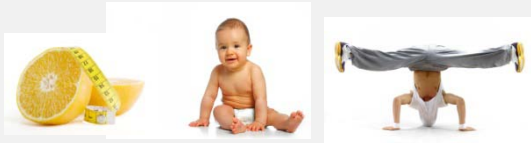
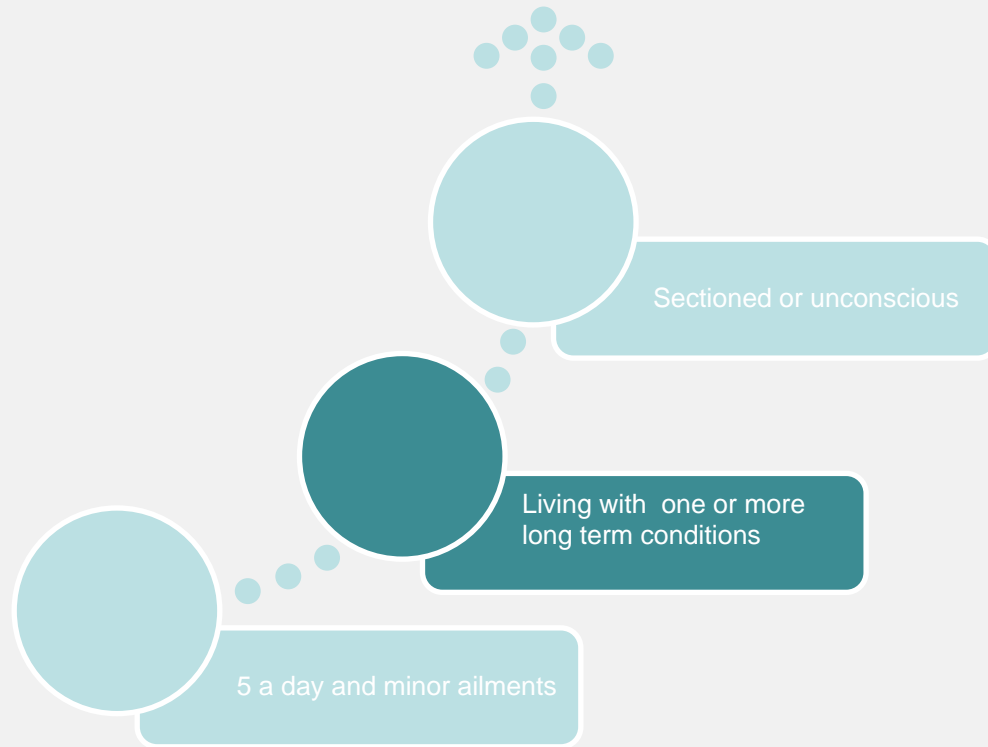


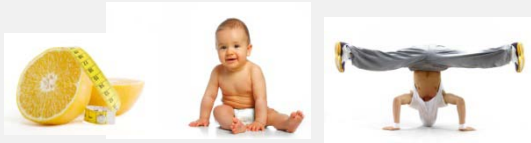
Commissioning Support for Self-Management: Oxfordshire case study

Rachel Martin
Assistant Director QIPP Delivery, LTC and Self Care



The self care continuum

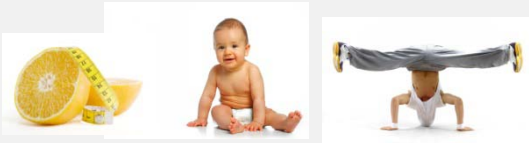




What do we mean by self care/self management in Oxfordshire?

Building the ability of individuals to manage the symptoms, treatment, physical and psychosocial consequences and lifestyle changes inherent in living with a long term disorder

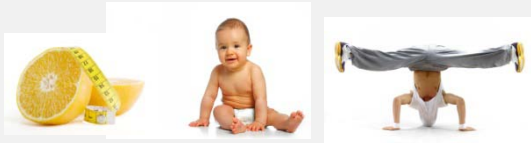
....or helping people to help themselves.



The Oxfordshire Approach

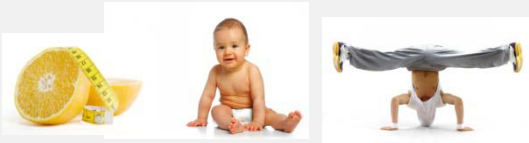
Self care projects:

- Patient Education programmes – Choosing Self Management for Life
- Carer education programmes – Confidence to Care
- Web based self care plan and information resource – www.oxfordshireselfcareplan.co.uk
- Workforce development – Supporting Self Management for Life

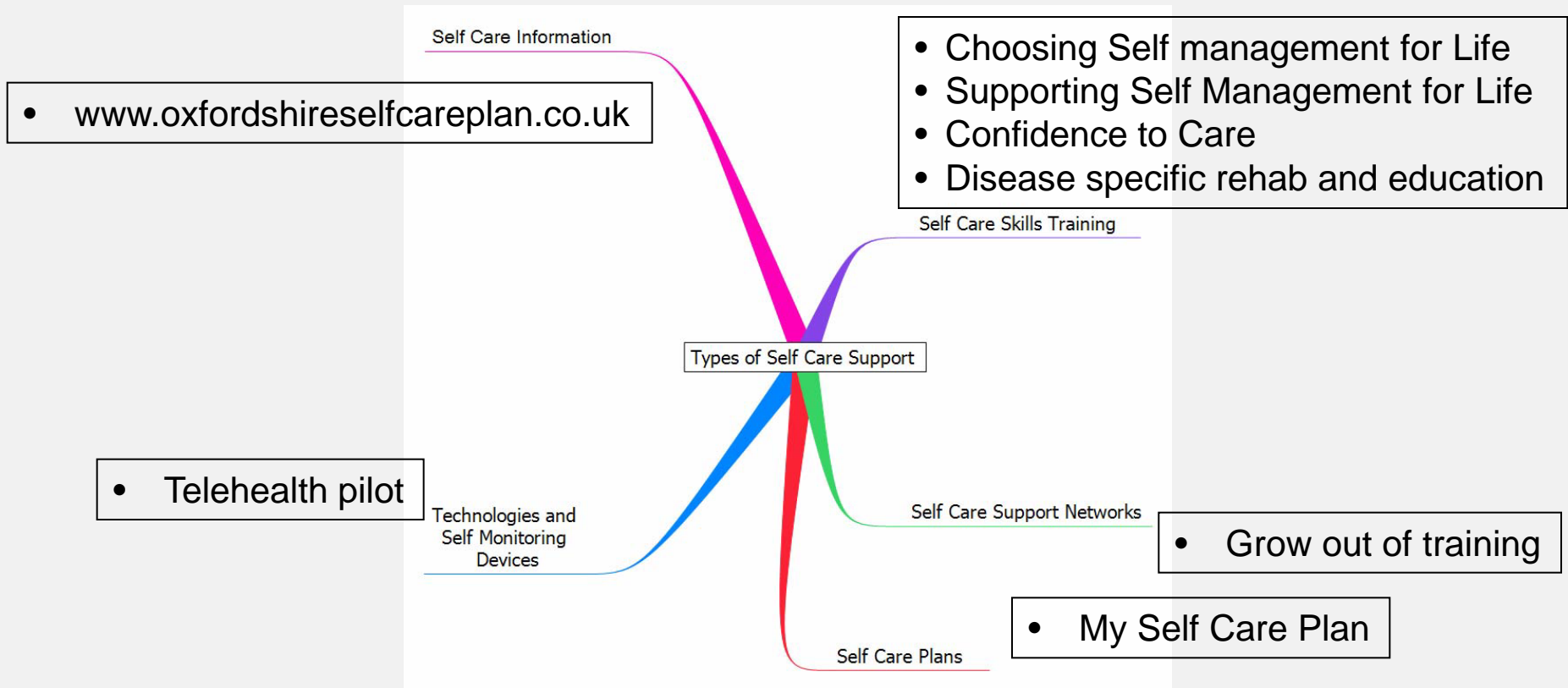


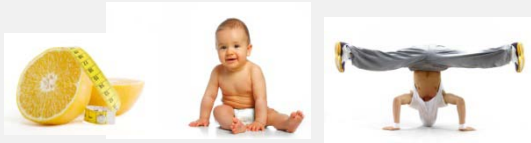
Important related projects

- Telehealth pilot
- Development of integrated community teams
- Upgrading predictive risk modelling tools and becoming more sophisticated about how we use them
- System focus on reducing delayed transfers of care and promoting older people's independence
- Pulmonary and cardiac rehab, specialist Diabetes Nurse team
- Case Management



RESEARCH EVIDENCE ON THE EFFECTIVENESS OF SELF CARE SUPPORT, Dec 2007, DH





Evolving the strategy

Step 1: Early 2009

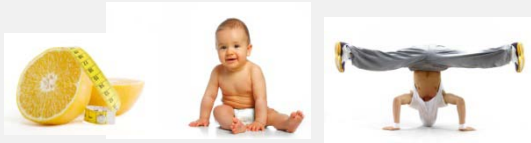
- 5 EPP courses a year commissioned by PBC, for 3 financial years (9/10, 10/11, 11/12)

Step 2 : Autumn 2009- Summer 2010

- Whole system planning event identified developing support for self care as 1 of 5 major transformation programmes needed
- Senior manager appointed to lead development
- Began to research options and approaches
- Began to build support

Step 3: Autumn 2010- Spring 2011

- Develop a simple strategy and a means to communicate it
- Design , deliver and evaluate a pilot
- Incorporate ambitious roll out plan in 11/12 QIPP plan
- Build networks for support and influence



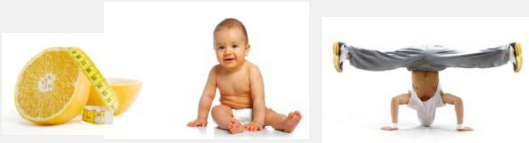
Evolving the strategy

Step 4: Summer 2011-now

- Project manager
- Single tender waiver to allow pilot partners to deliver expanded programmes
- Deliver QIPP plan commitments
- Ongoing work to manage stakeholders and to “sell”
- Create GP commitment

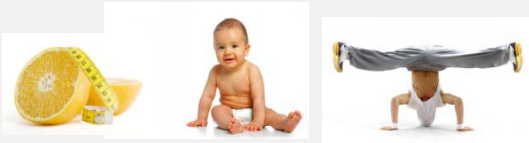
Step 5: Next steps

- 12/13 QIPP planning and delivery
- Really embed in primary care
- Longitudinal evaluation – potentially with King’s Fund



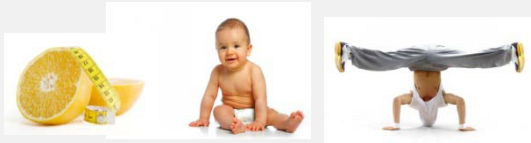
Choosing self management for life x 26

- 7 session programme
- Targeted at patients with 1 or more long term condition
- Focus is on understanding what it means to live with a condition for life, and how you can take control of it, rather than it having control of you
- Patients encouraged to use My Self Care Plan and to form long term informal support networks
- GPs, pharmacists, community teams and secondary care clinicians can all actively promote
- Currently recruitment is done by direct mail from practices



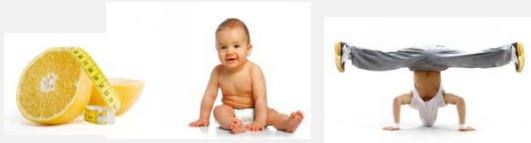
Confidence to Care x 8

- Commissioned by social care
- Timetabled so at least some programmes same day, time, place as patient programmes
- Common language and content
- 5 session programme
- Targeted at people with a long term caring responsibility
- Focus is on looking after yourself so you are able to go on caring
- Carers encouraged to form informal support networks
- GPs, pharmacists, community teams, secondary care clinicians and voluntary sector can all actively promote



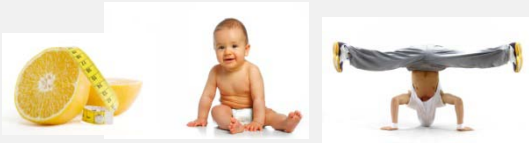
My Self Care Plan

- Electronic or written plan that patient can share with professionals
- Accessed via a website that incorporates major information resource (www.oxfordshireselfcareplan.nhs.uk)
- Encourages patients to think about what they want to change about their lives
- Takes a person through a structured thought process that helps them set manageable and achievable goals
- Developed by patients in partnership with a healthcare professional who can help them stay motivated and who can ensure plans are clinically sensible
- Includes crisis management plan for the underlying physical condition(s)
- Introduced in patient, carer and workforce training programmes



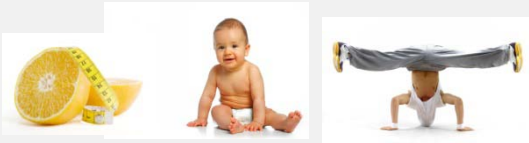
Workforce education – Supporting SM4L

- Community provider incentivised to train 400 front line staff between December 2012 and April 2013
- Courses for 25 nurses from respiratory, diabetes and neuro nurse teams at main acute
- Course for staff in main voluntary sector provider of wellbeing and recovery action planning with MH service users
- Courses for qualified and unqualified staff in 28 pharmacies



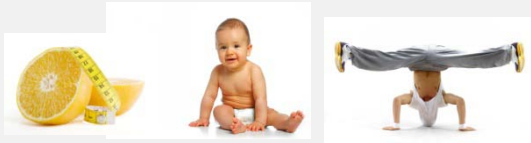
Mistakes/problems/barriers

- Unable to meet very ambitious savings targets for this year.
- Nature of targets set, and inability to meet them, have both impacted on primary care engagement.
- Community of patients being developed who want to make self care plans, but community of clinicians to work with them not yet in place.
- Self care plan technology still not really fit for purpose.
- Still no widely recognised GP champion.



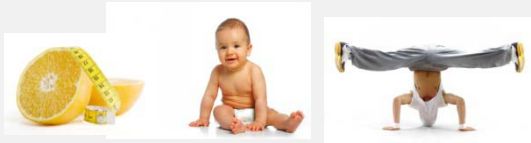
Successes

- Focussing delivery wherever we found support and active engagement.
- Creating an irresistible tide of support that the cynics can't counter.
- Being really honest about the risks, the unknowns, the lack of clear evidence.
- Evolving the products in partnership with expert providers.



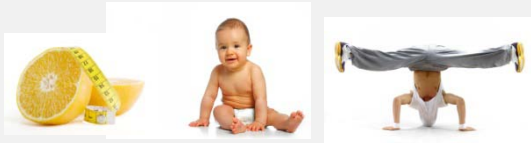
Immediate hurdles

- In terms of savings, self-care is difficult to quantify. Poor evidence base and long lead time on return on investment make it difficult to justify in year savings for QIPP.
- Successful delivery is dependent on primary care's active participation in the programme.
- Getting the MSCP tool fit for purpose and into widespread use.
- Ensuring development of co-ordinated treatment plans by integrated community teams works with, not against, MSCP.
- Ensuring that roll out of ACG predictive risk tool in primary care supports pro-active patient identification and referral for self management support.



Next year's commissioning plan

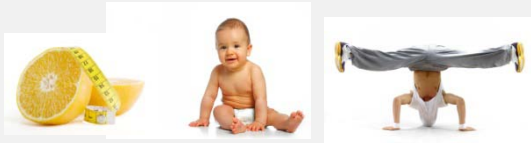
- Up to 55 CSM4L – or equivalent
- Up to 7 SSM4L – or equivalent
- Access to online equivalent for up to 100 patients
- 1 x b5 self care locality co-ordinator per primary care locality to;
 - Provide practical support to practices to set up and run patient courses
 - Run self care planning clinics with patients and support patients with development and delivery of their plans
 - Provide follow-up support to both patients and clinicians via telephone
 - Do the data entry of MSCP plans onto the system for patients who do not use computers
 - Deliver clear targets for numbers of self care plans created
 - Make themselves redundant over a three year period by embedding self care support into usual care in primary care in their locality
- Communications and marketing campaign
- Tender for 1 lead provider
- Tender modelled on minimum/maximum volumes basis , and annually renewable contract
- Will need to be competitively tendered



The money

2011/12	£,000
26 patient and 5 staff courses	211
Comms and MSCP printing	10
MSCP website and booklet development , and licence	45
1 off incentive payment to community health provider for staff training and adoption of MSCP	120
Total	386

2012/13	£,000
55 patient and 7 staff courses	460
Comms campaign and MSCP printing	18
GP backfill to attend training x 24	16
On line courses for 100 patients	20
Locality self care leads x 4	121
Total	635



Outcomes we hope to deliver

- Improved clinical outcomes (eg improved HbA1C scores, reduced COPD exacerbations, improved depression scores)
- Reduction in unplanned ACS admissions
- Reduction in outpatient appointments
- Reduction in GP and practice nurse appointments
- Improved medication compliance
- Improved uptake of weight loss, smoking cessation, new medicines advice service and other pharmacy led programmes
- Improved patient perceptions of quality of life and confidence to manage as measured by LTC 6, HIEQ, EQ5D and SQ28 section of GP survey
- **Patients and staff saying they like it and think it works**