

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

1. Preface

This Outline Service Specification (OSS) has been developed to assist NHS commissioners to put in place appropriate arrangements to ensure people with long-term conditions have informed choice of, and access to, services that best enable them to manage their condition

The NHS Operating Framework 2009/10 objective is that *“over the next 2 years, to ensure those living with a long term condition receive a high quality service and help to manage their condition.....everyone with a long term condition should be offered a personalised care plan...”*

The three key policy commitments underpinning this are:

- **The White Paper *Our health, our care, our say*** - providing integrated care plans for those with long term conditions by 2010. This commitment was re-affirmed in the NHS Next Stage Review
- ***Your health, your way*** - the NHS Choices website providing information about the choices that should be available locally to people with long term conditions to enable them to self care
- **Information Prescriptions** – signposting people to information and advice to support self management
- **NHS Constitution**
- **High Quality Care for All** - including the use of Personal Health Budgets to enable patients to have more choice and control over the services they receive.

The Department of Health has produced a guide to Commissioning Personalised Care Planning. This specification sits alongside that document.

The aim is for personalised care planning and patient information to come together as a seamless, facilitative and holistic process of care delivery that promotes empowerment and choice, enabling people with a long term condition to:

- **be more independent**
- **make informed choices about the services they receive (or do not wish to receive)**
- **be in control of their condition(s)**
- **to become experts on their own condition (s)**
- **become more actively engaged in self care.**

The concept of personalised and integrated care is not new: this specification is about embedding it in service delivery and underpinning excellence in the management of long term conditions, building on existing good practice. To do this will require fundamental changes to existing approaches to delivering services to the people concerned. Such changes may require clinical leadership, education and training as well as pump priming.

In this document, the word “services” means both care planning and the services delivered as a result of the care planning process. The phrase “care planning services” is used to mean the services people receive as a result of the care planning process, not the care planning process itself.

For definitions of other terms used in this document, see annex 2.

2. Purpose of this Outline Service Specification

The overall aim of this OSS is to help people with long term conditions to “live well, longer”. This specification supports commissioners to commission a different approach and type of care that:

- helps to delay or arrest deterioration in a person’s condition by helping them to be more aware of self-care and how/when to use services
- assists the person to manage their own care and thereby re-gain control
- takes a holistic approach to the individual and the management of their condition
- over time, widens the choices available via the establishment of a robust feedback loop. This may mean that:
 - the way in which care planning is commissioned (and the provider(s) it is commissioned from) and managed may need to change
 - services people currently receive as a result of the care planning process are modified in some way (or even de-commissioned altogether) and new ones developed.In this way, innovation and service development will become an inherent part of what is being commissioned.
- helps to embed the principles of personalisation; patient information and choice; and self-care.

This OSS is not primarily intended to be used to commission new services from scratch, or additional services, but to help commission a fundamental step-change in existing ways of working and service networks.

The care being commissioned will not be exclusively medical but will include elements of social and psychological care. This is crucial for establishing more effective long term conditions management.

Using this specification to commission Personalised Care Planning	
This OSS	X
<ul style="list-style-type: none"> Is intended as a checklist for commissioners to help them change the way in which care planning for people with long-term conditions is delivered 	<ul style="list-style-type: none"> It is not a detailed service specification, nor a blueprint for an Enhanced Service
<ul style="list-style-type: none"> Is to help commission a fundamental step change in existing care planning delivery, which may in turn require cultural and behavioural change by providers 	<ul style="list-style-type: none"> It is not primarily intended to be used to commission new services from scratch
<ul style="list-style-type: none"> Reflects accepted good clinical practice 	<ul style="list-style-type: none"> Again, it is not about commissioning new or “extra” services per se, but a radically different and dynamic mode of service delivery
<ul style="list-style-type: none"> May require some pump priming money to facilitate the step change and overcome any cultural inertia eg workforce training and investment in clinical leadership 	<ul style="list-style-type: none"> Care planning will not necessarily require any additional resources, but may require current resources to be deployed in a different way
<ul style="list-style-type: none"> Is about commissioning a mix of care planning services – social and psychological as well as health – in various settings 	<ul style="list-style-type: none"> It is not about commissioning exclusively medical care
<ul style="list-style-type: none"> May require a stock take of existing networks of provision to establish the baseline ie what services exist and how effective these are 	

What will be commissioned will vary from PCT to PCT because of the individual and personalised nature of the services: in fact, in future some services may be commissioned directly by patients who have a Personal Health Budget but this may not, at least initially, mean commissioning new, different or additional provision – but it will certainly mean commissioning (a) the care planning approach in the delivery of existing services and (b) a robust feedback loop to inform commissioning decisions for the future.. .

Both (a) and (b) are vital in terms of stimulating innovation and service development. It is essential that commissioners understand what people with long-term conditions need and want if they are to commission the right care planning services and enable as much choice as possible is available. Increased personalisation is likely to lead to greater efficiency as the services will be used appropriately.

Scope and Definition of Service

This OSS takes a personalised approach to care planning for people with long term conditions. It covers provision for adults and children and supports service delivery in a community-based setting.

The care planning services commissioned will need to be sufficiently flexible to meet the wide ranging needs of people with long term conditions, i.e. those with:

- complex needs, for whom care planning is likely to be co-ordinated by one professional following a joint assessment of need, and who may need more frequent care planning reviews
- moderate and low needs, for whom the care planning process will include information about how their condition will impact on their lives and support for self care

These services will also need to be capable of continual change supported by a process which involves patients and the public planning and designing them and seeks the views of users on an ongoing basis and makes adjustments in the light of this. Both commissioners and providers need to put in place an approach to communications that raises awareness amongst local people about what care planning services are available available and the variety of ways they can have access to these.

The care plan review and the use of the plan in subsequent interactions with health, social care and other agencies/providers will then ensure the individual's goals, needs and lifestyle wishes are placed at the centre of their care - instead of the individual having to fit around existing provision.

Partnership proposals from both the statutory and other sectors are encouraged, as well as innovation in service delivery and review. This will become more crucial as more people direct their care, support and become the holders of their budget.

The model of delivery should therefore:

- ensure that the necessary specification/infrastructure to enable a care planning approach to be implemented is put in place
- take account of the fact that providers will need to be well aware of, and tap into, existing networks of provision (whether support groups, equipment, information, training, clinical or social care delivery etc)
- recognise the need to work seamlessly across organisational boundaries
- be proactive, flexible and responsive to the varied needs of individuals
- include a feedback loop that supports the continual development and evolution of care planning services, linked to care reviews
- be capable of being monitored and measured to help look at the impact of care planning and Information Prescriptions, the choices that patients are making and how this will inform future commissioning
- have a process for initiating regular reviews suited to the needs of the individual
- include mechanisms for raising awareness levels amongst all health care professionals of the needs of people with long-term conditions.

Learning from local approaches to care planning in other areas, eg for people with learning disabilities will be helpful in guiding commissioners work to implement care planning for people with long term conditions.

Valuable lessons can also be learnt around the way plans can be co-produced from the work in Social Care with Personal Budgets and person centred planning techniques¹.

3. Parties to the agreement

Care planning services may be commissioned by:

- PCTs
- PBC Groups
- and/or jointly with Local Authorities by both of the above
- in the future services may also be commissioned by patients who hold their own budget

Commissioners need to take a flexible approach to commissioning care planning, support for self care as set out

¹ <http://www.dhcarenetworks.org.uk/Personalisation/Topics/Latest/Resource/?cid=5802>
<http://www.dhcarenetworks.org.uk/Personalisation/Topics/Browse/Supportplanning/>

in 'Your health, your way' and Information Prescriptions that involves a wide range of providers. At the same time they need to ensure consistency and standardisation of quality of care for people with long term conditions in line with national policies.

The specification could be commissioned via:

- social enterprise organisations
- third sector providers
- GMS, PMS, APMS practices
- from other local primary care contractors

4. Background

Some 15 million people in England have one or more long term conditions. Personalised care planning is essentially about addressing an individual's full range of needs, taking into account their health, personal, social, economic, educational, mental health, ethnic and cultural background and circumstances at the heart of their care and helps to ensure that services are designed around their needs. It recognises that there are other issues in addition to medical needs that can impact on the person's total health and well-being. It is therefore a holistic process, seeing the person "in the round" with a strong focus on helping people together with their carers to achieve the outcomes they want for themselves, for example to live independently or return to work.

Personalised care planning can be called different things, for example in social care it is sometimes referred to as "Support Planning", in some parts of the country it is called "Personal Health Planning" or "Health and Well-being Planning". Although the terminology used for this process of engaging and planning with people can vary, the most important thing is that people with long term conditions are given the opportunity to discuss their goals and what is important to them, are listened to, are given the information and signposting at the right time and are supported to be more actively involved in their own health (supported self care).

The outcome of the discussion, whether a paper or electronic document, or just something verbally agreed or written into a person's notes is the care plan, This might also be called a support plan or health plan or something else suitably descriptive. The terminology used should depend on what is preferred locally by people with long term conditions and their health and social care professionals and it may vary depending on level of need, for example people with complex health and social care needs for whom the planning process is more detailed may prefer the term "care" or "support" plan whereas people with lower level needs or who are more active may prefer the term "health" or "personal" plan.

The introduction of care planning for people with long-term conditions is supported by key policies:

- The Long Term Conditions PSA Target (2004/05 to 2007/08):

To improve health outcomes for people with long term conditions by offering a personalised care plan for vulnerable people most at risk, and to reduce emergency bed days by 5% by 2008 through improved care in primary care and community settings.

- The *Our Health Our Care Our Say* White Paper commitment:

By 2008 we would expect everyone with both long term health and social care needs to have an integrated care plan if they want one. By 2010 we would expect everyone with a long term conditions to be offered a care plan.

People with long term conditions will be supported to take better control of their care and condition through a wide range of initiatives. These include a major new focus on self care and self management.

- High Quality Care for All: NHS Next Stage Review Final Report

Over the next two years, every one of the 15 million people with one or more long term conditions should be offered a personalised care plan, developed, agreed and regularly reviewed with a named lead professional from among the team of staff who help manage their care.

Information Prescriptions can be provided as part of a care plan. These are a people centred, rather than a service driven mechanism, for providing people with long-term conditions or care needs, and their carers, access to a range of information relevant to the management of their health, care and wellbeing. They guide people with long-term conditions to reliable sources of information that enable them to take more control of the management of their condition. They are provided by health and social care professionals at different points along the care pathway and should be tailored to individuals needs. Information Prescriptions signpost individuals to sources of information on a range of issues such as what treatments are available, benefit entitlements, local support groups and employment advice. They can be presented as a piece of paper listing contact points or may be presented as a collection of leaflets, DVDs or online resources.

Information prescriptions support the rights and pledges regarding patient information set out in the *NHS Constitution*:

“The right to make choices about your NHS care and to information to support these choices...The NHS commits to offer you easily accessible, reliable, and relevant information to enable you to participate fully in your own healthcare decisions and to support you in making choices. This will include information on the quality of clinical services where there is robust and accurate information available (pledge).”

The resources to support care planning for people with long term conditions are in PCT baselines.

World Class Commissioning

The implementation of this OSS will contribute towards the achievement of World Class Commissioning competencies – see annex 3.

5. Summary of Local Need

A detailed summary of local health and social care service needs for people with long-term conditions should be drawn from the joint strategic needs assessment, done with Local Authority partners.

Additionally, care planning requires integration of local partners at strategic and individual level. At strategic level this means making use of Joint Strategic Partnerships, Joint Commissioning Boards and Local Area Agreements to support planning and commissioning with shared goals. At individual level it means establishing multidisciplinary teams with the mix of skills to meet the needs that are being identified.

Commissioners will need to develop mechanisms that enable them to quantify the gap between the numbers of people with long-term conditions that already have a care plan in place and those that do not have a care plan but would want one if it were offered. The number of people with long term conditions is predicted to increase because of lifestyle choices and an ageing population.

Whilst it is difficult to assess volumes of service that need to be commissioned it is essential to assess prevalence of various long term conditions within the local population. This will need to be carried out on a rolling basis to ensure that the services being commissioned reflect current health needs.

Additionally, in order that improvement can be monitored, an important part of the implementation of this OSS is the establishment of the baseline. Commissioners need to understand the range and scope of services, ie care planning and services delivered as a result of the care planning process, that are currently being commissioned and their effectiveness.

6. Service Objectives and Intended Health Outcomes

The overall aim is to ensure people with long-term conditions get the choice of, and access to, health services and information that best enable them to manage their condition. This should:

- reduce health barriers to quality of life

- reduce unnecessary and often unplanned health/care service use
- increase the number of people with a long-term condition who feel supported to manage their condition(s).

Services will need to demonstrate that they measure quality of life of people with long term conditions. The tools used could be generic or condition specific and should, insofar as possible, be person-centred.

This should be achieved through:

- the provision of more individualised services
- a holistic approach to the service delivery
- more focus on the prevention/progression of disease and complications
- greater choice – including supporting people to make healthier and more informed choices
- support for self care
- providing care closer to home.

This should result in:

- people remaining healthier, more independent, and who are able to work/take less time off sick
- people having access to a full range of self care support services (not just medical ones), tools, equipment and information, lifestyle advice
- people becoming experts in their own care, so they can take control over their lives “empowered and informed individuals” through skills training courses such as Expert Patient Programme
- people using services more appropriately eg reduced hospital admissions (people with long term conditions are frequently heavy users of NHS services)
- a reduction in health inequalities.

7. Service Outline

No single model will meet the needs of all people with long term conditions. Care planning services should develop over time in an iterative manner and in consultation with the people who use the services.

It is unlikely that commissioners and providers will get service provision right first time so all parties will need to be prepared to be flexible. Robust feedback loops should be built in at the outset to ensure that both providers

and commissioners gain a clear understanding about what people do and do not want and then develop services accordingly.

Ways in which this can be approached are starting to be developed in Social Care and helpful information can be found at:

<http://www.dhcarenetworks.org.uk/>

For those with complex needs care planning requires a care coordinator who can navigate complex health and social care systems and ensure that the full range of services agreed in the care plan are provided, although the level of input from the care coordinator will vary according to the level of need that a person has.

Some people, for example those with lower level needs may not be receptive to the term “care plan” as it may infer a lack of independence or feel paternalistic, which is the opposite intention of personalised care planning. Different terminology such as “health planning” or “personal planning” may be agreed. The important thing is that people are given the opportunity to discuss their goals and what is important to them, are listened to, are given the information and signposting at the right time and are supported to be more actively involved in their own health (supported self care).

Care Planning Reviews:

Care planning reviews are important for two key reasons: first, to make sure that care planning services are actually meeting the expressed needs of the individual, and second, to provide a feedback loop for service development.

- frequency should be determined according to the needs of the individual; people with more complex needs are likely to require longer, more detailed and more frequent reviews.
- mechanisms for managing the review should be flexible and agreed with the individual concerned.
- format will vary between individuals and may be as simple as a telephone call. People should be consulted on the frequency and type of their individual review.

Work on outcome focused review has been done as part of the Transformation of Social Care and helpful information.²

It is important to note that delivering services that meet users needs (as defined by users) may mean from time to time the de-commissioning (parts of) existing services.

The diagram below illustrates how the process might work in two different scenarios.

² See <http://www.dhcarenetworks.org.uk/>

Checklist for commissioning personalised care planning

- ❖ Needs assessment – assess the prevalence of various long term conditions for the PCT's population
- ❖ Baseline mapping – existing services and providers (from all sectors) and their effectiveness, as well as joint working arrangements
- ❖ Assess numbers of people who already have a care plan, taking into account that it may be referred to as something similar such as a support plan or a personal health plan
- ❖ Assessment of the quality of care planning (taking into account it may be called something similar such as support planning or health planning) i.e. not just a tick box procedure
- ❖ Gap analysis – how many people do not have a care plan and might want one and how many people are routinely offered information for their condition
- ❖ PCT named senior manager with responsibility for care planning
- ❖ Develop detailed specification to implement care planning for PCT population
- ❖ Market development – assessing potential providers, encouraging innovation

Personalised Care Planning for People with Long Term Conditions



People with long term conditions are at different stages on their journey, with different lives, different roles and different goals



*Not a complete list

Contact with Health/Social Care Professional/
Staff Member

Made via

For example:

- QOF Review
- Practice nurse appointment
- Social care worker
- Referral to community matron
- Referral to specialist nurse or consultant
- GP appointment
- Referral to specialist service

Already has a care plan? Improve quality,
aim for Gold Standard Vision*

Offer Care Planning

*As described in commissioning personalised care planning:
a guide for commissioners DH 2009

Lorna 78 years old

Lorna lives alone and wants to remain independent. She loves cooking and is a self taught chef. She's had diabetes since 50, was diagnosed with skin cancer at 74, has arthritis which causes problems with her knees and mobility and mild heart failure. She finds her failing

health a hindrance to her life and this has caused her frequent hospital admissions which she loathed. She often feels lonely and isolated and wants to get out more, including attending her local bingo hall once a week with her neighbour.

Jack 55 years old

Jack has recently taken early retirement, is married and has a 13 year old daughter. He has been a heavy smoker for 40 years and was recently diagnosed with COPD. Jack is on the Quality and Outcomes Framework (QOF) register in his local GP practice, which means he

will have regular reviews with his GP and nurse practitioner to monitor his condition. At his last review Jack was referred to a specialist respiratory team and was offered personalised care planning with the specialist respiratory nurse.

Workforce approaches and behaviours needed to deliver

We adopt the "common core principles to support self care" (www.skillsforhealth.org.uk)

- **Ensure individuals are able to make informed choices.** Support them to make decisions based upon their needs and preferences. Shift emphasis from "I know what is best" to listening to people's stories, what do they really want? What are their goals? **Communicate effectively** to enable people to assess their needs and develop and gain confidence to self care. Use communication and relationship skills that encourage and support people to work with you to identify strengths and abilities as well as areas for development. Finding solutions together, building on existing skills
- **Support and enable individuals to access appropriate information** to manage their self care needs – accredited, timely and relevant information. Continuous information throughout the person's "journey"

- **Support and enable individuals to develop skills in self care** – know what services are available in your area that you can offer to support self care such as Expert Patient Programme and how to access these. Offer your support, your knowledge and expertise for people to develop self care/self management skills
- **Support and enable individuals to use technology to support self care** – consider what equipment and devices are available and can support people to be independent, think about telehealth and telecare.
- **Advise individuals how to access support networks** and participate in planning, development and evaluation of services – people with LTCs really value speaking to others with the same condition, learning from their experience and feeling they are not alone. Know what is available and give people advice about them, promote people both receiving and giving support to others
- **Support and enable risk management** and risk taking to maximise independence and choice

"We don't make assumptions about what people want, we listen to them..."

"We see the care planning consultation as "a meeting of two experts", the individual and their clinician/professional..."

"We focus on wider, holistic needs not just medical..."

"We don't "do to" people, we "do with" them..."

"We work across agencies, we have developed protocols for sharing information..."

"People with complex needs have a named lead who ensures coordination of services..."

The examples below illustrate how personalised care planning can proactively support people to be more in control, manage their condition better and get the most out of their lives. They show people at different stages of their journey, and the different professionals that might lead and be involved in the process. More examples, involving staff such as AHPs and mental health professionals can be found at www.dh.gov.uk/longtermconditions

Lorna

Lorna is offered case management with a community matron, Andrea. At the initial home visit, they explore details about Lorna's daily life, things she wants to do, can do for herself and what she finds difficult. Andrea also asks what Lorna has been doing to support her health and together they build up a picture of Lorna's life, helping to complete the first contact needs assessment. Lorna says it is a priority for her to live independently but her family worry. Lorna thinks they may pressure her to move to residential care.

Andrea asks Lorna to explain how she feels before she reaches a crisis such as a hypoglycaemic episode or a flare up of her arthritis and what are her own warning signs, which Lorna describes in detail. Together they agree that a telephone number for when she feels like this will really help so that either Andrea or one of her colleagues can talk on the phone and if necessary visit her. The various medications Lorna takes cause confusion so Andrea describes Lorna's medication in detail and together they devise a simple system for correct dosage at correct times with clearly marked, colour-coded containers. They discuss the different options that might support Lorna to stay at home, including monitoring devices. Andrea arranges to visit when her daughter (who is her main carer) is there so that she can be involved in the discussion to support Lorna.

Follow up continues with a joint needs assessment, which suggests Lorna is eligible for social care support. She arranges a visit from a social care worker (Claire) who is part of a multidisciplinary team in the GP practice. Claire completes an assessment of Lorna's social care needs following which she is allocated an individual budget. The emphasis through the care planning discussions on what Lorna wants to do and her goals make it easier for Lorna to plan her support the way she wants and achieve her desired outcomes.

Lorna takes a cash individual budget and employs her neighbour to assist with her personal care needs and also to support her to get to the bingo hall once a week. She also purchases a laptop to enable her to do her shopping on-line and also keep in touch with family members who live in various parts of the country. Lorna feels sure these activities will make her feel less isolated even though she will be doing this from home. Lorna's daughter (her main unpaid carer) is also offered an assessment in her own right and is allocated an individual budget which she uses to go on two weekend breaks.

Lorna's agreed care plan is called care/support plan to accommodate the different terminology used by health and social care professionals, breaking down language barriers. The plan records her goals for remaining independent, feeling less isolated, staying out of hospital, being able to control her diabetes and continuing to cook and enjoy her food. From a social care perspective, the plan has to be "signed off" by a team manager agreeing that it meets Lorna's assessed needs and keeps her safe, healthy and well. The plan is a written document and is printed off and put in a yellow folder with all her other important information such as the medication she is taking and her doctors appointments. Lorna wants her daughter to have full access to the plan and feels more confident and reassured about the coordination of her services, contingency plans for when she has a crisis, that she is getting more out of her life and has more independence and control.

Jack

At their first meeting the specialist nurse Kate, finds out about Jack and his general health and well being: how much he understands his condition, how it affects his life, what he wants to do, whether he has any worries or fears, and how his health makes him feel. They explore what he is already doing to support his own health and the main areas he wishes to discuss.

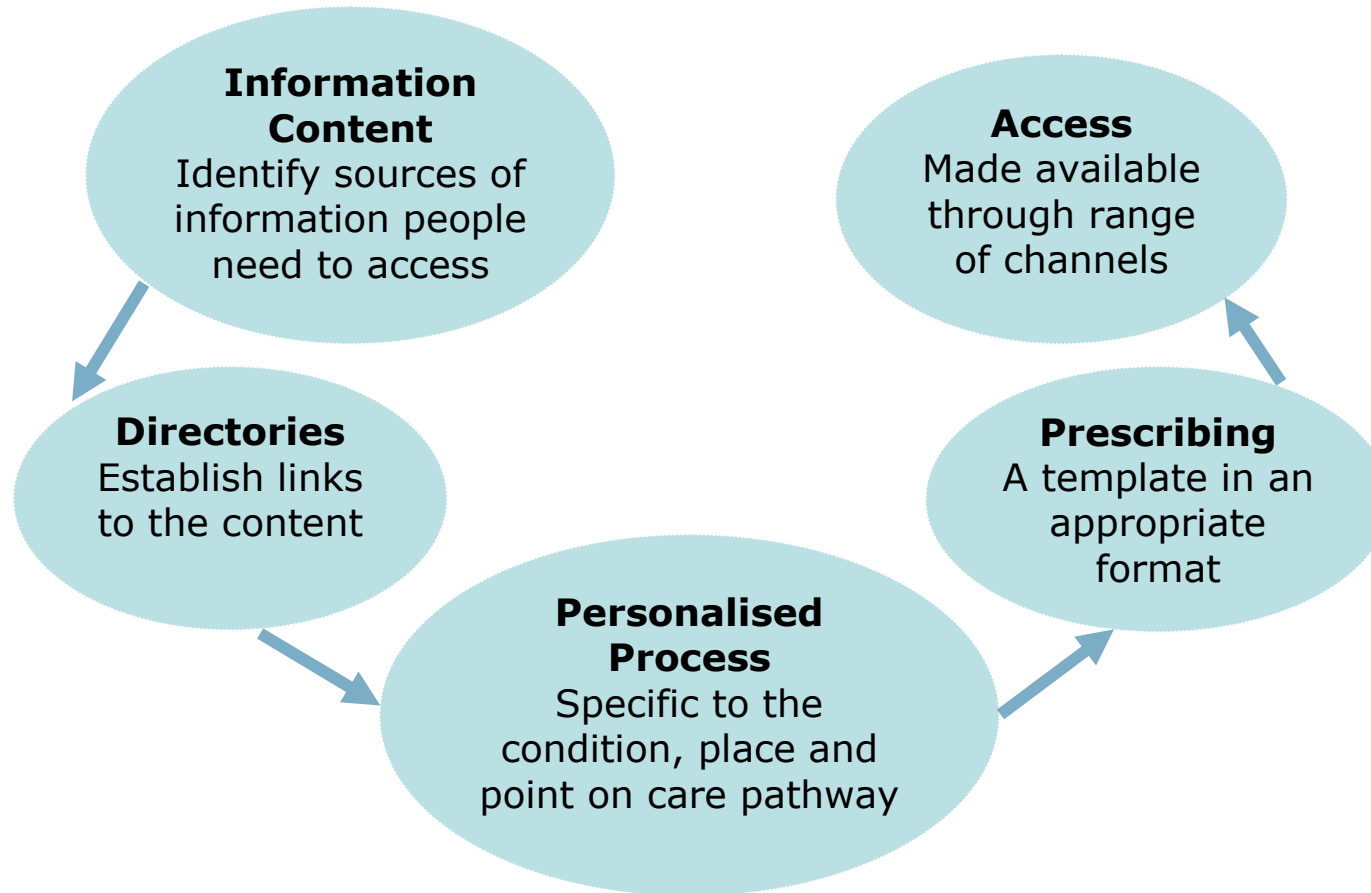
Jack tried many times to give up smoking but found it too difficult. He worries about his health, and feels very low which makes everything harder for him, in particular giving up smoking and getting out more. He lacks energy and feels apathetic and this is impacting upon his relationship with his wife and daughter. Jack is relieved to be able to tell someone that he is feeling depressed and has very little motivation to take basic care of himself, let alone attempt something as challenging as stopping smoking.

Kate helps him to think about his immediate future and what he would like to do. Jack says he wants to be more active, to get out more, to get back into playing golf but has little motivation. He doesn't want to take anti-depressants in addition to his other medication. Together they explore other options, which could include Cognitive Behavioural Therapy, which has had recent extra funding from the local PCT. Jack thinks this might help him so he is referred.

Before his next consultation, Jack is sent a leaflet inviting him to consider questions he might want to ask or issues to think about beforehand. This reflective phase of the care planning process helps him prepare for the meeting, making him feel valued and equal. Jack already feels much more positive and says he wants to consider stopping smoking. His specialist nurse tells him about the services available including smoking cessation clinics, which he decides to try. Jack is still struggling to accept he has COPD but in partnership with Kate and drawing from her expert knowledge in the condition he is able to access information and develop his own knowledge and understanding on managing it better, including changing his inhaler and reducing his steroids. Kate's approach is that Jack is an expert on living with his condition and they work in partnership. Jack is offered information about local peer support groups, including a trusted on-line social network site linked to NHS Choices (although he is not IT literate, his daughter is able to help him).

Within 6 months Jack is feeling much better. His mood has lifted, he is able to get out more, even playing golf twice a week. He has managed to stop smoking over the last two months – a significant achievement, boosting his confidence. Jack's current and future goals are recorded in his care plan which he keeps. His treatment plan and medications are included in the back of the care plan. Having the discussion and a formal record helps him to focus on what he wants to do.

Process for Information Prescriptions



8. Integrated Governance

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

Any commissioned service must meet all current quality requirements. Compliance with relevant NICE guidance is also required.

User and Public Involvement – The continual development of care planning services for people with long term conditions needs to be strongly founded on engagement with service users and should be a dynamic process. Providers should be required to demonstrate active engagement with people and local communities in developing services, self care plans or in supporting people to utilise self care opportunities. Providers should demonstrate how they respond to user feedback and this is to be used to shape and improve services. Involving family carers and supporters will help deliver the components within this service specification. Local Involvement Networks (LINks), the voluntary sector and advocacy organisations are all further mechanisms to seek active involvement in service planning, delivery and monitoring.

Safeguarding: PCTs need to ensure that the care planning process includes a safeguarding risk assessment and that a clear process for monitoring any identified risks is in place.

This process needs to take account of the fact that there may be fewer safeguards in place for people who wish to use personalised budgets to 'purchase' certain elements of their care plan provision from private and/or "uncommissioned" providers.

Professional competency, education and training – Provider staff will be required to demonstrate their professional eligibility, competence, and continuing professional development in order to remain up-to-date and deliver an effective service which is culturally appropriate.

Local workforce development plans should recognise the need to develop the local workforce to ensure that care planning is done both comprehensively and well.

Whilst one key professional is likely to be the 'lead' for care planning for an individual, theirs will be a coordinating role and input will be required into the care planning process from other team members (this will include health, social care and other local authority staff). It will be important to develop the right skills to make the care planning process a proactive and successful one, rather than a paper exercise.

Health and social care professionals involved in service delivery to people with long term conditions will need to support people in having their say. They will need to work with service users as equal partners. The workforce therefore needs to be trained in the appropriate skills and behaviours that will cultivate these approaches.

Commissioners will want to be reassured that the mechanisms to achieve this are in place and that providers are familiar with the Common Core Principles to support Self Care. Thought should be given to the use of expert patients as part of any training and development and that they too could be trained to provide support to people alongside professionals.

Staff appraisal on an annual basis and at an appropriate level will also be required. Commissioners will need to be reassured that practitioners have the required competencies at an appropriate level.

Commissioners should be satisfied that providers who deliver the services described have a planned, regular programme of education, training and support for their staff.

Providers should ensure safe staffing capacity at all times and staff should be able to demonstrate that they have participated in any necessary training, for example infection control, manual handling, risk assessment as required.

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

The provider will ensure that staff undertaking user assessments will have full CRB checks/clearance.

Information management - The protection, use and disclosure of patient information must comply with the information governance policies and guidance set out in the NHS Information Governance Toolkit which can be found at <https://www.igt.connectingforhealth.nhs.uk/>. This encompasses the NHS Codes of Practice on Confidentiality, Records Management and Information Security and supports delivery against core standard C9 of Standards for Better Health. All staff should undertake the information governance training provided on-line at <http://www.igte-learning.connectingforhealth.nhs.uk/igte/index.cfm>.

Equipment– Providers will be expected to adhere to Medicines and Healthcare Regulatory products Agency (MHRA) advice and guidance on selection of appropriate equipment, training in its use and ongoing management, troubleshooting, and quality assurance processes that ensure the accuracy and reproducibility of test results.

Clinical audit and review – Providers will be required to demonstrate their coordination of and involvement in regular inter-professional and inter-agency meetings and regular audit of the service interventions and outcomes such as drug therapies or well-being and behaviour changes.

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

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4139666.

Managing complaints – providers should have in place a complaints system that reflects the arrangements introduced on 1 April 2009. This provides an opportunity for all organisations to review their local systems so they can both respond flexibly to complaints, concerns and complements and feed the resulting lessons into their work on learning from service users feedback to improve services.

The new approach which focuses on the complainant and enables organisations to tailor a flexible response that seeks to resolve the complainant’s specific concern should provide valuable feedback to ensure providers are continually enhancing their responsiveness to service users.

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

9. Information management/ requirements

Any monitoring that PCTs want to put in place should be proportionate to the activities being commissioned and where possible make use of existing information eg, survey information such as the GP Patient Satisfaction surveys, and practice disease registers.

Commissioners will want to be reassured that a robust feedback loop is in place that supports the ongoing development and enhancement of the services being provided.

Providers will need to put in place registers of people with long term conditions. Commissioners will want to work with providers to ensure this information informs the panning and commissioning of future services for people with long term conditions.

Information collected from providers may include:

- evidence that the agreed activity has occurred
- numbers wanting/not wanting a care plan
- contact numbers– where consent is provided
- assessment numbers
- use of information prescriptions
- patient communication/access needs
- numbers receiving an information prescription
- types of information requested by patients/carers
- whether patient has a carer/guardian and whether they have received a copy of the care plan or their own information prescription
- method(s) used to provide information e.g. provided directly by service, redirected to information centre, electronic format (such as NHS Choices), provided by pharmacy, posted to home address
- service outcomes – what happened i.e. service take up and details of any services that were refused.

Commissioners will also want to take account of any local measures for long term conditions that have been put in place by SHAs.

10. Service Monitoring and Evaluation

Monitoring and evaluation should sit within the PCT's contract monitoring cycle. Service providers will need to demonstrate the effectiveness of the service to commissioners possibly at regular times during the year and, at the least, on an annual basis. This will need to be provided to the commissioners in an annual report, which will inform any annual review process or meeting. The process by which this evaluation is achieved can also be used to show the outcomes of the service to other key stakeholders such as users and family carers. Service evaluation should be built in from the commencement of any service and should cover, as a minimum, the following areas:

- **User Experience** – The experience of service users is central to the development of these services. Individual views on their experiences and satisfaction levels will need to be measured through an on-going, systematic process to test whether the service is engaging with individuals, family carers and supporters in a way that supports them. Different and innovative approaches to obtaining these views and experiences may be necessary, eg through capturing stories of community members experiences of the NHS and applying the learning from these. These processes should also be stratified where possible to show any differential impact on disadvantaged groups (e.g. Black and Minority Ethnic groups, deprived groups, males, females etc) and any

resultant service changes (planned or achieved) should be highlighted.

- **Service Activity** – Volume of work against any agreed activity levels and distance from profile, capacity, needs and demand analyses, workforce arrangements, real time referral data to other care pathways or appropriate agencies recorded appropriate Read codes. Commissioners will want to monitor secondary care activity to help them understand the impact over time of care planning for people with long term conditions.
- **Clinical Outcomes** – Regular analysis and interpretation of clinical outcomes data as well as regular analysis and interpretation of PPA data for prescribing.
- **Quality and Governance** – Quality criteria will need to be established (in agreement with commissioners) and measured with standards needing to be met on a continual basis. Results of clinical audits will be used to inform service provision during the year. EQIA data should be used to underpin local integrated service provision.
- **Value for Money** – Cost effectiveness or ‘best value’ analyses of the primary service outcomes in relation to comparative costs of hospital activity or those services providing equivalent quality of care.

11. Funding

There will be no fixed or nationally agreed price for services commissioned under the OSS. In many cases what is required is a change in the model of service delivery rather than entirely new services. These changes may in some cases require pump priming funds.

12. Contract Management

For example:

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

13. Review, variation and de-commissioning process

In their agreement with practices PCTs may want to consider the inclusion of the following clauses/arrangements

Suspension arrangements

Payments under the scheme will be suspended if at any time the contract holder is unable to provide services in line with the agreed service specification.

Before any suspension the contract holder and PCT will meet discuss the reason for the suspension identifying any possible resolution.

If the matter is not resolved the PCT will issue a suspension notice to the contract holder within 7 days.

Notice period

Either party may exit the agreement by giving 3 months written notice.

Decommissioning

It is likely that as a result of the feedback process commissioners will from time to time wish to decommission services. Arrangements for the exit of the contract holder from the agreement whether it is due to termination or because the agreement has come to an end should be included. The inclusion of an exit plan that details the processes to manage the exit of the contract holder from performing the Services is recommended.

Termination

The PCT may terminate the scheme within 28 days if, following suspension of payments the contract holder fails to re-establish services according to the service specification or take appropriate action to address deficiencies within eligibility criteria.

Before issuing an exit notice, the parties will meet to discuss the reason for termination.

If after this meeting the reason for terminating is not resolved then the relevant party will issue an exit notice.

The PCT right to claw-back monies as a result of underperformance or failure to deliver on agreed action plans shall survive the termination of this agreement.

Appeal procedures

Either party can appeal against a suspension or termination notice using the Trust Contract Appeals process

Review and Variation

Feedback from service users should support the review process and arrangements for incorporating changes resulting from this should be included.

14. Signatories

Signatures from both parties as those accountable for the agreement

Resources

The *Evaluation of Information Prescriptions: Final Summary Report* (OPM, GfK and The University of York, August 2008)

www.informationprescription.info/resource

NHSLA Standards for Patient Information

<http://www.nhs.uk/standards/patient-information/>

Common Core Principles to support self care, Skills for Care, Skills for Health, 2008

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084505

Understanding what matters: A guide to using patient feedback to transform care, DH, 2009

Transforming Community Services: Ambitions, Actions, Achievement, Transforming Services for People with Long-term Conditions, DH, 2009

'Your Health, Your Way – a guide to long term conditions and self care', DH, 2009

Supporting People with Long Term Conditions, Commissioning Personalised Care Planning, A Guide for Commissioners, DH, 2009

Raising the Profile of Long term Conditions Care, A Compendium of Information, DH, 2008

For Department of Health publications see:

<http://www.dh.gov.uk/en/Healthcare/Longtermconditions/index.htm>

Definitions

Care Plan, (other names include Support Plan, Personal Health Plan, Health and Well-being Plan, Personal Plan): a single, overarching document, in written or electronic form, which records the outcome of discussion between the individual and the professional(s). It should be readily accessible by the individual and to all others who have a legitimate reason to access it, including out of hours and emergency services

Care planning services: the services people receive as a result of the care planning process

Personalised Care planning (other names include Support Planning, Personal Health Planning, Health and Well-being Planning): a continuous, dynamic process of discussion, negotiation, decision making and review that takes place between the individual and the professional(s) –who have an equal partnership. The process should be led by the individual, with that person at the centre, and be based upon their strengths, goals, aspirations and lifestyle wishes

Long Term Conditions: Those conditions that cannot, at present, be cured, but can be controlled by medicines and other therapies

Information Prescriptions: Aim to guide people with long-term conditions or care needs, and their carers, to relevant and reliable sources of information to enable them to feel more in control and better able to manage their condition and maintain their independence

Your Health Your Way: To empower and support people with long term conditions to understand their own needs and be able to make informed choice about the self care support they wish to access from the resources available.

Services: care planning and the services delivered as a result of the care planning process

Achieving World Class Commissioning Competencies through the implementation of care planning³

World Class Commissioners are recognised as the local leaders of the NHS – Ensuring that people with long term conditions are offered personalised, proactive care planning and a wider range of choice to support them to manage their condition will help build their reputation within the community.

World Class Commissioners work collaboratively with community partners to commission services that optimise health gains and reduce health inequalities – Developing fully integrated care planning promotes partnership working between health and social care providers, local government and the third sector at both strategic and individual levels.

World Class Commissioners proactively seek and build continuous and meaningful engagement with the public and patients to shape services and improve health – The essence of care planning is about truly engaging with people, encouraging their input and views about their care and finding out what can really make a difference to support them to achieve optimal health and well-being. This means that ‘micro level’ engagement is taking place across the whole population of those with long term conditions who take up the offer of care planning. This could be deemed one of the most effective ways to engage with people whose voice would otherwise not have been heard.

World Class Commissioners lead continuous and meaningful engagement with clinicians to inform strategy and drive quality, service design, and resource utilisation – Working with local clinicians such as GPs, nurses and specialist consultants to implement care planning, and feeding information from care planning into commissioning decisions, will ensure that services commissioned as part of the process are based on local knowledge and needs.

World Class Commissioners manage knowledge and undertake robust and regular needs assessments that establish a full understanding of current and future local health needs and requirements – Care planning tailored to individual need is a way of establishing local needs and requirements through aggregated data collection from individual care plans. It also has the ability to provide granular information that can identify health inequalities and unmet needs.

World Class Commissioners prioritise investment according to local needs, service requirements and the values of the NHS – Personalised care planning can be a vehicle to understanding where local requirements are most needed and determining where investment priorities lie. It can also reveal services that are less popular which can support decommissioning.

³ Extract from Supporting People with Long Term Conditions: A guide for Commissioners, DH, January 2009

World Class Commissioners promote and specify continuous improvement in quality and outcomes through clinical and provider innovation and configuration – Allowing the patient voice to feed into decision making through localised implementation of personalised care planning will result in better quality service driven by the needs of the local population.

World Class Commissioners effectively stimulate the market to meet demand and secure clinical, health and well-being outcomes – Personalised care planning, together with *Your Health, Your Way*, should stimulate provision of a wider range of services by a plurality of providers to meet holistic needs. This should drive choice, continuous improvement and innovation by stimulating new services together with information to support decommissioning.