



Llywodraeth Cynulliad Cymru
Welsh Assembly Government

Designed to Improve Health and the Management of Chronic Conditions in Wales

An integrated model and framework



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Improving Health and the Management of Chronic Conditions in Wales: An Integrated Model and Framework for Action

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Designed for Life highlights that improving the management of chronic conditions is a necessary and key part of achieving more sustainable, effective and efficient health and social care services in Wales. The Wanless and Beecham reports point to the need for better partnership working and more effective use of resources and the remodelling of chronic conditions management is imperative in our drive towards sustainable world class health supported by a world class health and social care system for all. With trends indicating a growing prevalence of chronic conditions among an ageing population coupled with the legacy of the impact of heavy industry on people's health in Wales it is crucial that action is taken now to improve health and remodel services to deal with the health challenges of the 21st century.

The impact of chronic conditions on people's lives and services in Wales is of growing concern. Wales has the highest rates of long-term limiting illness in the UK accounting for a large proportion of unnecessary emergency admissions to hospital.

This document supports our Community Services Framework and will help us to achieve our goals of improving health and well being across Wales. It sets out where we are now, where we need to go and how we will get there over the next 3 to 5 years. As a mainstream programme of action it aims to ensure that the right services are provided in the right place and at the right time by refocusing services and resources to meet local needs more effectively in partnership with all stakeholders including patients, service users and carers.

Effective health promotion, prevention and self care approaches are integral to this approach. This will help ensure that chronic illness is avoided wherever possible and that people are more informed to manage their health and well being in their own communities and in the context of their everyday independent lives.

Delivering a remodelled system which is fit for purpose for the challenges of today and tomorrow demands strong leadership, courage and determination at all levels. Building upon the work already begun across Wales, such as the Quality and Outcomes Framework, National Service Frameworks and the Expert Patient Programme, and integrating them in a whole system will be key to help transform and improve the management of chronic conditions.

This document signals the beginning of a long term process which is essential providing the strategic approach to systematically drive forward the necessary changes to services across Wales. A proactive, planned and integrated approach combined with strong partnership working and a robust approach to implementation at local, regional and national levels is now required to deliver modern services that are capable of improving the health, well being and quality of life of people living in Wales.

A handwritten signature in black ink, appearing to read "Ann Lloyd", with a long horizontal line underneath it.

Ann Lloyd

Head of Department for Health & Social Services

1. Introduction

1.1 Background

Patterns of disease are changing, with the burden shifting from the young to the old, and from communicable to chronic conditions.¹ In Wales this is of particular significance, where the impact of an ageing, industrialised society compounds the effect, placing even further demands on the health and social care system. This is reflected in increased admissions to hospital, rising waiting times, delays and an over-dependence and reliance on the secondary care system. We know such a trend is predicted to rise, and the need to find solutions, and to change the system of care to manage chronic conditions, is both imperative and urgent.

Living with chronic conditions can have far reaching implications on all areas of life and can have a particularly profound affect on the social life and independence of individuals, their families and other carers. Support is increasingly needed in the areas of employment (supporting return to work), housing, transport, benefits and pensions for example to help people maximise their independence within their own communities. The effective management of chronic conditions does not lie with health alone, but is dependant upon strong partnerships with patients, carers and other service providers such as social services and the voluntary sector. Getting this right is pivotal to the future sustainability of health and social care services in Wales. In moving this agenda forward we need to build on work and partnerships developed to date and generate a real commitment to drive the changes necessary forward. This is not another initiative but a mainstream programme of work to be integrated across service, planning, commissioning and provision.

This paper sets out where we are now, where we need to go and how we will get there monitoring progress over the next 3 to 5 years. It identifies how we can best improve and manage care across the care pathway, the way we work, the systems we operate, roles and responsibilities, and the engagement of people in their own care. It embraces the principles of equality of opportunity (Sections 77 of the Government of Wales Act 2006²) and focuses on public and patient needs, associated risks and the provision of the right care in the right place at the right time, set within the wider context of the social and community settings of their every day life.

1.2 Policy Context

The Health and Social Care policy context is embodied within this work, ensuring better integration, joint planning and working and use of resources to improve the care of those living with chronic conditions.

Designed for Life sets out the strategic framework working towards the establishment of world class health and social care services in Wales over the next ten years. The vision aims to develop the role of local communities in creating and sustaining health. The promotion of independence, service user involvement and clinical and professional leadership are of central importance.³

The aspirations for social care are more fully set out in the complementary document *Fulfilled Lives, Supportive Communities*.⁴ This highlights the importance of developing services which involve people and which work effectively together to meet their needs locally. This also reinforces the need to support active and fulfilled lives using appropriate technology and ensuring the protection of those most vulnerable in our communities.

The Communities Services Framework sets out a strategic vision for integrated community services across Wales in which the chronic conditions framework forms a key central feature.

The Welsh Assembly Government has adopted the social model of disability as the basis for all its work on disability and recognises that disadvantage and social exclusion often stem from barriers in society rather than from an individual's impairments. Service planners and commissioners should be aware that people living with chronic conditions often have impairments that may be hidden from view such as fatigue and pain and that the severity of symptoms of the condition may fluctuate significantly from one day to the next.

The Assembly is committed to achieving high standards across the public service, and its aims and expectations are set out in *Making the Connections*.⁵ This emphasises the need to design and operate services around the needs of the users, not the provider, taking into account all associated risks, and ensuring high quality, easily accessible and responsive services. The implications of this have been set out more clearly in the report of the Beecham review.⁶ Across Wales local government and health care bodies – local authorities and Local Health Boards – have responsibility for the same geographical areas, and therefore the same resident population. They also have a joint statutory duty to produce a local Health, Social Care and well being Plan. Clear working arrangements between a full range of agencies including local authority departments of Housing, Education, Leisure and Transport, and voluntary and independent sector

organisations are essential to help enable people with chronic conditions to live as independently as possible and to realise their full potential.

Considerable progress has already been made in improving the direction and standards needed for the treatment and care of specific chronic conditions. This includes CHD, diabetes, renal and mental health National Service Frameworks (NSF)⁷ and Service Development and Commissioning Directives for arthritis and chronic musculoskeletal conditions, respiratory conditions and epilepsy currently being developed.⁸ NSF's addressing the particular needs of groups such as children and older people also provide an essential basis from which this work will build. It will provide further support with a more generic focus across chronic conditions to ensure that the key common themes are realised and further improvements made.

2. Chronic Conditions – where are we now?

“Having arthritis completely took away the life I had. It took my self confidence and my independence. It may not be a killer disease but it takes your life nonetheless” (Member of Arthritis Care in Wales)

2.1 Faced with a patient with a chronic condition, health professionals tend to focus on the medical management of that condition, ensuring that the right drugs are prescribed, the appropriate tests are undertaken and that advice on adopting a healthier lifestyle is given. Patient’s concerns also include the social, psychological or emotional consequence of being diagnosed or labelled as suffering from a chronic condition. This may include coping with fear, anger, frustration and denial, and also the effect the chronic condition is going to have on their job, relationships and perhaps other caring responsibilities. Helping people to cope with their difficulties and make the most of their lives, by encouraging self management and independence is therefore essential. For people living with chronic conditions and their carers we also know they experience:

- Long waits
- No systematic care plan
- Varying standards
- Being passed from one system to another
- Unnecessary bureaucracy
- Unnecessary treatments and care
- Little understanding of what they should expect from services
- Complex and fragmented services
- Lack of involvement in their own care

2.2 Even the terms are confusing as they include chronic disease, chronic conditions, life-long limiting disease and long-term conditions all of which are used interchangeably.⁹ This document uses chronic conditions as an overarching term.

Chronic conditions are those which in most cases cannot be cured, only controlled, and are often life-long and limiting in terms of quality of life. They can require differing levels of support due to disease progression or the fluctuating nature of the disease and require ways of dealing with them that are often quite different to acute and emergency health care. The differences between chronic and acute conditions are highlighted in table 1.

Table 1: Differences between acute and chronic conditions: ¹⁰

	Acute conditions	Chronic conditions
Onset	Abrupt	Generally gradual and often insidious
Duration	Limited	Lengthy and indefinite
Cause	Usually single	Usually multiple and changes over time
Diagnosis and prognosis	Usually accurate	Often uncertain
Technological intervention	Usually effective	Often indecisive; adverse effects common
Outcome	Cure possible	No cure
Uncertainty	Minimal	Pervasive
Knowledge	Professionals knowledgeable, patients inexperienced	Professionals and patients have complementary knowledge

2.3 The Profile of Long Term and Chronic Conditions in Wales¹¹ clearly identifies the extent of the problem. In summary, we know that in Wales:

- There is a higher proportion of reported limiting long-term illness (23%) compared with England (18%), Scotland and Northern Ireland (20%)
- $\frac{1}{3}$ of adults report having at least one chronic condition
- $\frac{2}{3}$ of over 65 year olds report having at least one chronic condition with $\frac{1}{3}$ having multiple chronic conditions
- $\frac{3}{4}$ of over 85 year olds report having a limiting long-term illness
- Most commonly reported chronic conditions treated in Wales are arthritis (14%), followed by respiratory conditions (13%) and chronic heart conditions (9%)

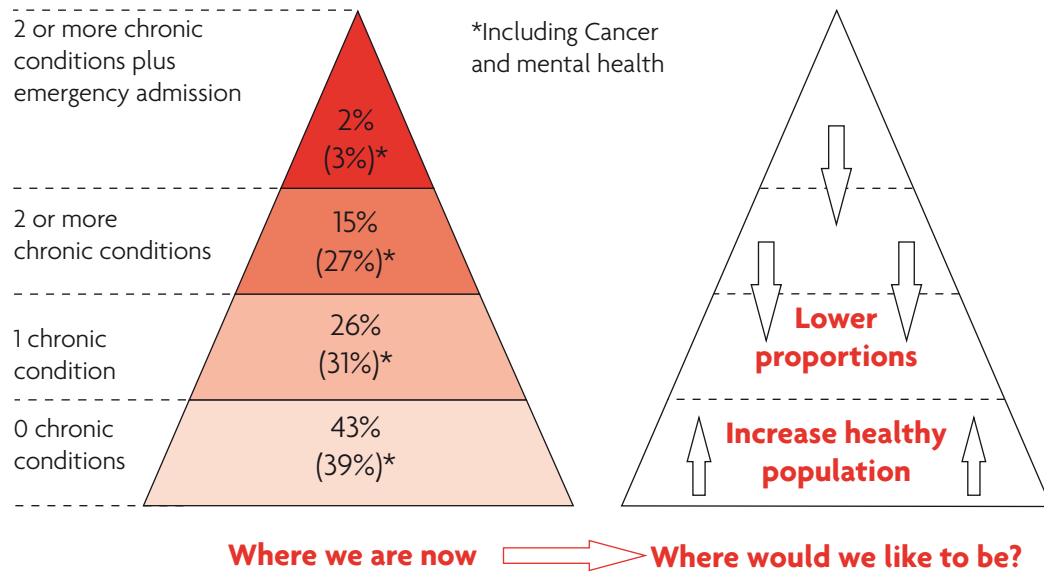
- Considerable geographical variations in reported long term limiting illness have been identified, ranging from 19% in Cardiff to 30% in Merthyr
- Intensive users of in patient services have on average 3 chronic conditions
- It is estimated that there will be a 12% increase in adults with at least one chronic condition and 20% increase in those over 65 by 2014

2.4 Other data from the Quality and Outcomes Framework (QOF) and the Patient Episode Database (PEDW) further reinforce the considerable impact chronic conditions are having on healthcare services. This information will also be supported by the forthcoming Wales Audit Office (WAO) Review which examines the impact of chronic conditions on service provision, assesses the level of service provision currently provided and reviews arrangements with the health and social care community to re-shape services. Preliminary findings to date suggest that there is considerable scope for service improvements and in-patient efficiencies. Further local analysis of this information by WAO and local planners will provide details on where and how resources should be targeted to help best manage the care of people with chronic conditions more appropriately, safely and effectively in the community, consistent with strategic policy directions.

2.5 Current services predominantly react to emergencies, rather than prevent them arising in the first place. We know that of those patients admitted to hospital, 1 in 6 of all admissions and 1 in 4 emergency admissions are attributable to a chronic condition. Many of these admissions are unnecessary, inappropriate and avoidable. These admissions are often as a result of inappropriate care and an inadequate general support infrastructure for people with chronic conditions and their carers in the community.

2.6 We also know that it is often only a small proportion of patients that account for using a large proportion of healthcare resources, including emergency admissions and regular visits to GPs, as highlighted in figure 1 (taken from a study of 5 GP practices in Swansea).

Figure 1: CCM Population Projections for Wales



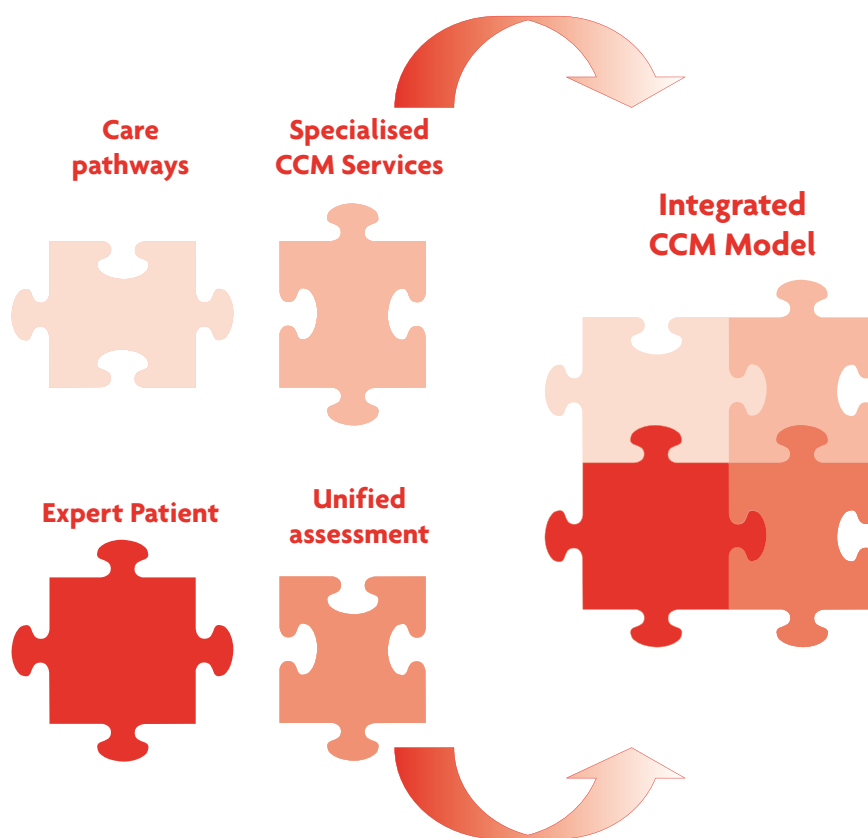
- Total emergency admissions from sample practices, aged 18 and over, to Swansea NHS Trust in 2005 = 2,217
- Top 3% of triangle accounted for 1,301 (59%) of these admissions

Information such as this will help us understand how we can best utilise our resources to ensure that the unnecessary burdens of chronic conditions are, where possible, prevented and managed effectively with our partners to deliver better care in the future.

2.7 Chronic conditions do not exist in a vacuum. In Wales there are currently many existing schemes, initiatives, services and programmes that contribute to the management of chronic conditions. These include Unified Assessment, National Service Frameworks, specialist nurse services, Expert Patient Programme (EPP), social services care management and care pathways. However, these often run in a fragmented and uncoordinated way (figure 2), are not always linked or mainstreamed into core services, and are sometimes dependent on the goodwill or enthusiasm of one or two people. In some cases we have seen evidence of duplication of services where roles and responsibilities overlap, and sometimes where clear gaps in patient care emerge.

We are not always fully utilising the total resources at our disposal to best effect, whether the patients themselves or those within the statutory, voluntary and independent sectors. This must change, but not in a fragmented way – in a clear, coordinated and consistent way. We must break down traditional organisational and professional boundaries and ensure our services are planned within a seamless whole system. This integrated model and framework for managing chronic conditions will help set out the foundations to achieve this, bringing together the skills and expertise from individuals and organisations across Wales to enable this to happen.

Figure 2: From fragmentation to integration



3. Where do we want to be?

3.1 In Wales we know what we want. We want to have world class health supported by a world class health and social care system for all. We want where possible, to prevent or delay chronic conditions arising and, where they do arise, ensure that they are managed in an integrated way with patient and carer involvement. This should maximise their quality of life and maintain as far as possible a normal pattern of life within their community.

We want to ensure that the needs of individuals, particularly those from more vulnerable groups, are recognised and met. This includes both core needs (such as housing, financial and social support) and more specialist care needs which are identified and coordinated in a simple and efficient system, building on schemes such as unified assessment, new developments in IT and other technologies, and more integrated multidisciplinary team working.

We want to give individuals the skills and support to help manage their conditions within their local communities. We need an outward-looking culture in which the holistic well-being of all patients and their families is the driving force, irrespective of the organisation, the professionals concerned or their social standing.

Rebalancing services to address this will mean more than relocating care and treatment closer to home, from the acute to primary and community settings. To be successful it will require a whole systems focus and a change in approach, working in partnership with all stakeholders. This will move away from task-focused work to engagement with the individual, family and other significant carers, working within the home and the local community. This provides an opportunity to draw on additional capacity and expertise, not just from family and friends, but also from a wide range of voluntary and self-help groups. These provide a range of support services and add value by maintaining inclusion in social activities in the community.

A focused, integrated approach to chronic conditions is central to achieving this.

3.2 The following sets out the challenge, aim and objectives for the work and provides a basis to determine what needs to be done and to monitor progress.

Long-term challenge - to improve health and well being and reduce the incidence and impact of chronic conditions and the inherent inequalities that exist across Wales

Aim - to improve prevention, detection and management of chronic conditions locally, through an integrated, holistic approach, based on targeted, proactive population management, supported by care pathways self-management and community support.

The objectives are based on improving health and well being and care and support as well as the systems and processes to achieve this. Each of these will have a set of baseline data against which progress towards achieving them can be monitored (See paragraph 5.4)

Objectives

- Improve healthy lifestyles and well being in the community
- Prevent and delay the onset and early deterioration of chronic conditions
- Improve the quality of life for people living with chronic conditions
- Reduce the impact of chronic conditions on secondary care and care homes
- Increase self management, independence, and the participation of people with chronic conditions and their careers
- Improving the quality of patient care closer to home
- Improve prescribing and medicines management
- Reduce health inequalities and improve economic activity

3.3 Key Principles

The following key principles underpin the basis for an **Integrated Model and Framework for Action for Chronic Conditions in Wales**:

- **Health improvement interventions** underpinning the prevention and holistic management of chronic conditions including wider health determinants. It is at this stage that chronic conditions may be prevented or delayed and, even as they develop, secondary and tertiary prevention continues to play an important role in improving the quality of life of those living with these conditions.
- **Early identification and appropriate treatment and support** for individuals to maintain healthy, active lives. When care and support is necessary, people's chronic conditions are identified and dealt with as early as possible and in the most appropriate place and way, to help avoid unnecessary complications arising and to sustain well-being.
- **Supporting independence through self care and self management** are essential if we are to achieve more sustainable health and social care. Engaging the patient in their health and social care and supporting self management through education programmes such as the Expert Patient Programme (EPP) and other support mechanisms, can help people manage their conditions, reduce symptoms and make better use of health services.
- **Proactive and planned population management** across all 4 levels of the model to ensure that the right care and support is identified and services delivered at the right place and in the right way and by the right people, with the active engagement of carers and patients. Actively assessing need, managing risks, planning and managing care and coordinating services with all key partners is fundamental and will need good communication and information systems to commission accordingly. The specific needs of vulnerable and minority groups should also be planned and integrated into service delivery.
- **Graduated and integrated services** will need to be planned, commissioned and coordinated to meet the needs of individuals and carers, according to clear quality standards and care pathways. Where appropriate services may need to be clustered to meet collective needs dependent upon local circumstances and other risk factors. Multidisciplinary teams, jointly-commissioned health and social services, shared care, workforce developments and new roles in the community will all be needed to ensure seamless and effective services

for patients across the pathway. The Health Act (1999) Increased Flexibilities provides further opportunities to take this forward. Services will need to make use of the latest assistive technology such as telehealth and telecare and specialist equipment as well as existing resources which may need to be re-focused to reflect changing needs.

- **Clinical leadership, shared culture and commitment** by all involved is crucial in supporting and sustaining the transition to make this approach work. Planners, commissioners and managers will need to identify and actively engage clinical leads to help ensure that this work is driven forward, commissioned and delivered effectively.

4. What do we need to achieve this?

4.1 We need to develop a clear, consistent evidence-based approach to chronic conditions management (CCM). In this the individual and their families or carers, not the system or processes, are the focus and are empowered to manage their condition. This will need to be supported by a range of tools to help support individuals, manage the data and consolidate best practice as well as a planned and structured programme of work to support its delivery locally.

The Welsh Chronic Conditions Model builds on evidence and developments to date from across the UK and internationally, drawing from the “International Overview of the Evidence on Effective Service Models in Chronic Disease Management” (2006).² This review outlined the most important elements in achieving improved outcomes for people with chronic conditions, and the following key elements appeared consistently:

- Broad managed care programmes
- Targeting high risk people
- Sharing skills and knowledge
- Patient and carer involvement in decision making
- Self management education
- Self monitoring, telemedicine and telecare

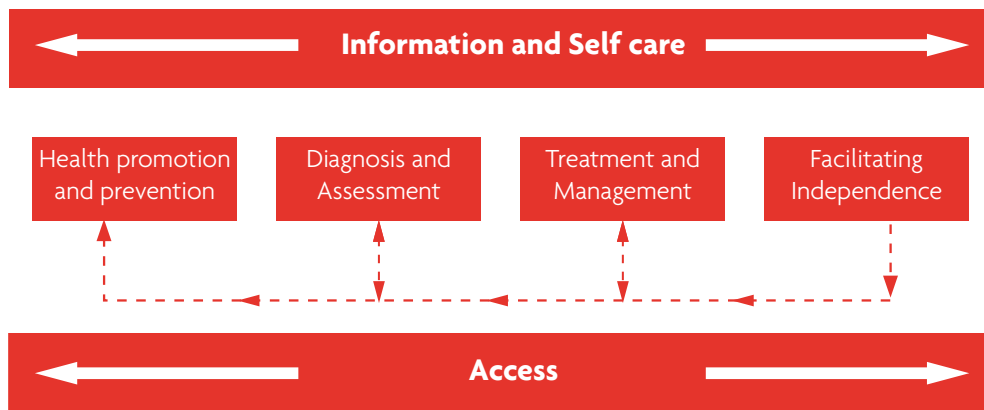
The evidence also supports effective and targeted prevention, care and support in managing chronic conditions in the community. It recognises that different strategies and levels of care are necessary to prevent conditions arising or deteriorating and to meet the changing needs of people as the complexity of their chronic conditions develop and evolve.

The Welsh Chronic Conditions Model has been designed to focus on the needs of individuals and where possible to prevent or delay chronic conditions arising. For those living with conditions they should be supported and treated within their own homes or local communities, ensuring that the movements and transactions between primary, secondary, acute and social care are managed and monitored efficiently across the care pathway (figure 3).

The strategic pathway of care, which was informed by patients, identifies a number of common themes where the needs and support of individual conditions will vary and change in time. The Assembly is currently producing a series of condition-specific Service Development and Commissioning Directives based on this approach (Arthritis and Chronic Musculoskeletal, Respiratory, and

Epilepsy) which brings together established evidence from NICE, and other professional and expert bodies within this wider context.

Figure 3: Strategic pathway of care



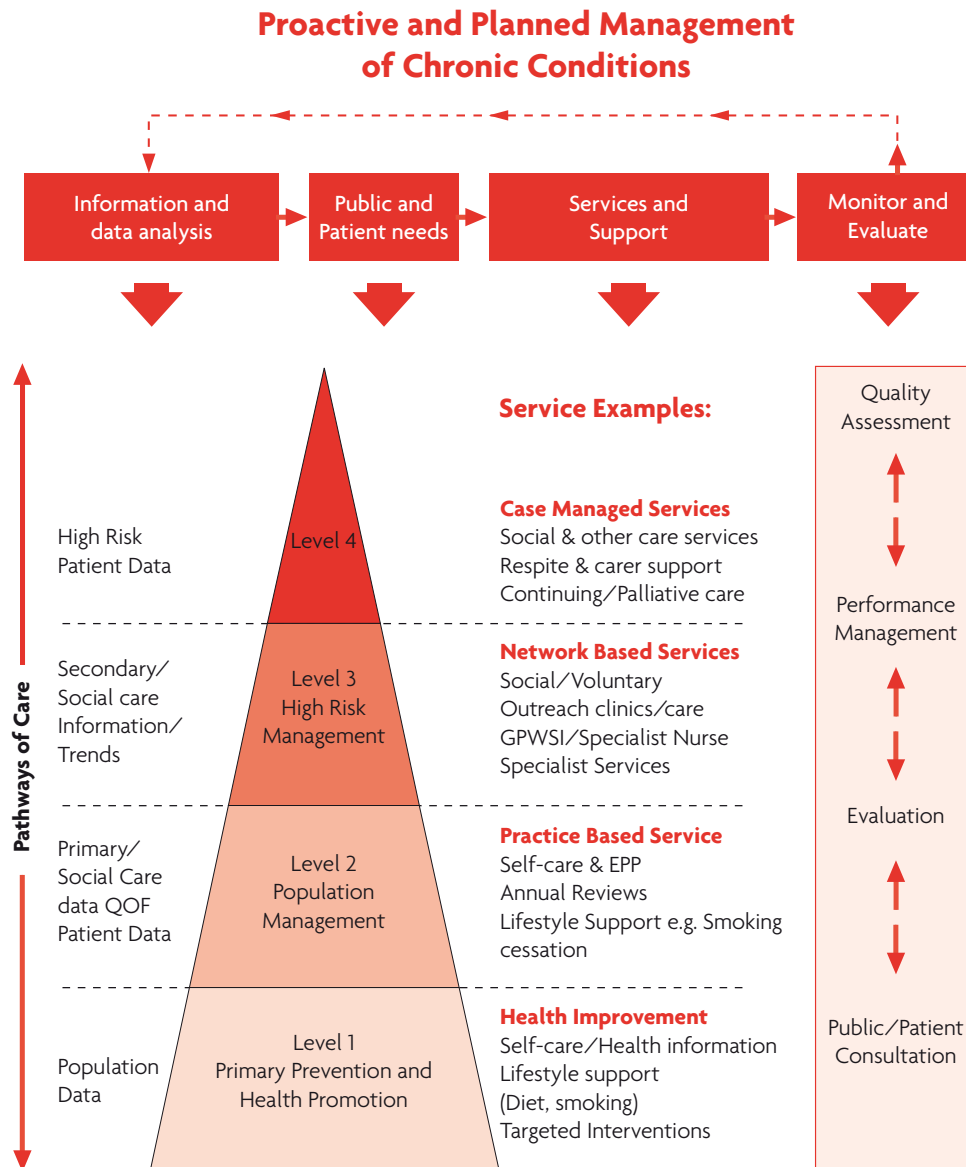
4.2 The Welsh Chronic Conditions Model (Figure 4) builds on other similar models, but in addition includes the prevention of illness as an integral element. It also recognises the need for a **planned, proactive, integrated and managed approach** drawing from many disciplines and acting simultaneously across all four levels.

This model is based on a population approach to CCM and allows a clearer basis from which to plan, coordinate and commission services and support. It identifies 4 levels of care to ensure that services and support are targeted and managed effectively, according to increasing risk and care needs, proactively identifying those at risk of moving across each level (1-4). Intervening appropriately will help prevent unnecessary problems arising and in some cases chronic conditions developing.

Planning and managing the care and support needed for more vulnerable and minority groups will need to be addressed in a focused and targeted way integrated with mainstream service delivery.

The Model (Figure 4) illustrates increasing levels of care as health risks increase. At each level there are a range of specific services or interventions provided by a range of services either already currently available or which could be developed to meet individuals' needs. It also illustrates the type of information required to help measure the prevalence and impact of chronic conditions in the population, identify need and plan services and monitor the quality of care provided.

Figure 4: The Welsh Chronic Conditions Model



The following summarises what each of the levels include, based on patient perspectives and illustrated with specific case studies:

Level 1: Primary prevention and health promotion

- Strong infrastructure to promote healthy lifestyles across communities
- Promotion of :
 - Healthy eating
 - Exercise
 - Smoking cessation
 - Weight management
 - Moderate drinking
 - Social inclusion
 - Healthy environment including work places and homes
- Promotion of shared responsibility to maintain health and well being
- Where appropriate, early diagnosis through screening

Level 1 Example

People identified at risk of chronic conditions - whole population and all ages. Some specific groups may be targeted as having higher risk factors including:

- **Children**
- **Ethnic Minorities**

Some people may be targeted as having specific risks for a range of reasons including:

- **Family History**
- **Areas of Social Deprivation**

e.g. Overweight male smoker with family history of heart disease attending smoking cessation group and undertaking exercise referral for help and support to stop smoking and reduce weight, to help reduce longer term health risks.

Level 2: Population management: 'Practice based' CCM Programme

- GP 'practice-based' services, built around the new General Medical Services (GMS) Contract with registration of patients
- Targeted information, monitoring and proactive management
- Referral to Expert Patient Programme (EPP), other self management programmes and voluntary sector services (such as Diabetes UK), and to national screening if appropriate (such as diabetic retinopathy screening)
- Early identification, assessment and diagnosis of chronic conditions and factors impacting on these such as housing
- Support to ensure effective active self care and management of their conditions at home or in the care settings in which they live
- Secondary prevention to ensure complications are prevented, slow down deterioration and help avoid further chronic conditions arising
- New forms of housing such as extra care housing and housing with Telecare to enable people to remain in their own homes longer

Level 2 Example

People in early stages of chronic conditions who can have their disease progression delayed by good management, education and empowerment.

e.g. Newly diagnosed diabetic or asthmatic given lifestyle advice and attending an Expert Patient Programme or diabetes education programme.

Regular reviews in general practice by an appropriately trained nurse.

Patient held records to identify and share own treatment goals.

Level 3: High Risk Management: 'Network based' CCM services

- Services provided at "network" level for patients at high risk, depending on locally developed plans
- May include services for patients with failure of 'control' (e.g. deteriorating blood tests) at level 2, or requiring new intermediate type services (e.g. diabetic or other specialist, physiotherapist, occupational therapist, investigations – e.g. echocardiography, GP with special interest (GPwSI) services)

- Services may be provided in community-based facilities, hospitals, other health centres / clinics, or in individual GP practices on behalf of the network
- Proactive / multi-disciplinary assessment and management of high risk patients coordinated using registers and other electronic aids
- Clearly defined evidence based care pathways
- Tertiary prevention to help manage deterioration and further complications
- Effective use of information systems (QOF patient registers, electronic records) health and care technologies and joint health and social care assessment (unified assessment) and care planning
- Referral to specialist services to help manage their condition at home
- Patient held management plans
- Engagement and support of carers in line with the provisions of the Carers (Equal Opportunities) Act 2004 ¹³

Level 3 Example

People who are beginning to have their everyday life impacted on by their condition, and those who have had one or more admissions to hospital that needs to be planned against for the future.

e.g. Patient with COPD struggling to walk to local shop, lacking in confidence, and frightened when breathless - needs education, support and attendance at pulmonary rehabilitation classes. Patient held management plans for early intervention at the beginning of exacerbation.

Level 4: Case managed services

- Holistic case assessment based on Unified Assessment principles
- Case management of complex high risk case with care coordinator
- Identification of complex cases because of historic service uptake (frequent admissions) or on the basis of additional patient risk assessment (multiple conditions and frailty), and needing multi-sector assessment etc
- Managed by an identified care co-ordinator for holistic cross agency assessment (unified assessments) and targeted, integrated health and social care management including housing, and social services

Level 4 Example

People requiring frequent admissions for one or more chronic condition. Often one disease receiving priority but others are causing management complications.

e.g. Heart failure patient with reduced appetite repeated hypoglycaemia episodes which require hospital admissions or intervention from emergency services. Patient needs coordinated multidisciplinary care package to prevent emergency situations that may lead to admission

4.3 Services and Support will need to be planned and coordinated across a range of providers in health, social care the voluntary and independent sectors. Joint packages of care, new joint roles and joint services will play an important part in meeting the changing needs of individuals and carers in an integrated and seamless way. The Health Act Flexibilities provides further opportunities to enable this to be progressed. This also includes services required to support self management and independence such as the Expert Patient Programme and voluntary sector support schemes.

Services will need to be designed along clear patient and care pathways taking account of co-morbidities and ensuring that cross cutting services such as pain management and palliative and end of life care are in place. Services will need to be commissioned both at an LHB/local authority and regional level clustering services where appropriate, building on clinical networks such as the cardiac network, sharing skills, expertise and knowledge in the most effective way. The

Commissioning Framework provides further directions on how this may be achieved.

4.4 Identifying and collating key baseline data and information is crucial for informing the planning and delivery of effective services for chronic conditions, aligning services accordingly and monitoring progress. Understanding the profiles of chronic conditions across GP practices and stratifying the practice population across the levels aligned to different levels of care services is important. This is a prerequisite in aligning current services and identifying gaps in provision to inform the commissioning process.

Data on local population health status, disease prevalence, service provision, such as admissions and referral data in both health and social care systems will help determine population needs and inform how local services should be coordinated. The QOF data will form an important source of data enabling this to take place. Other social, hospital and pharmaceutical data will also be needed to give an overall picture and provide the basis for ongoing monitoring and evaluation.

4.5 Proactive and planned management across all 4 levels at practice population locally will be essential. Commissioners will need to ensure that information is used to assess the local population needs at each level and coordinate, manage and monitor local services to meet these at GP practice population level (based on an average 30 - 50,000 population).

A designated Chronic Conditions Care Coordinator working closely with practice teams, local authority social services and their localities would help:

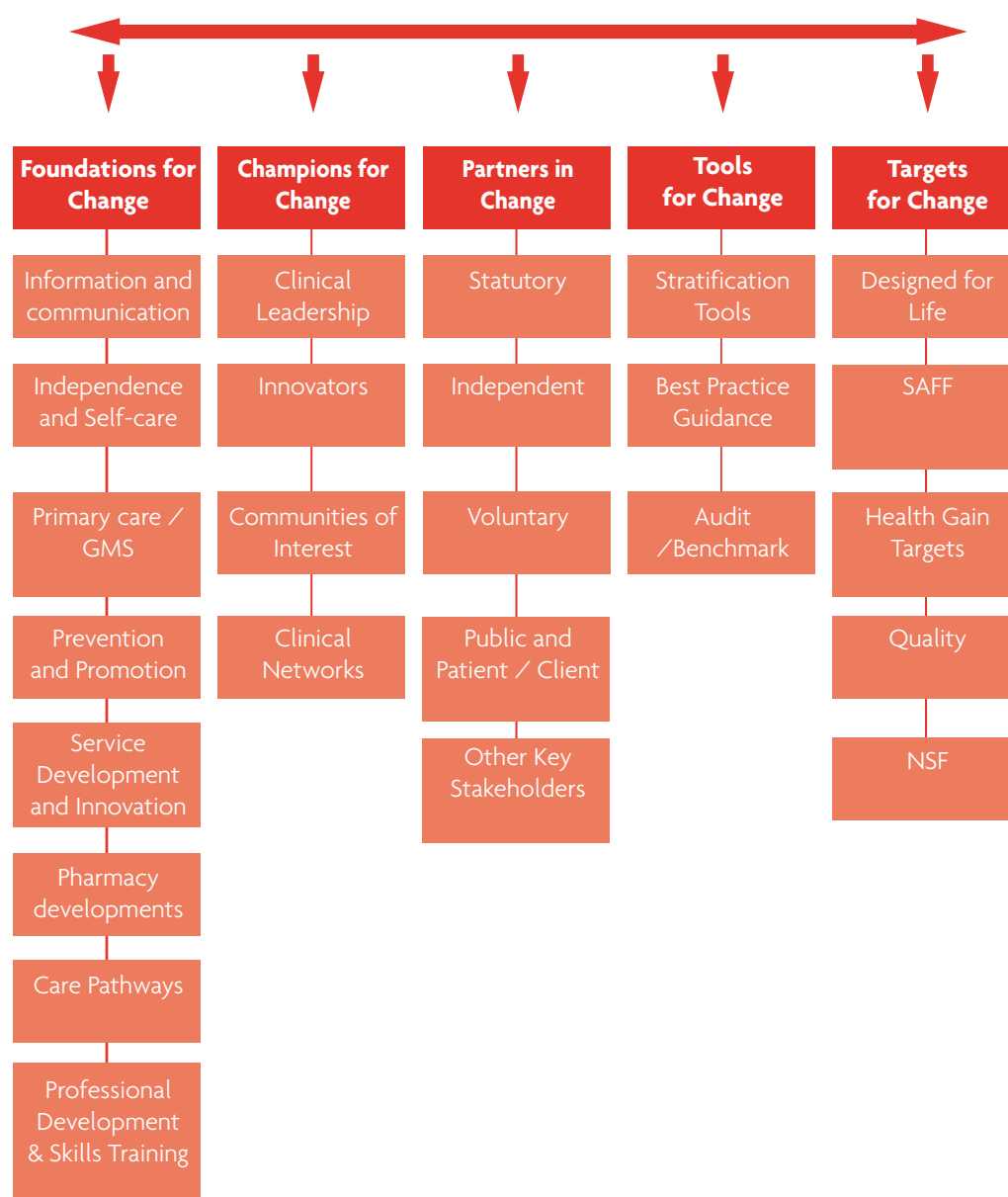
- Stratify practice populations across the 4 levels
- Identify, plan and coordinate services to meet the needs at each level
- Liaise with patients, carers and service providers from private, voluntary statutory and independent agencies
- Monitor patient progress and service delivery across primary, secondary and social care
- Coordinate primary care collaborative networks and networked services
- Advise on the commissioning of chronic conditions services

This will help ensure that the right care and support is delivered at the right place and in the right way, according to clear care pathways and protocols and making use of the latest technology. It will help ensure most effective use of existing joint resources available.

5. How do we take this forward? – A Framework for Delivery and Strategies for Action

Achieving the CCM objectives will require concerted action across a number of fronts to improve well being, care and the systems and processes supporting this. It will need careful planning of services to ensure firm foundations are set to move away from ‘initiatives’ towards a permanent programme of work fully integrated within mainstream service delivery and making effective use of all resources available. Action will be needed to build on existing work, strengthening partnership joint planning and shared resources. Developing tools and mechanisms to share expertise and identifying champions to support implementation and maintain momentum for change will be essential (Fig 5).

Figure 5: Chronic Conditions Management Framework for Delivery



5.1 Foundations for Change

A number of key themes drawn from both research and practice have been identified as essential to underpin the implementation of the model. These 8 elements have been explored in further depth by multidisciplinary Task and Finish Groups which have scoped current evidence and practice in Wales, and have identified gaps and opportunities for future development. This work will help strengthen links between key elements of existing work and will form the foundations for delivering the key objectives identified. Issues of social inclusion have also been recognised as a core theme across this work influencing risks and the ability to engage with local communities and in self care. Future planning and commissioning for chronic conditions management will need to take account of and promote social inclusion.

Further details of the key papers and actions identified at local and national levels will be published within a more detailed implementation plan. In summary they include:

▀ **Prevention / Promotion**

A number of health promotion programmes are already in place across communities in Wales, supporting and promoting better health and well being, including Health Challenge Wales.¹⁴ They include a range of Wales-wide and local interventions encouraging healthier eating, exercise and smoking cessation as well as targeted programmes addressing the needs of disadvantaged groups. We need to ensure that future programmes and services are effectively targeted at meeting the needs of local communities across all levels of the triangle both in preventing illness and in helping support the quality of life of those living with chronic conditions.

▀ **Independence and self-management**

A large proportion of care for people living with chronic conditions is provided through self care by individuals, their carers and local communities. Greater emphasis is needed to identify how we can actively involve local people and patients in their health care. We need to support independence and self care in a holistic way, with support from individuals and agencies including housing, social care and employment, as well as services provided by therapists and other health professionals. The impact of wider environmental change should also be addressed ensuring that barriers to independence are reduced wherever possible. This should be as far reaching as improved access to appropriately equipped public transport, improved housing conditions,

increased community safety, better road safety and injury prevention activity for example.

Primary care teams will have an increasing role in supporting independence, working in close partnership with the voluntary sector and building on developments to date. Schemes and initiatives to support independence include the Expert Patient Programme (EPP), condition-specific education such as the diabetes DAPHNE or DAFYDD programmes, Telecare and Telehealth, Want 2 Work and Care and Repair. These programme can make significant improvements to people's lives and by maximising independence can help reduce visits to GPs, outpatient visits, A&E admissions and hospital admissions¹⁵. These help people with chronic conditions and their families and carers to develop the skills and confidence to self-manage, remain independent and where appropriate return to work.

► **Training and professional development**

Training and workforce planning will need to take account of the projected demands and skills needed in supporting better chronic conditions management. Delivering improvements will require the development of new and joint roles, innovative practice, and working across traditional organisational and professional boundaries. Roles and responsibilities will need to be clearly defined, the skills of the voluntary sector fully utilised and carers support needs addressed. Commissioners of services will need to work in partnership with the Welsh Assembly, NLIAH and the Workforce Development Education and Contracting Unit to take this forward within the context of Designed to Work: A workforce strategy to deliver Designed for Life.¹⁶ The development and training needs of professionals, patients and carers will need to be identified and addressed. This will need to include NVQ, undergraduate and postgraduate training and skills development to enhance more specialist skills to support delivery. Skills to support people caring for themselves and for others are also important. This will need to ensure that everyone has the abilities and information necessary to support its delivery in practice building on the work of Skills for Health.¹⁷

► **Information and communication**

Effective communication and information systems form the basis of good service delivery and patient care in managing chronic conditions in the community. Identifying information needs, accessing and analysing relevant data and using this to plan and commission services will need to be strengthened. We also need to ensure that information for the public,

health and social care professionals, carers and patients is seamless, easily accessible, reliable, consistent and informative. This includes the effective transfer of patient information across primary, secondary and social care as well as ensuring that the basic one-to-one communication needs of individuals are also addressed. National services such as NHS Direct and local information services, whether voluntary or statutory, should identify opportunities to link and build on collective information and skills.

▸ **Pharmacy Development**

The correct administration and use of medicines is integral to good chronic conditions management and community pharmacists play an important role in supporting this. This includes improving medicines management, providing front line information and support for better prescribing in a community and acute setting and supporting hospital discharge. Identifying how the pharmacy contract and other developments such as enhanced services could support better patient care will need to be examined.

▸ **Primary Care Team / GMS contract**

The primary care team plays a pivotal role in supporting chronic conditions management. It is at the heart of local communities and is often the first contact point for people diagnosed with chronic conditions. The extended primary care team and its links with social care organisations will be central to the delivery of effective chronic conditions management. Opportunities to build on developments such as enhanced services and other progress to date will need to be considered. This includes QOF and the population management of CCM, integrated and specialist services and the role of GPwSI and nurses with special interest (NwSI). Social work support and the wider support of voluntary services, will also ensure that all skills and resources are appropriately used to deliver holistic care and support for people living with chronic conditions.

▸ **Service Development and Innovation**

Service development and innovation, building on evidence of effective service provision and local practice is essential. We need to build on innovations to date, share best practice and ensure it is integrated within mainstream service delivery once proven to be effective. Innovation is often less to do with novel or unique solutions than new approaches to analysing and resolving problems. Service provision will need to be reviewed in light of needs across each of the levels. Joint service

provision and planning is necessary to ensure the best use of all resources across primary, community and social care. An innovative approach to service provision depends on a number of factors, not just the quality of the innovation. Appropriate leadership, skills and culture are also vital. Improved and new technologies through schemes such as telecare and telehealth offer opportunities for improving the management of chronic conditions which need to be further developed.

► **Care Pathways / protocols**

The need to ensure clear, consistent and accountable processes in supporting chronic conditions care has been long accepted. Many health communities have developed a range of patient and integrated care pathways to support this in practice. We need to take stock of progress to date and identify the next steps and tools needed to improve care across the pathway with all partners involved. Particular attention will need to be made in supporting this across the extended primary care and social care teams.

5.2 Champions for Change

A coalition of champions and local innovators will need to be identified and supported to lead the change. The programme will actively seek to identify innovative leaders in the field to help demonstrate the approaches taken and achieved outcomes. The partnerships and innovation forged through the development of the Health Social Care and Well Being Plans to date should be built on to ensure that the wider environmental changes such as better access to transport and adapted housing, are integrated and shared across Wales. Managers, and clinical leaders and local champions will need to work collaboratively by planning across health and social care to make this a success. The voluntary sector, carers and those living with chronic conditions will also play an important part in championing new approaches and solutions. Key partners that can also help to champion and influence the wider environmental changes across Wales to support the independence of people with chronic conditions and daily disability, should also be fully engaged in driving this agenda forward.

5.3 Partners in Change

The engagement of all key partners has already begun. The combined focus and coordination of resources, skills and expertise across Wales will ensure we have the best chance of success. This includes all statutory health and social care agencies as well as their formal representative bodies. This work will also help focus the work of other organisations such as the National Leadership and Innovation Agency for Healthcare (NLIAH), Informing Healthcare (IHC), National

Public Health Service (NPHS), the Wales Centre for Health (WCH) and the Social Services Improvement Agency (SSIA) towards the key objectives as well as actively engaging with health and other professionals, the voluntary sector and local people living with chronic conditions. Harnessing the commitment of local Health, Social Care and Well Being partnerships will also be a key prerequisite for integrating and improving the management of people with chronic conditions locally.

5.4 Tools for Change

A number of developments are already underway to help support the delivery in practice. The Assembly is working closely with the NPHS to help develop a consistent core baseline data set to help inform progress towards the objectives. This will ensure that a common set of information is being used nationally and locally to help monitor progress and help evaluate the outcomes and progress.

Work is also being taken forward to develop a CCM stratification tool across the 4 levels. The NPHS and IHC are developing a system that best fits the needs in Wales, taking account of the vehicle by which this may be most easily applied in practice. The need to consolidate and share best practice has been identified. Future work will include the development of a resource and support mechanisms which brings best practice and guidance together to continue to improve service delivery.

5.5 Targets for Change

A number of targets which contribute to better chronic conditions management already exist. These include Service and Financial Framework (SAFF), Designed for Life, health gain and quality standards. Some of these are disease-specific and others relate to service delivery. Designed for Life identified a number of milestones relating to chronic conditions including the remodelling of chronic conditions services within an integrated framework. The local government performance measurement framework includes social services performance indicators for specific service user groups. Further work will be undertaken to help consolidate, align and update these for all organisations involved.

6. Chronic Conditions – what next?

6.1 Creating Commitment and Momentum from all involved, at both local and national levels is essential. This has already begun in Wales and will need to be reinforced through local Health Social Care and Well Being Partnerships and other collaboratives. We must build on this, strengthening coordination, sharing developments and expertise to date and planning the next steps. The Assembly will help support and drive this work forward with its partners, focusing developments and delivery in a more integrated way. We will bring together and share the skills, resources, knowledge and expertise across Wales, locally and nationally, from patients to professionals. We will help people to help themselves.

We will work through the Regional Offices (of the Department of Health and Social Services of the Welsh Assembly Government) to support this and use the expertise of NLIAH to facilitate Communities of Interest and other appropriate mechanisms to share and communicate progress. We will work actively with key partners such as the Welsh Local Government Association and Directors of Social Services. We will create a climate in which good management of chronic conditions is made easy and is central to healthcare delivery, not the exception. Engaging all partners in change is essential – professionals, carers, patients and the public – in supporting this. We will identify champions to help lead the way and develop tools to support change. Targets will be reviewed and aligned to ensure they support and enhance the momentum for change. Incentives, rewards and recognition will also form an important vehicle for driving and maintaining the momentum for change.

6.2 Commissioning and Networking Change underpins the next steps in driving this work forward. More effective and targeted commissioning for CCM across care pathways and the 4 levels of care is essential. This work is part of a wider improvement agenda and will enable more flexibility and collaboration regionally for more specialised services. It will also encourage joint commissioning locally across shared services. Key levers and incentives to help achieve the programme vision will need to be considered. Workforce planning will also need to be considered and take account of projected needs and demands on resources across the health and social care portfolio. This will be consistent with the workforce planning strategy *Designed to Work*.¹⁸

Clinical and commissioning networks will play an important role in supporting this work as will the involvement and views of local people and those living with chronic conditions. Mechanisms to encourage involvement of service users, carers and local people will need to be established to support service development and delivery. This may be in the form of Local Service Development Advisory Groups (LSDAG) or other appropriate mechanisms.

6.3 Monitoring Progress and Evaluating Impact: Monitoring and evaluating the impact of the Chronic Conditions Framework locally and nationally over the next 3 to 5 years will be important. Measuring progress against objectives, learning from others and identifying any changes that may be needed will help ensure we continue to learn from our combined efforts and keep us focused on achieving our objectives (Appendix 1). An evaluation Framework to support this across Wales will be developed by the Wales Office for Research and Development (WORD) and its wider research networks, providing a consistent and coordinated basis for monitoring and benchmarking progress.

The core objectives provide the baseline information from which clear outcomes and outputs can be evaluated. A common baseline data set drawing from QOF, primary, secondary and social care data, other voluntary and independent sectors and patients themselves will be developed to help ensure a full and consistent picture of progress.

This work will complement the quality requirements consistent with the Healthcare Standards for Wales¹⁹ addressing patient, clinical and operational requirements.

A more detailed national implementation plan based on the evidence and feedback from the 8 sub groups will be produced by the Welsh Assembly Government to inform the next steps. The following Framework (table 2) outlines more broadly the actions needed to take this forward and monitor and measure performance. Once more precise baseline data has been established further details will be provided.

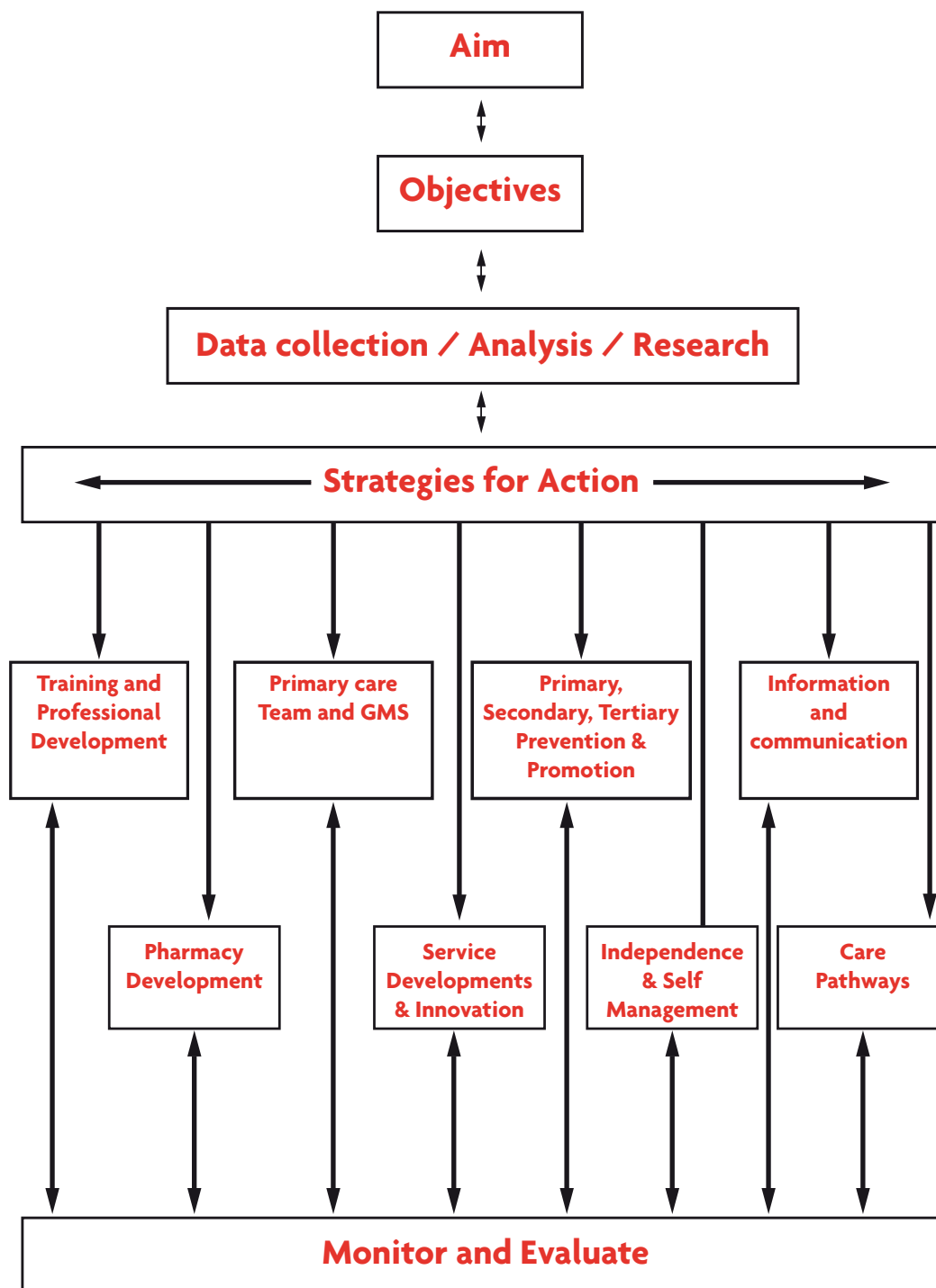
Local Action Plans for CCM will need to be produced by LHBs in partnership with all key stakeholders. These will outline in more detail the actions needed to achieve the objectives on a local basis.

Table 2: Framework for Local Action Plans

	SYS2007/2008 YEAR 1 BY 1/4/2008	2008/2009 YEAR 2 BY 1/4/2009	2009/2010 YEAR 3 BY 1/4/2010
INFORMATION AND COMMUNICATION BASELINE WORK	<ul style="list-style-type: none"> ▪ Baseline data established and analysed locally and nationally ▪ Primary / Community Care Services scoped and reviewed ▪ Local CCM plans developed 	<ul style="list-style-type: none"> ▪ Baseline data stratified and integrated into practice commissioning process ▪ New services commissioned to meet the needs 	<ul style="list-style-type: none"> ▪ Baseline data used routinely to monitor and evaluate progress and inform future needs
SYSTEMS / MANAGEMENT	<ul style="list-style-type: none"> ▪ Systems established to monitor and evaluate management of CCM 	<ul style="list-style-type: none"> ▪ Evidence of planned and commissioned integrated services across 4 levels e.g. case management; specialised services; self-care and prevention. programmes 	<ul style="list-style-type: none"> ▪ Evidence of improvements on service delivery and patient care
INDEPENDENCE AND SELF CARE MANAGEMENT	<ul style="list-style-type: none"> ▪ Self management and self care needs identified ▪ Plans and resources identified 	<ul style="list-style-type: none"> ▪ A range of self help/care services commissioned to support patient needs and in place, including Expert Patient Programme 	<ul style="list-style-type: none"> ▪ Evidence of increased self care and management services and impact on service delivery
PRIMARY CARE	<ul style="list-style-type: none"> ▪ Identify and engage clinical leaders involvement in Local Action Plans 	<ul style="list-style-type: none"> ▪ Commissioning arrangements to support PC collaboration and networked services 	<ul style="list-style-type: none"> ▪ Evidence of improved performance and patient care ▪ Develop reinvestment schemes

SERVICE DEVELOPMENT AND INNOVATION	<ul style="list-style-type: none"> Identify and test opportunities to strengthen and improve primary and community services for CCM including telehealth and telecare, specialist services and direct access 	<ul style="list-style-type: none"> Service developments implemented Successful innovative approaches integrated into mainstream health and social care services 	<ul style="list-style-type: none"> Evidence of improved Service delivery and innovation
PHARMACY DEVELOPMENTS	<ul style="list-style-type: none"> Local medicines management review undertaken and development plans produced 	<ul style="list-style-type: none"> Local action plans implemented to improve medicines management Evidence of improved medicines management 	<ul style="list-style-type: none"> Evidence of improved medicines management
PREVENTION AND PROMOTION	<ul style="list-style-type: none"> Primary and secondary prevention activities mapped and reviewed Integration of programmes across the care pathway 	<ul style="list-style-type: none"> Monitoring and implementation of prevention programmes across the 4 levels 	<ul style="list-style-type: none"> Evidence of impact of quality of life, healthy lifestyles and wellbeing
CARE PATHWAYS	<ul style="list-style-type: none"> Development and implementation of ICPs across CHD, COPD and mental health. Scope wider evidence and impact of care pathways, protocols and systems support 	<ul style="list-style-type: none"> Identify plan and commission pathway development needs based on review findings. 	<ul style="list-style-type: none"> Implement care pathway programme across Wales. Evidence of impact identified.
PROFESSIONAL DEVELOPMENT AND SKILLS TRAINING	<ul style="list-style-type: none"> Review of skills training and workforce development needs to ensure a CCM and actions needed 	<ul style="list-style-type: none"> Implement key actions identified to meet needs 	<ul style="list-style-type: none"> Evidence of and impact on improved patient care

Figure 6: Evaluating the CCM Framework



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Appendix 2

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