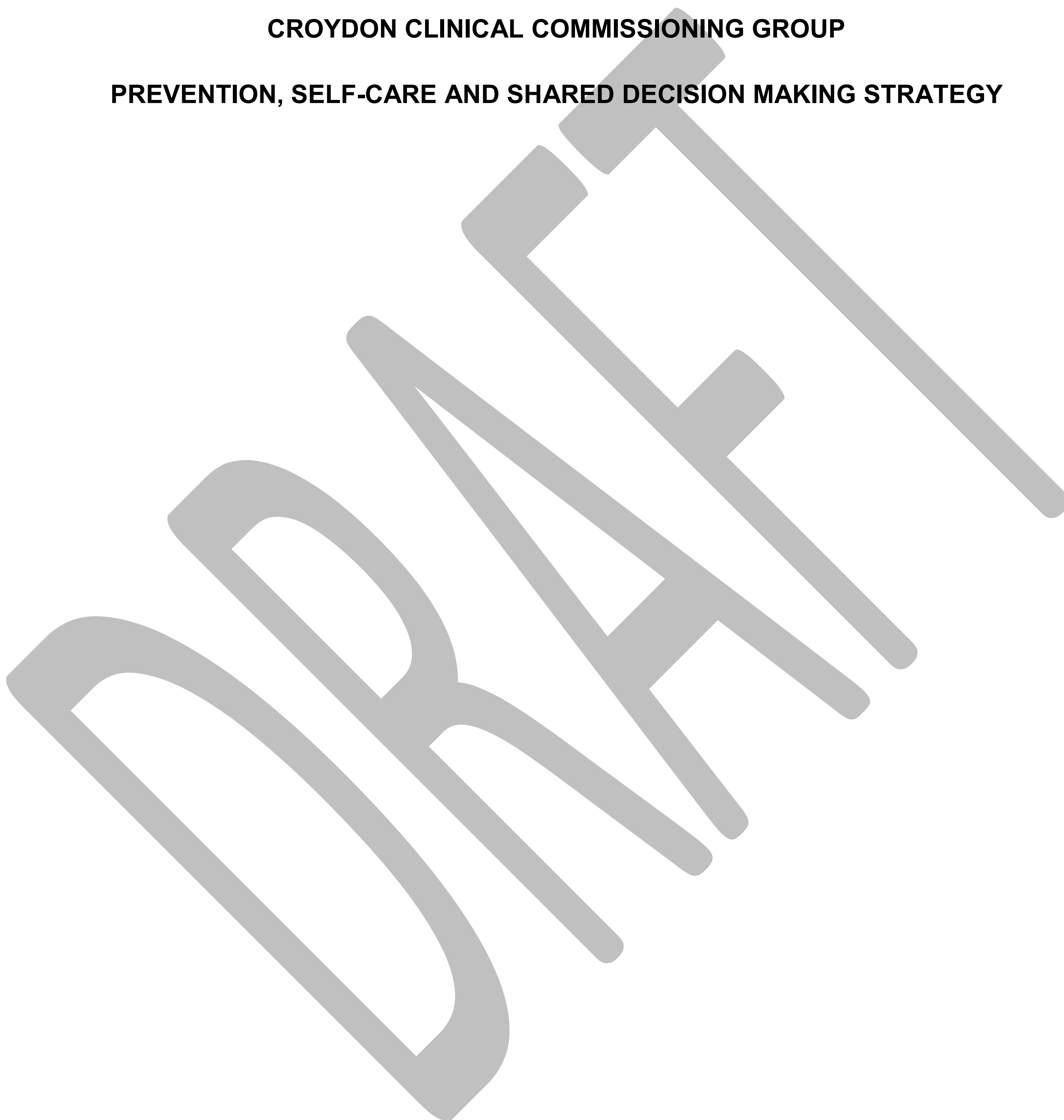
NHS

Croydon Clinical Commissioning Group

CROYDON CLINICAL COMMISSIONING GROUP

PREVENTION, SELF-CARE AND SHARED DECISION MAKING STRATEGY



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Executive Summary

Prevention, Self Care and Shared Decision Making (PSS) is a priority area for Croydon Clinical Commissioning Group (CCCG). A third of ten and eleven year olds measured in 2010/11 were overweight or obese, nearly a third of adults in our poorest communities smoke tobacco and around 1 in 6 patients attending Croydon Urgent Care Centre in 2012/13 were just provided with advice,

This strategy will guide the way in which CCCG enables residents and patients to take greater responsibility for their health. It has a wide remit including: tackling the common risk factors for many of the main diseases affecting people in Croydon; self care for minor ailments; improving the appropriate use of health and care services; supporting self-management for people diagnosed with long-term conditions; increasing levels of shared decision making between patents and clinicians.

Many of the major diseases affecting patients in Croydon are caused by common risk factors such as high blood pressure and obesity, and associated lifestyle behaviours such as poor diet, low levels of physical activity and tobacco and alcohol use. Prevention has been identified by the Kings Fund as a priority area for the new Clinical Commissioning Groups.

Self care has numerous benefits – it prevents disease, slows progression and reduces demand for specialist services. Currently around 18% of GP consultations relate to minor ailments that could be treated by the patient and their family or by pharmacies.

Self-management is a sub-set of self care. For people diagnosed with long term conditions, self- management involves following complex medical regimens and making changes in lifestyle such as losing weight and increasing physical activity.

An increasing number of patients in Croydon are being diagnosed with long term conditions and for them to be supported effectively the borough needs to develop services so that they are in line with models of best practice.

Shared Decision Making is a process in which service providers and users work together to choose test, treatment, management or support packages, based on evidence and the service user's informed preferences. Shared Decision making can

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be supported through the use of specially designed information resources called Patient Decision Aids (PDAs).

There are a number of factors that will impact on the implementation of this strategy. Croydon health services are experiencing severe financial constraints due to both national resourcing of the NHS and local savings targets, while demand is increasing.

The numbers of children and older people in the borough are rising, with both groups requiring higher than average levels of care. Our local population is becoming increasingly diverse with an expected BME population of 50% expected by 2025. The use of new technologies such as smart phones and broadband internet is now commonplace, but their utilisation by health services has lagged behind other sectors.

CCCG aims to drive PSS in the borough through: using commissioning tools and processes such as contracting to drive PSS; embedding preventive approaches wherever possible; systematically developing PSS workforce skills; using targeted communications based on social marketing principles. Given current financial constraints, Croydon CCG aims to implement this strategy within existing activities, services and programmes, so that for the most part there will be no additional budget expenditure.

Ultimately it is Croydon's residents that are our key partners in making full engagement with PSS a reality – as individuals, families, patients and communities. They will need to lead and own the PSS agenda through being enabled to take responsibility for their own health – we hope that this strategy provides them with the means to do this.

Action Plan and Finance

Given the current financial constraints that Croydon is facing, Croydon CCG will be implementing this strategy within existing activities, services and programmes, so that for the most part there will be no additional budget expenditure. However in order to effectively facilitate behaviour change around PSS, it is recommended that £13,000 is allocated to identify priority areas and assess effectiveness of PSS actions and £25,000 is allocated to a social marketing behaviour change programme to coincide with Self Care week 2013.

Any section in the main text of this strategy that refers to a specific action will be appropriately referenced.

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Strategic Objective	Action	Lead Agency	Status	Direct Additional Cost	Start	Finish	Measure of Success
1. General	1.1 Convene PSS Strategy Implementation Group (PSIG) inc.reps from CCCG, Croydon Council, VCS, service users	CCCG	Not yet	None	07/13	06/14	Strategy implemented - documented in final evaluation report
	1.2 PSS research	Croydon Council	Not yet	£13,000 (2,000 baseline responses, 2000 post interventions, 6 focus groups)	07/13 07/14	09/13 09/14	Research analysis produced
	1.3 PSS needs assessment	Public Health, Croydon Council	Not yet	None - PH SpR x 5 days	07/13	07/13	Needs assessment produced

1.4 PSS Strategy implementation evaluation – 6 and 12 months	Public Health, Croydon Council	Not yet	None	12/13 07/14	02/14 09/14	6 month and final evaluation reports disseminated
1.5 Develop PSS communications plan (inc social media, emails, texts, social marketing, embedded comms)	PSIG, CCCG	Not yet	None	09/13	09/13	Communications plan produced
1.6 PSS Patient and Public Involvement plan (inc GP patient participation groups)	CCCG PPI lead	Not yet	None	09/13	09/13	Patient and public involvement plan produced
1.7 PSS provider engagement programme	CCCG	Not yet	None	11/13	03/14	Provider PSS action plans
1.8 Embed PSS within CCG Clinical Network implementation plans for local priorities (inc relevant partners for delivery)	CCCG Clinical Leaders Group	Not yet	None	09/13	10/13	CCCG Clinical Network priority implementation plans

2.Increased levels of prevention and self-care	2.1 Revise contracts to incorporate prevention interventions (employee and service user)	CCCG	Not yet	None	10/13	12/13	Contract revision paper
	2.2 Assess feasibility of prevention incentivisation e.g. LES, CQIN	CCCG	Not yet	None	07/13	07/13	Documented assessment of feasability
	2.3 Assess contracts re enhancing core mental health protective factors and promoting physical health amongst people with mental illnesses	CCCG Mental Health commissioning lead	Not yet	None	10/13	11/13	Contract revision paper
	2.4 Make Every Contact Count feasibility paper	PSIG, CCCG,	Not yet	None	10/13	10/13	MECC Feasibility paper
	2.5 Increased GP use of prevention (obesity, smoking, alcohol, wellbeing) tools / apps	CCCG CLG	Not yet	None	10/13	03/14	Read code data on number of tools / apps 'prescribed'

2.6 Technology / apps embedded within reconfigured pathways – diabetes, cardiology, cancer, respiratory, dementia	CCCG CLG	Not yet	None – service redesign leads to incorporate	06/13	03/14	Pathway documents
2.7 Self Care Week Social marketing / behaviour change campaign a) Borough wide b) North Croydon Community Champion engagement and Asset Based Community Development programme c) Children's Centres obesity / imms programme	Croydon CCG communications lead	Not yet	£25,000	06/13	12/13	Number of materials distributed, number of community champion and other engagement events, % increase in imms uptake, use of Pharmacy First scheme
2.8 Prevention / Self Care Health Campaign Programme	Public Health, Croydon	Not yet	None	Ongoing		6 pharmacy campaigns, 12 community campaigns

		Council					delivered
3. Improved LTC self-management support	3.1 Recommission diabetes patient education (inc follow up and refresher education)	CCCG	Spec sent to DH	Ian Knighton to confirm	08/13	12/13	% newly diagnosed patients completing course
	3.2 Redesign cardiovascular, diabetes, dementia, respiratory pathways	CCCG	Diabetes, CVD leads in place	Consultant fees TBC	06/13	12/13	Pathway documents
	3.3 Review LTC patient education needs and use findings to develop LTC patient pathways	CCCG	Not yet	None	05/13	09/13	Education options appraisal document, revised pathways
	3.4 LTC6 Patient survey	Service Provider TBC	Not yet	None – provider KPI	04/14	06/15	Performance reports

	3.5 Year of Care Funding Model feasibility appraisal	CCCG	Not yet	None	09/13	09/13	Documented decision
	3.6 Increase use of telemedicine / e-communication to support LTC self—management (inc assessing use of FLORENCE texting system)	CCCG	Not yet	None – telemedicine lead in place	04/13	03/14	TBC
4. Increased levels of shared decision making	4.1 Shared decision making skills in secondary care - mapping current activity	Public Health, Croydon Council	Not yet	None MR to liase w/ TN-S re current activity	07/13	05/13	SDM mapping doc
	Increase use of patient decision aids in primary care	CCCG	Not yet	None – clinical leaders to decide 5 priority PDAs	06/13	11/13	Read code data on number of PDAs ‘prescribed’, increase in no of patients reporting support to share in decisions from baseline

	4.2 Patient decision aids embedded within reconfigured pathways – diabetes, cardiology, cancer, respiratory, dementia	CCCG	Not yet	None – service redesign leads to incorporate	06/13	03/14	Pathway documents
5. Increase workforce capacity to support PSS	5.1 PSS Croydon health and care workforce development	CCCG	Not yet	None, Agnelo Fernandes to liase with Croydon Local Medical Committee and Croydon Senior Medical Staff Committee	07/13	07/14	Development and delivery of CPD PSS training for health and care professionals
	5.2 Assess feasibility of Croydon Make Every Contact Count training course	Workforce and Community Relations, Croydon Council	Not yet	None	11/13		Documented decision

5.3 PH training programme	Public Health, Croydon, Croydon Council	Ongoing	None	Ongoing	Ongoing	Number of attendees broken down by employer

Introduction

Derek Wanless' 2002 report on the future funding of healthcare services in UK envisaged three different scenarios, each with its own resource implications. The 'fully engaged' scenario in which people took active ownership of their own health, and engaged with health and healthcare services through a dramatically increased use of information and technology, was associated with better health outcomes and a lower increase in costs.

Croydon 2013 finds us in a time of flatlining or reduced funding for healthcare, a rising demand for healthcare services and low levels of technology uptake even as innovation and diffusion takes place at pace in other sectors. All the conditions are in place for a 'perfect storm'. It is against this background that Croydon CCG launches its Prevention, Self Care and Shared Decision Making (PSS) Strategy.

PSS are fundamental principles guiding the way in which Croydon CCG will operate, allowing us to: support residents and patients to engage with and take responsibility for their own health; commission services that enable PSS; support organisational and workforce development around PSS across the borough; ensure that whenever possible, PSS is embedded in encounters between service users and providers.

While the strategy and accompanying action plan have been produced by Croydon CCG, we hope that this is a document that stimulates discussion amongst everybody involved with health and wellbeing in Croydon - on how PSS can be used to make full engagement with health and healthcare services a reality for the borough. It may in due course be appropriate for a PSS strategy to be owned by Croydon Health and Wellbeing Board.

1. Context and Drivers

Prevention, self care and shared decision making (PSS) are everybody's business in Croydon. Given the challenges that the borough faces, both in population health and financial terms, not prioritising PSS is not an option. This is going to mean new ways of working for us all, changing how services are delivered, and the ways in which service users access care and interact with healthcare and other professionals.

A preventative approach should be taking place alongside treatment and service provision at all levels. Patients need to be involved in decisions relating to their health whenever possible. Residents must be supported in caring for themselves and their families, and in using services appropriately – in taking more responsibility for their health

Croydon CCG

NHS Croydon Clinical Commissioning Group is responsible for commissioning health services to meet the requirements of our population, and these include acute, community, mental health, maternity and children's health services. Our overall goals are to improve health outcomes, maximise health efficiencies and ensure that people are seen in the right place and the right time with an emphasis where appropriate on self-management of illness, and this will involve delivering care closer to home.

To support us in doing this we have set up six geographically aligned GP clinical networks. These will ensure that general practices are fully involved in the commissioning process, and also support the CCG in addressing needs at a local level through their knowledge of local pockets of deprivation, long term conditions prevalence and vulnerable populations.

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Our 9 priority areas for 2013/14 as outlined in our ‘Three Year Integrated Strategic Plan 2013/16 and Operating Plan 2013/14’ are: prevention of ill health and self-management; long term conditions; older people’s health, adult health; children and young people; planned care; primary and community services; urgent care; medicines management. During the 2013/14 we are also going to introduce primary care mental health pathways and develop the pathways for diabetes, cardiology, respiratory, cancer and dementia.

For the GP Clinical Networks to support PSS effectively it will be necessary for them to develop robust relationships with relevant stakeholders and partnership groups within their areas. For example, to improve children and young people’s health, networks will need to build strong relationships with Children’s Centres and Family Engagement Partnerships which coordinate multi-agency responses to children pre-birth to five with specific needs and their families.

Finance

This strategy is going to be implemented during a period of severe financial constraints. The NHS is currently being required to deliver efficiency savings of at least 4% a year. In addition to this, during 2012/13 savings of £21m against a target of £25m (4%) have been being delivered locally by Croydon Clinical Commissioning Group, and further savings of £20m (3%-4%) will be required in 2013/14. Local authorities, including Croydon Council, are expected to manage a funding reduction of 26% over a four year period.

Croydon’s Population

At the same time, there is a rising demand for services. This is partly due to changes in the population, with greater numbers of older people and children, both groups requiring more care than the general population. However a significant part of this increase is due to the inappropriate use of services – for example accessing urgent

care services, when only advice or information is needed. One aspect of this strategy is about developing ways to manage this demand.

Croydon's population is becoming increasingly diverse. Nearly 100 languages in addition to English are spoken and the black and minority ethnic community is expected to reach 50% by around 2025. Ethnicity has a particular bearing on the ways in which PSS place. Engagement with services can be dependent on language proficiency. Lifestyle and behaviour impact on the risk of developing disease. Family relationships affect the way in which self-care takes place. Targeted approaches are required using the assets and resources of Croydon's different communities, such as our Community Health Champions (Action 2.7).

Technology

Technology has an important role to play. Communicating via email, text message and mobile phone is now commonplace with 76% of UK adults in 2012 having access to broadband and 92% owning a mobile phone[1]. Despite this, the adoption and use of new technologies by healthcare providers has lagged far behind that of other sectors, even though this can often be achieved at low or even no cost.

Florence is a SMS texting telehealth service that uses text messages for the remote monitoring of asthma and hypertension and to support medicines adherence and smoking cessation. There are numerous apps, software programmes that can be used on smart phones, which can be downloaded free of charge such as NHS Quit Smoking app or Myfitnesspal. All Croydon CCG pathway redesign will assess the utility of using and incorporate text, mobile, ecomms and social media whenever benefits are likely. (Actions 1.4, 2.5, 2.6, 3.6)

[1] http://media.ofcom.org.uk/facts/

Mental Health

Croydon CCG recognises that PSS is as much about mental health and wellbeing and social needs as it is about physical health, and that these areas are all interdependent. For example depression caused by debt can inhibit self-care resulting in weight gain, while having a stroke is associated with an increased risk of depression. If services are to be effective then they will need to address mental, physical and social health needs.

The core protective factors identified as having a significant influence on mental health and well-being are enhancing control, increasing resilience, facilitating participation and promoting inclusion. The New Economics Foundation has identified five ways to promote wellbeing - through creating social networks, being physically active, helping others, taking part in lifelong learning and living in the moment.

Croydon CCG will ensure that: all relevant commissioning decisions enhance the protective factors for mental health; the mental health services that it commissions also support self care and prevention for physical health; frontline behaviour change interventions, particularly amongst service users with risk factors for poor mental health, include the five ways of promoting wellbeing. (Action 2.3)

Outcomes

The overarching strategic driver for health and social care in Croydon is Croydon Health and Wellbeing Board's 'Joint Health and Wellbeing Strategy 2013-18'. Effective PSS will have a positive impact on all six of the strategy's improvement areas.

Developing family skills around self-care will give our children a good start in life. Reducing smoking rates will lower the risk of developing lung cancer and reduced levels of obesity will lower the risk of developing diabetes. Increasing residents' skills so that they are able to treat minor ailments themselves will support independence.

Using models of international best practice for long-term conditions will result in the commissioning of integrated, safe, high quality services. Making shared decision making the norm will improve people's experiences of care.

Successfully enabling PSS amongst residents and services will support Croydon CCG in achieving our objectives in our nine priority areas and will result in improved health outcomes in four out five of the domains of the CCG Outcomes Indicator Set 2013/14: preventing people from dying prematurely; enhancing quality of life for people with long term conditions; helping people to recover following episodes of ill health or following injury; ensuring that people will have a positive experience of care.

Other Strategies

This strategy will not be implemented in isolation – there are interdependencies with numerous other regional and local strategies and programmes. These include:

- Croydon HWBB Health and Wellbeing Strategy
- Croydon CCG Integrated and Strategic Operational Plan
- Croydon CCG Primary and Community Care Strategy
- Croydon CCG Urgent Care Strategy
- Croydon CCG Medicines Optimisation Strategy
- Croydon CCG Communications and Engagement Strategy
- Croydon CCG Long Term Conditions Strategy
- Croydon Council Adult Social Care Commissioning Strategy
- Croydon Children and Young People's Plan 2013-2015
- Croydon Council's Early Intervention and Family Support Programme
- Croydon Healthy Weight Strategy
- Croydon Council's Primary Prevention Plan
- Better Services, Better Value SW London health services review

Empowering Croydon

Ultimately it is Croydon's residents that are our key partners in making full engagement with PSS a reality – as individuals, families, patients and communities. They will need to lead and own the PSS agenda through being enabled to take responsibility for their own health – we can only provide them with the means to do this. To participate fully in taking care of their own health, every resident will need to be provided with the necessary skills, knowledge and resources to promote wellness, prevent the onset of disease, self-care and self-manage when necessary, and to share in the decision-making process - "No decision about me, without me."

2. The Case for Change

If we are to provide high quality healthcare that meets patient's expectations, then Croydon residents must be supported to be fully engaged with their health. Despite this:

- In an analysis of calls to NHS Direct over a two week period in 2012, 16% either required no action or could be dealt with at home or by pharmacies.
- Around 18% of patients attending Croydon Urgent Care Centre in 2012/13 were just provided with advice.
- 18% of all GP consultations relate to minor injuries, conditions requiring little or no medical intervention.
- Around 1 in 6 two year olds in Thornton Heath had not received the MMR vaccine in 2012.
- Over a fifth (22.6%) of Croydon children in Reception and over a third (37.6%) of children in Year 6 measured in 2010/11 were either overweight or obese.
- Just under a quarter of Croydon adults (23.5%) were estimated to be obese in the period 2006-08.

- Estimated physical activity levels for Croydon residents are below the national average.

- Croydon is in the top 20% of areas in the country with the highest number of fast food outlets per 100,000 population.

- Almost a quarter of adults in Croydon smoke tobacco and amongst the poorest communities this is closer to a third.

- Around 800 Croydon residents are diagnosed with diabetes every year.

- The leading cause of death in Croydon is cardiovascular disease.

- Three out of every five people aged over 60 suffer from a long term condition accounting for over half of all GP appointments and nearly two thirds of planned hospital appointments, but making up just 31% of the population.

3. Prevention – Definitions and Best Practice

Many of the diseases affecting Croydon residents – cardiovascular disease (CVD), chronic obstructive pulmonary diseases, type 2 diabetes and cancer – are linked by common and preventable risk factors such as high blood pressure, high blood cholesterol and overweight, and by related major behavioural risk factors: unhealthy diet, physical inactivity, tobacco and alcohol use. It is estimated that 80% of cases of heart disease, stroke and type 2 diabetes and 40% of cancer cases could be avoided if these risk factors were eliminated.

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A Kings Fund[2] report identifying priority areas for Clinical Commissioning Groups states that expenditure on prevention is 'an excellent use of resources'. In a review of more than 250 studies published on prevention in 2008, nearly 80% were within the National Institute for Health and Care Excellence's threshold for cost effectiveness.

While specific prevention services can be commissioned e.g. a smoking cessation or weight management service, Croydon CCG aims to embed prevention interventions within encounters between Croydon's service providers and service users wherever possible. These can include brief interventions around diet, physical activity, smoking, alcohol and drug use, and promoting wellbeing. We will assess the effectiveness of incentivising these using levers such as LES or CQINS. (Actions 2.1, 2.2)

This will take place both in primary care and through revising contracts with our providers so that preventative approaches are embedded within their services. Wherever benefits are likely, these will include the use of communications such as text messages or tools such as the Department of Health endorsed BMI iPhone tracker. (Actions 1.5, 2.5, 2.6, 3.6)

We will work in partnership with Croydon Council and NHS England to support them in fulfilling their objectives around prevention and addressing the determinants of health in areas such as screening, health promotion, employment and housing

One example of prevention good practice is Salford's Make Every Contact Count (MECC) programme. This aims to ensure that all frontline staff are able to provide consistent simple information and signposting resulting in service user behaviour change for health gain. There are a wide range of participating services include

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[2] http://www.kingsfund.org.uk/publications/articles/transforming-our-health-care-system-ten-priorities-commissioners

housing, employment, youth, leisure and recreation, health improvement and NHS hospital trusts.

To support organisations in embedding MECC, the programme has reviewed employment induction processes, mandatory training programmes, behaviour change competencies in job descriptions, and staff appraisal processes. Croydon CCG will assess the feasibility of developing a local MECC programme.(Action 2.4)

4. Self Care – Definitions and Best Practice

The Department of Health has defined self-care in the following way: *'The actions that people take for themselves, their children and their families to stay fit and maintain good physical and mental health; meet social and psychological needs; prevent illness or accidents; care for minor ailments and long term conditions; and maintain health and well-being after an acute illness or discharge from hospital' (Department of Health, 2005).*

People currently deal with many health problems without consulting NHS services. Effective self-care improves quality of life through preventing disease, slowing or minimising deterioration, and reducing the severity of symptoms and pain. It improves user satisfaction with the quality of the services that they are receiving and reduces demand for specialist services.

The model outlined by the Self-Care Forum (Fig. 2) shows self-care as taking place on a continuum, from individuals making choices about living healthily, via self-caring for minor ailments to self-managing long term conditions and finally to in-hospital care.

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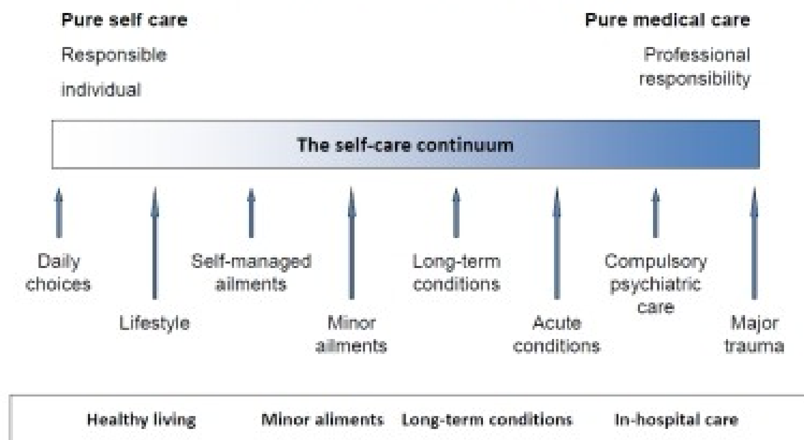

Fig 2: The self-care continuum. Source: Self Care Forum

An important aspect of self care is enabling people to use services appropriately and resources effectively. One of the most significant challenges currently facing Croydon's healthcare system is the large number of residents that are not engaging with the care best placed to address their needs.

This includes: seeking advice and treatment for minor ailments that could be treated at home; making GP appointments for minor ailments that could be treated in pharmacy; attending A+E or making 999 calls when telephone advice from NHS 111 or booking a GP appointment would do. Croydon CCG will support residents in developing their knowledge around making use of the right service at the right time. (Actions 1.5, 2.7, 2.8)

It is estimated that approximately £20million worth of medicines prescribed in Croydon are not taken as the prescriber intended and this can lead to poorer patient outcomes as well as wasted resources. Of those people not taking their medicines properly, 45% do so intentionally and need to be empowered to raise their concerns about their treatment, whilst others are unable to manage their medicines and will need to be supported to do this. Croydon CCG's Medicines Optimisation Strategy will address this area.

Supporting residents to make more effective use of resources will involve developing the role of Croydon's pharmacies. The borough's Pharmacy First Scheme delivered by community pharmacies is open to anyone living and working in Croydon. It aims to: reduce inappropriate use of emergency services; increase access at GPs by treating minor ailments in community pharmacies; utilise the professional skills of community pharmacists; encourage self-care. Patients suffering from a wide range of minor ailments such as diarrhoea, fever or cystitis attend the pharmacy in person, and will receive a consultation and they will be provided with advice and treatment if necessary. The treatment will be free of charge if the person does not pay their prescription charges. (Actions 1.5, 2.7, 2.8)

Self Care Week is an annual health promotion campaign taking place in November organised by the Department of Health and the Self Care Forum. In 2012 key self-care messages were communicated using websites, social media and a generic toolkit, which included national campaign tools, resources and messaging, for local organisations to develop their own approaches to promote self-care initiatives.

Croydon CCG aims to both participate in Self Care Week and to use the approaches and resources that have been developed for the campaign throughout the year - self care week every week. (Action 2.7)

5. Self-management – Definitions and Best Practice

Self-management is a sub-set of self-care. For people with long term conditions, self -management commonly involves understanding and following complex medical regimens, and making challenging changes in lifestyle, such as weight loss or increasing exercise. Self-management involves three different kinds of tasks: care of the body and management of the condition, adapting everyday activities and roles to the condition, and dealing with the emotions arising from having the condition.

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To support people with long term conditions so that they are able to self-care can have a dramatic impact on their quality of life, as well as reducing their need for emergency health and social services and the incidence of unplanned hospital admissions.

There are a rapidly increasing number of patients in Croydon diagnosed with long term conditions, conditions that last a year or longer, impact on a person's life, and may require ongoing care and support. These include cardiovascular disease, dementia, COPD, diabetes and HIV. Many patients have been diagnosed with two or more. Much of this is being driven by greater numbers of older people, but the increasing prevalence of obesity is also a significant risk factor for cardiovascular disease and diabetes.

Croydon CCG's Integrated Strategic Operating Plan for 2013/14 includes redesigning the pathways for several long term conditions including cardiovascular disease, dementia, diabetes and respiratory diseases. (Actions 2.6, 3.2, 4.2)

There are several models for the effective prevention and management of long-term conditions. Components of the Expanded Chronic Care Model[3] include: measureable goals for improved care; emphasising the importance of self-management; integration of evidence based guidelines into daily practice; focus on teamwork and an expanded skills mix to treat long-term conditions; developing clinical information systems; developing partnerships with community support organisations.

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3 http://www.blogs.usask.ca/SHORE/Chronic%20Care%20Model.pdf

The Year of Care[4] states that for a patient to be informed and engaged, the following are necessary: an awareness of processes and options, being supported emotionally and psychologically; patient access to their own records; goal setting; being sent test results prior to consultations; structured education / information.

Effective patient education begins immediately on diagnosis; thereafter people need access to regular updates in best practice in managing their long-term condition. For example, diabetes self-management education that educates patients as to the nature of the condition and its management, sets specific behavioural objectives, and supports a repeated process of attempting new self-management practices, monitoring their success, and then attempting revised plans has been shown to improve self-management behaviours and metabolic control.

Wherever there is the evidence to support it, people diagnosed with other long-term conditions should be provided with similar patient education programmes to support them in developing the necessary knowledge and skills to self-manage their condition/s. (Action 3.4)

To facilitate the delivery of integrated health and social care for people with long-term conditions, it will be necessary to use new approaches to commissioning services. One of these is the Year of Care Funding Model[5]. This is based on an annual budget agreed per person adjusted according to their risk and need rather than use of services. (Action 3.6)

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4 http://www.diabetes.nhs.uk/year_of_care/

5 http://www.selfmanagement.co.uk/sites/default/files/files/Supporting%20the%20local%20implementation%20of%20the%20year%20of%20care%20funding.pdf

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The Year of Care aims to deliver a more effective use of resources by focussing providers on moving away from episodic, activity driven funding flows towards person centred care irrespective of organisational boundaries with providers focussing on jointly delivering a year's worth of care. Croydon CCG will assess the feasibility of developing new commissioning models.

6. Shared Decision Making - Definitions and Best Practice

Shared decision making is a process in which service providers and users work together to choose test, treatment, management or support packages, based on evidence and the service user's informed preferences. Within the context of a user centred care system, the term 'shared decision making' is used more broadly to describe all aspects of people's involvement in their own health, wellbeing and care.

Research shows strong proven benefits from shared decision making, including:

- better treatment adherence, creating greater effectiveness and value
- improved confidence and coping skills
- fewer patients choosing major surgery, creating cost savings
- improved health behaviours such as greater exercise and reduced smoking
- more appropriate service use, particularly fewer emergency admissions

The use of specially designed information resources called Patient Decision Aids (PDAs) support patients in making their decisions[6]. These contain information on specific conditions that is accurate and balanced, ask questions that allow patients to think about the ways in which treatment consequences might affect them, and summarise the reasons for choosing, or not choosing, an option.

The MAGIC (Making Good Decisions in Collaboration) Programme currently taking place in Cardiff and Newcastle is developing shared decision making in both primary

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6 http://sdm.rightcare.nhs.uk/

and secondary care in areas such as antibiotic prescribing, early breast cancer and benign prostrate hypertrophy[7]. Changes in clinician behaviour have been facilitated by the use of: information campaigns; lunchtime staff presentations; communications via intranets, blogs and Twitter; training sessions using role-play; developing EMIS read codes and then extracting data to create local shared decision making 'league tables'.

NHS Right Care have produced patient decision aids for 36 different conditions, each decision aid having been produced by an advisory group made up of clinicians, patients, voluntary and community sector organisations and Department of Health policy leads. They can be accessed at www.sdm.rightcare.nhs.uk.

Given that PDAs have been shown to reduce hospital activity and associated costs — up to 38% fewer procedures and savings of 12% to 21% in a study of patients eligible for hip and knee replacements[8] - Croydon CCG will incorporate PDAs within pathway redesign when possible. (Action 4.1, 4.2, 4.3)

NICE Medicines Adherence CG76 makes recommendations as to how healthcare professionals can help patients to make informed decisions by facilitating their involvement in prescribing decisions, and support them in adhering to the prescribed medicine. These include clearly explaining the pros and cons of a particular treatment, clarifying what the patient hopes the treatment will achieve, and helping patients make decisions based on likely benefits and risks. Croydon Medicines

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www.health.org.uk/areas-of-work/programmes/shared-decision-making/the-programme/

8

N Engl J Med 2013; 368 6-8, 'Shared Decision Making to Improve Care and Reduce Costs'

Management Team will be supporting general practice skills development in this area.

Shared decision making needs to take place not only at the point where care is provided, but also at the strategic and commissioning level with service users involved in the co-design, co-commissioning and indeed co-production of care. Croydon CCG is committed to proactive engagement around service planning and design with patients and the public. This will include the systematic involvement of patient participation groups linked to general practices as well as local voluntary and community sector groups, Croydon Healthwatch and the wider Croydon population. (Actions 1.1, 1.6, 1.8)

7. PSS Across the Life Course

While self-care occurs throughout the life course, childhood (starting in the womb) is the crucial developmental period during which the foundations for virtually every aspect of future development - physical, intellectual and emotional – are laid. It is vital that families utilise their self-care skills during this period so that healthy choices become the norm, healthy living patterns around food and physical activity become embedded, and physical and mental health and wellbeing is promoted and treated in an appropriate setting.

Current specific priority areas for children's health in Croydon are: healthy weight; reducing risk taking behaviours and the incidence of pregnancy and drug and alcohol misuse; reducing infant mortality; improving emotional health and well being; improving the uptake of childhood immunisations. Improvements in these areas are being driven by Croydon Children and Families Partnership through the 'Croydon Children and Young People's Plan 2013-2015'.

An important driver for the delivery of the Healthy Child Programme conception to age 5 will be Family Engagement Partnerships, in which the specific needs of young

children and their family are addressed through a coordinated multi-agency response that will include GPs, Children's Centres, Health Visitors, Midwives, Early Intervention Consultants, Croydon Referral and Information Support Service (CRISS), Croydon Team Around the Setting; Family Resilience Service and the Voluntary and Community Sector. (Action 1.8)

The working environment plays a central role in adult health and wellbeing. In 2010 - 11, about 26.4 million working days were lost due to workplace injury and ill-health. There are many things that both employees and employers can do not only to reduce their risk of work-related ill-health but also to ensure that time at work actually improves health. Croydon CCG will use the commissioning process to ensure that service providers support workforce self-care as well as patient health. (Action 2.1)

Developing self-care amongst elders will ensure that this group continue to fulfil their potential, make a contribution and have improved resilience. Older people in Croydon utilise healthcare services to a greater extent than younger adults and this group will be supported to self-care around minor ailments and healthy living, but there will also be an increased focus on self-management of long term conditions and reablement following hospitalisation. Diagnosis with a long term condition is a life course event that can bring about improvement in patient PSS behaviours.

Croydon CCG's objective for Older People's Health is to maintain people at home, including care and nursing homes, and reducing the need for attendance at hospital. (Actions 3.2, 5.1)

8. Workforce Development

Improving PSS in Croydon does involve the commissioning of specific services, but if it is to become effectively embedded within the local healthcare system then the way in which local healthcare and other professionals interact with service users to support behaviour change for health gain and to support their decision making about treatment options needs to be systematically developed.

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This can take place through CPD processes such as training courses, via online modules and during appraisal so that high quality PSS practice becomes the norm. PSS competencies should also be included in job descriptions as a matter of course. PSS workforce development needs to take place across the healthcare system and include general practitioners and practice nurses, community and acute staff, Croydon Council and voluntary and community sector employees, and care and nursing home staff. (Actions 5.1, 5.2, 5.3)

All relevant local workforce development bodies and organisations including the Local Education Committee, Croydon Senior Medical Staff Committee, Croydon CCG GP clinical networks and Croydon Council will need to be involved to drive this forward.

As well as developing workforce skills to support self-care, Croydon CCG as a commissioner of services from providers that are major employers in the borough, will assess ways in which contracts and other levers can be developed to facilitate activities and programmes around employee self-care. (Action 2.1)

Supporting PSS workforce development has benefits in both health and financial terms. For example, Bellin Health System, a US healthcare provider with two hospitals, implemented a workforce health programme involving employee health needs assessments, the provision of health coaches, nutritionists, fitness experts, and support groups, and work solutions such as workplace design and rehabilitation[9]. This has seen both an improvement in employee health and no rise in employee health costs since 2002.

9. Communications

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9 http://www.aha.org/research/cor/engaging/index.shtml

Communications to both professionals, and patients, families and carers, will play an essential role in developing PSS in Croydon. Croydon's health and care system needs to increase its use of now common mediums such as text messages and social media. PSS messages can be embedded as matter of course in other communications. In order to bring about behaviour change for health improvement and more effective service use amongst priority groups, there is a need for communications campaigns based on social marketing principles such as generating service user insights and segmenting markets.

At a national level, Public Health England is delivering six social marketing programmes to improve health outcomes. These are: the Smokefree smoking programme; 50+ early diagnosis and wellbeing initiative; Change4Life for families and 35-55 year old adults; 11-19 Youth strand; Start4Life, focused on pregnant women and mothers of 0-2 year olds; a programme of innovation targeting new issues.

To ensure effective communications around PSS, Croydon CCG will: assess ways for increasing the use of text messages, email and social media for PSS; embed PSS messages within other communications where this is possible; promote the systematic use of national health social marketing campaigns; deliver a 2013 Self Care Week Social Marketing Campaign targeting children, families and young people, and BME communities. (Action 1.5, 2.5, 2.6, 2.7, 2.8, 3.6)

Fig 2: Croydon Right Treatment leaflet

10. Dependencies and Risks

Critical dependencies for the successful implementation of this strategy include: the implementation of the strategies and programmes listed in the introduction; the successful delivery of schemes improving appropriate use of resources such as Pharmacy First, GP First, NHS 111; the continued delivery of services that support self-care such as Public Health Croydon's smoking cessation and adult and child weight management programmes; the continued participation of Croydon primary and secondary schools in the Healthy Schools Programme and School Sports Partnership; local employers implementing workforce health schemes; Croydon healthcare professionals participating in CPD around PSS.

Risks include Croydon Clinical Commissioning Group lacking the capacity to implement the strategy, poor 'buy-in' from partners and the significant budget reduction being experienced by local authorities and NHS financial constraints resulting in an inability to resource self-care and shared decision making related programmes and services.

11. Engagement with Partners

A Croydon Self Care Strategy is potentially relevant to many different local organisations including NHS Trusts, Croydon Council, major employers and voluntary and community sector organisations. In order to engage with and involve these organisations, it is essential that it is endorsed by Croydon Health and Wellbeing Board and championed by other Local Strategic Partnerships including the Children and Families Partnership.

In order for Croydon CCG Clinical Networks to be effective they will have to develop robust partnerships with relevant local stakeholders including children's services, mental health, drug and alcohol services, criminal justice and social care services. All Clinical Network priority implementation plans should specify the roles and activities of other relevant agencies that need to be involved. (Actions 1.1, 1.8)

12. Commissioning PSS

Croydon CCG will:

- ensure that those services which it commissions and are responsible for promote and support PSS, both amongst employees and service users, and wherever possible embed prevention, self-care and shared decision making within encounters between service users and service providers.

- ensure that throughout the commissioning process, providers are made aware of and put in place mechanisms that support the provision of the common core principles of PSS, to be embraced by all those working with service users.

- drive workforce development around PSS.

- in addition to commissioning services that have a clear evidence base, pilot services that use innovative approaches - given the challenges that face Croydon, continuing to work in the same way is not an option.

- increase the uptake of new technologies – mobile phone, web-based, social media, telemedicine - through facilitating innovation and commissioning services that utilise technology to improve health outcomes.

- explore innovative approaches to the commissioning process itself in order to drive the integration of services, centred around the patient.

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13. Strategic Objectives

Croydon CCG's Strategic Aim for its 'Prevention of Ill Health and Self- Management' priority area is to reduce the overall mortality rate for amendable diseases.

To support achievement of this, we will be measuring achievement against the following objectives:

12.1 To increase levels of primary prevention amongst Croydon residents

This will be measured using data collected by Public Health Croydon tracking the prevalence of lifestyle behaviours that put health at risk, such smoking, alcohol, and BMI.

12.2 To increase levels of self care amongst Croydon residents.

This will be measured in three ways:

i) Through measuring an increase in self care knowledge amongst Croydon residents through 2,000 responses to a self-care questionnaire distributed and analysed by Croydon Council pre and post implementation.

ii) By using data collected on a monthly basis by Croydon's Medicines Management Team, breaking down users of Croydon's Pharmacy First scheme in terms of age, ethnicity and postcode.

iii) The number of community engagement events delivered by community champions during Self Care Week 2013 and increased childhood

immunisations uptake in targeted areas in the three months following Self Care Week 2013.

12.3 To improve self-management support for patients with long-term conditions.

This will be measured using the LTC6 six item patient questionnaire, which uses validated questions measuring the knowledge, beliefs and perceptions necessary for people with long-term conditions to sustain change over time. Administering the questionnaire will be one of the KPIs for the provider of intermediate tier diabetes services and can be introduced into other care pathways e.g. COPD, heart failure.

12.4 To increase levels of shared decision making.

This will be measured through: documented evidence that patient decision aids have been incorporated in the reconfigured patient pathways for diabetes, cardiology, cancer, respiratory, dementia and through read code data identifying the number of patient decision aids 'prescribed' to patients in the five priority areas identified by CCCG clinical leaders; an increase in the number of patients feeling supported to share in decisions from baseline levels.

12.5 To increase workforce capacity to support PSS.

This will be measured by the number of Croydon CPD courses established in 2013/14, the number of attendees on all PSS related courses in Croydon during 2013/14 broken down by employer / professional role and by the number of Croydon health and care post job descriptions that include PSS related competencies.

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Appendix 1: Croydon CCG PSS Programme Plan 2013 – 14

	Jul-13	Aug-	Sep-	Oct-	Nov-	Dec-	Jan-	Feb-	Mar-	Apr-	May14	Jun-	Jul-14	Aug-	Sep-
PSIG Meetings															
PSS Research															
Comms Plan															
PPI Plan															
Revise Contracts															
Incentivisation Feasability															
MH Assessment															
Provider Engagment															
Implementation Plans															
PSS HNA															
MECC Paper															
CLG Apps Selection															
CLG PDA Selection															
Tech/Apps in Pathways															
PDAs in Pathways															
Self Care Week Campaign															
Recommission Diabetes															
Redesign Diabetes Pathway															
Review LTC Patient Education															
LTC6 Patient Survey															
YoC Feasability															
FLORENCE Project															
SDM Mapping															
PSS Workforce Development															
MECC Training Feasability															
PH Health Campaigns															
PH Training Programme															
6 Month Evaluation															
12 Month Evaluation															

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