A Guide to the Implementation of the Long Term Conditions Model of Care

Learning from the Long Term Conditions QIPP Workstream

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Foreword

The operating method of the LTC QIPP commissioning development programme has been to identify leading examples of implementing the evidence based drivers for managing people with LTC (risk profiling, integrated care teams, and maximising self care), and share that experiential knowledge. This has been an iterative process as more and more experience has been gathered.

As the Commissioning Board takes on responsibility for the workstream, it is timely to collect and collate that accumulated knowledge, to be available to you as you go forward. This handbook has been prepared by the coaches, with input from many participants and is an excellent resource. I very much hope you will find it helpful, use it, and add to its content with your own knowledge.

Finally none of this would have been possible without the many participating teams, the chairs, speakers, presenters, and demonstrators at the learning events – and not least a fantastic LTC QIPP team of coaches and events organisers. The results have been extraordinary given the organisational environment, and I pay tribute to you all, with deep gratitude.

Sir John Oldham

National Clinical Lead QIPP

Section One

This guide has been produced using the learning and outcomes from the Long Term Conditions (LTC) Commissioning Development Programme and overarching LTC QIPP workstream. It has been devised to enable teams from across whole health economies to implement the long term conditions care model required to manage the demographic changes that make long term conditions a national priority.

The challenge

Currently:

- The NHS, as currently configured for long term condition care, is **not sustainable** in the face of the projected future level of need.
- There are around **15 million people** living with a long term condition (LTC) in England
- These people are the **main driver of cost and activity** in the NHS as they account for around 70% of overall health and care spend.
- They are **disproportionately higher users of health services –** representing55% of GP appointments, 68% of outpatient attendances, 72% of inpatient bed days, 58% of A&E attendances and 59% of practice nurse appointments, 40% of calls to the 111 service.
- Around **170,000 people die prematurely** in England each year in total, with the main causes being cancers, circulatory diseases and respiratory conditions.

In the Future:

- Demographic projections outline a **252% rise in the number of people over 65** by 2050 and consequently one or more LTC.
- While the number of people with any long term condition should be relatively stable over the next 10 years, DH estimates that there will be a **30% increase in the number of people with three or more long term conditions over a 10 year period (2010 – 2020).** In a quarter of people with multiple LTCs, one of the conditions will be depression.
- The Scottish School of Primary Care's Multimorbidity Research Programme shows that the majority of over-65s have 2 or more conditions, and the majority of over-75s have 3 or more conditions and that more people have 2 or more conditions than only have 1
- The average cost per year of someone **with a long** term condition is around £1,000; which rises to £3,000 for someone with two conditions and to £8,000 for people with 3 or more conditions.
- The goals of the QIPP Long Term Conditions Workstream have been **incorporated into the financial settlement** clinical commissioning groups will receive. Therefore more effective management of people living with long term conditions will be pivotal to the success of clinical commissioning groups.

What this means for patients:

- Patients universally say that they wish to be treated as a whole person and for the NHS and social care to act as one team. Despite this, those people who have more than one condition, particularly older people, face an **increasingly fragmented response.**
- Long term conditions **"needs" transcend the organisational boundaries** of social, primary, community and secondary care. The current system fragments care for individual patients and this lack of continuity often leads to poorer outcomes and hospital admissions

The LTC QIPP Workstream has driven forward the changes needed to improve patients' experience of care:

- The current NHS requires a paradigm shift in the provision of health care to meet the needs of a population in which most of the disease burden is attributed to chronic diseases. The shift calls for a radical reappraisal of the current patterns of investment in health care if changing population needs are to be met effectively and the NHS is to be sustainable for the next generation.
- The QIPP challenge; therefore is not only to transform the way we deliver care to those people with long term conditions and contribute to the current financial imperative of £20 billion savings, but also to set the NHS itself in a better position to remain viable for the future.
- No healthcare system as it is currently configured for long term conditions care is sustainable – it is everyone's responsibility to help change this. Unless we work together to achieve this change for long term conditions care, - clinicians and managers, primary and secondary care, health and social care – the NHS is not sustainable.
- The NHS was set up in the 20th century primarily to deal with the burden of illness from communicable diseases. Thankfully as the 20th century progressed we overcame that burden with innovation in treatment and prevention. The 21st century NHS faces a burden from non-communicable diseases and mainly for long term conditions and their multi morbidities. It now needs transformational change in culture to ensure another step change and further innovation in order to be a viable entity for the future. That step change is from see, treat and discharge to identify, integrate and co-manage.

Section Two – the model and background work

The Long Term Conditions QIPP Workstream

A national support and improvement programme has enabled teams across local geographic areas to implement an evidence based system for supporting patients with multiple long term conditions. The programme has facilitated and enabled local health economy teams to deliver change at scale and pace, in a measured and supported way.

The task required strategic translation of policy into pragmatic implementation solutions to change the care model to:

- Service provision that is centred on patients need and responds in a holistic manner (Patients eye model).
- A commissioning model that eliminates silo working; whilst commissioning for co morbidities become the norm, akin to the human spine and its nerve supply and the generalised strength that comes from the individual components (specialisms of disease focus) working as a co- ordinated unit (Common spine model).
- A fiscal model that supports health and social care teams to integrate care in a more successful and sustainable way; better aligning the funding flows and incentives with peoples' needs to support rather than inhibit organisations to work together (Year of Care funding model) for people living with long term conditions alongside achievement of the efficiency savings.

A number of key elements have formed part of this workstream:

- *Topic expert group* - with opinion leaders and examples of best practice to enable distillation of the evidence into pragmatic primary drivers to enable system change.
- *The Ignition Phase* -sites from across the country tested out the evidence based model on an identified cohort of people with LTCs to ensure proof of concept and transition of the international evidence base within the English NHS and social care system.
- *The Operational Phase* -to make a real impact on multiple long term conditions we need to move from pockets of innovation and good practice to spreading and sustaining these improvements across the whole of England. This was the premise of the Operational Phase. Taking the learning from the Ignition phase, a **National Commissioning Development Programme** was co-produced with colleagues (LTC clinical and managerial leads) from within each SHA region. This one year development programme has supported the emerging Clinical Commissioning Groups (CCGs) and their stakeholders in implementing the LTC common spine model through the adoption of 3 primary drivers in each local health and social care economy: The triad of transformational change.
    - ***Systematic risk profiling of the population***
    - ***Integrated locality care teams including social care, community services, allied health professionals and general practice***
    - ***Systematised support for patients to self-manage***
- *Year of Care*– changes to the financial model. A commissioning group has designed a number of recommendations for changes to payment by results and tariff that will ensure that the commissioning model supports the care and commissioning model being promoted through the workstream, with a particular focus on realising efficiencies. This work has commenced with the Early Implementers (7 sites) and the Fast Followers (25 sites).

The Evidence Based Care Model and the three Drivers

The LTC care model is based on a wealth of international evidence; it has received widespread support from organisations such as the King's Fund[1], Nuffield Trust[2] and QISMET[3]as it has been shown to improve clinical outcomes and reduced unscheduled hospital admissions.

A topic expert group agreed a model of care for the long term conditions workstream based on the following three primary drivers which are the critical features of all best practice long term conditions care programmes nationally and internationally. Where a common LTC model, based on these three primary drivers, has been effectively applied, indications are that unscheduled admissions can be reduced by 20% and length of stay by 25%.

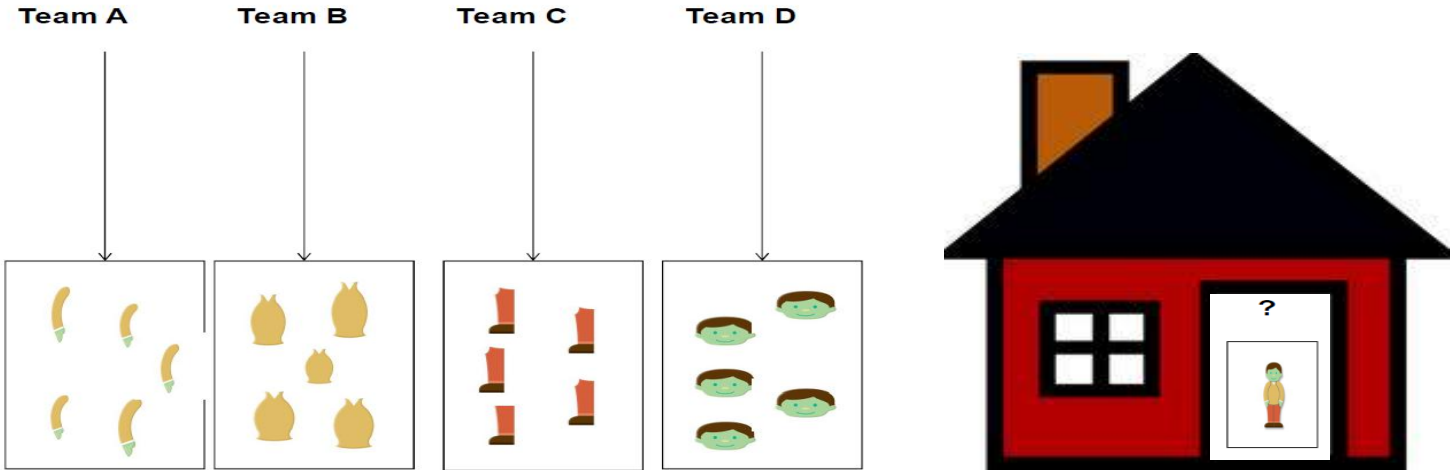
Systematic risk profiling of the population

Using validated risk profiling to support commissioners to understand the needs of the population and manage those at risk. A risk prediction tool will identify a list of patients that are at high and medium to high risk of accessing healthcare services. This will assist in preventing disease progression and will allow for interventions to be targeted and prioritised. It will enable identification of resource need and resource utilisation.

Integrated locality care teams including social care, community services, allied health professionals and general practice

The NHS creates systems and mechanisms that focus around the parts of people they feel responsible for (see figure 1). This has created fragmentation and duplication, particularly when dealing with people with multiple problems which increasingly are the majority of people we deal with. For the patient it is often just confusing. We also know the outcomes are poorer.

Figure 1–Within current service models care can be fragmented and duplicated

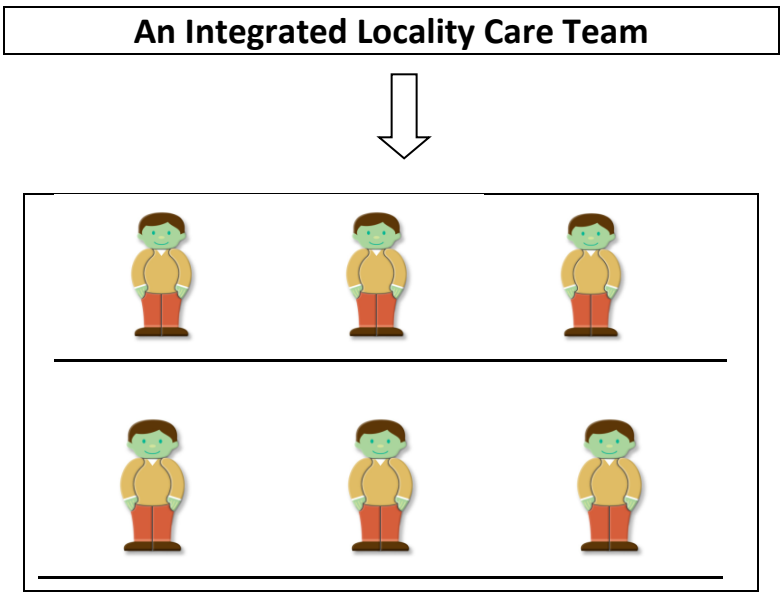


The system change required is the creation of functionally integrated holistic teams at a locality level. These teams should include community services, allied health professionals, social services, and specialist nurses and should be linked to GP practices. The integrated health and social care teams should be based around a locality (or neighbourhood; experience suggests a population size of 30 -50,000) to provide joined up and personalised services. Neighbourhood care teams provide a single main point of contact for patients and carers. Each patient has a key

[1] http://www.kingsfund.org.uk/
[2] http://www.nuffieldtrust.org.uk/
[3] http://qismet.org.uk/

worker within this team who coordinates their care and acts as the point of contact. **Integrated teams pool expertise for the bespoke benefit of individual patients; this is not about diluting expertise.**

Figure 2– An integrated locality care team embraces specialist services when necessary, but treats a patient holistically, regardless of their condition(s).Thus moving from a biomedical model to a psycho-social medical model.

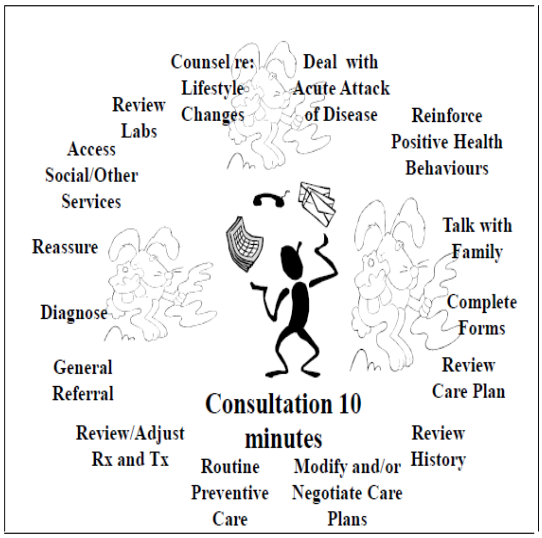


Systematising support for patients to self management

Moving away from the traditional model of care (see, treat and discharge) to a chronic care model where self management support is a responsibility and an integral part of the delivery system. Care is delivered by a prepared proactive workforce enabling patients to move away from being passive recipients to becoming informed and activated to self manage (identify, integrate and co-manage).

Traditional Model → **Chronic Care Model**

SICKNESS CARE MODEL
(Current Approach - Physician Centric)



- Care is Proactive
- Care delivered by a health care team
- Care integrated across time, place and conditions
- Care delivered in group appointments, nurse clinics, telephone, internet, e-mail, remote care technology
- Self-management support a responsibility and integral part of the delivery system

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The fourth element in this process is the need to **do them all systematically and comprehensively at the same time.**

This model of care addresses the physical, psychological and social aspects of care for people living with multiple long term conditions; it improves their clinical outcomes and reduces the number of unscheduled admissions. The care model has a common spine for all long term conditions that recognises that the greatest increase we will see is in the numbers of people living with co – morbidities. This is not to say that in the integrated teams, that look holistically at patient's needs, there will not be a specialist nurse; rather they will be embedded in a team that possess multiple skills best suited to managing what will be a majority of their patients: people with multiple conditions. These specialist skills will be retained as will be their connection and mentoring from secondary care. However, they will look at patients holistically and work with others collectively to meet the assessed patient need .This will ensure that the neighbourhood team can offer the right care, in the right place at the right time, as opposed to separately, in discrete specialist teams which patients report as disjointed and confusing.

Section Three - making it happen

Driver 1: Systematic Risk Profiling of the Population

Implement information systems that support registration, recall and review for people with multiple long term conditions and support data sharing across partner agencies in real time.

Primary care should be at the heart of the delivery system and that system should focus on prevention not just treatment. The healthcare system needs to focus on total population health within long term conditions not just respond to the needs of individual patients. We need to shift from a reactive hospital based system of unscheduled care towards one which is founded on a preventive, anticipatory approach to managing long term conditions on a whole-person basis. A first step is to stratify your local population in terms of their pattern, seriousness and complexity of long term conditions to identify those individuals most at risk of future crises.

An integral part of this approach or framework is to design, develop, and implement a system which supports a personal health record or electronic care plan and the sharing of information to support practitioners working across sectors and agencies.

Improvement Change
• Identify individuals at high risk of requiring complex care by using a risk prediction tool and electronic searches applied to local health and social care datasets. Then share this information with the people who need it so that care can be proactive. • Share information and communicate real time data with the relevant people; it is vital to improving care. Ensure clinical access to real time urgent care data sources in a combined dashboard. This approach will aid the systematisation of proactive care. It will help move from a treatment system to a preventative system.

Top Tips for Implementing Risk Stratification & Predictive Modelling Solutions

Do	Don't
1. Do… Understand the clinical and business needs for risk stratification and predictive modelling so that you can build a solution that meets existing (and potential future) needs. Agree on the benefits you are trying to realise which form the measures against which the success of the project can be measured 2. Do…. Know who your stakeholders are and engage with them as early as possible and throughout the implementation. Possibly the most important stakeholder will be your local LMC. Work with them on developing your information governance and data security mechanisms 3. Do… Learn from those that have already implemented successful risk stratification/predictive modelling programmes and don't be afraid to recycle existing resource materials such as information sharing agreements. 4. Do….. Understand the difference between risk stratification and predictive modelling (see appendix 2) and avoid using the phrases interchangeably – they're related but different. Also understand	1. Don't…. Use the predictive modelling data to replace local intelligence or clinical judgement – predictive modelling tools are designed to be a useful addition to clinical judgement, not a replacement for it. 2. Don't…. Underestimate the challenge of getting and sustaining clinical engagement. Working effectively on this area from the outset and managing it well can make a dramatic difference. Identifying and working with a clinical lead/champion will help tremendously 3. Don't… Forget it's about an end to end to end solution that starts with informing patients about the use of their data for risk stratification and predictive modelling purposes, moves on to data extraction/collection, preparing it, running it through the tool, validating the outputs, making it available to users, training staff on how to interpret and use the data and ends with managing the realisation of benefits. 4. Don't… Underestimate the costs associated with the provision of a solution. There are costs

exactly what your algorithm is predicting – there is an important difference between risk of emergency admission, risk of readmission and risk of high cost in the next 12 months 5. Do… Use an algorithm for predictive modelling that will analyse individual clinical events and build a predictive score for that, takes into account morbidity burden rather than just use of NHS resources or hospital admissions in the previous year. 6. Do…. Include primary care data. Algorithms that are based on just hospital data will successfully predict admissions or readmissions but incorporating data from GP practice systems will give a richer source of diagnostic information and will improve the performance of the predictive model 7. Do…. Consider the how clinicians and others access the information and how user friendly the tool is – ideally they should be able to access information on their desktops and it shouldn't take more than three clicks of the mouse to get to the information they use 8. Do…. Consider the difference between the information that front-line staff such as GPs and Community Matrons need to case find and the information that practice managers or CCG staff may want access to understand how well resources are being used – your technical solution needs to be able to meet both needs. 9. Do…. Devise a method for tracking climbers and new entries. Once you have reviewed your top X% of patients at risk, you will not want to do this exercise again when the data is refreshed (unless their risk score has changed significantly). Devise a method to focus on those patients that move risk scores or which enter the top X% for a first time 10. Do…. Present GPs with their own data during training and make sure the trainers understand the data and how the risk stratification tool and predictive models work. Do acknowledge and accept that some 80 – 90% of patients identified by the tool will be known to the GP/Community Matron – it's the remaining 10 – 20% that need to be reviewed and are potentially suitable for case management 11. Do.... Stratify your whole population. There will be significant numbers of patients at risk outside the over 65 cohort. 12. Do.... In certain circumstances use the system to identify the highest risk patients and then ask yourself if you have provided them with all the basics – a care plan shared with all the relevant parties, vaccinations, medicines review	associated with each stage of the end to end solution and effective project management, not just those associated with developing the software or buying software licences 5. Don't… Try to make your solution all things to all people. Your risk stratification and predictive modelling solution will be one of several business/clinical intelligence tools used. The trick is to know how to combine data from your risk stratification and predictive modelling tool with data from other tools to create the intelligence you need to drive informed decision making 6. Don't…. Forget to refresh the data regularly. A risk score is only ever a snap-shot in time. Ensure you have a mechanism for refreshing data regularly and removing obvious anomalies like patients who have deceased in the period between when the data was collected and the risk scores calculated. 7. Don't…. Only use the predictive risk score as a method for finding patients suitable for case management or other programmes of care. The top 5% list will typically have 250 – 500 patients on it which is far too many for a community matron or an MDT to review. By applying additional filtering criteria such as age, number of LTCs, rapid risers and fallers and/or more an emergency admission in the previous year, a more targeted list can quickly be created. 8. Don't…. Spend ages trying to work out how to measure avoiding a hospital admission. It is impossible to measure something that doesn't happen. You can only benchmark your data against last year's LTC ICD10 codes. However, once you have a risk profile of your population you can start to measure the relative costs of patients with similar risk profiles who have and have not had access to specific services to see if certain programmes of care are effective in reducing costs 9. Don't… Forget that benefits realisation requires a community of interest. Establishing a user group or community of interest will provide a mechanism to share good practice and drive the programme forward. The larger the community of interest and the more clinical input, the greater the benefits that can be realised. 10. Don't… Forget that at the end of the day, to tool will produce data. It's what people do with this data and the changes they effect that will make the difference

Driver 2: Integrated Locality Care Teams

Strengthen the contribution of integrated locality care teams to improving care coordination for people with multiple long term conditions. Provide better, local and faster access to services for patients with multiple long term conditions at an earlier point in the care journey to activate proactive care.

The top 1-3% cohort of people identified from risk stratification require a careful holistic assessment based on a psycho- social medical care model. Many people will have social, psychological, economic and environmental factors that cause additional complexities to their needs. Service delivery should be re-designed to support people with multiple morbidities. This type of care delivery requires a fully integrated response across health, social care, housing, employment, benefits and voluntary sectors. An integrated care team containing health and social care personnel is best placed to help deliver this.

Improvement Change
• Integrated care teams pool expertise, not dilute it. The combined skills are used to the bespoke benefit of individual patients. This eliminates silo working and duplication of effort and interaction with patients “treat the whole of me and act as one team” • Care should be integrated to enable primary care teams to access specialist advice and support. Implementation of effective primary/community/secondary/social care infrastructures including single point of access. And we mean single – not multiple single points of access for COPD, CVD, Diabetes etc. (Yes they do exist in the same geographies!) • Target those identified by risk prediction tools as at high risk then tailor care for individuals through a case/care management approach using multi-disciplinary teams that include social services and actively encourages dynamic case finding approaches. Develop capability within multi-disciplinary primary and community care teams using personal development plans and learning plans to develop core skills and retain appropriate specialist competencies. • Agree and communicate with the patient, carers and across services to define who has responsibility for co-ordination, overview and review of the care plan. Introduce a holistic assessment utilising a social matrix bio-social methodology as opposed to purely medical methodology. Ensure development and implementation of disease pathway “brokerage” at neighbourhood level.

Top Tips for Implementing Integrated Locality Care Teams

Do	Don't
1. Do ... co locate member of integrated care team where at all possible. The cost benefits in improved communication, and reduced phone call time is substantial. 2. Do…. triangulate who is involved with the patient from an early stage, whether GP, practice nurse, community teams, social services or secondary care to ensure care is joined up. Ensure the right professionals are involved to gain the best outcomes. 3. Do…. have a named clinician taking ownership for coordinating a patient's care. 4. Do…. have good knowledge and accessible information about other services to sign-post to as this is key. 5. Do…. Have strong partnership arrangements with care homes, ambulance services and A&E. 6. Do…. spend time building relationships between health and social care. Take social care staff out to meet practices to help them directly build relationships. 7. Do…. pull your key facts together in a briefing document for your team so you give out a unified message. 8. Do…. identify clinical champions and use these clinicians to explain the benefit of your implementation to other clinicians. 9. Do…. use an administrative role to give the project sustainability. Often ICT team working can break down as there is over reliance on one professional to keep driving the work forward. 10. Do…. create space for teams to learn and share from each other (shadowing opportunities), spending time outlining roles, responsibilities and establishing common outcomes. 11. Do…. get the right level of engagement in the practical work from all organisations, people with authority to implement the agreed decisions. 12. Do….start with a local agreement of what success will look like for you, and then work back into enabling that, with quick wins first at a very practical level.	1. Don't…. focus on task-orientated team working. With an integrated care team it is everyone's responsibility to ensure the right information and sign posting is provided so the patient can access appropriate care when needed. 2. Don't…. underestimate staff's resistance to change and working differently. 3. Don't…. over manage patients. You need to make sure you manage the right cohort of patients and provide appropriate care. 4. Don't…. forget to recognise that the top 0.5% or 1% of the patients across the area is not the same as the top 0.5% of the patients in each practice. Unless this is recognised the team will not be targeting the right cohort of patients. 5. Don't…. blame others for what appears to be failed processes, be open and honest and see the opportunities for improvement. 6. Don't…. assume that team members know what each other team member does, or fully understand the other organisations involved in the ICT. 7. Don't…. look to willing volunteers with no mandate to act. 8. Don't…. put team members in the same office and assume they are going to become "integrated" because they share an office space! Work needs to be done with teams well before integration to understand all roles and points of cross over and continue to do development work with the team after integration, and keep up the team meetings. 9. Don't….assume that your meaning of an integrated team is the same as another person's. 10. Don't….. rely on just integrating organisations, there needs to be a focus on integrated processes 11. Don't….. waste time waiting for a single IT system

Driver 3: Systematised Support for Patients to Self Manage

Health and social care professionals should work in partnership with people with long term conditions to enable them to better understand and manage their condition, to help them feel more in control of their lives, support problem solving, and to direct them towards the type of support and information they need. Prepare your workforce for partnership working by gaining senior buy in, identifying knowledge and skills gaps, and coordinating training and support that focuses on attitudes, skills, roles and infrastructure. Move people with long term conditions from passive to activated, engaged and informed patients by implementing collaborative care planning, goal setting and goal follow up. Commission and develop a menu of options to enable better self management and support e.g. peer support groups, self care portals, information prescriptions, assistive technology support or active group education. Always remember carers may be the people needed to enact co-management

IMPROVEMENT CHANGE
Use an evidence based framework such as the Year of Care Programme[4] and their tools to: • Assess how your organisational processes and commissioning are supporting self care • Assess how informed and engaged your patients are • Assess your workforce commitment to partnership working • Develop an action plan to systematise self care support in your area

Top Tips for Systematising Self Management

Do	Don't
1. Do…. Support people with LTC to prepare for their consultation by: holding their own record; owning their own care plan; having access to all test results (plus explanatory information); having access to clear, concise, personalised information; and completing an agenda setting sheet. 2. Do…. Support people to tell their story by having clinicians asking open ended questions. 3. Do…. Build empathy and trust using communication skills such as: affirmation; normalisation; reflection; and summaries. 4. Do…. Invite people to set priorities in their agenda and start to set behavioural goals. 5. Do…. Support people who express that their goal is important to them (using scale 0-10, with 0 being not important, and 10 being extremely important) at more than 7 by setting a short action plan. 6. Do…. Use confidence scaling (0-10, with 0 being not confident, and 10 being extremely confident) to identify challenges. 7. Do…. Invite the person with a LTC to set the	1. Don't…. Forget to scope out all self care support locally and coordinate in one place either via web or toolkit. 2. Don't…. Underestimate the importance of developing working partnerships with voluntary sector organisations, council adult services, physical activity services, libraries, carer support, mental health trusts and hospital trusts. 3. Don't…. Underestimate the importance of a communications strategy that involves events, press releases and articles to the public. 4. Don't…. Assume all partners know about and how to refer to each other's services. 5. Don't…. Just think about health care, think about all social elements that can affect living with a LTC, e.g. housing, finance. 6. Don't…. Assume individuals know how to self manage. 7. Don't…. Close your mind to the possibility of true partnership with individuals in producing an individual holistic care plan. 8. Don't…. have shared decision making as a

[4] http://www.diabetes.org.uk

parameters for follow up: who, when, how 8. Do…. Make sure that goal setting is realistic and should include an achievable quick win for the first goal. 9. Do…. Make tools easily available in an electronic form on the GP practice clinical system. Do…. Get patients to share their stories and if possible to agree to be photographed/filmed, as this makes it real. 10. Do…. Engage with a wide patient audience and listen to what they have to say. 11. Do…. Implement the premise that the patient knows best. 12. Do... Make it easy for patients with low confidence to easily access support when they leave a consultation 13. Do... make it easy for GPS and HCP to sign post/refer patients to self management support 14. Do...make use of existing resources and build on what you have-local capacity building is often the most cost effective option 15. Do.... make sure that what you do is quality assured 16. Do review your current disease specific education and rehabilitation programmes-are they as effective as they could be?	separate programme; make sure it is embedded in every interaction. 9. Don't forget... patients and communities are a key resource and can be trained to deliver much of the self management support needed. 10. Don't forget... a LTC is for life so support needs to be there when things change

A Step by Step Guide to Doing the Work

Steps	Supporting documents & information
1. Identify core people for your implementation team	Click here for the LTC programme FAQs Click here for top tips on forming an implementation team
2. Identify key leads and sub groups	Learning from programme implementation teams suggests an overarching steering group with key driver task & finish groups. Establishing robust clinical and managerial leadership is key, with accountable organisational governance structures in place
3. Complete the LTC diagnostic to establish where you are at with LTCs, gaps in service and to action plan	Click here to access the LTC Programme diagnostic tool
4. Establish what stakeholder engagement is required to support your work	Click here for the Benefits wheel -a tool to help assess stakeholder engagement and action
5. Agree ICD 10 codes for primary or primary and secondary diagnosis you will track to measure improvement in emergency admissions and length of stay	Track a subset of Ambulatory Care Sensitive Conditions that represent the relevant conditions where benefits can be achieved for patients with multiple LTCs. Click to see ICD10 list
6. Complete LTC6 questionnaire to establish a baseline using a 100 patients	The LTC6 is a patient questionnaire that can be used to track service improvements. Click here
7. Develop a local project implementation plan Setting 8/15 /30 day challenges within your own health economy	Click here for Primary Driver - Traffic Light Assessment
8. Look to learn from other sites that have shared their learning and the resources & tool from the programme	Link to LTC website Link to Virtual Interactive Programme to download past WebEx recordings Link to LTC Commissioning Pathway
9. Track your changes using the outcome measures defined as key milestones linked to each of the three drivers	Link to milestones
10. Track impact of your work through emergency admissions and length of stay	Click here for link to programme dashboard
11. Repeat LTC 6 questionnaire after 12 months	

Further Resources to Support the Implementation of the LTC Model of Care

- **Commissioning for LTCs Website**- contains all the resources/tools/WebExs that have been developed to support the LTC QIPP programme. http://www.networks.nhs.uk/nhs-networks/commissioning-for-long-term-conditions/about-us

- **Risk Profiling**
  - Nuffield Trust - http://www.nuffieldtrust.org.uk
  - QIPP Digital Technology Team – http://www.connectingforhealth.nhs.uk/systemsandservices/qipp

- **Integrated Locality Care Teams**
  - Nuffield Trust- http://www.nuffieldtrust.org.uk
  - King's fund - http://www.kingsfund.org.uk
  - Audit commission- http://www.audit-commission.gov.uk

- **Self Care**
  - Self Care Forum- **http://www.selfcareforum.org/**
  - Year of Care Programme- http://www.diabetes.nhs.uk/year_of_care/
  - Know Your Own Health- http://kyoh.org/
  - QISMET - http://qismet.org.uk/
  - Co Creating Health - Health Foundation - http://www.health.org.uk/areas-of-work/programmes/co-creating-health/
  - Self Help Nottingham – Commissioning tool kit - http://www.selfhelp.org.uk/
  - Skills for Health - http://www.skillsforhealth.org.uk/
  - Skills for Care - http://www.skillsforcare.org.uk
  - Expert Patient Programme CIC - http://www.expertpatients.co.uk/
  - Royal College of General Practitioners e Learning -http://www.elearning.rcgp.org.uk/
  - QIPP Digital Technology Team - http://www.connectingforhealth.nhs.uk/systemsandservices/qipp
  - 3 Million lives - http://3millionlives.co.uk/

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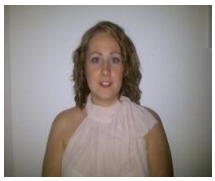

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Appendices

Appendix 1

The Operational Phase – LTC Commissioning Development Programme

The Operational Phase began in July 2011with a staggered start in each SHA geography. A twelve month **LTC Commissioning Development Programme** was co-produced in each region by the LTC QIPP team, GP colleagues and LTC leads. Each regional programme was bespoke to reflect the needs of each area and to build on work already underway and consisted of:

- Three meticulously planned, sequenced development workshops through "accelerated implementation events"
- local learning events and action focused meetings where required
- A virtual interactive programme - WebEx presentations demonstrating what works elsewhere and how they've done it.
- Access to virtual and social networks and resources
- Shadowing/buddying opportunities
- Support from a LTC National Coach within each region

Who took part?

Teams from across the South West, South East, South Central, London, East of England, West Midlands, East Midlands, Yorkshire & Humber and North West joined the programme.

147 Clinical Commissioning Groups joined the programme, forming implementation teams with local stakeholders from across locality health and social care systems.

The programme population coverage is 35 million

How did teams track changes?

Changes were tracked using sensitive outcome measures defined as key milestones linked to each of the three drivers

Key Milestones to Implementing Risk Profiling

1. Choose, populate and test a risk profiling tool
2. Ensure that 20% of practices covering a minimum of 50% of the population within the CCG or cluster have committed to implementing a risk profiling tool and have a plan to systematically use the data with the integrated neighbourhood teams
3. Set a date when all practices that have implemented a risk profiling tool are systematically using the data with the integrated neighbourhood teams to pro actively manager patients identified as "at risk"

Key Milestones to Implementing Integrated Locality Care Teams

1. The implementation team have chosen, defined and communicated an integrated locality care team model to be rolled out across the CCG/Locality.

2. The implementation team have identified the skill and knowledge requirements of all members of the integrated locality care team and used this to identify the skills and knowledge gaps.

3. The implementation team have identified and engaged all relevant stakeholders/clinicians and developed an action plan to embed the integrated locality team model in a minimum of 20% of practices covering a minimum of 50% of the population within the CCG/locality

4. All Integrated locality care teams attached to every practice /locality are using risk profiling data to proactively case manage patients identified "at risk".

Key Milestone to Systematising Support for Patients to Self Manage

1. The implementation team will map their current self care position to establish the baseline upon which to measure improvement.
2. By ..... systematised self care support for people identified with LTCs using risk profiling will be in a minimum of 20% of practices covering a minimum of 50% of the population within a CCG/locality.
3. By..... systematised use of the LCT6 demonstrates that people who have LTCs feel well supported to self care and feel involved in decision making by achieving at least 75% in each of the last statements of the questionnaire.

What data did we collect?

Quantitative Data

- Emergency Admissions
- Length of Stay
- % of teams achieving each macro level milestone
- % of teams with a date set to achieve each macro level milestone

How did we collect the Quantitative data?

Measures were tracked relating to the whole subset of Ambulatory Care Sensitive Conditions .These specific ICD-10 codes represent the relevant conditions where benefits can be achieved for patients with multiple LTCs. This data was taken from CCGs participating in the workstream and was collated centrally on a monthly basis by the South Quality Observatory, accessed via a programme specific link to the dashboard. To track improvements baseline data has been collated from 2008/09 going forward until 2013/14. The national coaches collated a regional view of the % of macro milestones achieved and date set to achieve each month.

How did we collect and submit the Qualitative data?

The LTC 6 is a 6 item patient questionnaire **View here.** These measures indicate changes in knowledge, beliefs and perceptions which are necessary to sustain change over time. The Implementation Teams identified 100 patients with LTCs and administer the questionnaire prior to any changes were made to the care model or commissioning model and then repeated 12 months later.

Appendix 2

Defining the Difference between Risk Stratification and Predictive Modelling

Risk Stratification is the task, subdividing the population into risk buckets based on their likelihood of experiencing a particular adverse event in the future

Predictive Modelling is the tool used to deliver that task.

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