental change with new and flexible responses to the delivery of care. One of the drivers for change includes more people living longer, being treated in the community with higher dependency, complexity and risk.

The recently published Next Stage Review reinforced DH overarching policy that rehabilitation services should be provided for all those who need them. Expert community clinicians should act as champions of quality, service redesign, commissioning for quality and clinical experts and leaders in rehabilitation services.

In social care rehabilitation is better known as 're-ablement' and relates to an intensive level of care that follows an acute episode which is focuses on improving independence and self care. Re-ablement is well recognised within the social care sector and most authorities have or are looking to develop this service.

The remainder of the chapter includes examples of 'rehabilitation' good practice case studies.

Relevant policy documents and resources associated with the rehabilitation agenda can be found in the Chapter 10 the Bibliography. This also includes relevant documents associated with the World Class Commissioning agenda and procurement.

Case Study 1

Community Falls Service
Stockport PCT

P

A Community Falls Service that provides assessment and rehabilitation of older people at risk

Why?

> The PCT identified a gap in service within the Falls pathway between the front end GP service and Acute sector. This was evidenced by local needs of the population at risk and trends in use of the acute sector for falls related incidents

> National policy and good practice guidelines also played an important role in defining commissioning and investment priorities

What did we do?

> The service aimed to provide a seamless user journey along the falls pathway with people being assessed, treated, signposted and rehabilitated appropriately. The emphasis is on Prevention and Recovery

> The service adopted good practice from around the country to suit local population needs and clinical expectations

The service includes:

> Falls Screening Programme for appropriate signposting by Falls Co-ordinator or other health professional

> Primary Care based Multi- professional Falls Clinic which is a one off multi factorial assessment to look at falls risk

> Otagu Exercise programme: a physiotherapist led programme of individualised exercises for up to 12 months

> Balance Exercise Group: a physiotherapist led 10 week supervised exercise course to improve strength and balance

> Education Sessions

What we expect to achieve?

> Improved Health Outcomes

> Reduction in falls

> Reduction in attendance/admissions to A&E and Acute inpatient wards due to falls

Quality

> Improved Quality of Life for older people at risk or with falls

> Promote an independent lifestyle among the older population

Performance

> Reduction in CareCall referrals to NWAS

> Overall decrease in the number of cases conveyed to the emergency department by NWAS

> Access to multi factorial falls assessment

> Decreased referrals to consultant led clinics

Value for Money

> Cost efficiency will be realised by less referrals to Acute Secondary Care

Case Study 1 (continued)

Community Falls Service
Stockport PCT

P

A Community Falls Service that provides assessment and rehabilitation of older people at risk

Skill Mix and Training

> Up skilling of staff as assessment clinics are Nurse, Physio and Pharmacist led

> A knock on learning effect on Community Physios and GP's on Falls management

Lessons Learned

> A realisation of the need for a Strategy Group early on in the process

> More structured feed back from stakeholders would have been useful

> A named commissioner would have provided better leadership

Key strengths

> An integrated model of care delivery across health and social care e.g. Active case management and Intermediate Care Rapid Assessment Service

> Appropriate specialist assessment of falls risk and early rehabilitation programmes

> Preliminary screening of all referrals to direct people to the most appropriate level of assessment

> A personalised intervention package for each user of the service

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Case Study 1 (continued)

Community Falls Service
Stockport PCT

P

A Community Falls Service that provides assessment and rehabilitation of older people at risk

Why is it included?

- The programme has demonstrated a score of 3 or above on at least 5 of the WCC competencies
- There is evidence to suggest that a logical approach has been followed in commissioning this service
- The planned project is a community based Falls service that aims to provide a continuum along the falls management pathway and also streamline falls service care delivery

Good practice table

WCC Competencies	1	2	3	4	5	6	7	8	9	10	11

Commissioning steps	1	2	3	4	5	6

Effective Health and Care Pathway	0	1	2	3	4

Case Study 2

Pulmonary Rehabilitation Programme
Berkshire West PCT

D

Pulmonary Rehabilitation programme: To optimise individuals physical and social performance and autonomy

Why?

The key driver for the change was the 'prevention' agenda

- Identification of a gap in service provision. The only service that existed was provided by secondary care AFTER admission
- To reduce levels of morbidity, disability and handicap
- Reduce admissions in hospital
- Increase personal confidence though education and knowledge
- Improved quality of life and functional ability
- Reduce the number of exacerbations experienced by individuals

What did we do?

- The programme is being delivered in local authority sports centres by community physio, community matrons and local authority exercise trainers to individuals who considered themselves functionally disabled by COPD (usually MRC grade 3 and above) unless they are unable to walk, have unstable angina or have had a recent myocardial infarction
- There are 2 programmes run annually in each of the 3 locality areas of Berkshire West PCT (Reading, Wokingham and West Berkshire). They are delivered in the form of 2 x 2 hour sessions per week for 7 weeks for 10 individuals. Each session provides I hour of physical activity and exercise and 1 hour of disease education covering nutritional, psychological and behavioural interventions

What we achieved?

- Greater focus on the health promotion and preventative agenda
- Users taking greater responsibility of their health outcomes
- A shift to a recovery model of care from the traditional maintenance model of outcome for long term conditions
- Rehab services that are aimed at improving quality of life and functional ability
- Reduced dependency and crisis management and acute admissions to hospitals
- Cost of admissions outweighs the cost of the programme
- Training and new ways of working:
  - certificated pulmonary rehab process training was undertaken by all multidisciplinary team members
  - cross fertilisation of knowledge relating to pulmonary rehab from nursing/therapy/exercise trainers.

Case Study 2 (continued)

Pulmonary Rehabilitation Programme
Berkshire West PCT

D

Pulmonary Rehabilitation programme: To optimise individuals physical and social performance and autonomy

Lessons Learned

> Need for larger critical mass

> The high uptake means that there is a requirement for more frequently run programmes

Key strengths

> Improved clinical outcomes which includes
  – improved oxygen saturation levels
  – reduced need for oxygen therapy
  – less breathlessness using the BORG scale for exercise

> Noted improvements in quality of life

> Increased knowledge of condition and how to respond to it using the Bristol COPD questionnaire

> Improved quality of life using St Georges chronic respiratory questionnaire

> Ongoing individual user supportive relationships

> Reduced number of unplanned hospital admissions in a 12 month period

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Case Study 2 (continued)

Pulmonary Rehabilitation Programme
Berkshire West PCT

D

Pulmonary Rehabilitation programme: To optimise individuals physical and social performance and autonomy

Why is it included?

- The PCT has been able to demonstrate that they have achieved 3 or more in at least five of the WCC competencies
- The PCT has followed clear and logical steps in its commissioning approach for this new service
- This is a good example of a service which works at the front end of the health and care pathway but has impact on other tiers

Good practice table

WCC Competencies	1	2	3	4	5	6	7	8	9	10	11

Commissioning steps	1	2	3	4	5	6

Effective Health and Care Pathway	0	1	2	3	4

Case Study 3

Cardiac rehabilitation
Salford PCT

D

Redesigned the cardiac rehabilitation service to ensure it better met the needs of the patient through a menu type approach. This means that the solution is individualised to meet the patient need and is able to offer life long access to affordable leisure facilities

Why?

> Patient and public involvement group highlighted that the service was not meeting their needs and there was no opportunity to individualise the programme to met their particular needs

> National guidance set out expectation regarding cardiac rehabilitation service and the local service was not responsive enough

> British Heart Foundation (BHF) and the Big Lottery were accepting bids for the design of cardiac rehabilitation service. This gave the local service an opportunity to bid for funding

What did we do?

> Seconded a cardiac nurse to redesign the service to enable it to offer a menu approach to cardiac rehabilitation. The secondee took on a commissioning role and set up a process to take this forward which resulted in the development of a project initiation document which was agreed as part of the funding arrangement with BHF .

> Piloted each service change to ensure that it was fit for purpose and met the patient need

> Set up a cardiac rehabilitation group that was a sub group of the local CHD group which was a multi agency group which in turn reported to the Local Action Team. The cardiac regroup included team members, patients through the local support group, key partners including Salford Community Leisure

> The service links closely with Salford Heart Care the local voluntary group for the social and well being components of the person's recovery. Self-management of the person's condition and lifestyle risk factors is encouraged at all points throughout the pathway

Used the national audit of cardiac rehabilitation to assist in reviewing performance in relation to:

- access
- DNA's
- completion of programmes

> Developed service specifications and service level agreements for the service based on a menu approach

> Undertake patient experience surveys to establish why patients did not finish a rehabilitation programme and this is used to critically review the menu process and the design of the current programmes

What we achieved?

> The Cardiac rehabilitation service has been redesigned:
- been able to manage a 37% increase in referrals without an increase in budget
- been an increase in take up of the service
- menu driven approach which enables a programme to be tailored to the individuals needs
- introduced a continuous improvement approach whereby the team review performance and patient feedback on an on-going basis to ensure that the service continues to meet their needs, this includes following up with patients who do not complete the agreed programme of care
- team committed to improving the service

Case Study 3 (continued)

Cardiac rehabilitation
Salford PCT

D

Redesigned the cardiac rehabilitation service to ensure it better met the needs of the patient through a menu type approach. This means that the solution is individualised to meet the patient need and is able to offer life long access to affordable leisure facilities

- expanded to other conditions within CHD
  - implantable cardiac defribullators
  - angina
  - heart failure
- increased multi-disciplinary approach within the team that has resulted in staff multi-tasking and reduced professional boundaries
- community focused with menu options and function testing now undertaken in the community rather than within an acute hospital
- service current meets all national and local targets and meets best practice in relation to a menu approach

> Shared planning process in place with commissioners regarding the future direction of the service

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Lessons Learned

> Lack of data availability has made the task more difficult to achieve. This meant that processes had to be set up to collect the necessary performance data and patient feedback forms

> Need to have clarity regarding the training requirement of staff who are expected to change their role and work in more of multi disciplinary way

> Need to engage with specialist staff to ensure that the service changes are sustainable and maintain/improve outcomes for patients using the service

Why is it included?

> This has resulted in cardiac rehabilitation service that is user focused and is able to develop a programme that meets their needs and required outcomes

> The programme has demonstrated a score of 3 or above on at least 5 of the WCC competencies

> There is evidence to suggest that a logical approach has been followed in commissioning this service

Good practice table

WCC Competencies	1	2	3	4	5	6	7	8	9	10	11

Commissioning steps	1	2	3	4	5	6

Effective Health and Care Pathway	0	1	2	3	4

Case Study 4

An early discharge support service for Stroke
Berkshire West PCT

I

An early supported discharge and rehabilitation service for people who have suffered a stroke

Why?

> The area was identified as a key gap in the Stroke Strategy in Berkshire West and was prioritised by the Berkshire West Stroke Collaborative

What did we do?

> This was a commissioner (PCT) led and funded service initiative which was undertaken to
  - achieve more timely discharge together with improved outcomes for eligible complex stroke patients through the provision of intensive, multi-disciplinary, stroke-specialised rehabilitation in the community that follows seamlessly and immediately from the intensive rehabilitation received in the acute Stroke Unit, and dovetails with timely and appropriate stroke skilled support from Local Authority Community Care
  - provide adequate scope to support the implementation of the key acute objectives of the National Stroke Strategy by optimising patient flow across the hyper-acute patient pathway (specifically, early scanning and thrombolysis, and treatment of all stroke patients in a stroke unit) in Berkshire West
  - increase capacity to deliver intensive, stroke specialised rehabilitation to complex patients already in the community who would benefit and otherwise face acute readmission or being left with avoidable increased dependency

> A project group with multi stakeholder membership was formed to oversee development was set up. An existing service, the community based neuro-rehab team has been expanded to deliver the service Local area groups were established with clinician, partner and public representation. Communications were undertaken through existing forum

> Service changes are overseen by the Director of Clinical Services at a monthly review Steering Group attended by project managers and representatives from Commissioning, Local Authority partners and Practice Based Commissioners

What we aim to achieve?

> The programme aims to achieve:
  - reduction in deaths due to stroke
  - reduced levels of dependency following stroke
  - reduction in Acute (Tariff) bed days, Excess bed days, and total bed days
  - maximising capacity in the acute stroke unit, essential for achieving Stroke Strategy and Operating Framework targets for all stroke patients to spend the majority of their acute spell on a stroke unit
  - by freeing up capacity in the stroke unit, enabling more stroke patients to be thrombolysed when the service becomes available in the autumn 2008
  - improved support to patients and carers
  - improved stroke specialist skills of formal and informal carers

Case Study 4 (continued)

An early discharge support service for Stroke
Berkshire West PCT

I

An early supported discharge and rehabilitation service for people who have suffered a stroke

Lessons Learned

> The programme has not been delivered or evaluated to understand the key lessons as yet completely

Key strengths

> Commissioner led and funded

> Measurable health outcomes

> Patients and carers to be supported and informed by a Centre of Excellence in Stroke care

> Steering group jointly managed by PCT, Providers, Local Authority and representatives from Practice Based Commissioners

Why is it included?

> This is a good example of a service which impacts on stabilisation, and specialist intervention and treatment leading to early recovery

> The PCT has been able to demonstrate that they have achieved 3 or more in at least five of the WCC competencies

> The PCT has followed clear and logical steps in its commissioning approach for this new service

Good practice table

WCC Competencies	1	2	3	4	5	6	7	8	9	10	11
	■	■	■	■		■					■

Commissioning steps	1	2	3	4	5	6
	■	■	■	■	■	

Effective Health and Care Pathway	0	1	2	3	4
				■	■

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Case Study 5

Health and Social Care Rehabilitation and Long Term Neurological Conditions Service
Surrey PCT

D

A joint service drawing together both Surrey County Council and Surrey Primary Care Trust to provide a fully integrated intermediate service in East Surrey that best meet population needs

Why?

- The service was established in 2002 in accordance with the stated strategic aims of the Government, Surrey County Council and the Primary Care Trust
- The joint working was aimed at reducing delayed discharges from hospitals, reducing admissions to hospitals and to provide for effective and efficient intermediate care in the community

What did we do?

- The model was developed to ensure a fully integrated service under a Director appointed jointly by both organisations
- The key elements of the service include community nursing, social care, residential care homes, a community hospital, intermediate care and therapies
- A partnership board of senior staff from the county council, PCT and provider trust to oversee governance arrangements
- Agreements between the PCT and the County Council on the balance of funding contributions and responsibilities
- Formal section 28 agreements for major aspects of the service
- Performance accountability to both the primary care trust and county council
- This service combines both health and social care services in East Surrey to a population of 160,000. Services available in East Surrey are:
- **Rapid Response:** This team incorporates the Intermediate Care Team (including the falls team), Social Care team and Home based care service and is based at East Surrey Hospital. The main focus of this service is to avoid and divert admission form the acute hospital and to prompt timely discharge by prompt response to referrals minimising the risk of delayed transfers
- The team has been highly successful in reducing the need for long term placements
- **Step Down Beds:** To develop individual packages of care and to ensure patients who fall into the re-imbursement fines category are cared for in a suitable environment
- This programme has ensured that discharges get expedited and there is proper discharge planning
- **Promoting Independence Programme:** A medium stream rehabilitation service designed to reduce the effect of the user's disability and therefore reduce an individual's dependency on paid and unpaid carers and the need for long term care
- **Urgent Treatment Centre:** This is a 7/365 days a year nurse led service that offers assessment and treatment for minor injuries, primary care diagnosis, advice and treatment to people in the surrounding rural communities.

Case Study 5 (continued)

Health and Social Care Rehabilitation and Long Term Neurological Conditions Service
Surrey PCT

D

A joint service drawing together both Surrey County Council and Surrey Primary Care Trust to provide a fully integrated intermediate service in East Surrey that best meet population needs

What we achieved?

- The Health and Social Care team receives around 440 referrals per month of which 224 referrals are accepted, 75 are usually complex. This equates to 45,971 bed days saved between April-December 2005
- The development and success of the step down beds has been effective due to the integration of the health and social care team. Between May and December 2005, 434 bed days have been saved . The step down beds are fully utilised with an average length of stay of 20 days
- Another resource used by the Health and Social Care Team is the 10 intermediate care beds at Tandridge Heights. The average length of stay for users is 14 days. The use of these beds has been successful in preventing the need for long term placements for service users
- The team has made a real impact on average lengths of stay in the acute hospital through early intervention and the provision of rehabilitation
- The average LOS for hip/knee replacements has been reduced from 10 days to 5 days through better planning of Community Services
- LOS for hip replacements following falls has been reduced from 37 to 14 days
- COPD average LOS has reduced from 18 to 5 days
- Delayed Discharges because of social care has been maintained at 0 since October 2004

Lessons Learned

- The joint service development demonstrates how partner working has enabled an innovative approach to how services in the community can be delivered and received. It has had a knock on affect on acute pathways and long term care as well

Key strengths

- Real difference to quality of care and outcomes for users and carers
- Innovative approach to intermediate and rehabilitation service delivery
- Complete integrated approach to service delivery between health and social care
- Joint performance management with a single Director and a management board

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Case Study 5 (continued)

Health and Social Care Rehabilitation and Long Term Neurological Conditions Service
Surrey PCT

D

A joint service drawing together both Surrey County Council and Surrey Primary Care Trust to provide a fully integrated intermediate service in East Surrey that best meet population needs

Why is it included?

- The PCT has been able to demonstrate that they have achieved 3 or more in at least five of the WCC competencies
- The PCT has followed clear and logical steps in its commissioning approach for this new service
- This is a good example of a service which impacts on major part of the health and care pathway

Good practice table

WCC Competencies	1	2	3	4	5	6	7	8	9	10	11
		■	■	■		■		■		■	■

Commissioning steps	1	2	3	4	5	6
	■	■	■	■	■	■

Effective Health and Care Pathway	0	1	2	3	4
		■	■	■	■

Case Study 6

COPD Support and Rehabilitation Service
Greenwich PCT

D

Greenwich COPD Clinical Service Framework which includes Pulmonary Rehabilitation Programme

Why?

- COPD was the leading cause of hospital admission in Greenwich in 2005 accounting for approximately 1/20 emergency admissions daily (2 patients). Whilst information suggested that most hospital admissions were appropriate for patients with exacerbations of COPD, reductions in admissions and length of stay would only be achieved with a suitable alternative model of care
- Currently there is no national framework for the management of COPD and services vary nationally. A Clinical Service Framework was therefore developed in partnership between clinicians and managers from Greenwich Teaching Primary Care Trust (GTPCT) and Queen Elizabeth Hospital NHS Trust (QEHT) to manage COPD in Greenwich

What did we do?

- The Framework, which incorporates COPD NICE guidelines (2004), outlines a robust model of care to the management of COPD in Greenwich. The inter professional team, part employed by GTPCT and part employed by QEHT, promotes whole system initiative working across the primary and secondary pathway
- Launched in 2006, the Framework has several key components, priority being to support the elements of prevention and acute exacerbations:
  - by identifying COPD patients more effectively they can be targeted for smoking prevention
  - by managing acute exacerbations more proactively, earlier discharge from hospital could be facilitated and further emergency admissions avoided
- The Steering Group that produced the Clinical Service Framework was chaired by a Consultant Physician and members included Managers from the PCT and the Acute Trust, Specialist Nurses, Physiotherapists, General Practitioners and advice was sought from Practice Nurses, Allied Health Professionals, Pharmacists, Smoking Cessation Advisors, Respiratory Physiologists and representatives of various interested stakeholders including the Expert Patient Program who had expert patients with COPD who shared their experience about their care
- Since the team was recruited and started to deliver services in late 2006, the COPD service has worked with a broad range of stakeholders including social services, benefits teams, palliative care teams, primary care mental health workers (to support the management of mild to moderate mental health problems which include anxiety, depression and panic), intermediate care, breathlessness nurse, pharmacists, telecare and telehealth, the London Ambulance Service and local leisure initiatives
- A physiotherapy led pulmonary rehabilitation has been established to enable a 7 week programme of exercise and education. This has been held mainly in the local leisure centres in conjunction with Healthwise (a partnership between Greenwich Leisure Limited, GTPCT, Woolwich Development Agency and the Healthy Greenwich Network) and their team of exercise instructors. Healthwise have provided free venues and have also established follow up maintenance exercise classes which ensures patients have an exit route for exercise once pulmonary rehab has finished. The maintenance classes are run at a parallel time to pulmonary rehabilitation in the same venue which allows patients to access a physiotherapist for advice if needed. The maintenance classes have been called "Breathewise"

Case Study 6 (continued)

COPD Support and Rehabilitation Service
Greenwich PCT

D

Greenwich COPD Clinical Service Framework which includes Pulmonary Rehabilitation Programme

> In addition patients who have completed pulmonary rehabilitation have established their own Greenwich British Lung Foundation Breathe Easy group

> The team are currently working with LAS to establish a pathway for managing patients who call an ambulance

What we aim to achieve?

> The key outcomes and benefits have been realised despite the team really only being in operation for a year. The staff feel part of one cohesive community and acute team that are successfully enabling over 500 patients to manage their conditions at home and enjoy a better quality of life. For patients that are admitted the team are able to follow them up and support them

> In the first 6 months:
- non elective admissions with and without complications reduced by 26%
- bed days reduced by 25% with 26% saving on costs
- the trend in reductions has continued: In the last 9 months 210 patients have made an SOS call to the team. This resulted in 195 SOS visits. Of these SOS calls only 13% needed to be admitted to hospital and 77% were successfully managed at home

Pulmonary Rehabilitation outcomes have been positive:

> In the first year, 63% patients increased their walking distance by the minimally clinical important difference of 54m. The largest single improvement was 270 metres. A further 5/32 (16%) improved their walking distance but less than the 54m required to demonstrate a minimally clinical important difference; (41%) had a reduction in their anxiety score; 72% had a reduction in their depression score; 63% had an improved quality of life score which demonstrated a minimal clinical important difference

Lessons Learned

> Partnership working between clinicians and across primary and secondary care can make significant improvements in patient care and outcomes which has proved to be not only cost effective but safe. The joint working has also extended out to other agencies e.g. Leisure Centres, Breathe Easy thereby developing useful partnerships in managing COPD

> By empowering patients in managing their care, they are now in a position to enable further collaboration and partnerships now have the opportunity to be in a position to influence future developments

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Case Study 6 (continued)

COPD Support and Rehabilitation Service
Greenwich PCT

D

Greenwich COPD Clinical Service Framework which includes Pulmonary Rehabilitation Programme

Key strengths

- Alignment with NICE best practice guidelines
- Very positive user feedback
- Joint working (multi agency and multi professional collaboration)
- Robust outcomes measurements
- New ways of working
- A proactive and integrated management of the COPD pathway from prevention to rehabilitation

Why is it included?

- The PCT has been able to demonstrate that they have achieved 3 or more in at least five of the WCC competencies
- The PCT has followed clear and logical steps in its commissioning approach for this new service
- This is a good example of a service which impacts across a health and care pathway

Good practice table

WCC Competencies	1	2	3	4	5	6	7	8	9	10	11

Commissioning steps	1	2	3	4	5	6

Effective Health and Care Pathway	0	1	2	3	4

Chapter 8

Long Term Conditions

Chapter 8: Long Term Conditions

Context

The number of people with multiple chronic conditions is rising and forecast to continue to do so. Many health systems are now seeking to improve the way they respond to the needs of people with chronic illnesses

Impact

> There are approximately 17.5 million people in the UK with a recorded long term condition;
  - just 5% of inpatients, many with a long term condition, account for 49% of all acute bed days
  - only about 50% of medicines are taken as prescribed
> There has been a growing focus on prevention and management of long term conditions within the NHS and Social Care. 3 key areas for service development for people with chronic disease in the health sector have been identified:
  - using a personalised care planning approach to increase the flexibility of services to fit in with people's' needs
  - improving health professionals' skills and quality of service to manage long term conditions
  - improving the provision of information about long-term conditions to help people manage their own conditions
> With an ageing population, the emphasis on providing effective and efficient long term conditions care for the population is driving the commissioning agenda forward in this service area

Specific target

> The 2005-08 PSA target was to reduce inpatient emergency bed days by 5% by March 2008. This was more than achieved
> The aim for the 2008-11 PSA is to increase the proportion of people with a long-term condition who feel supported to manage their condition by local health services. Currently, 74 per cent of people said they felt fully or partly supported
> The key aspect of the NHS and Social Care Long Term Conditions Model is to drive forward the impetus for health, social care and third sector organisations to focus on improving care and outcomes for people with long term conditions
> The remainder of the chapter includes examples of 'long term conditions' good practice case studies
> Relevant policy documents and resources associated with the long term conditions agenda can be found in the Chapter 10: Bibliography. This also includes relevant documents associated with the World Class Commissioning agenda and procurement.

Case Study 1

Poole Intermediate Care Service
Bournemouth and Poole PCT

I

Poole Intermediate Care Services: An integrated health and social care service, delivered in the community and with single line management

Why?

- The key driver for the initiative was to build on the success of the Partnership for Older People Project (POPP) and to utilise this learning to further improve performance by providing integrated services that reduce hospital admissions and expedite discharges home
- The service represented a shared commitment to integrated working, boldness in creating new job roles, strong attention to performance management, relationship working with GP's and continued engagement of adults/ older people in service design, delivery and governance

What did we do?

- The adoption of a case finding model with Poole Hospital utilising information used by ward staff but previously not accessed by Social Care professionals. Thus rather than maintaining the historic referral and allocation model which led to extended length of stay, older people admitted to Poole Hospital are reviewed by a member of a locality team within 24 hours
- General Practitioners supporting pro-active whiteboard systems to be established within the surgeries, whereby Primary Care staff could identify people known to be at risk to the locality team in advance of a crisis occurring
- Paramedics having direct access to Team Leaders in order to avert admissions to hospital
- The creation of a new form of worker, Intermediate Care Assistant which as a core building block has overcome the traditional boundaries between Home Care Assistants employed by local authorities and Nursing Auxiliaries employed by Primary Care Trusts
- Establishing Locality Teams
- Partnership Working with Social Services, PCT, acute trust, voluntary and community groups, older people
- Managing Capacity
- Embedding the Consultants Role into the PICS service. Developing a Rapid Access Clinic managed daily by a consultant
- Establishing Information Systems
- Embedding the Rapid Response Service into PICS
- Embedding the traditional Hospital social work team effectively into PICS

What we achieved?

- Improved health outcomes
- Reduced admissions and expedited discharge
- The targets specified by Bournemouth and Poole Primary care Trust Commissioners are as follows:
  - 540 reduced admissions of those aged 65+ over the 06/07 baseline
  - 5000 occupied bed day reduction of those aged 65+ over the 06/07 baseline
  - Promotion of supported early discharge for those aged 65+, 360 per annum

Case Study 1 (continued)

Poole Intermediate Care Service
Bournemouth and Poole PCT

I

Poole Intermediate Care Services: An integrated health and social care service, delivered in the community and with single line management

> Quality
  – person-centred and timely response
> Performance improvement
  – evidenced by zero reimbursable discharge delays in September
> Value for money
  – high volume / low cost service (when compared to cost of bed days)
> Skill mix
  – multi-disciplinary working with knowledge sharing
  – closer working with consultants
> Training
  – gives staff access to both local authority and NHS training and opens up new career pathways

Contact

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Lessons Learned

> The team has learnt the need to:
  – embed Medicines Management into PICS and engaging with District Nursing more effectively
  – develop clearer Links with Long Term Conditions
  – develop a Pathway for Managing Clients that fall within boundaries of Bournemouth and Dorset
  – develop an Effective Communication Strategy
  – develop an On-Call Process for Team Leaders

Key strengths

> The adoption of a case finding model with Poole Hospital utilising information used by ward staff but previously not accessed by Social Care professionals. Thus rather than maintaining the historic referral and allocation model which led to extended length of stay, older people admitted to Poole Hospital are reviewed by a member of a locality team within 24 hours

> General Practitioners supporting pro-active whiteboard systems to be established within the surgeries, whereby Primary Care staff could identify people known to be at risk to the locality team in advance of a crisis occurring

> Paramedics having direct access to Team Leaders in order to avert admissions to hospital

> The creation of a new form of worker, Intermediate Care Assistant which as core building block has overcome the traditional boundaries between Home Care Assistants employed by local authorities and Nursing Auxiliaries employed by Primary Care Trusts

Case Study 1 (continued)

Poole Intermediate Care Service
Bournemouth and Poole PCT

I

Poole Intermediate Care Services: An integrated health and social care service, delivered in the community and with single line management

- Importantly, PICS is only 6 months fully rolled out and numerous system changes have taken place. This is illustrative of the maturity of the partnership that has been achieved at strategic and operational level
- Establishing Locality Teams
- Partnership Working with Social Services, PCT, acute trust, voluntary and community groups, older people
- Engagement of Local Communities
- Managing Capacity
- Successful Recruitment
- Embedding the Consultants Role into the PICS service. Developing a Rapid Access Clinic managed daily by a consultant
- Establishing Information Systems
- Embedding the Rapid Response Service into PICS
- Embedding the traditional Hospital social work team effectively into PICS

Why is it included?

- This is a good example of a service working across the health and care pathway
- The PCT has been able to demonstrate that they have achieved 3 or more in at least five of the WCC competencies
- The PCT has followed clear and logical steps in its commissioning approach for this new service.

Good practice table

WCC Competencies	1	2	3	4	5	6	7	8	9	10	11

Commissioning steps	1	2	3	4	5	6

Effective Health and Care Pathway	0	1	2	3	4

Case Study 2

Chronic Obstructive Pulmonary Disease (COPD) reconfiguration
Salford PCT

I

Improve the performance of this service which was high cost due to high number of admissions and longer length of stay against the national average.

Why?

> Why was the service change introduced
  - user dissatisfaction with service provision
  - higher than expected rates of admissions
  - longer length of stay (LOS) than expected
  - higher than expected level of smokers
  - higher level of cost than would be expected
  - all parties were aware that the current model was not meeting users and carers needs from a quality and value for money perspective

What did we do?

> Set up a multi disciplinary group to develop the new COPD strategy based on redefining the care pathway and developing an integrated approach. This included:
  - acute
  - PCT
  - primary care
  - community staff
  - user representatives
  - specialist staff

> The strategy has resulted in the development of a service plan which sets out the targets for the service through to 2013. This is based on improving user experience, health outcomes and quality of care

> The strategy was based on the local needs assessment which provided the base line for the development of the new strategy. This provided data on health outcomes and health needs across the whole population

What we achieved?

> Reduction in the number of emergency admissions by 20% in 2007/8 compared to the previous year. This has stemmed the increase in emergency admissions which has plateaued. The plan is to further reduce this over time

> Reduction in the LOS from 7.9 days in 2006/7 to 6.9 days in 2007/8 and the plan is to reduce this further over time

> A new strategy based on a vertically integrated service model across both the acute and community sectors

> A new care pathway which:
  - improved user care
  - made access to the service easier
  - streamlined process
  - reduced unscheduled care
  - reduced LOS
  - improved the cost efficiency of the service

Case Study 2 (continued)

Chronic Obstructive Pulmonary Disease (COPD) reconfiguration
Salford PCT

I

Improve the performance of this service which was high cost due to high number of admissions and longer length of stay against the national average.

Lessons Learned

> The process change needs to involve the right stakeholders at the beginning to ensure that progress can be achieved

> When developing an integrated model – need to define everyone's roles and conflict of interests, as there will be a need to satisfy different people's positions. To do this you need to establish this at the outset

> Users need to take an active role to ensure that the integrated model delivers the service at the right time at the right place

> To succeed the integrated model has to develop its own entity to ensure it has clear boundaries and management responsibilities

> Need to ensure that sufficient time is given to the planning and implementation phases due to the large number of stakeholders who have to be engaged to plan and agree the new service model

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Why is it included?

> The project has resulted in a reduction in the number of unplanned admissions and improved the length of stay for unplanned admissions

> The programme has demonstrated a score of 3 or above on at least 5 of the WCC competencies

> There is evidence to suggest that a logical approach has been followed in commissioning this service

Good practice table

WCC Competencies	1	2	3	4	5	6	7	8	9	10	11

Commissioning steps	1	2	3	4	5	6

Effective Health and Care Pathway	0	1	2	3	4

Case Study 3

Chronic Obstructive Pulmonary Disease (COPD) Pathway Review: Introducing a new service delivery model
Halton and St Helens PCT

I

To develop an integrated model of care for COPD across the Halton and St Helens PCT area to harmonise the services received by patients and reduce the number of admissions into the acute sector

Why?

> The COPD pathway review was carried out for the following reasons:
  - following PCT reconfiguration two different COPD pathways were identified which created inconsistencies in the range of services provided
  - respiratory disease is the single biggest reason for hospital admissions across the PCT
  - 46% of admissions could have been avoided as alternative Primary and Community Services were available
  - to provide a holistic range of services which taken together will reduce the number of admissions entering the acute sector

What did we do?

> Collated 'as is' service delivery baseline position to understand user flow

> Use of lean methodologies to identify areas for improvement

> Undertook options review of potential COPD service models

> Agreed a future state integrated model for COPD developed using front-line staff, users and best practice reviews (e.g. NICE guidance and British Thoracic Society recommendations)

> Introduced screening training for GPs to ensure accurate diagnosis and standard reporting back to GPs

> Made clear links to the smoking cessation programme

What we achieved?

> An integrated model of care for people with COPD which when implemented is expected to deliver the following benefits:

  - information and education of users following an exacerbation reduced from 8 to 2 weeks
  - reduction in repeat spirometry to around 10-20%
  - eduction in wait for people to get a prescription from a GP from 2 days to 2 hours
  - co-location of phlebotomy in centralised respiratory service so users do not have to travel from chest clinic to phlebotomy appointment
  - a maximum wait of time of spirometry in the community introduced
  - introduction of Community Respiratory Physician to bridge the gap between community and the acute sector by undertaking outreach work in community and to provide dedicated between support in the local acute trust
  - oxygen management service which could deliver potential savings of 10% in the first year (i.e. c£50,000) through better assessment, review and management
  - 40-50% of all COPD admissions staying less than 2 days
  - COPD attendances into A&E could be reduced by 20-30%
  - annual excess bed days could be reduced 30-50%
  - an integrated respiratory team which incorporates Community Services nursing, rapid response and pulmonary rehabilitation which could deliver likely savings within 12-18 months of c£182,000

Case Study 3 (continued)

Chronic Obstructive Pulmonary Disease (COPD) Pathway Review: Introducing a new service delivery model
Halton and St Helens PCT

I

To develop an integrated model of care for COPD across the Halton and St Helens PCT area to harmonise the services received by patients and reduce the number of admissions into the acute sector

Lessons Learned

> Senior management buy-in to drive the change and to champion project when move into implementation phase

> Need for flexible approach to stakeholder engagement (e.g. undertake 1-1 interviews with GPs at practices)

Key strengths

> Detailed investment appraisal and options analysis to select the preferred COPD model

> Wide ranging stakeholder engagement in the development of the COPD model

> Introduction of a health and care pathway approach to COPD

> Development of performance management framework which drives contract management

Why was it included?

> The programme has demonstrated a score of 3 or above on at least 5 of the WCC competencies

> There is evidence to suggest that a logical approach has been followed in commissioning this service

> PCT has attempted to introduce a health and care pathway approach

Good practice table

WCC Competencies	1	2	3	4	5	6	7	8	9	10	11
			■	■	■	■				■	

Commissioning steps	1	2	3	4	5	6
	■	■	■	■	■	

Effective Health and Care Pathway	0	1	2	3	4
	■	■	■	■	■

Contact

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Case Study 4

Chronic Obstructive Pulmonary Disease (COPD) – A condition management approach to commissioning services
Nottingham County PCT

I

By knowing who is at risk and intervening early we can provide care for twice as many people, for less money – and reduce the number of attendances at A&E by 60%

Why?

> Across Nottinghamshire 35% of the population smoke and are at risk of COPD. Over the past years around £23 million has been spent each year on COPD primary, community and acute services. Despite this level of investment there has been no improvement in COPD prevalence or incidence

> Only 47% of the at risk group were on a disease register

> Despite some pockets of good practice across the county the number of people turning to A&E and returning repeatedly with an 'acute exacerbation' indicated that the right services were not in place in the community and that clinical expertise and support was not targeted at these high risk groups

What did we do?

> The service redesign approach was based on being proactive about maintaining health – rather than reacting to illness and crisis. The PCT took the principles of Kaiser Permanente which focuses on an effective health and care pathway approach – knowing who is at risk and regular assessment to spot who has COPD of illness early; ensuring anti-smoking messages are well targeted, putting in place timely and appropriate levels of care and flexing the capacity, responsiveness and skills depending on the needs of individual patients

> Current services were mapped to understand the location of services, existing capacity, met and un-met demand, staff skills, service costs and performance

> Good stakeholder engagement was achieved with COPD clinicians across primary, community and acute providers to:
  - design a disease managed pathway that stated what best clinical practice and intervention would be needed at each stage of the condition to maintain or improve the condition – and ideally prevent the condition worsening and needing greater complexity of care
  - model the anticipated number of people likely to need care at each stage, the intensity of that care, the likely number of people whose condition would progress to moderate and severe, and the associated costs of care at each stage
  - agree the service specification which we would ask the provider market to respond to – this defines the range of services that we wanted a provider to deliver which was a seamless package to manage COPD but excluded health promotion and acute surgical hospital care

> The PCT are now considering the next steps to commission the new service and how quickly they can transition from the current approach to COPD to the new service

Case Study 4 (continued)

Chronic Obstructive Pulmonary Disease (COPD) – A condition management approach to commissioning services
Nottingham County PCT

I

By knowing who is at risk and intervening early we can provide care for twice as many people, for less money – and reduce the number of attendances at A&E by 60%

What we achieved?

> Commissioning this different model and focusing on keeping people as well as possible (stopping people developing COPD or if they already have it not letting their condition worsen) we will achieve for the same £23 million a
  - 54% increase in number of people on the COPD disease register and managed
  - shift in activity and costs to community based services from the acute sector
  - 60% reduction in A&E attendances

Key strengths

> Detailed investment appraisal and options analysis to select the preferred COPD model

> Wide ranging stakeholder engagement in the development of the COPD model

> Introduction of an effective health and care pathway approach to COPD

Contact

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Good practice table

WCC Competencies	1	2	3	4	5	6	7	8	9	10	11
		■	■	■	■			■			

Commissioning steps	1	2	3	4	5	6
	■	■	■	■		

Effective Health and Care Pathway	0	1	2	3	4
	■	■	■	■	■

Case Study 5

Neurology reconfiguration
Sheffield PCT

I

Improve the performance of this service which is currently providing inequitable service across the city and is not meeting user needs

Why?

- User dissatisfaction with service provision
- Known that there was unmet need but it was difficult to quantify as there was no minimum data set for this service
- Inequitable provision across the city with only half the city having access to outreach services
- No psychological or neuro-psychological input
- Service provision did not meet NICE guidance
- Service provision did not meet policy in relation to the NSF on LTC
- Merger of 4 PCTs into 1 which highlight the inequitable services across the city

What did we do?

- Set up a multi disciplinary group, the NSF implementation group which is now the LTC neurology implementation group and involved
- Service stakeholder representatives (acute, community, LA etc)
- User representatives
- Third sector representatives (neurological alliance – 2 seats on the forum)
- Carer representation (Sheffield carer forum)
- The implementation group provided advice and was consulted on the development of the new service specification which develops a health and social care integrated network for neurology services across the city

What we achieved?

- Developed a service specification regarding the development of an integrated service model through a NSF implementation group which is now the LTC neurology implementation group
- Service specification was based on the redesign of the service:
  - rationalise the pathways and build links with other services i.e. acquired brain injury and ME services
  - enhanced psychological input
  - stability in the workforce as the therapy workforce was small and isolated
  - succession planning specially within the therapy workforce
  - integration of social care into the pathway
  - 4 tiers of response:
    - enable discharge
    - updating and review of care plans within the community
    - rapid response when condition worsens
    - standard response which is goaled based and user centred

Case Study 5 (continued)

Neurology reconfiguration
Sheffield PCT

I

Improve the performance of this service which is currently providing inequitable service across the city and is not meeting user needs

- considered market testing but felt that integration of the service was more important to ensure consistency of service delivery and stabilisation of the service. The current user expectations are:
  - service availability
  - local as it can be
  - staff are knowledgeable regarding their conditions
- performance plan is in place and the new service starts in January 2009. Consultation process on the TUPE transfer of staff to the new integrated provider is almost complete and currently finalising accommodation arrangements

Contact

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Lessons Learned

> Transfer of resources from the acute sector is both time consuming and requires real commitment to make it happen

> HR commitment is critical when staff are being TUPE to a new integrated service provider

> Clarity about the outcome, in this instance it provided a win/win situation i.e. improved VFM whilst improving access to service especially in the community

> Need to balance access v delivery v improved working condition i.e. providing staff with more stability

Good practice table

WCC Competencies	1	2	3	4	5	6	7	8	9	10	11
		■	■	■	■			■			■

Commissioning steps	1	2	3	4	5	6
	■	■	■	■		

Effective Health and Care Pathway	0	1	2	3	4
	■	■	■	■	■

Case Study 6

Chronic Obstructive Pulmonary Disease (COPD) – Service redesign
Manchester PCT

I

Evaluation established that the service was focused mainly on the acute sector with significant gaps within the community. Developed a business case which resulted in two service specifications (Oxygen provision and Community clinic/outreach service), tender the service, had 5 bidders, shortlisted 3 who have been invited for interview

Why?

> Undertook an assessment of the service which established:
  - The current service was acute focused with gaps within the community
  - Acute element of the service
  - Service was not meeting user needs
  - Not compliant with NICE guidance

What did we do?

> Developed a level of care model involving key stakeholders (clinicians, specialist nurse, users, commissioners) this took 6 months to develop. The current service was assessed against this to establish gaps in provision

> Piloted a COPD community clinic which proved to be a success and provided evidence for the development of a business case

> Developed a business case for the establishment of an integrated community COPD service and a community oxygen assessment clinic. The business case set up the rationale for the change in service including findings from the pilot of a nurse led community clinic which found that just 5 of the 145 patients seen in the clinic needed a referral to the secondary care. Without this clinic all these 145 patients would have been referred to a secondary care consultant. This led to the development of two specifications:
  - a specification for the provision of Community Oxygen Assessment Clinics (including long term oxygen therapy and assessment for ambulatory oxygen), currently tendering for this service
  - a specification for a COPD Community Clinic / Outreach Service, including
    - acute exacerbation assessment and management
    - clinical governance of diagnostic testing in primary care
    - Pulmonary Rehabilitation

> Undertook a soft market testing approach to ensure that there would be sufficient interest. The service has been tendered and received 5 bids with 3 being shortlisted

> Developed a web page with information on COPD which can be accessed by users and professionals

What we achieved?

> The expected outcomes are:
  - improved access and choice
  - reduction in the level of admissions
  - development of an integrated community service
  - development of an acute service in the community
  - focus on preventative services
  - process that will ensure contestability
  - compliance with NICE guidance
  - improved efficiency which will result in cost savings

Case Study 6 (continued)

Chronic Obstructive Pulmonary Disease (COPD) – Service redesign
Manchester PCT

I

Evaluation established that the service was focused mainly on the acute sector with significant gaps within the community. Developed a business case which resulted in two service specifications (Oxygen provision and Community clinic/outreach service), tender the service, had 5 bidders, shortlisted 3 who have been invited for interview

Lessons Learned

> Need for collaboration between consultants, specialist nurse and commissioning manager to ensure all aspects of the service are understood

> Pilot assisted in understanding and provided evidence for the business case

> Combined clinical and management skills

> Clinical nurse had a good understanding of what was happening locally

> Talk to other PCTs to establish what they have been doing

> Involve users throughout the process to ensure that the solution meets their needs

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Good practice table

WCC Competencies	1	2	3	4	5	6	7	8	9	10	11
			■	■	■		■	■	■		

Commissioning steps	1	2	3	4	5	6
	■	■	■	■	■	

Effective Health and Care Pathway	0	1	2	3	4
	■	■	■		

Chapter 9

End of Life Care

Chapter 9: End of Life Care

Context

> Around half a million people die in England each year, of whom almost two thirds are aged over 75. The large majority of deaths at the start of the 21st century follow a period of chronic illness such as heart disease, cancer, stroke, chronic respiratory disease, neurological disease or dementia. Surveys of the general public have shown that most people would prefer to die at home. In practice, however, only around 18% do so. Most deaths (58%) occur in NHS hospitals, with around 17% in care homes, 4% in a hospice and 3% elsewhere

> The End of Life Care (EOLC) Strategy, the first for the UK, was launched in July 2008, backed by an additional £286 million Government funding, to be invested over the two years to 2011. The Strategy's aim is to improve care for people approaching the end of life whatever their diagnosis and wherever they are, including enabling more people to be cared for and die at home if they wish. It covers all adults with advanced, progressive illness and care given in all settings. The Strategy builds on and supports the visions for EOLC developed by the strategic health authorities as part of the NHS Next Stage Review

> "The Strategy aims to bring about a step change in access to high quality care for all adults approaching the end of life, irrespective of their condition or setting. Implementation of the Strategy should enhance choice, quality, equality, patient, carer and staff satisfaction and value for money. This will be achieved by:

- **Improved community services –** for example, asking PCTs, working with local authorities, to ensure that rapid response community nursing services are available in all areas 24/7. This will enable more people to be cared for and die at home if they wish;
- **Workforce training and development –** to train health and social care professionals in assessing the needs of people at the end of life and their carers and providing the best possible quality care;
- **Development of specialist palliative care outreach services –** we will encourage PCTs and hospices to work together to develop specialist services in the community, which will support all adults regardless of their condition;
- **Setting up a national End of Life Research Initiative –** to enhance understanding of how best to care for those at the end of their lives;

- **Quality Markers –** we have worked with SHA Next Stage Review EOLC Leads to develop draft national Quality Markers for EOLC. These are designed to be a guide against which commissioners and providers can assess themselves and be assessed by regulators. The three month consultation period for the QM began on 7 November 2008."

> The remainder of the chapter includes examples of 'end of life' good practice case studies

> Relevant policy documents and resources associated with the 'end of life' agenda can be found in the Chapter 10: Bibliography. This also includes relevant documents associated with the World Class Commissioning agenda and procurement.

Case Study 1

The Poole Palliative Care Service
Bournemouth and Poole PCT

D

A 24/7 day nurse led community generalist palliative service that gives users the opportunity to remain in their home at the end of life

Why?

- To bridge the service gaps and enable people to live and die in their place of choice where possible
- Improve users quality of end of life care
- Prevent and reduce unnecessary hospital admissions
- Reduce length of stay in hospital
- Respond rapidly to health / palliative care needs
- Considered national good practice and local and national priorities
- Holistic assessment of palliative care needs and complex equipment needs
- To provide complex packages of care to enable people to remain at home
- To improve quality of life and independence for as long as possible
- To strengthen joint partnership working with Primary Care Teams, Specialist Nurses and Specialist Palliative Care Teams. Aim to provide a first class holistic palliative care service without duplication to enhance care throughout the End of Life Journey whilst supporting carers and families

What did we do?

- The multi agency Community Palliative Care Operational Group was established and acted as a steering group. The expansion of the team into Poole was overseen by a working party including Providers and Commissioners of the PCT and the Specialist Palliative Care Consultants and Nurses already established in Poole
- A business plan was written by provider's service and adapted by commissioners, who then funded the service
- Referral criteria and forms were agreed and disseminated to all GP Practices and District nurses
- Monthly reporting to Operational group provided regular monitoring
- Individuals/ Carers satisfaction questionnaires were utilised
- The service was rolled out by localities, to ensure that the service delivered a high quality of care

What we achieved?

- Improved health outcomes
- Improved the quality of End of Life care and individual choice especially around care needs decisions

Quality

- Good symptom control
- User choice
- Facilitated early hospital discharge

Case Study 1 (continued)

The Poole Palliative Care Service
Bournemouth and Poole PCT

D

A 24/7 day nurse led community generalist palliative service that gives users the opportunity to remain in their home at the end of life

> Provided equipment in the home that prolonged independent living for as long as possible

> Provision of 24hour care at home as appropriate

Performance improvement

> Reduced unplanned hospital admissions

> Facilitated early hospital discharges

> Increased the number of deaths at home

> Implementation of End of Life Tools

> Improved communication with all health professionals involved with the individual

> Accessibility to professional advice

Value for money

> Improved peoples' end of life quality of care

> Improved carers experience and opinion of the service

> Hospital bed days reduced

Skill mix and Training

> Community Matrons, Sisters, Staff Nurses, OT's, HCA's, GSF/LCP facilitator and GP's with specialist interest in palliative care worked together as a team

> District Nurses, Care Homes, Intermediate Care Team, GP's were given appropriate training

Lessons Learned

> A more appropriately skilled mix team as the success of the team resulted in more complex patients requiring larger packages of care than anticipated at the beginning of the service

> Ensuring staff were competent in accessing and managing continuing health care funding as many individuals towards the last days of life qualify for this funding and initially staff did not have these skills

> Capacity for admin and clerical support

> Increase Occupational Therapy input

Contact

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Case Study 1 (continued)

The Poole Palliative Care Service
Bournemouth and Poole PCT

D

A 24/7 day nurse led community generalist palliative service that gives users the opportunity to remain in their home at the end of life

Evidence

Data for 2008 April–Sept	
Total Number of New Referrals	273
New Initial Assessments by Nurses	244
Nursing Assessments	214
GPwSI Visits	65
OT Assessments	99
Support/Reassessments by Nurses	312
Support/Reassessments by GPwSI	64
Reassessments by OT	141
Referrals Not Assessed	127
Referrals to Social Services	6
Facilitated Early Discharges	51
No Non Face- To Face Contacts	871
Total Number of Patient Contacts by the Team	5263
Number of Day Respite 'sitting' by HCA's	50
Number of Bereavement Visits	19
Number of Home Deaths	161
Number of Hospital Deaths	49
Number of Care Home Deaths	2
Number of Admission Avoidances	217
Number of Dementia PatientsLength of Time on Nursing Caseload (average)	8
Length of Time on OT Caseload (average)	64.94 38.04

Case Study 1 (continued)

The Poole Palliative Care Service
Bournemouth and Poole PCT

D

A 24/7 day nurse led community generalist palliative service that gives users the opportunity to remain in their home at the end of life

Key strengths

- Good uptake of the service
- Good partnership working
- Patient and carers satisfaction
- Reduced unplanned palliative care admissions
- Integrated working with Specialist Palliative Care services, Community Matrons and District Nurses

Why is it included?

- This is a good example of a service based in the community that has impact on both upstream and downstream of the tiered care pathway
- The PCT has been able to demonstrate that they have achieved 3 or more in at least five of the WCC competencies
- The PCT has followed clear and logical steps in its commissioning approach for this new service

Good practice table

WCC Competencies	1	2	3	4	5	6	7	8	9	10	11
	■	■	■	■			■	■	■	■	

Commissioning steps	1	2	3	4	5	6
	■	■	■	■	■	■

Effective Health and Care Pathway	0	1	2	3	4
		■	■	■	

Case Study 2

Palliative Care Service
Berkshire West PCT

D

Palliative care – where and when needed at the most appropriate setting

Why?

> The service change was introduced as part of a local health economy wide initiative to bring close clinical working between secondary care, PCT Community Services and voluntary sector to ensure that palliative care patients are assessed for the most appropriate care-setting. Historically patients have been disadvantaged by inappropriate banding (too low can leave unmet needs, too high causes unnecessary exposure to increased numbers of health professionals without additional benefit to the patient, and reduces service cost effectiveness)

What did we do?

> A hub and spoke model of service delivery was developed that facilitated:
  - integrated working with palliative care teams at Sue Ryder and RBFT to enable
    - sharing of good practice
    - shared Consultant cover across both units
    - shared Bed availability
  - consultant, clinical nurse specialists' weekly visits to support ward staff and GP's at West Berks Community Hospital to provide advice; review patients and improve knowledge base of ward staff
  - HIV specialist nurses, who are part of the multidisciplinary team, to support and deliver quick, efficient and effective liaison between specialist palliative care MDT and HIV teams
  - access to newly developed Symptom Control Guidelines on the PCT intranet for all professionals, including out of hours services; backed up by 24 hour access to consultant advice
  - training and support of out of hours service Drs and advice on appropriate 'stock' medication. Specialist pharmacists, as members of the Specialist Palliative Care Teams (BWPCT; Sue Ryder; RBFT), prompt access to advice relating to medicines management issues and safely monitored use of 'off license' medication
  - Macmillan Clinical Nurse Specialists attend Gold Standard Framework meetings at GP surgeries. Patients are then 'flagged up' to out of hours service thus making it possible for these patients to be immediately identified
  - provision of GP registrar week long training attachments to specialist unit and GP study days aim to recognise palliative care issues and improve symptom control management for patients in the community
  - close working with Wokingham and Newbury Cancer Care Charities identifies joint areas of working e.g. development of family support and bereavement services; education for community staff; development of volunteer services (current plans to develop befriending service for patients at home)

What we achieved?

> The service model is underpinned by excellence in the provision of palliative care by primary care and hospital teams. Supporting this activity is a key part of the PCMDT's role

> Patients move between bands as appropriate

> Prevent unnecessary and unwanted admission to hospital with good symptom management

> Access to 24 hour specialist advice and timely admissions to specialist unit

> Complex problems e.g. symptom control; psychological issues treated promptly and appropriately

Case Study 2 (continued)

Palliative Care Service
Berkshire West PCT

D

Palliative care – where and when needed at the most appropriate setting

> Identifies patients suitable for specialist palliative care intervention and enables efficient and appropriate use of resources including liaison with RBH and seamless transition between care environments for this group of patients

> Safe management of medicines; reduction in use of multiple medications; optimising of dose levels and availability of 'off license' treatments

Lessons Learned

> This model of working has enabled the needs of patients and carers to be met by the most appropriate professionals, using the most appropriate skills while minimising travelling distances for all parties

> The multidisciplinary focus has enabled staff to learn about each others roles and skills

> Efficient sharing of patient and clinical information enables staff to respond promptly and efficiently and minimises the times a patient has to 'tell their story'

Key strengths

> Prompt access for patient to the full multidisciplinary team appropriate for the complexity of the problems they face

> Advice and support to be given to non specialist palliative care professionals

> Delivery of care in the place of the patients choice where practicably possible

> End of life and symptom control issues identified in a timely manner and appropriate management planned

> Flexible and appropriate psychological intervention is offered which meets the needs of the patient and carers helping them deal with the complexities of living and dying with a life limiting illness

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Case Study 2 (continued)

Palliative Care Service
Berkshire West PCT

D

Palliative care – where and when needed at the most appropriate setting

Berkshire West NHS Palliative Care Service

> Mapping service delivery onto needs complexity

Notes

> The service model is underpinned by excellence in the provision of palliative care by primary care and hospital teams. Supporting this activity is a key part of the PCMDT's role

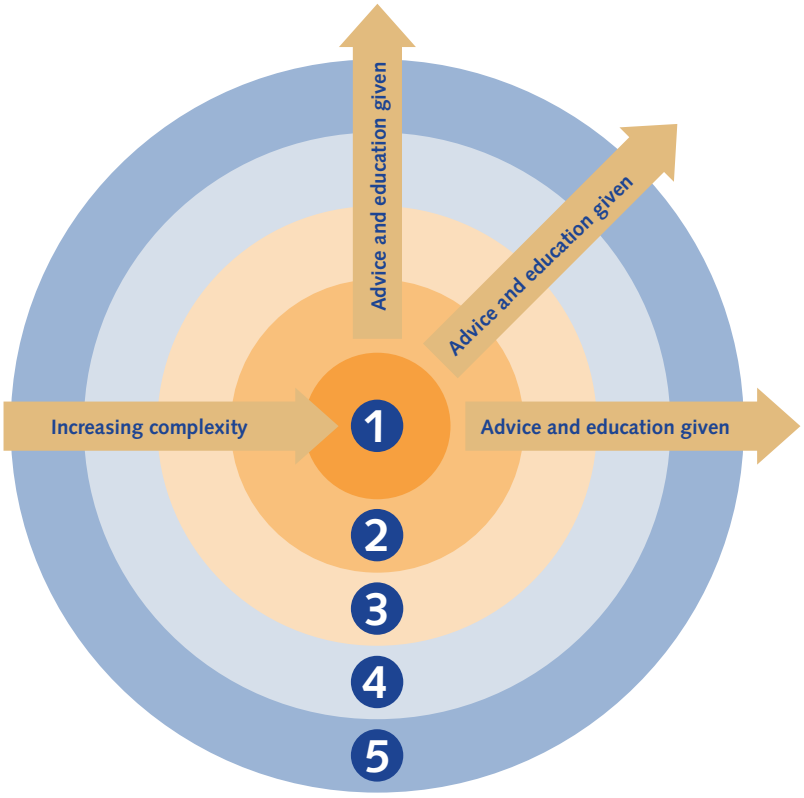
> 'Complexity' does not mean 'degree of distress', but rather the appropriate part of the healthcare system required to manage this distress

> Patients are disadvantaged by inappropriate banding (too low can leave unmet needs, too high causes unnecessary exposure to increased numbers of health professionals without additional benefit to the patient, and reduces service cost effectiveness). Patients move between bands as appropriate

> 'Clinical support' refers to advice specific to an individual patient while 'clinical education' refers to advice/ training in the general provision of palliative care

Key:

PCMDT	*Part of the Palliative Care Multidisciplinary Team*
Chaplin	*Chaplaincy*
CMN	*Community Macmillan Nurses*
Comp	*Complementary Therapies*
CP	*Clinical Psychologist*
Dt	*Dietetics*
DT	*Day Therapy*
Edu	*Education Programme*
FSS	*Family Support and Bereavement Service*
HCNS	*Hospital clinical nurse specialist (In palliative care)*
HIV	*HIV/AIDS Clinical Nurse Specialists*
Lymph	*Lymphoedema service*
OPA	*Out Patient appointment (medical)*
OT	*Occupational Therapist*
PhysT	*Physiotherapy*
SPCU	*Specialist Palliative Care Unit*



1	**SPCU Inpatient** • Full MDT inpatient assessment and management
2	**Direct contact with ≥2 PCMDT professionals** • (further assessment and/or treatment) • (e.g. CMN or DT plus OPA, OT, • FSS or CP)
3	**Direct contact with a PCMDT professional** • (e.g. CMN, DT, FSS or HCNS)
4	**Clinical support from PCMDT** • (e.g. seeking advice from a CMN, HCNS, FSS or Medical Consultant, but without need for face-to-face patient contact)
5	**No patient-specific contact from PCMDT** • PCMDT activity includes: Clinical education and training, maintaining supporting information (e.g. clinical guidelines), supporting • local and network strategic development

Case Study 2 (continued)

Palliative Care Service
Berkshire West PCT

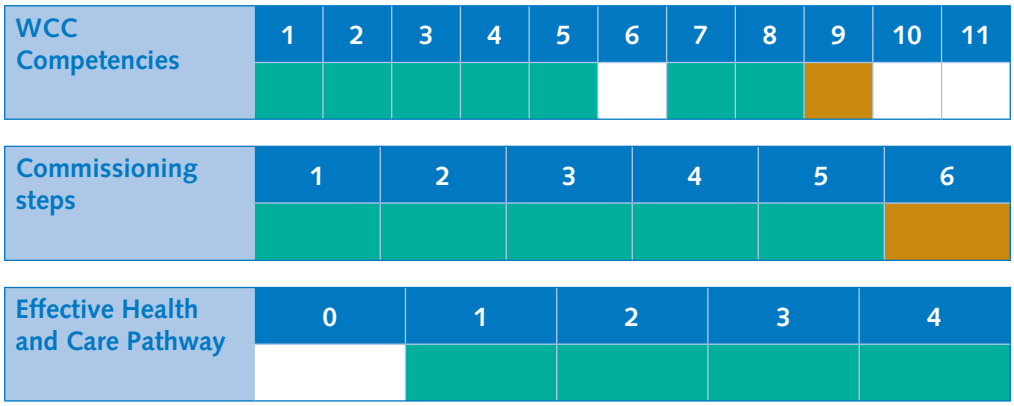
D

Palliative care – where and when needed at the most appropriate setting

Why is it included?

- The PCT has been able to demonstrate that they have achieved 3 or more in at least five of the WCC competencies
- The PCT has followed clear and logical steps in its commissioning approach for this new service
- This is a good example of a service working across the health and care pathway to provide a service that supports high quality patient care

Good practice table



Case Study 3

Community Palliative Nurse-Led Clinic
Hillingdon PCT

I

A management plan for all patients identified with a limited prognosis

Why?

> The health economy identified a gap in service for patients with a limited prognosis i.e. < 6 months. The Gold Standard Framework and NICE Guidelines were used as the basis of good practice to offer patients:
  - choice of preferred place of care
  - anticipatory care planning with clear prognostic indicators and predictors

> The preliminary work also evidenced that approximately 47% of patients in Care Homes were admitted to the Acute Sector

What did we do?

> The service aims to provide identified patients with a care management plan. The community Palliative Care Team adopted a Whole Teams approach on working across organisational boundaries. The team has established links within Care Homes and have begun a programme of education aimed at enabling staff to identify patients with a limited prognosis and supporting them in the implementation of PPC and in developing ACP. The focus has been on development of management plans for those patients with a limited prognosis who are residents of Care Homes with Nursing

What we expect to achieve?

> Reduction in Acute Care admissions of patients with limited prognosis.

> Reduction in A&E attendances and admissions

> A Care Management plan for all identified patients

> Collaborative working with key stakeholders including Nursing Homes

> Improved care and choice for patients with limited prognosis

> Efficient communication pathways between all relevant health care professions

Key Outcomes

> 6 months pilot project evidence has suggested that out of 40 deaths during this period, there has been only 1 Acute death

> 15 Nursing Homes and 92 patients have been identified and these patients now have management plan

Lessons Learned

> Better Stakeholder engagement; engagement with Nursing homes have been difficult

> Resource support; only 2 posts have been funded

Case Study 3 (continued)

Community Palliative Nurse-Led Clinic
Hillingdon PCT

I

A management plan for all patients identified with a limited prognosis

Key strengths

- This service complies with NICE Guidelines as well as the End of Life Care Initiative requirements
- Incorporates the Gold Standard Frameworks in Care Homes and the Liverpool Care Pathway tools
- Patients need and choice are at the centre of the service
- Works across organisational boundaries
- Service and Care Map for identified patients
- Holistic palliative management care assessment and plan

Contact

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Case Study 3 (continued)

Community Palliative Nurse-Led Clinic
Hillingdon PCT

I

A management plan for all patients identified with a limited prognosis

Why is it included?

> The planned Palliative care project is a community based approach to a perceived need for allowing patients with limited prognosis better care management and choice

> The programme has demonstrated a score of 3 or above on at least 5 of the WCC competencies

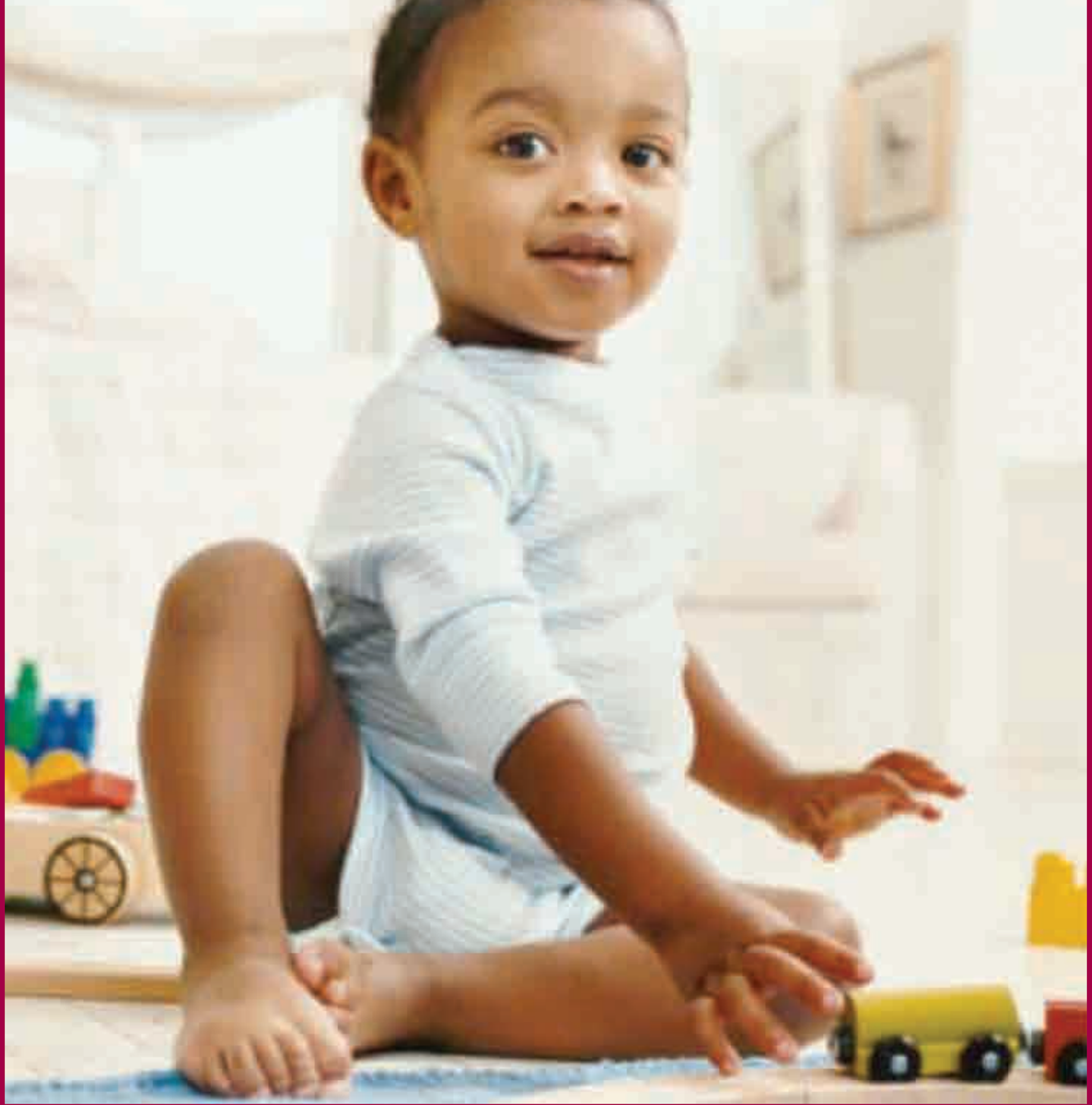
> There is evidence to suggest that a logical approach has been followed in commissioning this service

Good practice table

WCC Competencies	1	2	3	4	5	6	7	8	9	10	11
	■	■	■		■		■			■	

Commissioning steps	1	2	3	4	5	6
	■	■	■	■	■	

Effective Health and Care Pathway	0	1	2	3	4
		■	■	■	



Chapter 10

Bibliography

Chapter 10: Bibliography

Promoting Health and Well Being and Reducing Inequalities

Key Policy Links

- Department of Health: Health Inequalities
  http://www.dh.gov.uk/en/Publichealth/Healthinequalities/index.htm
- Department of Health. Our health, our care, our say: making it happen. London: Department of Health 2006
- Systematically addressing Health Inequalities, DH (2008)
- Tackling Health Inequalities: 2004-06 data and policy update for the 2010 national target, Department of Health and Health Inequalities Unit (2007)
- Independent inquiry into access to healthcare for people with learning disabilities – information and call to response forms, Department of Health and Health Inequalities Unit (2007)
- NHS Health Direct: Early Adopter Programme – Further guidance for SHAs and PCTs, Department of Health and Health Inequalities Unit (2007)
- High Quality Care For All: NHS Next Stage Review Final Report
  http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085825
- Health Inequalities Guidance and Publications http://www.dh.gov.uk/en/Publichealth/Healthinequalities/Healthinequalitiesguidancepublications/index.htm
- Health Inequalities: Progress and Next Steps, Department of Health (2008)

Further Links

Health Inequalities Intervention Tool

- The joint Department of Health/Association of Public Health Observatories Health Inequalities Intervention Tool is a new interactive online resource which draws together key data and modelling to help areas with the worst health and deprivation (the Spearhead Group) improve life expectancy quickly
  http://www.lho.org.uk/HEALTH_INEQUALITIES/Health_Inequalities_Tool.aspx

Health Inequalities – Basket of indicators

- The LHO were commissioned by the Department of Health to develop a local basket of inequalities indicators. The local basket of Health Inequalities indicators contains an initial set of 70 indicators http://www.lho.org.uk/HEALTH_INEQUALITIES/Basket_Of_Indicators/BasketOfIndicators.aspx

Health equity audit: a self-assessment tool

- The requirement for PCTs to use health equity audit to inform service planning and delivery was set out in the Priorities and Planning Framework 2003-06. The self-assessment tool should assist PCTs in assessing their readiness to use HEA, and identify issues that may need to be addressed in advance of the planning round
  http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4070715

How to Analyse Ethnic Differences in Health, Health Care and the Workforce: A Toolkit for the NHS.

- This is a toolkit which helps those involved in analysing and understanding how to interpret/use ethnic differences in health and health care. It is accompanied by a set of FAQs for quick reference.

Health Poverty Index

- The Health Poverty Index (HPI) is a web-based tool, originally commissioned by the Department of Health and now funded by The Information Centre for health and social care.
  http://www.sepho.org.uk/Topics/hpi.aspx

Creating Healthier Communities – A resource pack for local partnerships

- This is a practical guide which seeks to help drive forward local health improvement

Chapter 10: Bibliography (continued)

Promoting Health and Well Being and Reducing Inequalities (continued)

Further Links

Reports, Consultation Documents and Guidance

- Health Inequalities: Progress and Next Steps, Department of Health (2008)
- Tackling Health Inequalities: Status report on programme for action – 2006 update of headline indicators, Department of Health and Health Inequalities Unit (2006)
- Living well in London: the Mayor's draft Health Inequalities strategy for London (2008)
- Commissioning for equity. Inequalities in access to revascularisation in the NHS and in the independent sector. A technical report (2006)
- World Class Commissioning for the Health and Well-Being of People with a Learning Disability: A Guide, Department of Health (2009 due for publication)
- The Public Health Observatory Handbook of Health Inequalities Measurement, Centre for Health Economics, University of York (2005)
- High quality care for all: NHS Next Stage Review final report, Professor the Lord Darzi of Denham KBE (2008)
- Acheson D. Independent inquiry into inequalities in health: report. London: Stationery Office, 1998.
- Wanless D. Securing good health for the whole population: final report. London: HMSO, 2004.
- Review of the Health Inequalities infant mortality PSA target – Implementation plan for reducing Health Inequalities in infant mortality: a good practice guide, Department of Health and Health Inequalities Unit (2007)
- Health Inequalities: Concepts, Frameworks and Policy, 2004 http://www.empho.org.uk/THEMES/HI/hi6.aspx
- European Portal for Action on Health Equity http://www.health-inequalities.org/
- European Public Health Alliance http://www.epha.org/a/1997
- The Public Health Observatory Handbook of Health Inequalities Measurement http://www.sepho.org.uk/extras/rch_handbook.aspx
- Association of Public Health Observatories: Health Profiles – http://www.apho.org.uk/default.aspx?QN=P_HEALTH_PROFILES
- North West Public Health Observatory – Tools

Chapter 10: Bibliography

Services for Children and Families

Further Links

The Children's National Service Framework (NSF)

- The Children's NSF, is a 10-year programme intended to stimulate long-term and sustained improvement in children's health
  http://www.dh.gov.uk/en/Healthcare/NationalServiceFrameworks/Children/DH_4089111

Child Health Promotion Programme (CHPP)

- The new updated Child Health Promotion Programme (CHPP): Pregnancy and the First Five Years of Life, now known as the Healthy Child Programme, was launched on 17th March 2008 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/DH_083645
- Strategy for Childcare, Choice for Parents, the Best Start for Children
  http://www.everychildmatters.gov.uk/

Further Links

- Commissioning safe and sustainable specialised paediatric services: a framework of critical inter-dependencies

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_088068

Aiming High for Disabled Children (AHDC)

- AHDC (May 2008) sets out 3 priority areas to improve services for disabled children:
  - access and empowerment
  - responsive services and timely support
  - improving quality and capacity

http://www.dh.gov.uk/en/Healthcare/NationalServiceFrameworks/Children/Disabledchildrenandyoungpeople/index.htm

- Palliative Care services for Children and Young People: Better Care: Better Lives

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083106

- Transition from children's to adult services

http://www.dh.gov.uk/en/Healthcare/NationalServiceFrameworks/Children/Transitionfromchildrenstoadultservices/index.htm

Reports, Consultation Documents and Guidance

http://www.dcsf.gov.uk/consultations/conDetails.cfm?consultationId=1575

- The Bercow Report: A Review of Services for Children and Young People (0-19) with Speech, Language and Communication Needs

http://www.dcsf.gov.uk/bercowreview/

- Safeguarding Children

http://www.everychildmatters.gov.uk/socialcare/safeguarding/

- The Children's Plan

http://www.dcsf.gov.uk/publications/childrensplan/index.shtml

- Children's Workforce Development Council Corporate Plan April 2008 – March 2011 and Business Plan 2008 – 2009

http://www.cwdcouncil.org.uk/business-plan

- Children and Young People's Plan (CYPP)

http://www.everychildmatters.gov.uk/strategy/planningandcommissioning/cypp/

http://www.dcsf.gov.uk/publications/childrensplan/index.shtml

Services Children and Families (continued)

Further Links

- Focus on: emergency and urgent care pathway for children and young people http://www.institute.nhs.uk/index.php?option=com_joomcart&Itemid=194&main_page=document_product_info&cPath=71&products_id=396&Joomcartid=tednf6nil5198d9dn5ncr43t71
- Modernising maternity care: A commissioning toolkit for England (National Childbirth Trust 2006) http://networks.csip.org.uk/BetterCommissioning/Commissioningforcaregroups/Childrenyoungpeoplesandmaternityservices
- Joint planning and commissioning framework for children, young people and maternity services (Department for Education and Skills 2006).
- Industry techniques and inspiration for commissioners (Department for Education and Skills/CSIP 2006)
- Improving the quality and outcomes of services for children and young people through effective commissioning (Department of Health 2007)
- A transition guide to all services (Department of Health 2007)
- Better outcomes for children's services through joint funding (Department of Health 2007)
- Review of services for children and young people with speech, language and communication needs (Department for Children, Schools and Families 2008)
- Safeguarding children (Joint chief inspectors' report, 2008).
- Updated Child Health Promotion Programme http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/DH_083645
- Effective Health and Care Pathway Information Toolkit (DMIT) http://www.dh.gov.uk/en/Healthcare/Longtermconditions/DH_074772
- London Health Observatory: Determinants of Health – Crime http://www.lho.org.uk/HIL/Determinants_Of_Health/Crime.aspx
- London Health Observatory: Determinants of Health – Education http://www.lho.org.uk/HIL/Determinants_Of_Health/Education.aspx
- North West Children and Young People's Health Indicators http://www.nwph.net/cayphi/
- Child Health Profiles for the East of England http://www.erpho.org.uk/topics/Child_Health/ECM.aspx
- Centre on the Developing Child

http://www.developingchild.harvard.edu/

- Fatherhood Institute http://www.fatherhoodinstitute.org/
- National Collaborating Centre for Women's and Children's Health http://www.nice.org.uk/guidance/index.jsp?action=folder&r=true&o=29150

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Acute services in the community

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- Our NHS Our Future: NHS Next Stage Review – Leading Local Change 2008
- World class commissioning. Vision 2007
- World class commissioning. Competencies 2007
- Making the Shift: Key Success Factorshttp://www.institute.nhs.uk/index.php?option=com_joomcart&Itemid=194&main_page=document_product_info&cPath=69&products_id=267
- Making the Shift: A Review of NHS Experience http://www.institute.nhs.uk/index.php?option=com_joomcart&Itemid=194&main_page=document_product_info&cPath=69&products_id=266
- http://networks.csip.org.uk/IndependentLivingChoices/Housing/AboutHousingLIN/
- Commissioning housing support for health and well-being (CSIP 2008) This aims to help commissioners incorporate housing support in wider health and well-being strategies and meet local priorities. It explores types of housing support and the potential for joint commissioning, pooled budgets and budget alignment.

Further Links

- The **Personalisation toolkit** is an on-line resource to support councils to begin to plan and deliver the transformation of their social care systems, as set out in Putting People First. Its main focus is on learning from the Individual Budget Pilot programme
- http://networks.csip.org.uk/Personalisation/PersonalisationToolkit/?
- www.institute.nhs.uk/careoutsidehospital
- http://www.institute.nhs.uk/index.php?option=com_joomcart&Itemid=194&main_page=document_product_info&cPath=69&products_id=267
- http://www.institute.nhs.uk/index.php?option=com_joomcart&Itemid=194&main_page=document_product_info&cPath=69&products_id=266
- http://www.institute.nhs.uk/option,com_joomcart/Itemid,26/main_page,document_product_info/products_id,338.html
- http://www.dh.gov.uk/en/Healthcare/Secondarycare/Configuringhospitals/index.htm
- http://www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/Continuingcare/index.htm
- http://www.dh.gov.uk/en/SocialCare/Socialcarereform/Personalisation/index.htm
- http://www.dh.gov.uk/en/SocialCare/Socialcarereform/Careservicesefficiencydelivery/index.htm

Reports, Consultation Documents and Guidance

- http://www.cat.csip.org.uk/
- http://networks.csip.org.uk/IndependentLivingChoices/Housing/AboutHousingLIN/
- http://networks.csip.org.uk/BetterCommissioning/Commissioningforcaregroups/Socialanddomiciliarycareservices/
- Avoiding and diverting admissions to hospital (CSIP 2004)
- Telehealth in Kent: what's behind its success http://www.institute.nhs.uk/option,com_joomcart/Itemid,26/main_page,document_product_info/products_id,338.html
- Telecare – Service design (CSIP 2006).

Rehabilitation and Long Term Neurological Conditions

Key Policy Links

- Building Capacity for Work: A UK Framework for Vocational Rehabilitation 2004
- NHS Plan 2000, The NHS Improvement Plan 2004, Delivering the NHS Plan: next steps on investment, next steps on reform 2002
- National service framework (NSF) for long-term conditions 2005
- Better Routes to Redress 2004
- Our NHS Our Future: NHS Next Stage Review – Leading Local Change 2008
- Good practice in sight (RNIB 2008) This benchmarking tool aims to improve services for people with sight loss provided or commissioned by social services, including referrals to rehabilitation, training and counselling, to ensure a smooth journey from treatment to independent living

Further Links

- http://www.csip.org.uk/
- www.institute.nhs.uk/careoutsidehospital
- http://www.improvementfoundation.org/
- http://www.dh.gov.uk/en/SocialCare/Socialcarereform/Careservicesefficiencydelivery/index.htm
- http://networks.csip.org.uk/BetterCommissioning/Commissioningforcaregroups/Commissioningforpeoplewithdisabilities/

Chapter 10: Bibliography

Long term conditions

Key Policy Links

- The National Strategy on Long term care commissioning (as outlined in the NSF) outlines the 11 Quality Requirements from National Service Framework (2005) for Long term conditions
  http://www.dh.gov.uk/en/Healthcare/Longtermconditions/index.htm)
- Commissioning Framework for Health and Well-Being
  http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_072604
- A NHS Networks site that aims to help all those in the NHS involved in introducing this new way of working with people with long term conditions – not just managers in Primary Care Trusts at all levels but also clinicians, pharmacists, practice managers and people in social service
  http://www.networks.nhs.uk/3.php
- Supporting people with long term conditions: a blueprint to support local NHS and social care organisations in improving local services for people with long term conditions
  http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4100252
- A public sector link (Direct Gov) summarising information around various long term conditions including support services
  http://www.direct.gov.uk/en/HealthAndWellBeing/IllnessesAndConditions/LongTermConditions/index.htm
- A British Medical association Site supporting improved self care by people with long term conditions through self management education programmes
  http://www.bma.org.uk/ap.nsf/Content/selfmanagementpolicy
- National Service Framework on Long Term Neurological Conditions
  http://www.dh.gov.uk/en/Healthcare/NationalServiceFrameworks/Long-termNeurologicalConditionsNSF/index.htm
- Public Service Agreements and Departmental Strategic Objectives: The Government announced 30 cross-departmental Public Service Agreements (PSAs), setting out its top priorities as part of the Comprehensive Spending Review (CSR) in October 2007. These apply over the spending period from 2008 to 2011, replacing the department's SR04 http://www.communities.gov.uk/corporate/about/howwework/publicserviceagreements/
- A Royal Commission was set up to look into and report on long term care for the elderly; the commission reported in February 1999, having been appointed in December 1997
  http://www.royal-commission-elderly.gov.uk/call.htm
- A Good Practice Guide has been written in response to requests from NHS and social service organisations to help them implement the National Service Framework for Long-term Conditions http://www.dh.gov.uk/en/Healthcare/Longtermconditions/Bestpractice/index.htm

Further Links

- http://www.natpact.nhs.uk/cms/2.php
- A selection of six case studies on long term disease management programmes
  http://www.kingsfund.org.uk/publications/kings_fund_publications/improving_1.html
- Asthma UK, the British Heart Foundation and Diabetes UK have teamed up to produce this toolkit, which provides advice and support on all aspects of commissioning for long-term conditions, as well as national guidance, policies and case studies on best practice for commissioners across the UK
  http://www.commissioningforthelongterm.org.uk/index.php?page=aboutus
- DMIT is a voluntary good practice tool that the NHS may wish to use to strengthen their approach to Effective Health and Care Pathway. This web based tool provides data at Primary Care Trust (PCT) level on conditions contributing to high numbers of Secondary Care emergency bed days
  http://www.dh.gov.uk/en/Healthcare/Longtermconditions/DH_074772
- The Combined Predictive Risk Model, also developed by the King's Fund and their partners on behalf of DH uses a more powerful combination of hospital and community data to increase predictive power
  http://www.dh.gov.uk/en/Healthcare/Longtermconditions/casemanagement/index.htm

Long term conditions (continued)

Further Links

- Long term conditions Alliance- Scotland
  http://www.ltcas.org.uk/

Reports, Consultation Documents and Guidance

- What can we learn from the US experience in managing long term conditions? http://www.kingsfund.org.uk/publications/kings_fund_publications/managing_chronic.html
- A guide to the challenges of meeting the key needs of people with long-term neurological conditions, including speedy diagnosis, providing information to manage their condition and access to a full range of services such as housing and transport

Commissioning services for people with long-term neurological conditions (CSIP 2007)

- A model for extending choice to people with long-term conditions whose needs will change at different stages and feeding information from care planning discussions into the commissioning process to deliver personalised care services

Generic choice model for long-term conditions (Department of Health 2007)

- Natasha Curry, 'Predicting the risk of admission: the combined predictive model', Community Health and Social Care: Solutions for long-term conditions, (01.09.07)
- Natasha Curry, 'Predicting the risk of admission: the PARR tool', Health Care Risk Report 2006; 12 (6): 14-15 (May 2006)
- Richard Q Lewis, Nicholas Mays, Natasha Curry and Ruth Robertson, 'Implementing practice based commissioning', 2007;335;British Medical Journal 1168
  www.bmj.com
- Richard Lewis, 'Managing and improving care of chronic disease in the NHS', British Journal of Nursing vol 13, no3, pp125
- Jennifer Dixon, Richard Lewis, 'Rethinking management of chronic diseases', BMJ 2004, no 328, pp 220-222
  www.bmj.com
- Niall Dickson, Jennifer Dixon, 'Making the NHS cost effective', The Lancet Vol. 367, Issue 9525, Pages 1802-1803
  http://www.thelancet.com/
- An evidence review was commissioned as an early part of the NHS Institute's workplan to help us gain a greater understanding of current international, national, and local thinking about the different approaches in use for improving care for People with Long Term Conditions
  http://www.institute.nhs.uk/option,com_joomcart/Itemid,26/main_page,document_product_info/products_id,265.html
- In July 2006, the NHS Institute commissioned the University of Birmingham's Health Services Management Centre to produce a rapid review of key success factors to help the NHS make the shift in care of long term conditions from the traditional hospital setting to community-based care http://www.institute.nhs.uk/index.php?option=com_joomcart&Itemid=194&main_page=document_product_info&cPath=69&products_id=267
- A continuing care resource page
  http://www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/Continuingcare/index.htm
- Home page for the Health and Social Care Change Agent Team within CSIP
  http://www.cat.csip.org.uk/
- The Housing LIN is the national network for promoting new ideas and supporting change in the delivery of housing, care and support services for older and vulnerable people http://networks.csip.org.uk/IndependentLivingChoices/Housing/AboutHousingLIN/
- A resource tool page for commissioning for long term conditions
  http://networks.csip.org.uk/BetterCommissioning/Commissioningforcaregroups/Commissioningforlong-termconditions

Chapter 10: Bibliography

End of Life Care

Key Policy Links

- Department of Health's End of Life Care Strategy (2008) which aims to promote high quality care for all adults at the end of life. The document also sets out how the Government's commitment on end of life care will be delivered http://www.dh.gov.uk/en/Healthcare/IntegratedCare/Endoflifecare/index.htm
- "National End of Life Care Programme aims to support the implementation of the Department of Health's End of Life Care Strategy, by sharing good practice in collaboration with local and national stakeholders. The Programme website includes a large number of relevant case studies, which may be helpful. [website addresses] .The Programme was formerly the NHS EOLC programme. Part of its remit was, working with the Strategic Health Authorities, to support the national roll out and implementation of the Gold Standards Framework, Liverpool Care Pathway for the Dying and Preferred Priorities for Care tools."
- Policy guidance on the investment within End of Life Care Initiative which has been earmarked to specifically help support implementation of the:
  - Gold Standards Framework;
  - Liverpool Care Pathway for the Dying, and;
  - Preferred Place of Care tools
  - The initiative is being driven by SHAs who are identifying clinical priority groups and care settings at a local level
- End of Life Care: Resource Pack for those caring for or supporting people with a learning disability at the end of life, NHS End of Life Care Programme / NHS North East (2007). An approach to commissioning end-of-life care, including assessing the supportive and palliative care needs of both the patient and their family, and co-ordinating care with a range of partners including Community Services.
- End-of-life care: A commissioning perspective (National Council for Palliative Care 2007) A Framework for delivering palliative care services to children and young people.
- Better care: Better lives (Department of Health 2008) An analysis on the impact and costs of new services to increase choice in end of life care, changing patterns in utilisation of acute and community care services and the financial consequences of patients receiving care at home rather than in hospital.
- Improving choice at the end of life (King's Fund 2008)

Further Links

- Promoting innovative end of life care practice within ambulance trusts (October 2007)
- Improving end of life care for adults : making change happen : exmples of innovative practice. – case studies (October 2007)
- Building on firm foundations : improving end of life care in care homes : examples of innovative practice. (National Council for Palliative Care and NHS End of Life Care Programme, June 2007)
- Advance care planning : a guide for health and social care staff. (February 2007)
- Introductory guide to end of life care in care homes (National Council for Palliative Care and NHS End of Life Care Programme) [April 2006]
- Palliative care pathways project: Brent and Harrow 2001-2006
- Introductory guide booklet for EoLC Programme Managers/Facilitators [June 2005]
- Department of Health – Survey of expenditure by Primary Care Trusts on Hospice/Specialist Palliative Care Services for the year 2006/07 (7 February 2008)
- Department of Health – Operating framework 2007/08: PCT baseline review of services for end of life care [24 April 2007]

End of Life Care (continued)

Further Links

- Marie Curie Palliative Care Institute
  *http:*www.mariecurie.org.uk
  - 10 step continuous quality improvement programme for care of the dying using the LCP framework [November 2006] (web version available) Marie Curie Cancer Care publications
  - Liverpool Care Pathway: promoting the best practice in care of the dying (leaflet) -Guidelines for the use of the LCP: professional (leaflet)
  - Marie Curie Cancer Care: Delivering Choice Programme (describing its palliative care service improvement plan, via 3 flagship projects in Lincolnshire, Tayside and Leeds)
- Gold Standards Framework
  http:www.goldstandardsframework.nhs.uk http://www.dh.gov.uk/en/Healthcare/Longtermconditions/Bestpractice/Palliativecare/DH_4105215

A programme for community palliative care

- National Council for Palliative Care

End of life care : a commissioning perspective. (February 2007)
http://www.ncpc.org.uk/publications/index.html

- British Geriatrics Society
  http://www.bgs.org.uk/

Palliative and end of life care of older people (guidelines) [September 2006]

- Care Services Improvement Partnership

Delivering end of life care in housing with care settings [13 November 2006] (contains information on the current end of life care agendas and developments)
www.csip.org.uk/

- NHS Networks – Managing end of life care for people living in care homes in Croydon (pilot project)
  www.networks.nhs.uk

Reports, Consultation Documents and Guidance

- Impact assessment of the end of life care strategy. (Department of Health, 17 July 2008)
- Improving environments for care at end of life: lessons from eight UK pilot sites. (King's Fund, April 2008)
- Care provided by generalists at the end of life: scoping exercise on research priorities. (National Institute for Health Research, October 2007)
- The End of Life Care Strategy for England : how the government could change the way we die. (Help the Hospices, September 2007)
- End of life care strategy (National Council for Palliative Care) (1 August 2006)
- NHS End of Life Care Programme: progress report March 2006 (Department of Health, March 2006)
- Addington-Hall J, Shipman C, Burt J, et al, Evaluation of the education and support programme for district and community nurses in the principles and practice of palliative care: funded by the Department of Health [Executive summary also available] (King's College) [March 2006]
- Department of Health funded 3 year programme to train and support district and community nurses in the principles and practice of palliative care [outcomes of the training programme and brief DH summary of the findings of the King's College evaluation] [2006]
- Listening to older people: opening the door for older people to explore end-of-life issues (Help the Aged) [2006]
- Tackling cancer: improving the patient journey [part 3 concentrates on hospice provision and end of life choices] (National Audit Office) [25 February 2005]
- All Party Parliamentary Group on Dying Well
- Dignity in care (Department of Health)
- Gold Standards Framework Programme: a programme for community palliative care (NHS End of Life Care Programme)
- International Observatory on End of Life Care
- NICE guidance for supportive and palliative care for adults with cancer: 2004

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World Class Commissioning

Key Policy Links

- Department of Health: World Class Commissioning http://www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Worldclasscommissioning/Supportanddevelopment/DH_084999
- World Class Commissioning http://www.institute.nhs.uk/world_class_commissioning/general/world_class_commissioning_home.html
- Thinking Differently http://www.institute.nhs.uk/building_capability/new_model_for_transforming_the_nhs/thinking_differently.html
- Policy Guidelines and Toolkits http://www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Policyguidanceandtoolkits/index.htm
- How to Achieve World Class Commissioning Competencies. Practical tips for NHS Commissioners. DH (2008)

Further Links

- Stour Access System http://www.institute.nhs.uk/index.php?option=com_joomcart&Itemid=194&main_page=document_product_info&cPath=69&products_id=312

Tools and Templates

- http://www.institute.nhs.uk/world_class_commissioning/data_into_information/tools_and_templates.html
- http://www.institute.nhs.uk/world_class_commissioning/data_into_information/reading_material.html
- Commissioning – Practice Profiles http://www.lho.org.uk/commissioning/PracticeProfiles.aspx
- 'Intelligence to support world class commissioning' http://www.empho.org.uk/viewResource.aspx?id=10981
- Eastern Region Public Health Observatory: World Class Commissioning http://www.erpho.org.uk/topics/wcc/default.aspx
- Advice and guidance to businesses and UK central & local government procurement professionals http://www.supplyinggovernment.gov.uk
- Making a Bigger Difference http://www.institute.nhs.uk/building_capability/new_model_for_transforming_the_nhs/making_a_bigger_difference.html
- World Class Commissioning for the Health & Well-Being of People with a Learning Disability: A Guide, Department of Health (2009 due for publication)

Reports, Consultation Documents and Guidance

- Care and resource utilisation: ensuring appropriateness of care, Department of Health (2006)
- Improving outcomes in children and young people with cancer: guidance on commissioning services for young people, Mike Richards, National Cancer Director and Sheila Shribman, National Director for Children, for the Children and Young People Improving Outcomes Guidance (CYPIOG) Advisory Group (2008)
- Commissioning and managing screening programmes in the NHS in England, DH (2005)
- Who pays? Establishing the responsible commissioner, DH (2007)
- A Guide to Procuring Care and Support Services, Department for Communities and Local Government (2006)
- Developing the local government services market to support a long-term strategy for local government, Department for Communities and Local Government (2006)
- Smaller Supplier… Better Value? Office of Government Commerce (2005)
- Early Market Engagement: Principles and Examples of Good Practice, Office of Government Commerce (2006)
- How to Achieve World Class Commissioning Competencies. Practical tips for NHS Commissioners. DH (2008)
- A Catalyst for Change II: Tackling the long ascent of improving commissioning, Written for the Care Services Improvement Partnership by Janet Crampton, Health & Social Care Change Agent Team, Simon Ricketts, Warwick-i business insight (2007)
- Framework for procuring External Support for Commissioners (FESC): procurement at PCTs, DH (2006)

Appendix 1: Submitted Case Studies

The following table sets out the PCTs and Local Authorities that submitted case studies for each of the transforming community services six service areas.

Name of PCT/LA	Promoting Health and Well Being and Reducing Inequalities	Services for Children and Families	Acute Services Closer to Home	Rehabilitation	Long Term Conditions	End of Life
Berkshire PCT	✓	✓	✓	✓	✓	✓
Berkshire East PCT	✓	✓	✓	✓	✓	✓
Bournemouth and Poole PCT					✓	✓
Brighton and Hove PCT			✓	✓	✓	✓
Buckinghamshire PCT						✓
City and Hackney PCT	✓	✓	✓	✓		
NHS Dorset	✓	✓	✓	✓	✓	✓
NHS Durham	✓			✓	✓	
Coventry PCT	✓	✓	✓	✓	✓	✓
Doncaster PCT	✓	✓	✓	✓	✓	✓
Greenwich PCT	✓	✓	✓	✓	✓	✓
Halton & St Helens PCT	✓				✓	
Havering PCT	✓	✓	✓	✓	✓	✓
Hillingdon PCT			✓			✓
Islington PCT				✓		
Manchester PCT					✓	
Nottingham County PCT					✓	
Northamptonshire PCT	✓	✓			✓	
North East Essex PCT	✓	✓	✓	✓	✓	✓
Oldham Council			✓			
Oxfordshire Council		✓				
Rotherham PCT	✓		✓		✓	
NHS Sheffield			✓		✓	✓
Salford PCT			✓	✓		
Somerset PCT					✓	
Southampton City PCT		✓	✓		✓	
Stockport PCT		✓	✓	✓	✓	
Surrey PCT			✓	✓		
Telford and Wrekin PCT			✓	✓	✓	✓
Torbay Care Trust	✓		✓	✓	✓	✓
Trafford PCT	✓		✓	✓		
Warwickshire PCT	✓		✓		✓	
West Sussex PCT					✓	
Wirral PCT	✓			✓		
Wiltshire PCT	✓		✓	✓	✓	✓

Additional Notes

The Transforming Community Services guidance series has been developed to enable the delivery of innovative, modern, responsive and evidence-based community services of a consistently high standard, and improve the organisations providing community services, and the processes underpinning them, to ensure they are fit for purpose.

Titles in the Transforming Community Services guidance series include:

- Framing the contribution of allied health professionals
- Social enterprise: a guide to the right to request
- Standard contract for community services (published as an annex in the Operating Framework 2009/10)
- Currency and pricing options for community services
- World class commissioning resource pack for commissioners of community services
- Enabling new patterns of provision
- Review of information models and next steps
- Business readiness for PCT provision

Available soon:

- Guidance on information models for community services (Spring 2009)
- Quality framework for community services (Summer 2009)
- A series of transformation guides for clinical services (Summer 2009)
  - High quality care for children and families
  - High quality care in services for long term conditions
  - High quality care in acute services closer to home
  - High quality care in services for rehabilitation and long term neurological conditions
  - High quality in end of life care
  - Promoting health and well being and reducing inequalities

All published documents can be found on the Department of Health website.

Limited copies of printed guidance may be available by emailing: transformingcommunityservices@dh.gsi.gov.uk

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