



Llywodraeth Cynulliad Cymru
Welsh Assembly Government

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

Service Improvement Plan 2008-2011

January 2008



CCM Service Improvement Plan

Contents

	Page
1. Summary	5
2. Introduction	8
3. Background	9
4. What do we want services to look like?	11
5. Core CCM principles	15
6. The core CCM team	16
7. Delivering better CCM services - Key steps	18
8. Monitoring implementation and progress	21
9. Service Improvement Maturity Matrix	23

1 Summary

1.1 The delivery of co-ordinated, comprehensive and consistent Chronic Conditions Management (CCM) services in the community is not another initiative, but an integral part of effective mainstream service delivery in the community. This is a key Ministerial priority, the basis of which has been drawn from international evidence and published in *Improving Health and the Management of Chronic Conditions in Wales: An Integrated Model and Framework for Action*.

1.2 Services are currently unsustainable with an over-reliance on traditional, and often inappropriate, models of care; action is needed to ensure all resources in the community are used to best effect to prevent admission to hospital, to support better care and self-care within the community. Action to improve community services is necessary if we are to provide high quality services for sustainable primary and community-based models of care.

1.3 Improving CCM across Wales will depend on good planning and management in partnership with all stakeholders and will be closely monitored over the next three years.

1.4 A **proactive, planned and integrated approach** will need to be demonstrated, based on anticipatory care and evidence-based interventions.

1.5 The improvements needed are extensive and complex. The purpose of this CCM Service Improvement Plan is to help clarify the actions needed to implement the CCM Model and Framework,

improving prevention and the care of those living with chronic conditions. It sets out a new vision for CCM services in Wales.

1.6 LHBs in partnership with all stakeholders will need to produce a three year CCM local action plan to guide and support the progression towards achieving better CCM in local communities.

1.7 The CCM Service Improvement Plan for Wales aims to:

- integrate and more effectively plan, manage and where appropriate reconfigure existing services and support, to improve service delivery to patients over the next three years
- improve health and well being and minimise the risks associated with living with a chronic condition, while supporting and empowering people to maximise their independence in all areas of life
- simplify access to services and improve communication between patients and professionals
- reduce levels of morbidity and avoidable emergency admissions to hospital
- redress the balance of service provision across primary, community, social and secondary care
- provide comprehensive, consistent, preventative and anticipatory care

- build on the strengths within primary care to integrate services across organisational boundaries
- help clarify the actions needed to implement the CCM Model and Framework and set out a new vision for CCM services in Wales.

1.8 This vision will be delivered through:

- the promotion of healthy lifestyles and relevant support
- prevention and early intervention as fundamental elements of care across all levels of the model
- services planned around a generic CCM care pathway to support the provision of care within local communities as far as possible
- seamless care provided by integrated multidisciplinary teams working across primary, secondary and social care
- community-based health care, social care and social support provided in a planned and integrated way by appropriate organisations
- monitoring performance over time against clear actions and outcomes.

1.9 The key actions which will need to be jointly delivered over the next three years are:

- development of CCM Local Action Plans for joint implementation. Health Social Care and Well-being (HSCWB) Strategies will identify CCM as a key priority

- completion of a health needs assessment which identifies the prevalence and nature of the local CCM problem
- stratification of needs and risks, across all four levels of the CCM model, to support focused action
- reviewing current service provision in primary and community care to determine local actions and how combined resources can best be used to strengthen CCM community services
- all areas will have core CCM community teams established as a basis of the CCM service
- WAG will provide further guidance in the commissioning specification and produce a position statement about community nursing services
- identified future workforce skills, roles and responsibilities integrated into workforce planning
- implementation of a national signposting and information service
- Local Patient Service Advisory Groups established for each locality

1.10 To support local partners deliver this challenging programme, a maturity matrix sets out key developmental tasks. This maturity matrix will be used as a self assessment tool to understand the current position and determine local priorities and actions. It will constitute part of the Welsh Assembly Government's wider performance management and benchmarking process for the NHS.

2 Introduction

2.1 This is not just another initiative; it is an imperative if we are to meet the changing and growing health and social care needs of people in Wales - our close families, friends and neighbours - in a way that can be sustained in the future.

2.2 The World Health Organisation has recognised managing chronic conditions as the most important challenge for healthcare systems. Wales recognises this and has responded proactively to meet the challenges, in moving on from managing infectious diseases of the past to meeting the different support needs of possibly longer term chronic conditions, which are growing as people live longer lives.

2.3 The services and support needed will be very different; they will need to ensure people are cared for and supported and, wherever possible, helped to avoid the onset and early deterioration of these conditions.

2.4 Those affected will wish to continue to live normal, healthy, happy lives within communities. The service and support should therefore focus on ensuring this happens. Whether this involves

outreach specialist services, aids and adaptation, transport or more specialist clinical care, we need to be flexible and responsive - reorganising the local services and wherever possible avoiding unnecessary admission to hospital.

2.5 This CCM Service Improvement Plan provides more detail on how this can be achieved, and provides a maturity matrix by which progress can be identified over the next three years.

2.6 The gradual cumulative process of changing our services, strengthening care in the community, is essential and will need to ensure that all resources within our communities are used to help achieve this: the resources of individuals, neighbours, patients, carers as well as the combined skills of the statutory and independent sectors.

2.7 Partnership working across organisational boundaries, professional groups and with patients and carers will be crucial to delivering better care and support in practice.

3 Background

3.1 In Wales the older population is expected to grow by 11 % by 2020 and there is evidence that dependency increases with age. It is estimated that 75% of those aged 75yrs and over have at least one chronic condition and that approximately 78% of all health services expenditure is connected to chronic conditions.

3.2 *Improving Health and the Management of Chronic Conditions in Wales: An Integrated Model and Framework for Action* was issued in March 2007 in recognition of the increasing trends in the prevalence of chronic conditions, the association with an ageing society and the impact this will have on health and social care services. It drew on wide research to identify a model fitting Welsh needs, to help address these issues across Wales and to better manage chronic conditions in a more integrated and effective way. That document signalled the beginning of a long-term process to improve services within their communities, for people living with chronic conditions. It forms the bedrock of the *Community Services Framework* and will help to achieve our goals of improving health and well-being across Wales.

3.3 The evidence points to the need for more proactive and planned management using multidisciplinary teams to help improve the efficiency of both health and social care services and provide better care and support for service users, families and carers.

3.4 Concerted action across a number of fronts will be required to achieve the CCM objectives of better well-being, care and systems. A fundamental review and careful planning of services are now

required to ensure firm foundations are set, moving away from 'initiatives' towards a chronic conditions improvement programme of work, fully integrated within mainstream service delivery, making effective use of all resources available.

3.5 It is essential that the skills, resources and strengths of primary, community and social care are effectively utilised and built on, at all four levels, with support from secondary care where needed, as well as drawing on the wider support of the voluntary sector and community.

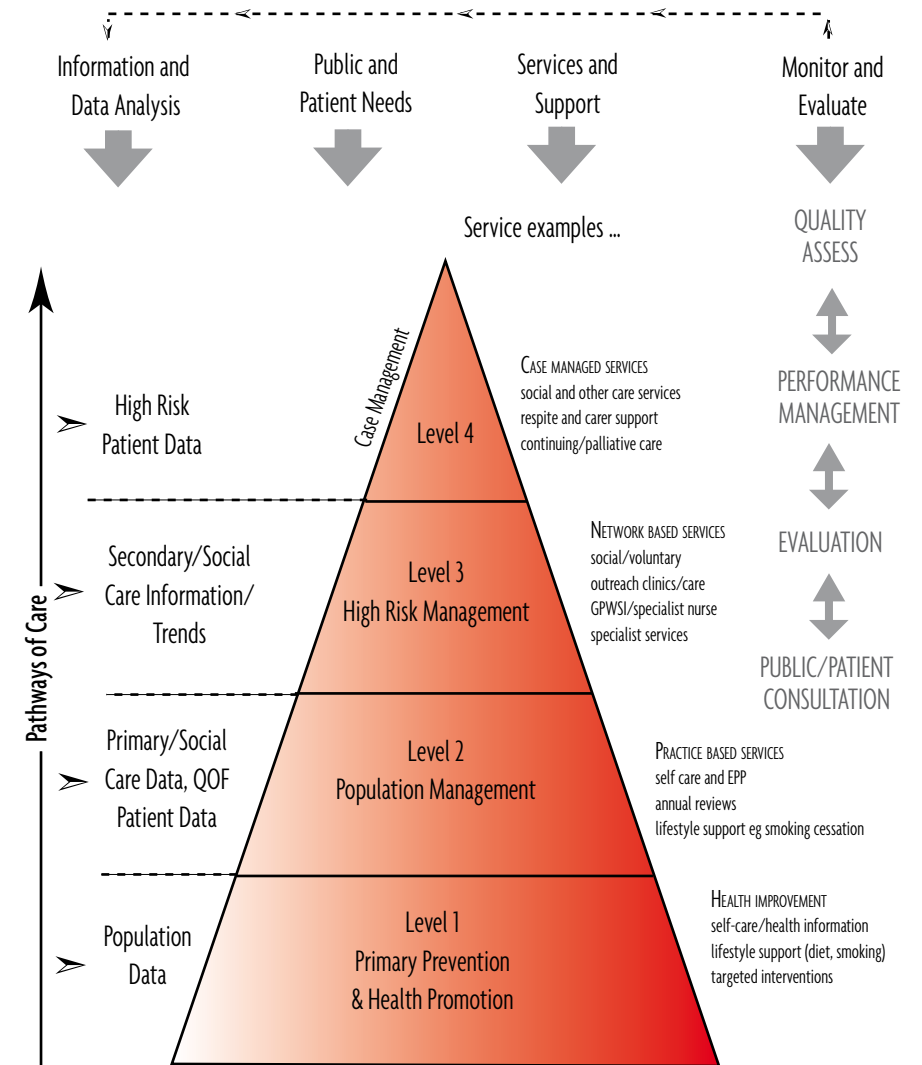
3.6 The following objectives for delivering the CCM model will form the basis of on-going monitoring of progress and evaluation of local change and service development:

- improve healthy lifestyles and well-being in the community
- prevent and/or 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
- increase self-management, independence, and the participation of people with chronic conditions and their carers
- improve the quality of patient care closer to home

- improve prescribing and medicines management
- reduce inequalities and improve economic activity.

3.7 The Welsh Chronic Conditions Model (Figure 1) is based on a proactive, planned and managed approach, identifying and addressing patients' needs across the care pathway. It is designed to focus on the needs of individuals and where possible to prevent or delay chronic conditions arising. The Model and Framework sets out the broad approach to ensure the right services are provided in the right place at the right time and meet local needs more effectively.

Figure 1: Proactive and Planned Management of Chronic Conditions



4 What do we want Services to look like?

4.1 Currently individuals with chronic conditions receive services from a number of different agencies; these are not necessarily co-ordinated or consistent. There is an inefficient use of resources and more importantly individuals and their families are not having their needs fully met and can find that the way services are organised further compounds the problems they already face.

4.2 Following publication of *Designed to Improve Health and the Management of Chronic Conditions in Wales: An Integrated Model and Framework* a number of events were held throughout Wales. During these events individuals who live with chronic conditions and staff from all sectors in the health and social care system consistently described current services as being fragmented, inconsistent, wasteful of time and resources, difficult to navigate and frustrating for all. These views reinforce the findings of the Welsh Audit Office's *Chronic Disease Management Review*.

4.3 Individuals, patients, carers and professional staff from all areas want high quality services that are patient-centred, local, co-ordinated, integrated and consistent. They want services that do not have to rely on admission to hospital when problems arise, that promote health and independence and that enable individuals to be cared for safely in the community.

4.4 The vision for future service provision is of an integrated service response to individuals' needs, where families will receive on-going and general health and personal support from a known care worker who is supervised by, and relates to, a multi-disciplinary

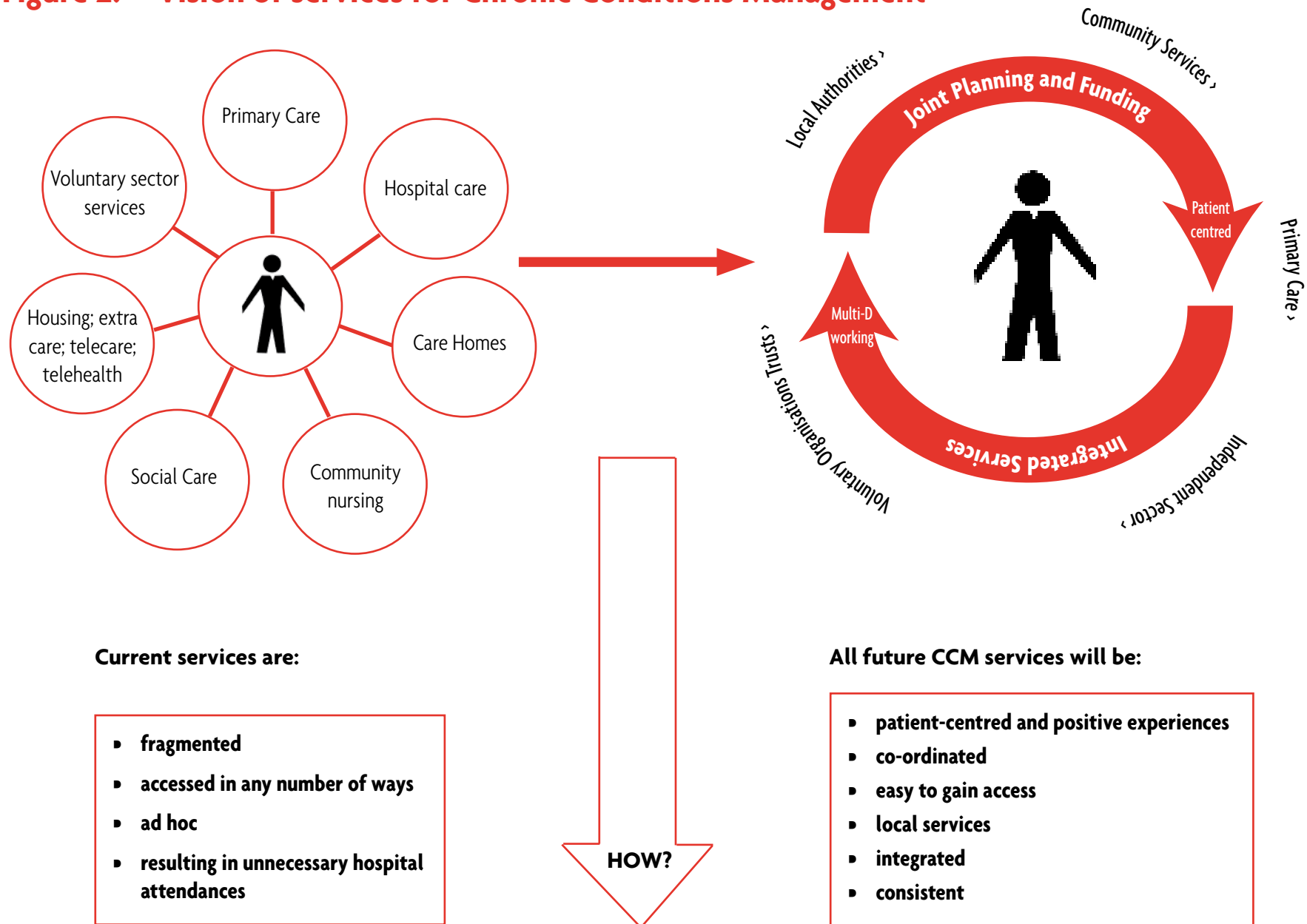
team with professional skills and access to specialist advice and care. When investigations or interventions are required these will be co-ordinated and available locally, unless the facilities of an acute hospital are specifically required. Individuals and their families will receive consistent advice and information and access to wider support in relation to employment, education and housing issues. Current views and the vision are captured diagrammatically in Figure 2 and further illustrated in the case stories given below.

4.5 Managing future demands in a sustainable way will depend on how well the total resources available within communities are used. These include the resources of statutory, voluntary and independent sectors as well as patients, carers and others in the community.

4.6 In particular, the integration of community nursing and therapy services and social care service across the care pathway need to be fully managed. Whilst some initiatives are being taken forward by the LHBs and their partners there is still a tendency to piecemeal developments rather than addressing the fundamental service development changes necessary to improve CCM and wider community services.

4.7 This will have a considerable impact on workforce planning and new roles, responsibilities and ways of working. Areas affected, include the role of the core CCM community team, community nursing and community therapy skills as well as new roles and joint responsibilities with social care. Workforce planning will need to respond to this now to ensure we are ready to cope with future challenges as they arise.

Figure 2: Vision of services for Chronic Conditions Management



4.8 Case story: Mr and Mrs Jones

Table 1. A pen picture of current scenario for CCM services

Mr & Mrs Jones, both aged 85 year old, live in their own home. Mr Jones has suffered from dementia for several years and is becoming increasingly dependent. His wife is his principal carer. Mrs Jones herself is unwell; she is an insulin dependent diabetic and has arthritis. Though independent and active, her mobility is gradually decreasing.

Both Mr & Mrs Jones are well known by the GP and practice nurse. Mr Jones has out patient appointments with his consultant, he attends a day care service 2 days a week, and a CPN visits monthly who arranged for an occupational health assessment for household aids and adaptations for Mr Jones. Mrs Jones attends 2 out patient clinics regularly; one for her diabetes and one for her arthritis, she also has regular appointments with a podiatrist and diabetic retinopathy service. Depending on her own health and her husband's condition, she can not always attend these appointments, as they are all in different places, requiring travel by bus. Following a social work assessment Mrs Jones was assessed by a community-based occupational therapist, meals on wheels were arranged and a home care package providing input twice a week was put in place.

Mrs Jones wakes up on Friday morning feeling unwell and disorientated, she struggles to get up and falls. After some time she manages to get to the phone and rings her daughter who lives 150 miles away. Her daughter rings the CPN and social work phone numbers and, unable to get through, she rings for an ambulance. Mrs Jones is admitted via A&E and as there is no support at home for Mr Jones, he is also admitted.

After 8 hours waiting in A&E Mrs Jones is admitted to the ward for tests which will have to wait until Monday, so she remains in hospital all weekend.

The hospital has not informed the social services department or GP. When the homecare service visits, the clients have disappeared. The GP is not aware of the position as they were admitted from a 999 referral.

On Monday Mrs Jones is still waiting for tests. On Wednesday she is seen by the consultant, as no tests have been undertaken she is discharged for tests in out patients. No care package has been previously arranged so Mrs Jones is referred to the hospital discharge team, but as it is Friday, this is left until Monday. Her husband has experienced a similar process although the consultant is erring on the side of caution and considering long term residential care, no unified assessment takes place. Both Mr and Mrs Jones go home after 10 days with the same package. The cause of the fall has still not been established, so Mrs Jones goes back to the GP. There is a real possibility of readmission.

Table 2. A pen picture of fully engaged and integrated scenario for CCM services

Mr & Mrs Jones, both aged 85 year old, live in their own home. Mr Jones has suffered from dementia for several years and is becoming increasingly dependent. His wife is his principal carer. Mrs Jones herself is unwell; she is an insulin dependent diabetic and has arthritis. Though independent and active, her mobility is gradually decreasing.

As a result of a carers assessment and established working relations between mental health and the CCM community teams Mr & Mrs Jones have a telecare and telehealth system installed at home, which monitors activities and risks in the home, assists Mr Jones' orientation, monitors Mrs Jones' blood sugar and allows for greater independence. They have a generic support worker who visits them three days a week to assist with personal care and signposting to other services as the need arises. Mr Jones receives support from the Community Mental Health Team and Day Care Services while Mrs Jones attends a local clinic. Mrs Jones's care needs are co-ordinated by the care co-ordinator and community nursing service and all her regular and specialist appointments take place in the local resource centre, which happens to be her GP practice.

Using the risk stratification tool and telehealth results, the care co-ordinator identifies that Mrs Jones' blood sugar levels have been unstable for a few days and makes an appointment for the specialist diabetic nurse to visit her at home. At her next regular appointment further blood tests are undertaken to assess her health status.

Mrs Jones trips on her way back from the bathroom on Friday morning, but is not badly hurt. She uses her pendant to contact the control centre who checks the station, arranges for the rapid response team to call immediately and rings her generic support worker to keep her informed. The community nursing service is informed and later the nurse and support worker call to the house earlier than anticipated that day. The nurse is able to refer directly for a local X-ray which shows no fracture, and with the care worker they adjust the care plan and inform the agencies concerned. An environmental safety assessment is arranged and some equipment and hand rails are supplied. Mrs Jones is not admitted to hospital and Mr Jones has attended the day care service as usual.

5 Core CCM Principles

5.1 The core principles underpinning the delivery of CCM services need to apply across all four levels of the model. Services in the future will:

- anticipate needs of individuals and carers
- involve individuals and carers in decisions about care
- be responsive to changing needs and circumstances
- be flexible enough to support the needs of individuals to their own requirements
- prevent unnecessary admissions and readmissions to hospital
- support planned discharges and admissions to hospital

5.2 In order to fully integrate CCM services across all sectors services will be based on:

- a single assessment process
- anticipatory and predictive care
- provision of information and signposting
- jointly managed and provided services
- proactive co-ordination, provision and commissioning

6 The Core CCM Team

6.1 Strengthening CCM community services and achieving the goals set out in *Designed for Life* will require a shift in resources from secondary to primary/community care, more effective use of existing resources and re-investment to support new service delivery.

6.2 This change agenda requires organisations to identify the skills and competencies of their current workforce, and the related training and education requirements to ensure the workforce is appropriately skilled and supported. Capacity within the existing workforce will have to be built up during the period of transition.

6.3 The provision of core CCM services is essential in delivering this shift and improving care and health outcomes. All areas will need to provide a core CCM service through a designated community team which is both jointly managed and co-ordinated across all sectors.

6.4 A pre-requisite for achieving a strategic shift in resources from hospital to community care are clear definitions for these services. The CCM Model describes 4 levels of patient need and services which best address these in the community. A core CCM team and a care co-ordinator are key components of future services. These are described below and further work will be undertaken by the Welsh Assembly Government in 2008 relating to commissioning and workforce planning.

6.5 The core CCM community team will provide care for a population base between 30,000 and 50,000 and will relate directly to primary care services and/or networks for that population.

The core CCM community team will provide co-ordinated care for individuals across primary, secondary and social care and will consist of:

- Holistic assessment of patient and carers needs including home environmental assessment to identify risks and scope to safeguard independence using adaptations and equipment
- CCM care co-ordinators providing essential overall management
- supervised home care workers working to a team/service model which allows referral to more specialised care as needed
- community pharmacy services to assist self-management and appropriate medication support
- common pathway offering a range of opportunities to achieve optimum independence
- community nursing teams, targeted to address needs at all 4 levels of the model
- specialist clinical and professional support
- emergency response team/service ensuring safety, security and responsiveness
- community support and signposting
- community voluntary support network.

6.6 CCM care co-ordinators are essential to ensure the CCM model works effectively. All areas will ensure care co-ordinators are part of the core CCM team, working across one or more locally based teams, dependent on local circumstances. They will be responsible for analysing the population in terms of the four levels and on that basis they will anticipate the needs of the population and individuals as well as plan and co-ordinate the service responses across primary,

secondary, community and social care and housing. They will inform primary care and joint commissioners of any needs and service-related issues and will monitor care and ongoing causes of local needs. The care co-ordinator role is distinct from that of the case manager, which is a clinical role managing and providing clinical care to individuals with high level complex needs and the care manager who is co-ordinating a range of commissioned social care services.

7 Delivering Better CCM Services Locally - Key Steps

7.1 Sound information about local prevalence and need is an essential requirement on which to base future service responses. LHBs will need to undertake an analysis of needs and current services across the four CCM levels, as the basis for informing the CCM local action plans:

- By December 2007 all LHBs and LAs will have completed a health needs assessment which identifies the prevalence and nature of the local CCM problem
- By April 2008 CCM baseline data will be established for local and national analysis
- By September 2008 all LHBs will stratify the risks and individuals with chronic conditions in their population
- The CCM Local Action Plan will be developed by LHBs and their partners by April 2008

7.2 The *Wanless 'Review into Health and Social Care Services in Wales'* (2003) and *'Designed for Life'* (2005) both identified that the NHS in Wales relies too heavily on the hospital sector to provide services - some of which could be better provided in or nearer individual's homes. Both these documents identified that it is essential to transfer some of these resources to support the development of more appropriate services within the community:

- During 2008/09 NHS Trusts, LHBs and Local Authorities will work together to determine how combined resources can best be used to strengthen CCM community services
- By April 2009 LHBs and NHS trusts will be able to identify the release of trust resources to support CCM in the community
- By June 2008 WAG will issue a commissioning specification for CCM, to support better commissioning of services

7.3 A fully engaged CCM framework provides a whole-system population planning base; a mechanism for developing real clinical leadership; in-built incentives to drive towards modernised, sustainable service and systemic linkage with Health, Social Care and Well-Being Strategies:

- By April 2008 Health, Social Care and Well-being (HSCWB) Strategies will identify CCM as a key priority with CCM Local Action Plans outlining key actions within the HSCWB strategy
- By April 2008 LHBs and NHS Trusts will have scoped out and reviewed current service provision in primary and community care and determined local actions

7.4 The development of community services across Wales have not necessarily matched changing needs. High quality services are provided but not always in a consistent or focussed manner, precious staff resources are not being utilised in the most effective or sustainable way and there are often gaps or duplications in service provision. All workforce strategies and demographic patterns highlight the need to educate and develop a more flexible and responsive workforce that relies less heavily on specialist professional skills but supports generic care needs with ready access to appropriate supervision and more specialist referral:

- **LHBs must demonstrate in their CCM Local Action Plans how their services will be proactive and anticipatory, planned, managed and effective**
- **NHS Trusts and LHBs will have agreed the local specification of a core CCM community team by September 2008**
- **WAG will provide further guidance in the commissioning specification and produce a position statement about community nursing services in Wales by June 2008**
- **All areas will have core CCM community teams established as a basis of the CCM service by June 2010**

7.5 The majority of care for people living with, or at risk of developing, chronic conditions will be provided locally. However services are organised there is a need for clear communication between all - patients, carers, professionals and organisations - to ensure that individuals are able to access the necessary information, support and services:

- **By 2009 LHBs Trusts and Local Authorities need to establish an infrastructure that transcends barriers, utilising to best effect the processes of Unified Assessment and Integrated Care Pathways**
- **WAG will work with key agencies and organisations to implement a national signposting and information service, by December 2009**
- **Local Patient Service Advisory Groups will be established for each locality by December 2008**

7.6 The CCM integrated model and framework clearly identifies 4 levels of care; at the population level the key focus is on preventing the onset of chronic conditions through health promotion activities and improving inequalities in health. At other levels early diagnosis, intervention and care will prevent conditions worsening unnecessarily and ensure people receive proactive care at, or near, home. Services need to be developed across all 4 levels in parallel:

- LHBs, LAs, NHS Trusts and partners will work together to ensure actions related to key determinants of health and chronic conditions (housing, education, transport, employment) are linked within the HSCWB strategy by April 2008
- Evidence based and effective interventions at each of the four levels will be determined and implemented locally

7.7 A clear performance management framework for local and national information will be determined in 2008. This will be fundamentally linked into broader joint commissioning plans and agreements: HSCWB strategies; Operational Plans; local agreements; quality standards.

- All health care systems will be expected to deliver services to the health care standards for Wales; WAG will work with HIW to identify and integrate assessment and monitoring of CCM related standards through the annual HIW review

8 Monitoring Implementation & Progress

8.1 The Welsh Assembly Government will establish and maintain a strategic and comprehensive infrastructure to support service development at a national and local level, through:

- **Research and Development** - evaluation framework and links with Universities to ensure applicable research and evidence; public and patient feedback; implementation across Wales; WAO review.
- **Development of a number of tools** to aid delivery of the model, including: a stratification tool developed by IHC to support detailed local needs analysis across all levels of the model; the development of Care Pathways and the Map of Medicine with NLIAH and IHC.
- **Information and Data** - Work with NPHS to develop service review tools for CCM and specific chronic conditions and a CCM baseline data set.
- **Workforce development and planning** - Working with NLIAH around a range of workforce planning issues including development of new roles and competency based posts.
- **Benchmarking progress** through CCM Local Action Plans incorporating the self assessment monitoring tool set out in this document.

8.2 The following maturity matrix has been designed to help identify the key elements and stages necessary to achieve service improvements. It looks at all areas related to chronic conditions that partnerships and organisations need to focus on; it considers current activities and progress that needs to be planned for, in a phased and integrated approach across all four levels of the model for chronic conditions management. The maturity matrix is structured around the following framework for service transition:

- local vision, priorities and partnerships
- local model and resources for delivery
- foundations for change
- agents for delivery
- monitoring and evaluation.

8.3 The maturity matrix can be used by LHBs and their partners to inform local commissioning plans and the CCM Local Action Plan.

8.4 CCM Local Action Plans will be produced by LHBs, in partnership with all stakeholders, by April 2008 at the latest.

The Local Action Plans will:

- i. Capture the actions identified within the CCM Model & Framework and this CCM Service Improvement Plan.

- ii. Take into account and address the findings of the WAO report “*Chronic Disease Management Review*” for the area.
- iii. Build on findings of local service reviews and health needs assessment.

The CCM Local Action Plan will inform and be included in the Health Social Care and Wellbeing Strategy, and will be monitored and performance managed through local partnership arrangements and the Regional Offices of WAG.

8.5 The following CCM Service Improvement Plan Maturity Matrix can be used as a self-assessment tool to determine local position and priorities. Mindful of the burden of regulation and self-assessment already placed on health and social care communities across Wales, it will be integrated into the annual modernisation assessment undertaken by NLIAH. It will also provide a consistent view on progress across Wales and will be used for benchmarking on a regional and national basis.

8.6 Implementation of the CCM model would ensure organisations meet many of the targets set within many WAG policy and strategy documents. Success will be measured against the actions identified in this CCM Service Improvement Plan and other targets such as Annual Operating Framework, Health Gain and Designed for Life.

8.7 Any changes made in the approach to managing chronic conditions need to be monitored. Their impact must be measured against locally developed criteria and national targets to ensure that the changes are resulting in improvements, for example in: quality of care and efficiency in the use of resources. This will allow for ongoing review of the approach adopted and for ongoing change where necessary.

8.8 The measure of success must relate to ends or outcomes (patients are less unwell or less dependent on services) rather than the means (we have an innovative service).

9 Chronic Conditions Management: service improvement maturity matrix



Needs assessment
Baseline review of local services
Shared vision
Partnership arrangements
Governance and accountability

Components of model
Basis for model
Best practice
Resources

Service development and innovation
Prevention and promotion
Independence and self-care
Care pathways
Primary Care/GMS
Pharmacy developments
Professional and skills development
Information and communication

Clinical leadership
Clinical networks
Patients and carers
Communities of interest
Commissioning

Monitoring progress
Performance management and monitoring
Audit/Benchmark
Monitoring
Evaluation of progress and patient outcomes

9.1 Local Vision, Priorities and Partnerships

Key Element	a) Initial Development	b) Progress in Development	c) Integrated mainstream services
Joint service developments based on an assessment of need in the population and locality	<ul style="list-style-type: none"> The needs of people with chronic conditions are extrapolated from primary and secondary care, WAO report, public health data and from users by LHBs and LAs, in order to support the Health, Social Care and Well-being Strategy 	<ul style="list-style-type: none"> Findings of health needs assessment at all four levels, using stratification tool, are used to model service needs of the future and inform commissioning 	<ul style="list-style-type: none"> Joint Health and Social Care needs assessment, with findings from local and national service reviews, citizen and patient surveys and primary and social care information, supports development of services
	<ul style="list-style-type: none"> WAG procure for Wales a risk stratification tool to identify high risk patients and re-admitters, to maintain and increase independence and prevent readmission 	<ul style="list-style-type: none"> Risk stratification tool to predict risk of population across four levels of model in use 	<ul style="list-style-type: none"> Stratification tool continually monitors patients and targets services at all levels. % patients in lower risk groups increasing. Higher risk group patients receive intensive 1:1 case management
A baseline review of all local services informs the development of the local model	<ul style="list-style-type: none"> LHBs, LAs and Trusts have scoped and reviewed the location and availability of: primary and community care services; bed usage and availability in local facilities; caseloads of community nursing, therapy and social work teams; self-care programmes etc 	<ul style="list-style-type: none"> Baseline service review information is considered jointly with health needs and is used to inform short term developments and model long term service needs 	<ul style="list-style-type: none"> Joint on-going review of services to continually improve service delivery. Innovative & sustainable ways of working are actively encouraged and supported across the organisations and partnership
A shared vision for the integration of CCM services directs future progress	<ul style="list-style-type: none"> LHBs, NHS trusts and Local Authorities acknowledge and understand the value of having a clear joint vision. Discussion has taken place in partnership meetings; NHS boards and LAs have been involved 	<ul style="list-style-type: none"> A long-term strategy for CCM across the health and social care community, includes: a vision and objectives for service provision; anticipated benefits; allocation of resources to support the strategy 	<ul style="list-style-type: none"> Clear joint vision and ownership for the integrated management of chronic conditions in the community is integral to the LA community strategy/plan. All local joint commissioning and delivery/operational plans include CCM

Key Element	a) Initial Development	b) Progress in Development	c) Integrated mainstream services
Agree and establish joint management, leadership and partnership arrangements	<ul style="list-style-type: none"> Lead directors in LHB and NHS Trusts are accountable for driving forward and delivering the CCM local action plan LHBs and LAs have a joint CCM local action plan as a priority in the HSCWB strategy 	<ul style="list-style-type: none"> LHBs, NHS trusts and LAs objectives and measures of success for developments and commissioning criteria are established The joint CCM local action plan is monitored regularly and used to agree further developments and changes 	<ul style="list-style-type: none"> Evidence of clear leadership for improving CCM at senior levels of all statutory, independent, voluntary and clinical partner organisations Organisations publicly communicate commitment to the management of chronic conditions through the HSCWB strategy, Annual Reports and other public documents
Demonstrating values of good governance, accountability and management of risk	<ul style="list-style-type: none"> Well developed governance structures and systems are in place in each of the partner organisations. Systems for identifying and managing risks and complaints are in place 	<ul style="list-style-type: none"> Systems from each organisation are revised to interlink and cross reference with each other. An agreed problem/dispute resolution protocol is in place 	<ul style="list-style-type: none"> All managerial and clinical protocols, standards and systems of governance related to chronic conditions are aligned and integrated across organisations. Agreed assurance mechanisms
	<ul style="list-style-type: none"> Differing health and social care eligibility and charging criteria understood locally; delegation of function and authority considered in terms of impact on jointly provided and funded services 	<ul style="list-style-type: none"> There are jointly agreed and approved systems in place to allow for the delegation of function and authority in jointly managed and provided services 	<ul style="list-style-type: none"> Full managerial and service integration
	<ul style="list-style-type: none"> LHB boards and local councils have agreed clear accountability and responsibility framework in which partners work, recognising statutory accountability 	<ul style="list-style-type: none"> Accountability to patients, clients and the public is demonstrated through the setting and monitoring of agreed joint and clinical standards 	

9.2 Local model and resources for delivery

Key Element	a) Initial Development	b) Progress in Development	c) Integrated mainstream services
Core CCM community team	<ul style="list-style-type: none"> LHBs, LAs and NHS Trusts scope and review community services & identify: where services need to be strengthened and integrated; the access and referral criteria to community hospital diagnostics, telecare and specialist services 	<ul style="list-style-type: none"> LHBs, LAs, NHS Trusts and primary care realign and utilise skills already in the community (eg diagnostics, therapists, community nursing teams for level 3 & 4, practice nurses and health visitors for levels 1,2 & 3) to meet needs and build capacity 	<ul style="list-style-type: none"> New roles and responsibilities developed to meet needs and strengthen community services. A system of case management exists for patients identified as high risk. Care is managed proactively at less intensive levels
	<ul style="list-style-type: none"> LHBs and NHS Trusts review secondary care services to assess which can be moved closer to community. CCM 'hubs' identified for provision of diagnostics and interventions in locality 	<ul style="list-style-type: none"> Services such as diabetic nurses, therapy services and diagnostics transferred from acute hospital settings to local premises/ resource centres. 	<ul style="list-style-type: none"> Services for CCM are fully integrated within and across service areas and managed as one service with clear links established to each organisation and service or generic workers
	<ul style="list-style-type: none"> LHBs identify population/primary care clusters or networks for area. The core CCM community services and teams needed are identified 	<ul style="list-style-type: none"> LHBs and NHS Trusts introduce care co-ordinator, case management and generic workers on a systematic and planned basis 	<ul style="list-style-type: none"> Core CCM teams provide planned and managed services with generic community support workers, generic community nursing & therapy staff etc

Key Element	a) Initial Development	b) Progress in Development	c) Integrated mainstream services
Local model for CCM is patient centred, anticipatory, responsive, evidence based and integrated across organisational and professional boundaries	<ul style="list-style-type: none"> Ensure consistent application and implementation of UAP 	<ul style="list-style-type: none"> The health and social care community uses unified assessment and care planning processes to assess patient need and intensity of care, across all four levels 	<ul style="list-style-type: none"> Outcomes from joint assessment and care planning process are reviewed regularly and used to further improve the standards of care provided to patients
	<ul style="list-style-type: none"> LHBs, NHS trusts, Social Services and voluntary sector have considered integrated team working and are pursuing a local approach to evidence based provision of care. Generic CCM care pathways are developed 	<ul style="list-style-type: none"> Integrated team working across social/health interface and between primary, community and secondary health is demonstrable across the generic care pathway eg Integrated Community Equipment Project 	<ul style="list-style-type: none"> Teams jointly managed, full interface across steps in care pathway with supporting clinical and managerial protocols/processes
Best Practice Guidance	<ul style="list-style-type: none"> Good practice is communicated to the wider health and social care community, through articles, workshops, locally run conferences 	<ul style="list-style-type: none"> All organisations have systems and processes for ensuring adherence to guidelines, audit with feedback 	<ul style="list-style-type: none"> Examples of best practice and evidenced local developments are systematically shared with others and mainstreamed
Resources	<ul style="list-style-type: none"> Current financial and staffing resources have been established and agreed between LA, LHB, NHS trusts and the non statutory sector. Resource 'savings' and clinician time needed to deliver CCM model are agreed in principle 	<ul style="list-style-type: none"> Impact of local CCM model quantified in terms of: demand and capacity requirements; finance; workforce; estates. A financial strategy for repatriating funds from secondary to primary care for on-going developments is agreed 	<ul style="list-style-type: none"> Whole system resource utilisation analysis undertaken, including secondary care costs, linked to a resource movement framework where efficiencies can be shown
	<ul style="list-style-type: none"> LAs and LHBs develop jointly managed projects/initiatives funded through the Joint Working Grant for management of chronic conditions 	<ul style="list-style-type: none"> LHBs and LAs use Health Act Flexibilities to integrate developments. Projects funded by Joint Working Grant are reviewed and protected through exit strategies and core funding, without detriment to those receiving the services 	<ul style="list-style-type: none"> LHBs and LAs fully utilise core funding and working arrangements in line with Health Act Flexibilities to commission and provide jointly managed integrated services

9.3 Foundations for Change

Key Element	a) Initial Development	b) Progress in Development	c) Integrated mainstream services
Service Development and Innovation <i>Services need to develop from being secondary care dependant to primary and community care led, with full integration of services caring for the same client/patient group</i>	<ul style="list-style-type: none"> Specific CCM developments are scoped, developed and monitored through HSCWB partnership arrangements to inform service re-design 	<ul style="list-style-type: none"> Services for CCM jointly developed within and across service areas; commissioned and managed as one service with clear links to each organisation and service 	<ul style="list-style-type: none"> Evidence of improved service delivery, patient improvements/outcomes is utilised within the joint commissioning process
	<ul style="list-style-type: none"> Plans in place to ensure innovations are developed, implemented and sustained appropriately. New technologies, of telehealth/telecare, new drugs and diagnostics included within the review to improve future services and care 	<ul style="list-style-type: none"> Joint management developments to support service development & innovation as well as minimise the conflict between organisations are implemented 	<ul style="list-style-type: none"> Successful developments in services and successful innovative approaches integrated into mainstream health and social care services
	<ul style="list-style-type: none"> LHBs and Trusts undertaken a review of: related referrals and admissions from primary care and care homes to secondary care to understand patterns; CCM services in secondary care 	<ul style="list-style-type: none"> Required capacity to support change within primary, community and social care has been identified 	<ul style="list-style-type: none"> CCM local action plan and commissioning documentation identify capacity to deliver the agreed model of care for all levels and services
Prevention and Promotion <i>Primary and secondary prevention strategies are important to help prevent the onset and limit the progression of chronic conditions and can help sustain quality of life for those living with these conditions</i>	<ul style="list-style-type: none"> LHBs work with NPHS, LAs and other partners to develop a strategic promotion and prevention programme with a whole population approach as part of HSCWB strategies 	<ul style="list-style-type: none"> LHBs ensure their whole population has access to targeted & focussed services, commissioned and monitored across all 4 levels 	<ul style="list-style-type: none"> LHBs and LAs evidence the impact of prevention and promotion initiatives on quality of life, lifestyles and wellbeing
	<ul style="list-style-type: none"> Primary and secondary prevention risks and services are mapped and reviewed with partners, across all 4 levels of care 	<ul style="list-style-type: none"> Evidence based primary, secondary and tertiary prevention services are provided, to ensure interventions are designed for all at risk 	<ul style="list-style-type: none"> Support development of robust generalised evidence for all preventative strategies and programmes
	<ul style="list-style-type: none"> Whole population generic public health and health promotion initiatives are supported and delivered locally eg: Welsh Network of Healthy Schools Schemes; all Wales Smoking Cessation Service 	<ul style="list-style-type: none"> Interagency working promoted for early screening, prevention & intervention within specific programmes to encourage healthy lifestyles eg alcohol, drugs and healthy eating, physical activity 	<ul style="list-style-type: none"> Long term funding provided, primary care fully engaged, High profile maintained

Key Element	a) Initial Development	b) Progress in Development	c) Integrated mainstream services
<p>Independence and self-care</p> <p><i>Maintain independence and ability to care for self</i></p> <p><i>Knowledge and support to retain independence and involved in care as an equal</i></p>	<ul style="list-style-type: none"> Mapping of local support services across all sectors and communities; generic and specialised including self management and self care needs 	<ul style="list-style-type: none"> LHBs and LAs have joint strategy for self care and management promoting independence and empowerment across all 4 levels of model. Includes identified funding streams and evaluation criteria 	<ul style="list-style-type: none"> Strategy evaluated and monitored on an on-going basis, identifying evidence of improved quality of life and impact on services
	<ul style="list-style-type: none"> Local use and funding of telehealth and telecare schemes included in above mapping exercise 	<ul style="list-style-type: none"> Use of self-management and monitoring tools by patient at home. Use of telecare and telehealth; extra care housing and remote home monitoring implemented 	<ul style="list-style-type: none"> Self-management training & education is incorporated into interactions between the patient and health and social care staff throughout care pathways
	<ul style="list-style-type: none"> Self management programmes, eg. Expert Patient Programme (EPP), are rolled out through all LHBs 	<ul style="list-style-type: none"> Range of self help/care services and condition specific programmes are commissioned to support patient needs on a local basis. Details included in local signposting and information services 	<ul style="list-style-type: none"> Self management and disease specific programmes are embedded as core community service with continuing investment & built into professional education programmes. Routine evaluation tool in place for each programme
	<ul style="list-style-type: none"> Patient/carer satisfaction surveys and audit of patient involvement are utilised in the development of programmes 	<ul style="list-style-type: none"> Pts involved in user panels. Innovative methods for involving patients in their care and condition management 	<ul style="list-style-type: none"> Findings built into service planning processes for all organisations; programmes revised to support patient participation and strengthen integrated patient self-management interventions

Key Element	a) Initial Development	b) Progress in Development	c) Integrated mainstream services
Care pathways	<ul style="list-style-type: none"> LHBs undertake scoping study of chronic conditions pathways in primary care to identify gaps and develop proposals to fill those gaps, reduce duplication and improve co-ordination 	<ul style="list-style-type: none"> Use outcomes of pathways scoping study to identify developments, tools and support required to strengthen chronic conditions pathways; develop evaluation tools 	<ul style="list-style-type: none"> Care is planned, commissioned and reviewed on the basis of the patient pathway across primary, secondary and social care
	<ul style="list-style-type: none"> Evidence based generic CCM pathway and condition specific care pathways are in place for COPD, diabetes, asthma, hypertension and coronary heart disease across primary secondary and social care 	<ul style="list-style-type: none"> Agreed referral protocols and thresholds for care in different settings and for integration and interaction between all agencies 	<ul style="list-style-type: none"> Systems and processes in place to ensure constant review and refining of care pathways and models of delivery in the light of new evidence
	<ul style="list-style-type: none"> NLIAH lead the coordination of Integrated Care Pathways (ICP) development across Wales 	<ul style="list-style-type: none"> ICP used with data rich clinical systems to inform the development of clinical systems and integration of the clinical record 	<ul style="list-style-type: none"> Findings from audit and evaluation of ICP programme across Wales utilised to inform improvements for integrated systems
Primary Care/GMS <i>A fully engaged local network is an effective driver for improving whole system efficiency</i>	<ul style="list-style-type: none"> LHBs include primary care services within service reviews - identifying GPs with special interests, local interface with community services and practice nursing services and skills for chronic conditions 	<ul style="list-style-type: none"> LHBs work with primary and secondary care colleagues to develop clusters/ networks, arrangements around natural communities; estates; patient flows; community regeneration plans and social services management 	<ul style="list-style-type: none"> LHBs have established Primary Care Networks to support and provide clinical leadership to commissioning decisions and provision of new models of care and reduction in secondary care dependency
	<ul style="list-style-type: none"> LHBs, local GPs and secondary care Consultants consider the service demands for chronic conditions in the area 	<ul style="list-style-type: none"> Analyse service utilisation and needs, and develop business plans for CCM service. Assessed by LHB standardised evaluation (governance, resources, performance measures, referral thresholds, evaluation) 	<ul style="list-style-type: none"> Evidence of improved performance and patient care
	<ul style="list-style-type: none"> LHBs and NHS trusts identify and engage primary care clinical leaders and gain involvement in local plans 	<ul style="list-style-type: none"> Test opportunities to strengthen and improve primary and community services for CCM across all four levels, including specialist services and direct access 	<ul style="list-style-type: none"> Review progress of new services and ensure integration within community and across communities if necessary

Key Element	a) Initial Development	b) Progress in Development	c) Integrated mainstream services
<p>Pharmacy Developments</p> <p><i>Pharmacists have a vital role in chronic conditions management, with an important role in improving self-care; in “marketing” the CCM system; through screening and early identification; in improving medicine management</i></p>	<ul style="list-style-type: none"> Local medicines management review undertaken and development plans produced Plan and deliver an action plan to substantially reduce medicine related hospital admissions Ensure timely transfer of relevant information about patient’s medicines between secondary and primary care; including care homes and community pharmacy Deliver improved public and patient education about medicines use 	<ul style="list-style-type: none"> Local action plans implemented and monitored to improve medicines management Pharmacy workforce is fully engaged with E-communications across care settings and E-prescribing are addressed through Informing Healthcare Public and patients involved in the development of campaigns to promote appropriate use of medicines to support self-care 	<ul style="list-style-type: none"> Evidence of improved medicines management Hospital admission rates due to inappropriate medication for chronic conditions are reduced Pharmacists in all care settings have appropriate access to GP patient records Public fully engaged with self care agenda
	<ul style="list-style-type: none"> The All Wales Clinical Pharmacists Group to scope and develop business cases to support local networks in their clinical area with clear terms of reference and communication pathways fully engaged with other networks LHBs work with contractor professions to ensure effective delivery of repeat prescribing and dispensing services and other enhanced services 	<ul style="list-style-type: none"> Welsh Committee for the Professional Development of Pharmacy (WCPDP) to support the delivery of leadership training that develops outward-looking local pharmacy networks by bringing together pharmacists across the public and private sectors Outcomes of Medicines and Older People standard of the NSF for Older People in Wales delivered and extended to all patients with chronic conditions 	<ul style="list-style-type: none"> Local networks to act as a resource for social care organisations to provide advice, guidance and to promote good practice and service development, in relation to medication
	<ul style="list-style-type: none"> Jointly assess current pharmacy workforce’s roles/responsibilities in light of CCM needs at all 4 levels, and identify gaps for future developments 	<ul style="list-style-type: none"> Pharmacy contribution enhanced by commissioning new roles and responsibilities through joint posts across primary, secondary and social care 	<ul style="list-style-type: none"> Flexible competency based workforce reflecting needs across health and social care

Key Element	a) Initial Development	b) Progress in Development	c) Integrated mainstream services
Professional Development and Skills Training	<ul style="list-style-type: none"> All partner organisations have jointly undertaken a review of roles/responsibilities, generic and specialist competencies & skills and development needs within current workforce, in light of CCM needs at all 4 levels. Joint CCM local action plan identifies current workforce issues and future workforce needs 	<ul style="list-style-type: none"> Joint workforce, development and training strategy, to support changes for existing workforce developed for action by all partners - including HEIs Commissioning partnership agreements to provide a flexible generic CCM workforce with appropriate professional infrastructure and leadership; contains capacity to deliver agreed model of care for people with chronic conditions within the wider population 	<ul style="list-style-type: none"> As needs change commissioning plans drive and reflect the need for new roles and teams Workforce: designed around patients; pathways & service needs; works across organisational boundaries; reflects a shift from secondary to primary care provision; evolves and develops in innovative ways as service needs change; involved directly in the development of roles
	<ul style="list-style-type: none"> Local partnerships are working with NLIAH, WAG and higher education institutes to ensure that the workforce needs of the future are met. Skills training for patients, carers and the voluntary and independent sectors are included 	<ul style="list-style-type: none"> Local and national training and education programmes to support changing expectations on workforce have been developed 	<ul style="list-style-type: none"> Implementation of the skills and education programmes within national programmes Analysis of the impact of the new service model on workforce and competency requirements gap analysis, strategy and action plan
	<p>Skills development needs are established for:</p> <ul style="list-style-type: none"> Generic worker with a cross sector focus Joint forums for GPs and consultants Shared leadership programmes Practice and community nurses 	<ul style="list-style-type: none"> Joint agreements over employment and link of line management and professional management in place Role descriptions and competencies for new and joint roles are agreed utilising national competency framework 	<ul style="list-style-type: none"> A local, joint training & development programme is in place, based on individual and collective training needs assessments which supports the on-going training needs of all staff, with full engagement of clinical leaders

Key Element	a) Initial Development	b) Progress in Development	c) Integrated mainstream services
Information and communication <i>Effective use of data to understand population needs and resource utilisation will enable organisations to:</i> <ul style="list-style-type: none"> - undertake risk stratification, strategic planning and prioritising; - undertake robust care planning; - monitor and review the impact of changes; - improve communication & staff education. 	<ul style="list-style-type: none"> ▪ CCM baseline data set established and analysed locally and nationally ▪ Community activity and outcome data - consider national development and understand data availability Use QoF data 	<ul style="list-style-type: none"> ▪ Local data stratified, analysed and integrated into local commissioning process ▪ Core activity and outcome data agreed and collected by NHS organisations ▪ Data utilised for audit and evaluation of service provision, eg. Reasons for unplanned admissions across acute, primary & social care 	<ul style="list-style-type: none"> ▪ Data used routinely to monitor and evaluate progress and inform future HSCWB plans ▪ Real time data is available to enable ongoing risk stratification and needs-based commissioning ▪ Investment has been made to infrastructure and analytical capacity to facilitate data analysis and meet the information requirements of the model
	<ul style="list-style-type: none"> ▪ Signposting: Info to pts needs to be in range of formats not just electronic. Available at points of access - GPs, pharmacies, libraries etc ▪ Informing Healthcare to establish new web portal to act as single authoritative source of information for patients, carers, public and professionals 	<ul style="list-style-type: none"> ▪ Information communication technology is utilised to support patients in coping with their condition The use of internet spaces for patients to input monitoring data electronically and access their records ▪ Standardised health messages 	<ul style="list-style-type: none"> ▪ Patient focussed outcomes ▪ Signposting services are fully operational at a local and regional level ▪ National signposting system and service in place
	<ul style="list-style-type: none"> ▪ There is a clear local communication strategy to integrate all systems across the health community, linked to Informing Healthcare 	<ul style="list-style-type: none"> ▪ Systems to enable access to information for community-based staff are in place 	<ul style="list-style-type: none"> ▪ Available Information is shared and accessible across all organisations in the health and social care community
	<ul style="list-style-type: none"> ▪ Individual organisations have communication protocols regarding service changes, developments, influence of all stakeholders 	<ul style="list-style-type: none"> ▪ Communication protocols from all organisations apply to chronic conditions management developments and refer to each other 	<ul style="list-style-type: none"> ▪ Annually reviewed, including: information sharing; information for patients, carers and staff; communication with, and between, all stakeholders

9.5 Delivery

Key Element	a) Initial Development	b) Progress in Development	c) Integrated mainstream services
Clinical Leadership <i>Clear leadership is required at all levels of organisations, to champion and drive through service improvements and make vision a reality</i>	<ul style="list-style-type: none"> LHBs, NHS Trusts and Local Authorities have: <ul style="list-style-type: none"> identified a champion at director level identified key primary, secondary and social care professional leads 	<ul style="list-style-type: none"> Operational champions required with focus, including leads from organisations, professions etc; Champions (not only medics, not only clinical) leadership at all levels 	<ul style="list-style-type: none"> Integrated leadership implicit within service delivery and management
	<ul style="list-style-type: none"> NLIAH have developed a Clinical Leadership Programme and established a national learning set Investment in leadership development for practice nurses and pc nurses/ therapists/SW 	<ul style="list-style-type: none"> LHB wide network of clinical leads to provide additional clinical advice for commissioning. Supported by national learning programme to facilitate rolling out of best practice Learning set development shared across Wales 	<ul style="list-style-type: none"> Integrated leadership supports service improvements in on-going basis Learning set forms basis of on-going improvement and learning
Clinical Networks	<ul style="list-style-type: none"> LHBs, NHS trusts and social services set up local networks that cut across primary, social and secondary care pathway, to improve service delivery and inform commissioning. Review and develop clinical policies/protocols 	<ul style="list-style-type: none"> CCM networks make connections and refer to specialist clinical networks as they link to the CCM care pathway 	<ul style="list-style-type: none"> Networks operate across organisational boundaries to ensure continual improvement and progression in maintenance of care pathway

Key Element	a) Initial Development	b) Progress in Development	c) Integrated mainstream services
<p>CCM Communities of Interest</p>	<ul style="list-style-type: none"> LHBs review existing models of local interest groups and support the establishment of a local CCM patient and carer groups - patient as innovators, with support from NLIAH Local teams and projects link in with communities of interest to learn, develop and identify groups and networks within organisations and locality 	<ul style="list-style-type: none"> Communities of Interest underpin and feed into CCM service improvement. Improvements and developments are benchmarked across local organisations LTC alliance, carer and patient networks and local volunteer & voluntary sector networks User panel 	<ul style="list-style-type: none"> Communities of interest are a recognised and mainstreamed approach to supporting improvement, benchmarking locally and nationally
<p>Effective planning and commissioning is a comprehensive and effective tool for change, that needs to be maximised to greatest effect</p> <p><i>CCM will only be systemised if supported by effective commissioning programmes and appropriate resource movement frameworks</i></p>	<ul style="list-style-type: none"> Preparation for effective commissioning is based on local need and service development Planning for CCM services is integrated alongside that for elective and unscheduled care. Links are established with the work being undertaken by Regional Commissioning Units Maximise opportunities for joint health and social care commissioning infrastructure 	<ul style="list-style-type: none"> Services are commissioned on the basis of local analysis of need and provision Community Partnership Agreements identify CCM as a priority and establish CCM as a joint and organisational commissioning priority within the new commissioning arrangements. Shared processes enable joint commissioning and financial decisions to be executed. Joint teams are working to the same objectives and outcome framework 	<ul style="list-style-type: none"> Services meet the needs of users more effectively, there is improved care and joint use of resources and feedback from users Services for CCM in primary, community and secondary care are commissioned on a care pathway basis. There is evidence of integrated services commissioned across 4 levels All commissioning to be outcome based, with sensitivity and responsiveness built in

9.6 Evaluation

Key Element	a) Initial Development	b) Progress in Development	c) Integrated mainstream services
Monitoring Progress	<ul style="list-style-type: none"> National monitoring and evaluation framework established by AWARD 	<ul style="list-style-type: none"> Local partnership undertakes on-going monitoring and evaluation to underpin service improvement 	<ul style="list-style-type: none"> Evidence of improvements to service delivery and patient care contribute to mainstreamed evaluation
	<ul style="list-style-type: none"> LHBs and NHS trusts collate all information from service reviews - local partnerships agree a performance management and monitoring mechanism LHBs and LAs, identified local chronic conditions objectives/targets, to supplement national performance targets and measure initiatives and programmes of work 	<ul style="list-style-type: none"> LHBs and LAs establish a performance management and monitoring mechanism for monitoring progress Performance against local targets measured within the evaluation framework. Feed back provided to the partnership and organisations 	<ul style="list-style-type: none"> Community activity and patient focussed outcome data utilised to monitor performance and inform planning and change
	<ul style="list-style-type: none"> Regular collation and use of data such as WAO, QOF, PEDW, and baseline data set to inform planning and progress 	<ul style="list-style-type: none"> Agreed systems for local measurements and priority for tried and tested clinical interventions 	

Key Element	a) Initial Development	b) Progress in Development	c) Integrated mainstream services
Effective performance in clearly defined functions and roles	<ul style="list-style-type: none"> Partners aware of each others performance management frameworks and some jointly developed monitoring mechanisms in place 	<ul style="list-style-type: none"> Well developed performance management systems that measure services re chronic conditions are in place in each of the partner organisations. Joint outcome based performance indicators for each level of the model have been identified, and/or the achievement of performance indicators in one partner organisation contribute to the performance management in others through an agreed, documented and reviewed framework 	<ul style="list-style-type: none"> All performance management systems related to chronic conditions are aligned and integrated across organisations. Regular monitoring reports and analysis are received by individual organisations, joint management/partnership boards and the Local Service Board
Audit/ Benchmark	<ul style="list-style-type: none"> Annual audit through self assessment tool (modernisation assessment) & local action plan Documentation of audit and analysis of results Regional and national benchmarking through self assessment tool in Service Improvement Plan 	<ul style="list-style-type: none"> Audit undertaken to demonstrate consistent compliance with process, outcomes and care 	<ul style="list-style-type: none"> Findings from audit systematically reviewed and used to revisit local action plan

Key Element	a) Initial Development	b) Progress in Development	c) Integrated mainstream services
Evaluation of progress and outputs/ patient focussed outcomes	<ul style="list-style-type: none"> ▪ Research and evaluation integrated throughout the local action plan 	<ul style="list-style-type: none"> ▪ The implementation plan supporting the strategy for the management of long-term conditions is underpinned by an evaluation framework 	<ul style="list-style-type: none"> ▪ Patient outcome measurements are included in the evaluation not just outputs
	<ul style="list-style-type: none"> ▪ All change implemented across the health economy is measured from the outset, with clear baselines established and qualitative and quantitative measures agreed 	<ul style="list-style-type: none"> ▪ Performance monitoring systems show a clear improvement in adherence to guideline and measures inputs, outputs and outcomes 	