

“Thanks for the Petunias”



A guide to developing and commissioning non-traditional providers to support the self management of people with long term conditions

This guide, which is a product of the Year of Care Programme, was sponsored by the NHS North East Innovation Fund, developed by Sandra King of Sandra King Associates, and led by a Steering Group comprising:

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"Thanks for the Petunias" - feedback from a contented user of a local community centre, following the official launch of the centre's community garden. A group of centre users 'the garden group' had helped to plan and develop the garden, transforming a bare plot of land into a multipurpose green space, including a play area, sensory garden and raised beds for wheelchair users. The community centre is run by a charity which is also a non-traditional provider of services to support people with the self care of their long term conditions. Note on language: this guide refers to 'people', 'persons', 'individuals' and occasionally 'service users'. The term 'patients' has been reserved for contacts with traditional health services, where to do otherwise might lead to confusion.

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For further information go to: www.diabetes.nhs.uk/year_of_care

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Foreword

Non-traditional providers (such as voluntary organisations, community groups and social enterprises) are important additions to routinely commissioned services. They are often deeply embedded in the communities they serve and can provide more 'tailor made solutions' for the needs of people with long term conditions (LTCs) identified through the collaborative care planning process.



Engaging with non-traditional providers in an effective way can lead to:

- Better outcomes for people with LTCs (social and clinical)
- More cost effective use of NHS resources (and social care)
- Widening of the local provider base

This guide is an important product of the national Year of Care Programme. Year of Care is a successful programme, originally piloted in three diverse health communities in 2007/10.

It had two aims:

- Firstly to make routine consultations between clinicians and people with LTCs truly collaborative, through care-planning
- Then to ensure the local services, that people need to support the actions they want to take to improve their health and well being outcomes, are available via commissioning

This guide is the outcome of the second work stream, to capture the outputs of care planning, and develop community based services to support self management.

Whilst the Year of Care pilot sites wished to develop the role of non-traditional providers they encountered a number of challenges for systematically commissioning such services. This guide offers a potential organisational model that addresses the numerous barriers that were raised. It also gives ideas as to how this could work on a practical level.

A key element in the guide is 'commissioning for sustainability', ensuring it becomes embedded in the local health economy, rather than becoming another well intentioned pilot that is cut when funding streams become tight.

This is not a definitive guide to commissioning, but an exploration of a possible organisational model that can be adapted according to local circumstance, resources and need. I hope that you find this guide helpful as you work towards effectively commissioning non-traditional providers to support people in your locality to manage their long term conditions.

Dr Sue Roberts
Clinical Lead, Year of Care Programme

Summary

The issue

Prevalence of long term conditions (LTCs) is predicted to rise, and the current systems supporting people with LTCs are not financially viable or broad enough in scope to support all their needs.

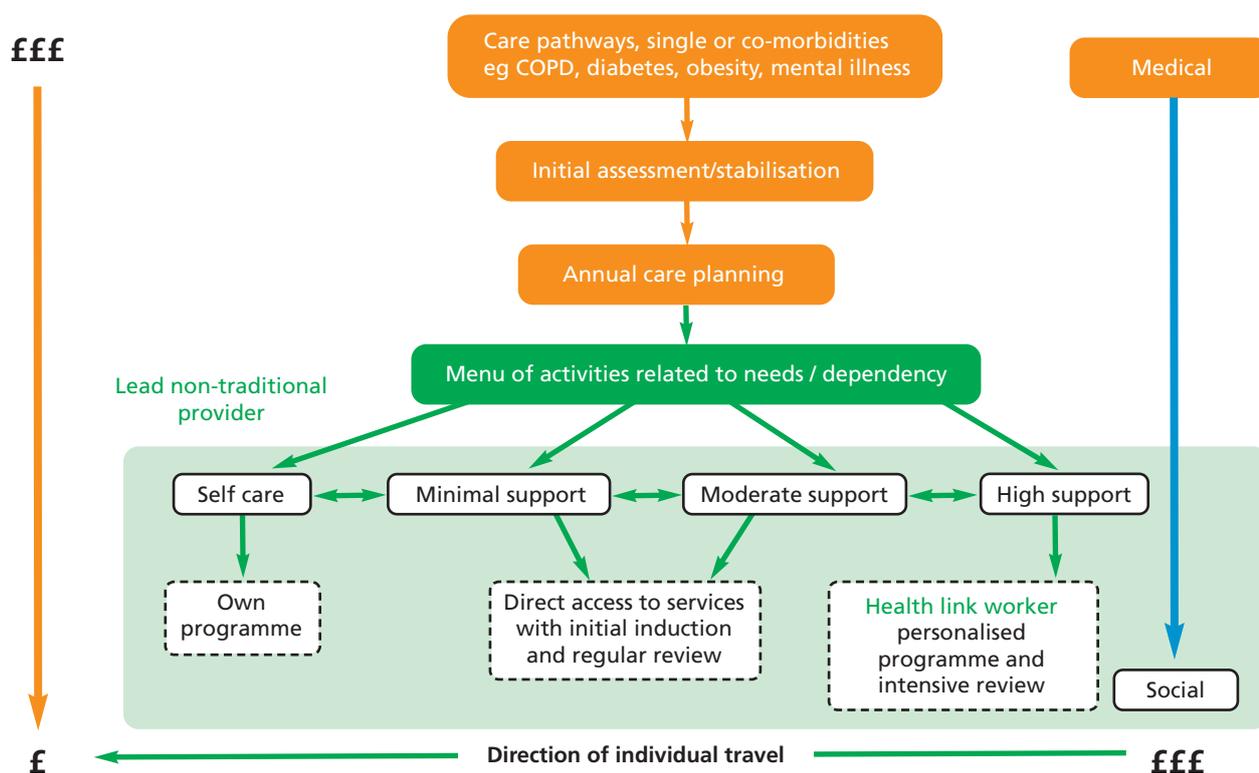
How does this guide help?

Offers new, practical and cost effective ways to increase the opportunities for self management for people with LTCs by engaging with local non-traditional providers (e.g. charities, community organisations and social enterprises) to meet their needs.

Pathways between medical and social models of health for people with long term conditions (see p21)

This is not an 'either or' situation, with the person either being supported by the NHS or by non-traditional providers, but rather a shift in balance.

- Interventions in orange are more traditional and fit with the medical model of health
- Interventions in green are non-traditional and are more aligned to the social model of health
- Green arrow shows the direction of individual travel, aiming for everyone to move towards the left hand side of the diagram (self care) with the associated reductions in cost of care
- Orange arrow indicates that those newly diagnosed (who may require specialist assessment and stabilisation) will have higher costs than those at the bottom who are largely managing their LTCs with support from non-traditional providers



This guide includes:

Top tips

e.g. The essential role of the Service Model Delivery Steering Group (p14)

Case studies

e.g. Bengali Men's Cookery Session (p9)

Food for thought

e.g. Why the on-line health directory is a critical part of this organisational model (p27)

Tools

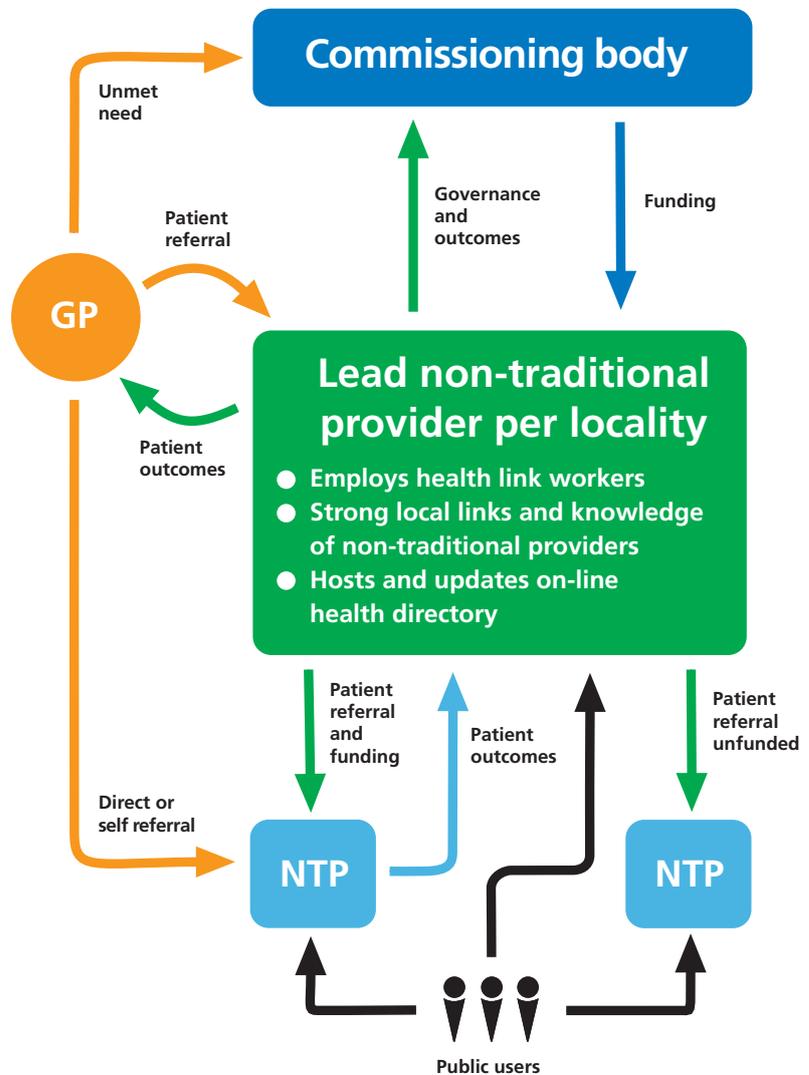
e.g. Measuring outcomes and effective data collection (p41)

This guide is of relevance to:

Commissioners, primary health care teams, Health and Wellbeing Boards, anyone with an interest in redesigning services to improve outcomes of people with LTCs.

A potential organisational model

The model shown below is described on p13.



Note: Non-traditional providers (NTPs) - two shown for illustration as there could be 1,000 or more.

This guide helps to address:

Self management of LTCs



Health inequalities



Personalisation



Sustainable commissioning



Section 1

Why commission non-traditional providers?

Introduction

This guide has been produced to support the effective commissioning and development of non-traditional providers (NTPs) to support people with Long Term Conditions (LTCs) in a local health economy. Engaging effectively with NTPs can help to increase the opportunities for supporting self management and improving their outcomes.



“This is not a quick fix, but it is an exciting opportunity to really get to grips with commissioning in a different way to improve patient self care of LTCs. It is clear to me that in order

to demonstrate patient outcomes GP buy-in will be essential.

The non-traditional providers can collect some outcomes data, but a lot of the relevant data is held by us. Going forwards we will need to ensure that we provide the baseline and outcomes data on our patients (pre and post intervention) in order that we (as commissioners) can decide on the validity and cost effectiveness.

There will need to be a change in culture which will not just be down to GPs and practice staff but also the third sector who will need to be flexible. I can see real benefits for my patients with LTCs.”

Caroline Sprake,
GP lead for Long Term Conditions,
Care First North East GP Consortia

Not another toolkit!

Anon, Commissioning Manager, Year of Care Pilot Site

Mindful of a plethora of toolkits to support commissioning, this guide seeks to signpost readers, where guidance already exists, rather than to duplicate existing tools. For example, the ‘Successful Commissioning Toolkit’ on the Audit Commission website¹ gives excellent practical guidance on how to commission from the third sector, so is listed in the references, further reading and useful websites section.

The need for the guide came from the Year of Care pilot sites which found that the biggest barriers to providing services to support self-management, in the context of care planning, were:

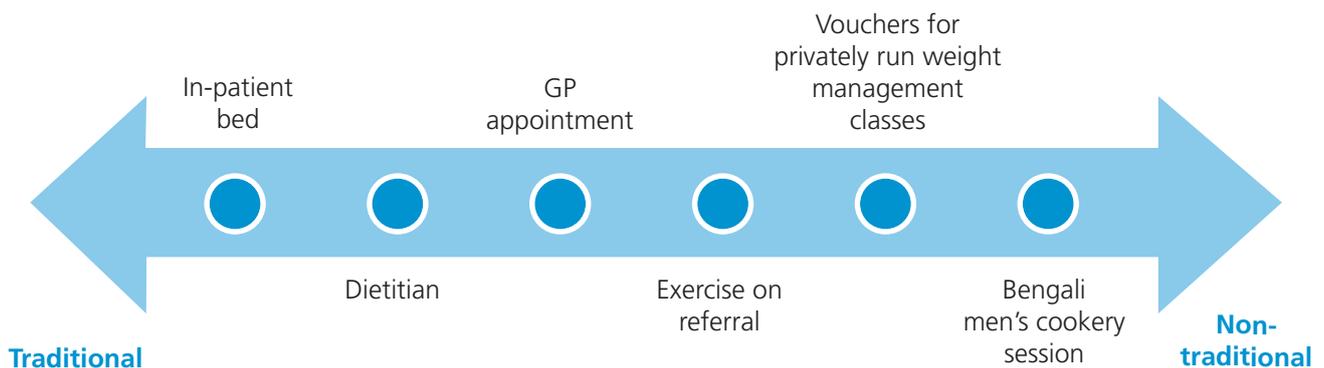
- Failure to stimulate NTPs to support lifestyle change
- Services provided by NTPs were fragmented, often on short term funding cycles and poorly understood (indeed not seen as ‘therapeutic’) by clinicians and practice staff
- Difficulties finding effective ways to demonstrate outcomes that were meaningful to both people with LTCs and GPs, and also that justified moving money around the system

Whilst this guide is geared towards NHS commissioners, the content and the proposed organisational model could be particularly useful for Health and Wellbeing Boards, as the approach lends itself to innovative partnership working, joint funding opportunities and pooled budgets. It will also be of use to people involved in service redesign for LTCs.

This guide should be used in conjunction with 'Getting to Grips with the Year of Care: A Practical Guide'² which gives a wider overview of implementing the Year of Care Programme. Further background information on the Year of Care approach to supporting people with LTCs can be found in Appendix 1.

What are non-traditional providers?

A person with one or more LTCs may have a number of providers who work with them to help them to manage their LTC. They will range from traditional and mainstream health service providers, to NTPs in the third sector (such as charities, community groups or social enterprises) or private sector. This can be demonstrated on the diagram below to be a continuum, with exercise on referral being in the middle, as an intervention that 15 years ago would have been considered non-traditional, but which is now more mainstream.



NTPs can complement the services that people with LTCs already receive from the NHS. NTPs can provide flexible, locally appropriate services that help individuals with various aspects of their self management.

Different people will have different needs. However, the majority of services that NTPs can provide to support people with the self management of their LTCs are likely to be in the following six domains:

- **Physical activity** e.g. community gardening project
- **Healthy eating/cooking** e.g. cookery club in a community centre
- **Arts for health** e.g. 'knit and natter' groups
- **Befriending** e.g. local volunteer led befriending scheme
- **Welfare rights/benefits** e.g. local Citizens Advice Bureau or advocacy centre
- **Volunteering opportunities** e.g. volunteering at community hub

This guide does not specifically seek to justify the therapeutic value of NTPs, as the evidence base for this is covered in other documents, some of which are highlighted in the references, further reading and useful websites section.

Why and how to develop NTPs is addressed throughout the rest of the guide.

Making the case

This is an exciting opportunity to get to grips with commissioning in a different way to better support people with their self care of LTCs. However, it will require significant cultural and systems changes across health and the third sector (and potentially the local authority), so it is important to be clear about the reasons why the change is needed.

Five key reasons are highlighted below:

- Current system is not financially sustainable
- A more flexible approach is needed to meet the personalisation agenda
- Service delivery models should address health inequalities
- Need to increase social capital and social connections
- The current systems for collecting and collating unmet need, and for health care staff to refer to NTPs, are not working

Current system is not financially sustainable

The existing model of supporting people with LTCs is not financially sustainable going forwards, due to the predicted increase in numbers of people with LTCs. In 2007, over 15 million people in England lived with a long term condition. This population are proportionately higher users of health services and account for 55% of GP appointments, 68% of outpatient and A&E attendances, and 77% of in-patient bed days³. Long range estimates indicate that the population of England is expected to increase to 74.7 million by 2081 (an increase of 24 million on the 2006 population), with 26% of these aged 65 and over⁴.

The public health white paper, 'Healthy Lives, Healthy People'⁵, stresses that "... it is not better treatment, but prevention – both primary and secondary which is likely to deliver greater

Case study of a non-traditional provider:

Bengali Men's Cookery Session, Tower Hamlets

The need: Traditionally, Bengali men are not engaged in cooking in the household, so were not aware of ingredients in dishes. This made it harder for them to understand how to eat healthily to better manage their diabetes.

The solution: Social Action for Health (SAfH), a local NTP, was already engaged with Bengali men, helping them to manage their diabetes. They employed staff from the local Bengali community so language was not a barrier. They had access to kitchen facilities in a local, well used, community centre. SAfH engaged a local chef to run the cookery sessions, and used their existing networks to recruit local Bengali men to the cookery club.



overall increases in healthy life expectancy." This guide particularly focuses on secondary prevention, commissioning services that will prevent worsening health for those people with existing LTCs, and thus reduce costly interventions in specialist care.

The table below, adapted from *Managing Long Term Conditions*, Audit Scotland, August 2007⁶, indicates how we need to move towards a new model of care that is less geared towards acute conditions and more geared towards LTCs. The table also indicates the move from a model of care that is hospital centred to one that is embedded in communities. A key success factor therefore, will be to ensure that over time, patient flow (and most crucially the funding that follows the patient) is towards community based care.

Current view	Evolving model of care
Geared towards acute conditions	Geared towards long-term conditions
Hospital centred	Embedded in communities
Doctor dependent	Patient centred with supportive team
Episodic care	Continuous care
Disjointed care	Integrated care
Reactive care	Preventive care
Patient as passive recipient	Patient as partner
Self care infrequent	Self care encouraged and facilitated
Carers undervalued	Carers supported as partners

A more flexible approach is needed to meet the personalisation agenda

There is a strong move, in both health and social care, towards delivering personalisation through person-centred thinking and planning. This links with the principle 'no decision about me without me' in the White Paper *Equity and Excellence: Liberating the NHS*⁷. The approach described in this guide should facilitate this process by offering more choice of services in local communities, built on the unmet needs of the population which are recorded and collated through care planning and fed into the commissioning process.

The personalisation agenda means there needs to be flexible commissioning and provision of services. The individual needs of people with LTCs are very personal and different and change over time. Adaptability is key and this has been built into the proposed operational model in this guide.

Service delivery models should address health inequalities

As the influential Marmot Review⁸ noted, people in the poorest neighbourhoods not only die sooner, but they will also spend more of their shorter lives with a disability. Current commissioning of services and support does not meet the needs of significant sections of our population.



“Focusing on inequalities should be central to all commissioning: it makes clinical, social and economic sense. People who are from our deprived communities, or who are marginalised in

terms of access to health and wellbeing information, support and services in other ways (e.g. people with a mental illness; some BME communities; people who are housebound) are more likely to:

- Present late with LTCs
- Require emergency or unscheduled care
- Experience more co-morbidity
- Be less likely to attend routine GP requests for attendance for reviews of their condition and are less likely to attend specialist clinics and outpatient appointments

These combine to make these patients more complex to manage clinically, and increase their risk of experiencing complications associated with poor management of their condition. Such patients therefore are more likely to need emergency care, unscheduled care and more expensive and complex clinical interventions.”

Jan Smithies, Health Inequalities National Support Team (HINST), Department of Health

People from deprived or more marginalised communities are less likely to feel in control of their lives in general (including their health and wellbeing) and thus less assertive, more socially isolated and less confident to self-manage their LTC and pro-actively make significant life changes.

NTPs are often better able to outreach, engage with, and provide the information, support and services in a way that is more appropriate, accessible and better received and thus have increased take up.

The approach in this guide very much fits the QIPP (quality, innovation, productivity and prevention) model⁷, especially if the prevention component is focused on preventing the development of complications from manageable conditions.

The organisational model proposed in this guide addresses health inequalities through Marmot’s recommended ‘proportionate universalism’ (e.g. giving more resource to the more disadvantaged communities whilst still putting resource into all communities). The proposed model also aligns with work to increase social capital and with the movement towards asset-based community development (building on abilities and strengths of communities rather than focusing on the needs and weaknesses)⁹.

Need to increase social capital and social connections

Although there is growing evidence about the role and benefit of social capital and social connections on health, the idea that a lack of social relationships is a risk factor for death is still not widely recognised by health organisations and the public. One study¹⁰ that highlights this demonstrates that social relationships (with friends, family, neighbours or colleagues) significantly increase our odds of survival.

Risk factors

Low social connections, as a risk factor, compares to more well-known risk factors as follows:

- Equivalent to smoking 15 a day
- Equivalent to problem drinking
- More harmful than not exercising
- Twice as harmful as obesity

The study analysed data from 148 previously published longitudinal studies that measured frequency of human interaction and tracked health outcomes for a period of seven and a half years on average. Importantly the study shows that social interactions are not just beneficial for our psychological health but also for our physical health. The organisational model proposed in this guide will have a positive effect on increasing social capital and relationships in local communities.

The current systems for collecting and collating unmet need, and for health care staff to refer to non-traditional providers, are not working

There were a number of pitfalls within the current systems that were identified by the Year of Care pilot sites and that need to be addressed in order for people with LTCs and health care practitioners (HCPs) to make better use of NTPs. Some of the key issues are highlighted in the diagram below. Further details of all the barriers identified are in Appendix 2.

Therapeutic value of NTP interventions not understood by HCPs

Vulnerability of NTPs when it comes to cost pressures

Artificial barriers across disease/health issues

Plethora of small contracts for commissioning managers to manage

HCP lack of knowledge of, and confidence in, services provided in non-traditional sector

Support for patients is based on medical model with little understanding of social model of health

Easily accessible, up to date information on a wide range of non-traditional providers does not exist

HCP referrals are not well developed or non-existent to the non-traditional sector

Difficulties feeding patient outcomes back to GP practices as NTPs rely on paper based reports which get lost

Some commissioners unsure of when to use different elements of procurement ie grant or tender

Lack of IT systems to record and collate unmet needs of patients with LTCs and feed into commissioning model to support their self care

Outcomes that can be effectively collected by NTPs do not often easily match those expected by commissioners leading to inefficient reporting mechanisms

Section 2

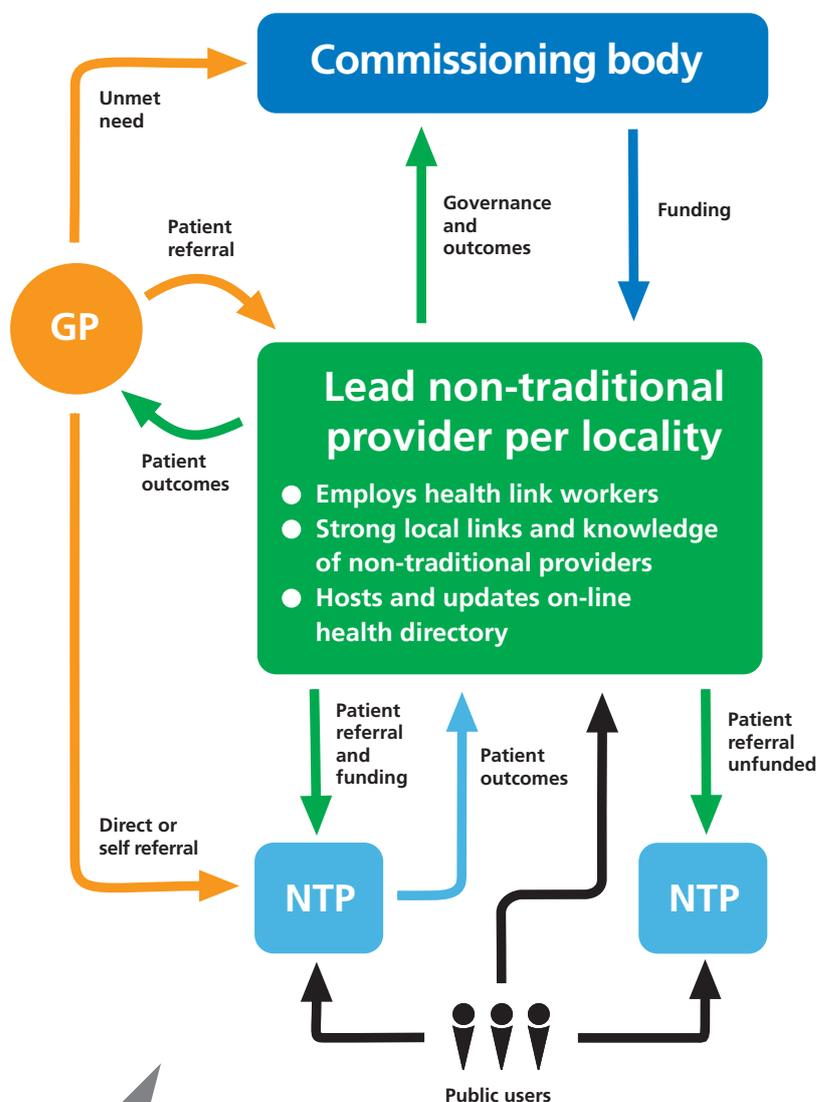
Making it work

A lead provider model

A significant number of barriers were identified by the Year of Care pilot sites to capturing patient unmet need and commissioning NTPs to meet that need. Some barriers were small and localised and could be relatively easily addressed, but there were many that were more fundamental. Research was undertaken to find models that could be used to address these barriers, and whilst there were examples of good practice to address some barriers, there was not one gold standard model that would address all the issues. What is described in this section is an organisational model that takes the best of existing models and puts it into a comprehensive framework.

A central feature of this model is simplified contracting arrangements:

- Commissioners have one contract with a small number of lead NTPs
- Lead NTPs take on the role of developing relationships with other local NTPs to meet identified patient needs, allowing for variability in each locality
- A much wider range of non-traditional services can be made available to people with LTCs without the commissioner having to enter into multiple contracting agreements



Note: Non-traditional providers (NTPs) - two shown for illustration as there could be 1,000 or more.

The terminology in the diagram may be new to some readers, but descriptions on the following pages clarify roles and relationships – demonstrating how this works for commissioners, primary health care teams, patients and non-traditional providers.

In an average GP Consortium area there might be a number of natural geographical localities (typically two to four), and a lead NTP may be required for each of these localities, to ensure a local presence and to increase ease of access for people with LTCs and likelihood of referrals from Health Care Professionals (HCPs). The organisational model on the previous page shows the relationship between one of the lead NTPs and the other key partners.

Top tip

It will be essential to have a strong and clearly focussed Service Model Delivery Steering Group.

The purpose of the group will be to ensure effective operation of the new delivery model, with regular reviewing and refining of systems. Suggested membership includes:

- GP commissioner
- Commissioning support staff
- Representative from the Health and Wellbeing Board
- User representative
- Secondary care clinician
- Public health lead for LTCs
- GP champion – provider

(The following members will need to join once the lead NTPs are in place)

- Chief Executives or equivalent from lead NTPs
- Project workers from lead NTPs (as decided by lead NTPs)

Further information on tasks for the Steering Group are highlighted throughout the rest of the guide, and further issues for them to think through are referenced in Appendix 3.



Non-traditional providers may include community gardening projects (addressing physical activity and social isolation) and mens' fishing clubs (addressing mental health issues and healthy eating).

The table below indicates the core functions of the different organisations in the organisational model.

Organisation	Core functions
<p>Commissioning body e.g. GP commissioning consortium</p>	<ul style="list-style-type: none"> • Convene Service Model Delivery Steering Group (see Top Tip opposite) • Identify need - interpret unmet need from GPs and link data from local Joint Strategic Needs Assessment (JSNA) and social marketing • Commission lead NTP, deciding on most appropriate funding mechanism (block funded or tariff based), and method (grant or procurement) • Agree key outcomes/performance measures, methods of effective data collection and frequency of reporting (see Appendix 5) • Review outcomes data and unmet need data and use to inform future commissioning rounds • Assess risk relating to service model and procurement/commissioning strategy • Undertake development and support where potential lead NTPs do not exist, or where they require encouragement and/or business support assistance to reach their full potential
<p>Lead Non-Traditional Provider e.g. local third sector organisation with knowledge of health issues in local population</p> <p>NB One organisation per locality would be easiest but a consortia of NTPs could work depending on local assets/organisations</p>	<ul style="list-style-type: none"> • Act as a single point of access for GP and commissioner • Employ health link workers who undertake initial assessment and action planning with referred patients (see Appendix 4) • Record progress and outcomes for individuals with LTCs using an agreed motivational tool such as the Outcomes Star (see Appendix 5) • Host, promote and update local on-line health directory using networks and links with local communities* (see Appendix 6) • Feedback individual outcomes to GP • Give individuals feedback on their personal results and collated feedback to commissioners • Produce annual report of care pathway jointly with commissioning body to feed into JSNA • Provide some non-traditional services for people with LTCs • Refer on to other local NTPs according to individual needs • Create appropriate business relationship (contractual or non-contractual) with other local NTPs, and set out risk, quality, performance and governance arrangements as required

Organisation

GP

e.g. practice staff working with patients with LTCs including GPs, nurses, administrative staff and health care assistants

Non-Traditional Providers

These are likely to be in the third sector but could also be in the private sector e.g. slimming club or dance class

Public

Core functions

- Staff trained to undertake care planning
- Care planning with people with LTCs and recording unmet need
- IT systems in place to record individual unmet need and extrapolate up to commissioner
- Refer people with high support needs to lead NTP
- Raise patients' awareness of the on-line health directory
- Engage in agreed patient performance monitoring and evaluation with lead NTP

- Provide people with services that will help them to manage their LTCs
- Those that receive funding from the lead NTP will also feed individual's outcomes back to lead NTP
- NTPs may be able to accommodate people in existing services where spare capacity exists, at no extra cost

- Direct access to NTPs – no referral required as these are organisations that already exist to provide a service in the local community
- Access NTPs either through existing channels, or through information in the on-line health directory

* Only one of the lead NTPs would be contracted to host the on-line health directory to cover the natural geographical area. Health Link Workers within all lead NTPs will be responsible for providing information to keep it up to date.

Although not specified within the operational model, specialist services would be able to sign-post their patients to local self-care opportunities available through the on-line health directory.

Top tip

The health link worker is a critical aspect of this model.

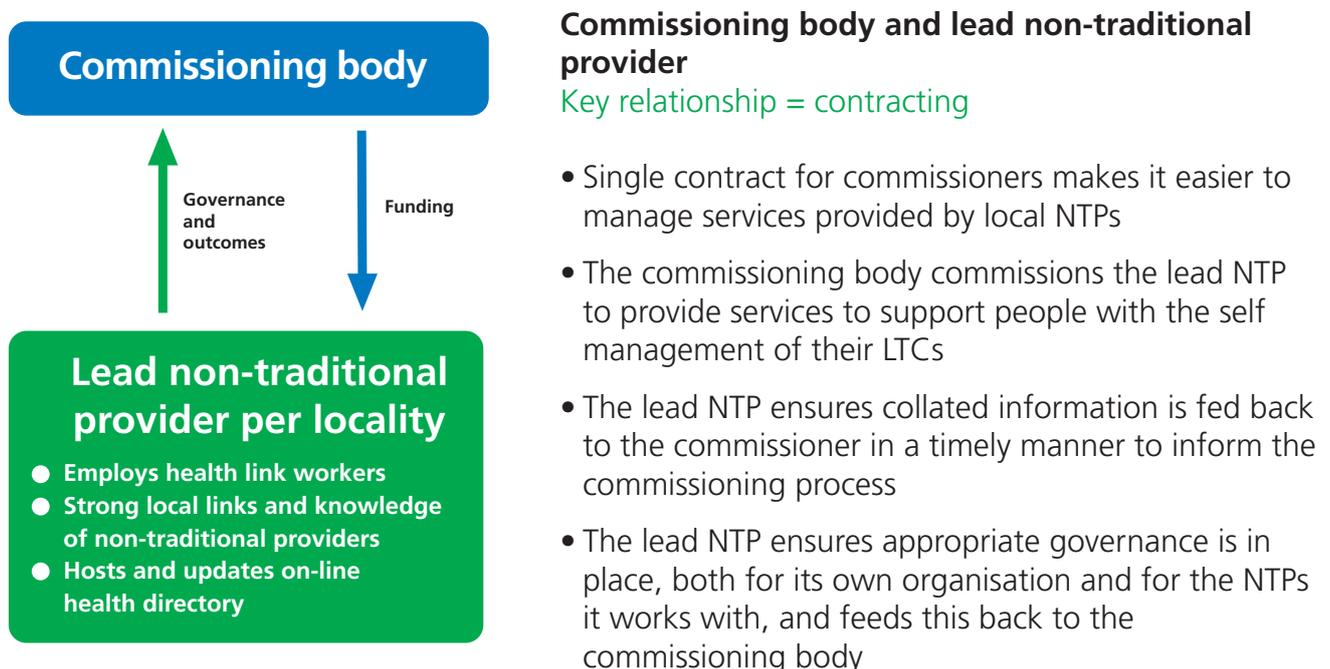
Recruited from the local area they are trained to support behaviour change and have a wide knowledge of local activities in the area being networked into other NTPs. Whilst they will be employed by the lead NTP it is strongly recommended that named health link workers are assigned to GP Practices in order to build trust and increase referrals between the organisations.

In some areas highly effective health trainers may already be using this approach. Further details on roles and responsibilities of health link workers can be found in Appendix 4.

Relationships between organisations

Having outlined the key functions of each organisation in the previous section, the relationships between the different elements of the operational model are clarified below. It is important to be clear about the relationships in order to:

- Avoid duplication
- Ensure effective and clear communication
- Promote seamless working relationships



Commissioning body

Unmet
need

Commissioning body and GP practice

Key relationship = needs assessment

GP

- Through the care planning process, primary health care teams record unmet need identified by people with LTCs to support their self management. This is recorded on practice IT systems
- Collated unmet patient need is fed back to commissioning body
- Commissioning body collates unmet need from all GP practices and uses to identify gaps in provision as part of a needs assessment process
- Commissioning body (with specific input from public health commissioners and locality commissioners) feeds unmet need into local planning process through JSNA and the Health and Wellbeing Board

"The best computer system in the world won't tell you what the unmet need is if clinicians don't have the consultation skills to be able to elicit from patients what their needs are, and how they'd like these met"

**Nick Lewis-Barned, Physician,
Northumbria Diabetes Service**



Overcoming IT Barriers

In 2011 the Year of Care Programme developed detailed requirements, including sample templates and reports for IT systems, to support this work.

The national suppliers of the main GP electronic record systems are engaged, and working to make these available in the near future.

GP practice and lead non-traditional provider relationship

Key relationship = referral, assessment, planning and outcomes

- Health link workers are employed by the lead NTP
- Named health link workers are assigned to specific GP practices
- GP refers patients with LTCs to their named health link worker in their locally based lead NTP
- Health link workers undertake action planning to integrate the self care of all of the patients' LTC(s)
- Clear reporting mechanisms for patient outcomes are agreed between GP and the lead NTP. This facilitates demonstration of increase in an individual's self reported health outcomes, and corresponding reduction in their use of NHS resources
- Practice staff build trust and rapport with staff in lead NTP so referrals increase



Top tip

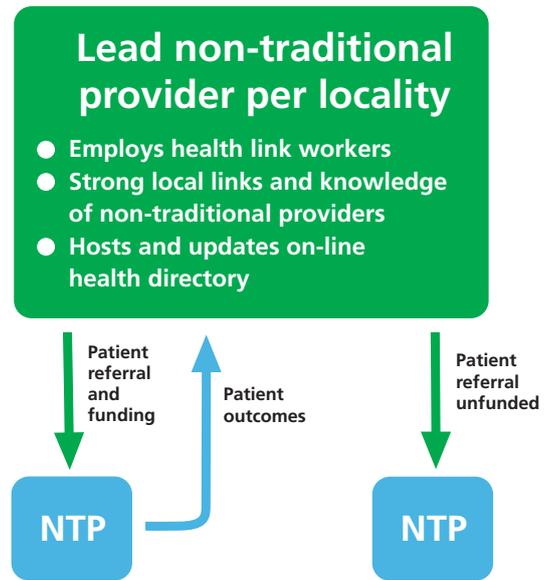
In terms of data collection, clarifying who does what, when and why may be boring but is very necessary!

Appendix 5 gives details on who does what in terms of effective data collection to measure patient outcomes, thus ensuring effectiveness and efficiency of the processes.

Lead non-traditional provider to other non-traditional providers relationship

Key relationship = outreach service provision

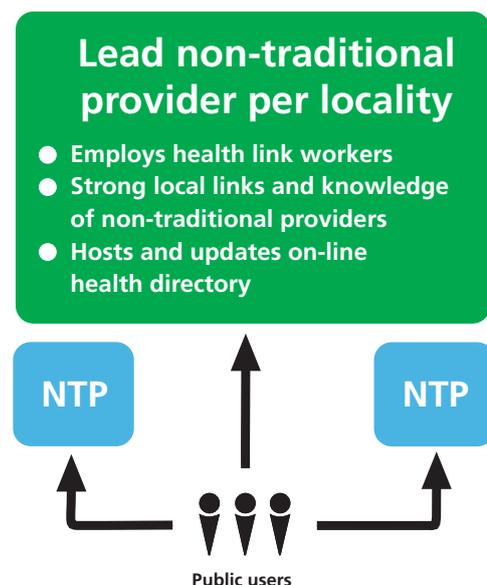
- There are two differing relationships here
- The NTP on the left is sub-contracted by the lead NTP to provide services to support patients with LTCs. This is a formal relationship with agreed patient outcomes being fed back from NTP to lead NTP. A percentage of the lead NTPs annual fee is specified by the commissioner to be sub-contracted to smaller NTPs for services provided, ensuring transparency and fair distribution of resources
- The NTP on the right is an informal relationship, where the health link workers in the lead NTP may suggest to a person with LTCs that they go along to the NTP. This informal arrangement, with no exchange of funds, means that the NTP cannot be expected to provide the same level of formal outcomes for individuals with LTCs to the lead NTP, but may choose to provide some agreed measures of value
- On-line health directory allows all NTPs to increase visibility and facilitate sign-posting between services



Non-traditional providers and the public

Key relationship = community engagement

- NTPs are independent entities and as such the public may already be able to access them directly, and this continues to exist in this model
- Public users can search the on-line health directory to find out about NTPs to help them with self management of their LTCs
- Sessions run by some NTPs are not always run to capacity due to lack of awareness of provision. Presence on the on-line health directory can help NTPs to recruit their 'target' audience



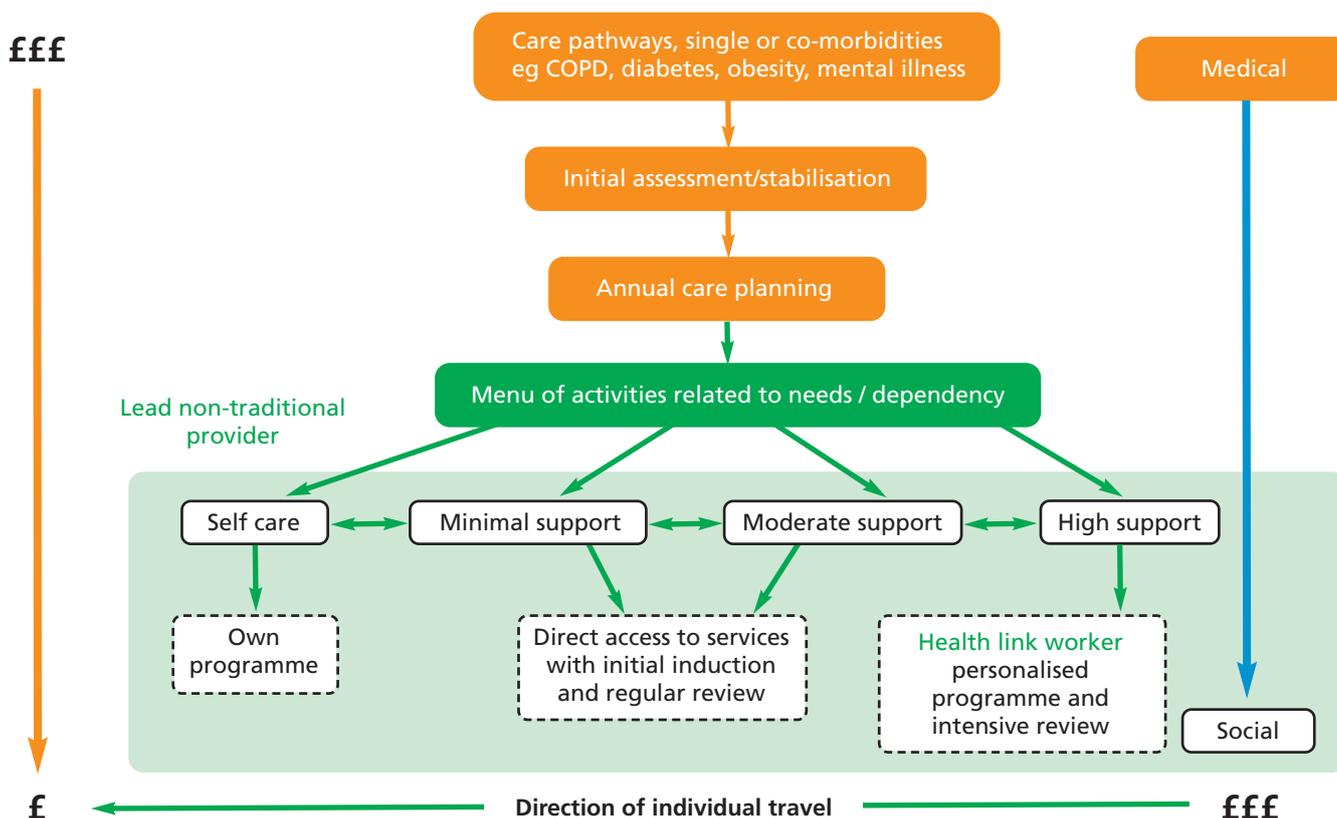
Top tip

There are two key principles that need to apply, whatever the shape of the model that you use in your local area to develop non-traditional providers to support people with the self care of their LTC(s):

1. Visible base in each locality, to increase awareness of lead NTP by health care practitioners
2. Ease of referral for health care practitioners

Clarifying the pathways between medical and social models of health

In order to improve 'patient care' it is important to take the most therapeutic interventions for each person from both the medical and social model of health. The model below shows the patient pathway and the transition from a medical to a social model of health.



The top half of the diagram (in orange) indicates the interventions that are more traditional and fit with the medical model of health. The bottom half of the diagram (in green) indicates more non-traditional interventions that are more aligned to the social model of health.

The green arrow at the bottom of the diagram shows the direction of individual travel, with the aim being for everyone to move towards the left hand side of the diagram, i.e. self care. This process will vary in ease and length of time according to the starting point of the person. Costs for those on the right hand side with high personalised support needs will be significantly higher than for those on the left hand side who are able to support their own self care programme. It also needs to be acknowledged that people may come in and out of different levels of support depending upon circumstances e.g. a recently bereaved widower may have relied on his wife to cook, or someone who may develop an additional LTC.

The orange arrow on the left hand side of the diagram above indicates that it is likely that newly diagnosed patients (at the top of the diagram), who may require specialist assessment and stabilisation, will have higher costs than those at the bottom who are largely managing their LTC with support from NTPs.

The diagram clarifies that it is not an 'either or' situation with the person either being supported by the NHS or by NTPs, but rather a shift in balance. More care being provided by NTPs supports a more personalised and locally accessible service for people. Services more suited to individuals' needs will improve their self management, leading to reduced complications and a corresponding reduction in the cost pressures on the NHS.

Cost and case mix

There are three potential ways to pay for the lead provider model described in this guide:

1. Block funding
2. Tariff system
3. A hybrid of the two

It might be desirable for commissioners to be able to look at a tariff structure for paying NTPs according to the level of input needed for each patient (low, medium, or high), however:

- Costs related to tariffs are difficult as the lead NTP can only provide the service because they are already in existence and have core funding for other elements of provision
- The lead NTP has costs associated with governance and managing the on-line health directory that would need to be accounted for outside of a tariff structure

Thought would also need to be given to tapered costs, where people with LTCs who can afford it are expected to make contributions towards cost over time.

For those unfamiliar with finances within the third sector, Appendix 8 describes financial flows for a fictitious lead NTP, and helps to demonstrate how the cost and case mix issues might be addressed.

Food for thought for commissioners?

Case study: One woman and her dog

Scenario: Woman referred from GP to lead NTP. During her initial goal planning session with the health link worker she identified her main goal to be weight loss, and decided she wanted to increase her physical activity levels to do this. The health link worker gave her advice on exercise. She did not want to attend the gym facility and decided to buy a dog.

Outcome: Through the dog walking she reports feeling fitter and losing weight. An added bonus is that she has increased her social contacts and confidence by chatting to other dog walkers.

Commissioning considerations: This woman was supported in her initial goal setting and planning by the health link worker, and the health link worker keeps in touch by phone to assess progress and motivation, recording outcomes for monitoring. However, the woman only attended the lead NTPs facilities once, for the initial appointment. Would the performance monitoring arrangements you put in place be flexible enough to demonstrate this to be a success for the lead NTP, or would it be deemed a failure as she only attended the facility once?

Practical steps to implementation

This section describes how to implement this lead provider model. It assumes that the Year of Care approach to working with LTCs is already being embedded in the local health economy, with the necessary changes to care pathways and the essential clinical staff training. There are three phases to developing the lead provider model, and the commissioning arrangements will be different at each phase. Key elements of each phase are detailed in the table overleaf.

Top tip

Recruit a GP champion:

Buy-in from local GPs and practice staff is critical. NTPs and commissioners who have had some success in this area agreed that recruiting a local GP champion early on in the process who can 'sell' the idea to local practices was a useful investment.

Top tip

Undertake a baseline scoping exercise

This is an important exercise as not only does it start to clarify the range and scope of local NTPs to help with planning and design, it can also be used to start to talk to health care professionals to raise awareness about the potential self care support opportunities for their patients, and thus starts to secure 'buy-in' to the work. A sample scoping exercise is in Appendix 7.

Phase	Key activities
Phase 1 0-6 months	<ul style="list-style-type: none">• Service Model Delivery Steering Group established (Appendix 3)• Baseline scoping of NTPs to identify range of current services, gaps and whether or not there are organisations that might take on the role of lead NTP (Appendix 7)• Review current information on need such as social marketing data and JSNA• Provide any support and training required to develop the local NTPs to take on lead NTP roles• Primary Health Care Team training in annual care planning• Securing buy-in from key players e.g. Chair local Health and Wellbeing Board, GP consortia, patient/user reps• Lead NTP procured• Project officer needs to be funded to do the asset development and set the systems up• On-line health directory established (Appendix 6)
Phase 2 6-18 months	<ul style="list-style-type: none">• Ongoing monitoring, review and refinement of process by Steering Group• Project officer role changes to overseeing quality and outcomes – constantly reviewing and re-engineering to increase quality and effectiveness• Focus on how to recruit people, initial engagement and behaviour change• Lead NTP sees where people are not maintaining behaviour change and will feed this back to GPs to ensure that quality and provision improve and that the needs of patients are met
Phase 3 18 months – 3 years	<ul style="list-style-type: none">• Build in an annual review event for GPs and NTPs to come together and build more effective relationships by looking together at outcomes data and reviewing processes/provision• Build in incentives for service users and NTPs for success and long term maintenance One method could be to build in to the performance framework and tariffs a way to monitor people one year on, and reward them for long term success such as 6 free sessions at the NTP for the person with LTCs and the commissioner pays the NTP for these sessions i.e. this would incentivise both NTP and the individual to succeed



“Existing NHS commissioning focuses on 6-12 weeks front end interventions (such as smoking cessation) - therefore perverse incentives are a danger - possibly encouraging providers to fail in order to be paid to see patients again. **The new model must find a way to address this issue and incentivise long term maintenance**”

Chris Drinkwater, GP Academic and Trustee of HealthWORKS, a Non-Traditional Provider

Top tip

Spend time early on ensuring that the most effective monitoring and evaluation systems are in place with non-traditional providers.

The following questions are taken from the Audit Commission Toolkit (1). They can be used to test and validate your approach to monitoring. They should be asked at regular intervals throughout the course of a financial agreement to ensure that reporting remains proportionate.

1. Can the information be provided in time with the provider's own reporting systems?
2. Can the information be provided less frequently?
3. Can the information be reported only by exception?
4. Is there an alternative item of information, perhaps more cost-effective, that could be used instead?
5. Can information that the provider already collects for another funder be used instead?
6. Can this information be collected on a sample basis?
7. Can this information be collected other than from the provider – such as a survey?
8. How can you assure the reliability of this information?”

Further ideas on measuring outcomes are in Appendix 5.

Section 3

Commissioning for sustainability

Having described a potential organisational model, this section addresses the essential work needed to ensure that any new commissioned services or developments will both work in practice and be financially sustainable.

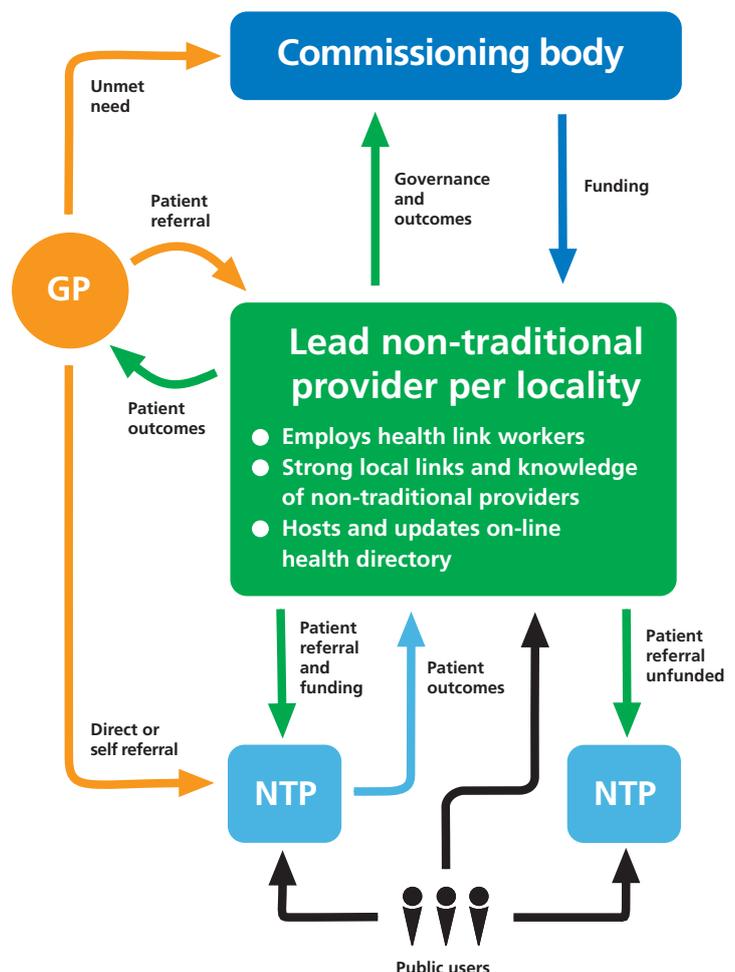
The role of the Service Model Delivery Steering Group in driving this process is paramount. The first key task is to describe clearly the intended health outcomes (both biomedical and quality of life) and what needs to happen, e.g. describe the details of service design that is needed locally. This will ensure that the Steering Group remains focused and that it is able to articulate this to other key partners.

While the traditional tasks of commissioning and procurement must still apply to ensure accountability and value for money, these tasks will have to be both interpreted and practised in different ways in order to implement this organisational model effectively, and address the barriers raised by the Year of Care Pilot Sites. Commissioners need to rethink the potentially cumbersome governance issues imported from relationships with larger organisations in order to make local decisions relevant to local services that are really used.

The key issues for commissioners which need to be addressed in new ways include:

- Financial impact
- Care pathway impact
- Contractual levers
- Activity management
- Procurement

Many of these issues should be handled, not at the procurement stage, but earlier in the commissioning process during the systematic design and development work that the Service Model Delivery Steering Group should lead.



Note: Non-traditional providers (NTPs) - two shown for illustration as there could be 1,000 or more.

Food for thought for commissioners?

The on-line health directory is a critical part of the Lead Provider Model described in this guide. **The lack of easily accessible and up to date information on local NTPs was a key barrier cited by health care professionals** as to why they do not refer patients to local NTPs. Several examples were found of on-line health directories that were started with the best of intentions, but which failed to deliver diverse opportunities for patients to engage with NTPs because the governance and hosting issues excluded many of the small local community based charities and organisations.

This is a good practical example of why and how commissioners will need to think differently to make this model work.

Test case exercise: Cat and dog shelter

In order to test whether your on-line health directory will be fit for purpose, think through the following scenario and ensure that the hosting, IT and governance systems that you set up for the on-line health directory will allow for the local cat and dog shelter to register if they wish to.

Scenario: A local GP occasionally suggests that patients who wish to do more exercise could volunteer to do dog walking at the local cat and dog shelter. This has been going on for some years and the GP has had some positive feedback from patients who have done this. It is a very informal arrangement and the GP has never had any formal discussions with the shelter and no funds change hands.

The lead NTP contacts the cat and dog shelter and asks them to register on the new on-line health directory, giving details about their dog walking opportunities. No money will change hands, and so the cat and dog shelter are not required to register on the website, but it would be useful if they did, to give a wider variety of options for physical activity to patients with LTCs.

Key point: If the registration process is so complicated, bureaucratic, and/or risk averse, that the cat and dog shelter do not register (meaning that this local, no-cost, informal physical activity option cannot be promoted), then you have failed!

Further issues: Further issues to consider when establishing an on-line health directory to support this model are given in Appendix 5.

Financial impact

Whilst government policy promotes 'prevention rather than cure', this is a long term strategy and in the short term, realistically, the model must show savings released from traditional care providers (e.g. specialists, community services such as dietitians and primary care activities such as repeat visits) from early on in the new model of service delivery. In order to be self sustaining, the financial impact, or 'value for money' aspect of the new organisational model is arguably the most important element of the commissioning process to get right.

In order to demonstrate financial impact it is essential that the Steering Group understand, and have quantified, the costs associated before the new pathway and the cost of care using the new pathway.

It is recommended that this be fully built into the performance management approach and that the frequency for monitoring this is set within small timeframes. At the outset, monthly or quarterly reporting and analysis in this area will inform the commissioner of the impact on traditional health care services, and any actions which may be required to ensure the optimal service delivery model is on track can quickly be discussed and implemented.

Care pathway impact

The service and pathway redesign needs to have a strong focus on the care pathway impact. Again, a task for the Steering Group will be to consider what the impact will be on other health services traditionally used in the care pathway (e.g. acute, community and practice based providers). In order for the pathway change to be effectively measured, there is a need to be explicit in anticipated reduction in episodes or change in case mix.

Key areas to build into performance management controls at the outset are:

- Retrospective audit of type and number of traditional care episodes for each person with LTCs commencing on NTP care pathway
- Retrospective audit of type and number of GP practice contacts for each person commencing on the NTP care pathway



"Quality of life outcomes for patients with LTCs are relatively easy for non-traditional providers to demonstrate – improving quality of life is in many cases our reason for existence. What has been harder to demonstrate, although we believe to be true, is the cost effectiveness of our interventions. I am pleased that the model described in this guide provides ideas as to how to demonstrate this on a local level"

Sarah Cowling, Chief Executive, HealthWORKS, a non-traditional provider

- The above two data set collections should be repeated once the person has been established on the NTP care pathway in order to assess the impact upon use of traditional care providers

For each data set required, the commissioning plan and service specification should **clearly state who is responsible for collecting, collating and analysing the data**. It is likely that the GP practice will have access to many different sources of data required from the GP patient record, and therefore collection and collation of this data is likely to be required from them. Further ideas on effective data collection are in Appendix 5.

The impact of the model on other service components, such as prescribing, must also be clarified. Traditionally, adherence with taking medications can be poor. Undoubtedly, there would be better health outcomes if better control of medical interventions were achieved. Also, in some conditions, such as hypertension, lifestyle change can reduce the need for medication.

A clear description of the outcomes expected needs to be laid out at the beginning of the process. Therefore it is essential that the new commissioned service models demonstrate improvements in cost effectiveness and concordant prescribing. Key areas to build into performance management controls at the outset are:

- What are the current interventions (before new care pathway)?
- Who initiated the prescribing or advice to prescribe (before new care pathway)?
- Has there been any change of prescribing intervention in previous 12 months?
- Once on amended care pathway, what are the changes to the above areas?

Contractual levers

The Steering Group should build contractual levers into the pathway to incentivise using more NTPs than traditional health providers. Examples include introducing a CQUIN indicator for acute and community provider contracts which offer Trusts incentives for supporting negative patient flow from them to NTPs. Opportunities may also exist for building similar levers into local or national quality frameworks for GPs e.g. Quality and Outcomes Framework (QOF).

Activity management

As with any similar 'traditional' service contract, the contractual documentation should describe some anticipated activity levels and how this will be managed across the contract term.

In order to balance budgets the Steering Group will need to think through how they will deal with potential mid-year over activity. However, if the financial impact of the model is demonstrating that it is cost-effective and saving NHS resources then rather than concentrating on how to ensure the activity levels are kept within original targets, it might be that they look to cost savings elsewhere in order to fund in year increases in activity.

The ability to make these decisions will be dependent upon the following two key actions:

- The commissioner and NTP(s) have designed and signed up at the outset to a comprehensive data set, collection/collation method and frequency of reporting schedule
- The commissioner has designed the new service/development to ensure that the impact of the new service/development can be fully evaluated across the previous and new patient pathway. This will involve analysing retrospective and prospective data. The commissioner should be clear in setting out who will be responsible for these functions which will mostly be split between the GP and the lead NTP. Appendix 5 gives more clarity on data collection roles

Procurement

As with other areas in the NHS, any commissioned development requires a robust procurement process which is compliant with EU law. The initial scoping exercise for NTPs in your local area (Appendix 7) will have indicated whether or not there are already organisations who could take on the lead NTP role. If there are, then the best course of action will be to go straight to tender, with the advantages that it can generate a range of potential providers with differing proposals and ideas for service delivery.

However, if the scoping exercise indicated that there is a lack of potential lead NTPs, then the commissioner can stimulate the market place. This may include, for example, facilitating provider development sessions. Commissioners can choose to pilot a service development, using a grant, before full procurement takes place. Operating a pilot with a known provider has the advantages of being quick to get off the ground and the service model can be tested out in a managed way. It is important to maintain a level playing field when engaging with providers. The local NHS procurement support centre could provide further guidance on this process.

A final thought for commissioners and service delivery steering group members....

All this hard work will really make a difference to peoples' lives, to better partnerships between clinicians and local people, and ultimately to the NHS.

Your work will mean it's not a chance that someone happens upon a service that supports their needs – in your patch everyone, particularly the vulnerable, will have chance to benefit.

"The staff are very respectful to individual needs and make everyone feel special. They empowered me to make choices about my lifestyle and did not judge when things may go wrong"

Person with LTCs talking about health link workers at a local non-traditional provider

I really think my patients are starting to take control – it's wonderful to see"

North East GP

Commissioning tools

A commissioning checklist and sample risk analysis framework can be found in Appendices 9 and 10.

References, further reading and useful websites

- (1) Audit Commission (2010) Successful Commissioning Toolkit - how to secure value for money through better financial relationships with third sector organisations
www.nao.org.uk/sectors/third_sector/successful_commissioning/toolkit_home/toolkit_home.aspx
 - (2) Diabetes UK (2008), Getting to Grips with the Year of Care: A Practical Guide
 - (3) Department of Health (2007) NHS Next Stage Review: Interim Report
 - (4) Health England (2009) Prevention and Preventative Spending: Health England Report No. 2.
 - (5) Department of Health (2010) Healthy Lives, Healthy People: Our strategy for public health in England
 - (6) Audit Scotland (2007) Managing Long Term Conditions
 - (7) Department of Health (2010) Equity and Excellence: Liberating the NHS
 - (8) Fair Society Healthy Lives (2010) The Marmot Review, Strategic Review of Health Inequalities in England – post 2010
 - (9) IDeA (2010) A Glass Half Full: How An Asset Approach Can Improve Community Health And Well-Being
 - (10) PLoS Medicine (2010) Social Relationships and Mortality Risk: A Meta-analytic Review
- Department of Health (2009) PCT Grant Making Powers to Commission Long Term Conditions Self Care Support from Third Sector Organisations
- North West Development Centre (2009) Social prescribing for mental health – a guide to commissioning and delivery, Care Services Improvement Partnerships
- NHS Diabetes Commissioning resource
www.diabetes.nhs.uk/commissioning_resource
- Year of Care resources
www.diabetes.nhs.uk/year_of_care
- Outcomes Star © Triangle Consulting Social Enterprise Ltd
www.outcomesstar.org.uk

Glossary

Asset based community development: Presents an evidence-based framework to help practitioners recognise that as well as having needs and problems, low income individuals, families and communities also have social, cultural and material assets. These are what help them overcome the challenges they face. There is a growing body of evidence that shows that when professionals begin with a focus on what individuals, families and communities have (their assets) as opposed to what they don't have (their needs) a community's efficacy in addressing its own needs increases, as does its capacity to lever in external assistance.

Health link worker: Recruited from the local area they are trained to support behaviour change and have a wide knowledge of local activities in the area being networked into other NTPs. A full overview of their roles and responsibilities is available in Appendix 4.

Joint Strategic Needs Assessment (JSNA): A process that identifies current and future health and wellbeing needs in light of existing services, and informs future service planning taking into account evidence of effectiveness. It is usually led by the local NHS and local authority to cover a specific geographic area.

Non-traditional provider: An organisation, outside of the NHS, that can help people with the self management of their LTCs. They are likely to be a local charity or community organisation (such as a community allotment project providing opportunities for physical activity, growing your own food and social contact), but could also be in the private sector (such as salsa dancing classes).

Outcomes Star: A tool to measure self reported health outcomes for people with LTCs. Further information is in Appendix 5.

Social prescribing : Social prescribing links patients in primary care with non medical sources of support within the community. Exercise on referral is a well known example of this.

Social capital : Social capital is the 'glue' that helps connect people, organisations and communities. It comes from everyday contact between people, and their forming of social ties and networks based on trust, shared values and reciprocity – 'give and take'. Definitions of social capital vary, but the main aspects include citizenship, 'neighbourliness', social networks and civic participation. However defined, it is important because it influences individual wellbeing, and health is an integral part of wellbeing.

Third sector : A term used to describe the range of organisations that are neither public sector nor private sector. It includes voluntary and community organisations (both registered charities and other organisations such as associations, self-help groups and community groups), social enterprises, mutuals and co-operatives.

Appendix 1

The Year of Care Programme

Spring 2011 *'Working together for better healthcare and better self care'*

The Year of Care (YOC) Programme has demonstrated how to deliver personalised care in routine practice for people with Long Term Conditions (LTCs) using diabetes as an exemplar.

Year of Care – introduction

- YOC enhances the routine biomedical surveillance and 'QOF review' with a collaborative consultation, based on shared decision making and self management support, via care planning
- And then ensures there is a choice of local services people need to support the actions they want to take to improve their health, wellbeing and health outcomes, available through commissioning

YOC provides practical evidence and support to implement the White Paper ('Equity and Excellence: Liberating the NHS') proposals for personalised care 'no decision about me without me' and locally driven flexible commissioning for people with LTCs. YOC has also been recognised to support the QIPP agenda for personalised care planning. The Royal College of General Practitioners endorses care planning as a professional standard for GPs.

Key points

Three years' work with three pilot PCTs (Tower Hamlets, Calderdale and Kirklees and North of Tyne) and parallel activity with other health communities to test transferability, has generated some important learning:

- Care planning works across diverse populations thus addressing inequalities
- People with diabetes report improved experience of care and real changes in self care behaviour. Where care planning has been in place for three years or more, there is improvement in clinical outcomes
- This approach to care planning is also highly valued and motivational for health care practitioners
- Successful implementation across a health community involves a partnership between grass roots ownership, local innovation and tailoring, and strong clinical (usually primary care) leadership

- This must be supported by local flexible commissioning, practice facilitation and tailored training - 'making it easy to do the right thing'
- YOC has stimulated new roles and improved team work, local service redesign and new approaches to commissioning
- YOC is cost neutral at practice level; there are savings for some

Year of Care will make available

- A guide to commissioning care planning
- A guide to commissioning non-traditional services to support self management
- A tested National Training Programme to support Care Planning delivery in primary and specialist care; this includes quality assured 'training the trainers', facilitation of delivery and links with unique IT templates to record patient goals, action plans and need for support services

'I've got to tell you, it's worked. It's worked very well, and you know it needs fine tuning to make it work better but it has been fantastic.'

A person with diabetes

'It's 100% better for me and the patients'

A GP

YOC has been recognised to support the QIPP agenda for personalised care planning.

www.evidence.nhs.uk/search?q=Personalised%20care%20plans%20for%20longterm%20conditions

Year of Care is a partnership programme being delivered by the Department of Health, Diabetes UK, The Health Foundation and NHS Diabetes.

Appendix 2

Barriers identified

The Year of Care pilot sites identified that the biggest barrier to providing services to support self-management in the context of care planning, was failure to stimulate non-traditional community based providers to support lifestyle change. Further exploration identified a significant number of additional barriers to developing non-traditional providers (NTPs).

Although perceptions may be unfounded, the range and extent of the issues is produced below (often using the original wording) to show the issues that the commissioners will need to manage.

Lack of awareness of NTPs by Health Care Practitioners (HCPs) and patients

- Lack of up to date info on NTPs - not knowing who does what in provider landscape – need to make personal connections
- GPs sceptical about some alternatives and lean towards medicinal solutions (Pharma industry)
- Lack of understanding across the whole team
- Not knowing the range of services provided already (including support groups – physical and virtual)
- Patients not knowing what are possible solutions – a menu of treatments is needed
- Difficulties with access for patients to information
- Need more empowerment and support for patients to access non-traditional/traditional care

Lack of belief in therapeutic value of NTPs

- Do healthcare staff understand roles of health trainers and vice versa? Some HCPs have lack of belief in effectiveness of Health Trainers
- Patient perceived value – convincing patient of real value of these services and the confidence to use/access them as they may perceive them as second rate. Is it worthy of access? Will patients see non traditional providers as ‘services on the cheap’?
- Are patients willing to participate (or able to participate)?
- Traditional providers support ‘health’ model. Community providers support ‘wellbeing’ model
- HCP lack of belief in effectiveness of non-traditional providers

Lack of skills or supporting infrastructure

- IT systems not yet in place to record unmet need
- Not able to capture unmet needs now, need to develop other methods (non-IT) of capturing unmet needs
- Still need to clarify unmet needs – recording an identified (identified as part of consultation) unmet need (in a consultation for instance) and capturing an unidentified unmet need (e.g.in a focus group) social marketing
- Data sharing agreements to enable feedback from NTPs to GPs and commissioners
- Consultation/Communication Skills to solicit unmet need not always in place
- YOC basics need to be in place before have time to do non-traditional provider development
- Quality of provision - governance
- No infrastructure. Lack of strategic development

Patient motivation

- Lack of interest – some patients not wanting to take ownership of their own health

Difficulty demonstrating outcomes

- Lack of feedback/communication between GPs and other health-care providers (including NTPs) especially when different computer systems are used
- Lack of demonstrable health outcomes
- Lack of demonstrable financial outcomes
- Health outcomes misses out quality of life issues
- Feedback to GP/patient confidentiality

Commissioning barriers

- Confusion by commissioners of when to use procurement vs grants vs commissioning
- PCT commissioning red tape barrier to small voluntary organisations
- NTPs may be dismissed because of the size and commissioner may view size = credibility

- Lack of forum for small non-traditional providers/local groups to understand NHS needs. NHS to understand what could be offered locally
- Lack of support and training for voluntary organisations to become potential bidders/providers
- Lack of coordination of new initiatives or existing services between health and social care (e.g. commissioning something new)
- Limited intelligence from social marketing on a small population level (e.g. healthy moves)
- Resistance to social enterprise in public sector

Systems barriers

- Artificial system barriers around condition e.g. 'diabetes' cooking courses, 'heart failure' classes when much is generic
- Artificial barriers across disease/health issues
- Language and cultural barriers
- Do they address all members of population e.g. ages, religion, employed (time restraints)?

Cost and time pressures

- Short contracts frustrating for non-traditional providers
- Tariffs – how much to pay? (NB need to ensure tariffs don't create unintended outcomes e.g. QOF payments for recording data)
- Vulnerability of NTPs when it comes to cost pressures – there are more important things to do
- Financial climate: current funding pressures means that these providers are disadvantaged because harder to enter the market
- GP time pressures – no time to meet with NTPs to develop relationships

Lack of clarity of roles

- GPs don't see their role as having to develop the market
- District nurses don't 'get' assessment and referral on – as it has not been part of their role traditionally
- Can patients already access or does GP have to refer and if the latter, struggling to keep up with referral criteria?

Appendix 3

Service Model Delivery Steering Group

The essential role of the Service Model Delivery Steering Group (Steering Group) is highlighted throughout the guide. This appendix gives some important additional issues that the Steering Group will need to focus on, as well as highlighting the main reference points throughout the guide:

- Purpose and membership (p14)
- First essential task (p26)

Examples of some of the issues that may arise for the steering group to address:

- Address demand management and the referral process to ensure it works for individuals with long term conditions, NTPs and primary health care staff
- Costs of following up non-attenders is high for NTPs due to time taken chasing up people. Build into review system/outcomes framework/risk matrix and potentially penalise GPs for high levels of inappropriate referrals that clog up the systems and waste time/money or reward GPs for those that don't do this. Additional training for HCPs on motivational aspects of referral may be one solution to address high non-attendance rates
- This is innovation so need to allow for the fact that some things may not work – steering group can address this and redesign going forwards
- If starting from scratch, need to allow for the fact that it will take 1-2 years of running the model for systems to bed in and to be able to produce key outcomes data and to refine and improve service provision and standards
- Commissioners on the steering group will need to start to commission secondary care differently as the model develops e.g. a secondary care dietitian may need to do fewer 1:1s with people with diabetes but spend an increasing amount of their time using their specialist skills to support healthy eating/cookery projects run by NTPs in the community. This is a cultural change and a new role for specialists around supporting front line staff and setting and monitoring quality standards rather than doing expensive 1:1s with a small number of individuals

Appendix 4

Health link worker overview of core competencies, duties and responsibilities

1. Job purpose 'support from next door not advice from on high'

To work with members of local communities to support them in identifying ways of achieving individual health improvement, with making choices, and to help make these choices sustainable.

This includes connecting with appropriate health services, and other NTPs to make best use of community resources to tackle health inequalities.

2. Main duties and responsibilities

Enable individuals to change their behaviour to improve their own health and wellbeing:

- Help individuals to identify realistic goals around health behaviour and to develop an incremental 'action plan' to achieve these goals
- Support individuals and help to review and revise 'action plans' as appropriate
- Find ways of enabling individuals to overcome the barriers preventing them from making lifestyle changes
- Signpost individuals to other agencies for information, advice, and resources to expand range of opportunities and knowledge
- Work in partnership and develop links with community groups, voluntary organisations and statutory agencies
- Run health activities sessions to identify and engage with individuals and raise awareness of potential for health improvement

Make relationships with communities:

- To prioritise work with marginalized communities and those experiencing the greatest inequalities in health
- Work with existing groups and support the development of new groups in order to identify and engage with individuals to raise awareness of health issues and individual choices for wellbeing

- To use a community development approach to health improvement based on principles of anti-discrimination and equity

Manage and organise time and activities to support members of communities:

- To maintain adequate records of all work undertaken, contributing to the collection of monitoring information and preparation of progress reports
- Report any safeguarding concerns about individuals and refer appropriately those whose needs cannot be met by health link workers
- Raise any new issues emerging from the work
- Encourage and facilitate other NTPs to regularly update the on-line health directory

Appendix 5

Measuring outcomes and effective data collection

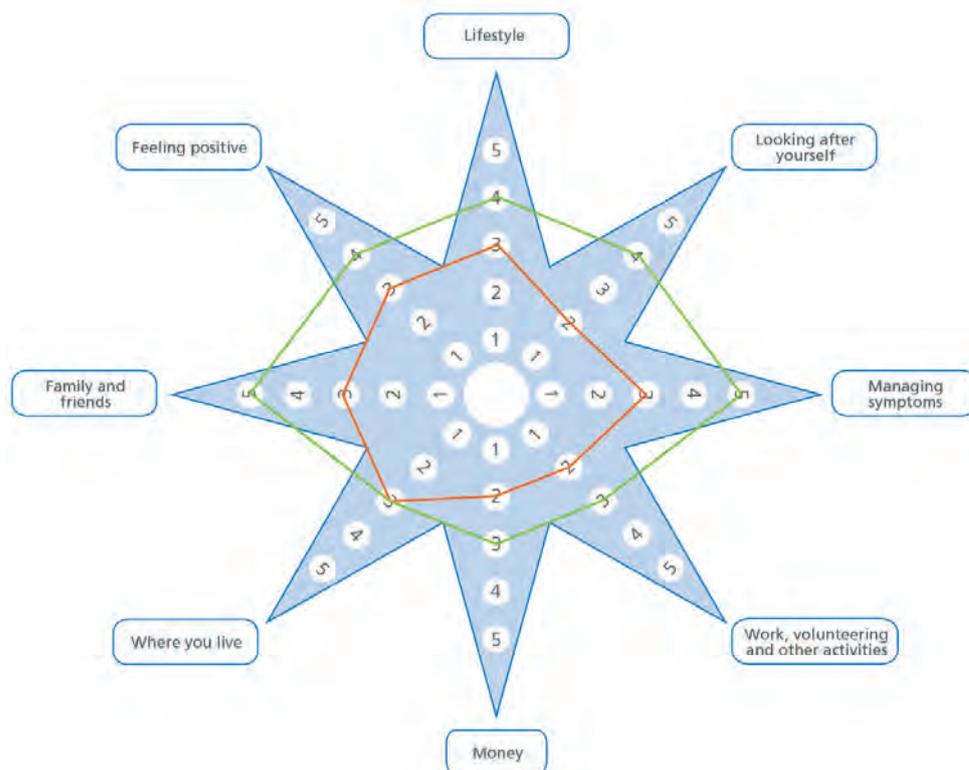
Tools for measuring outcomes

What outcomes to measure and how to measure them are key and must be agreed at the outset. The key factors in choosing the tool are that:

1. People with LTCs must find it motivating
2. Health link workers and GPs agree it is a useful tool to record and assess individual's progress
3. Commissioners agree it is an appropriate tool to assess outcomes for people with LTCs
4. It is appropriate to the local population i.e. accessible for those whose first language is not English

One example of a validated tool that could be used is the Outcomes Star. The diagram below indicates the individual's self reported scores at the start of an intervention (red line) and at the end of an intervention (green line).

Outcomes Star © Triangle Consulting Social Enterprise Ltd www.outcomesstar.org.uk



There are other tools available and it would be the role of the lead NTP to investigate tools that would work in their locality.

Effective data collection

It will be essential to establish an effective process for collecting information on health outcomes and potential NHS cost savings. The process must provide meaningful data whilst producing the minimum amount of bureaucracy. This would be a key issue for the Service Delivery Steering Group to focus on within the first six months of the project and to refine as necessary.

Data required	Lead NTP collects data via	GP practice collects data via	Commissioning role
Unmet need		Collected by Health Care Practitioner (HCP) within annual care planning appointment with patient. HCP records on IT template (on GP electronic record system). Admin staff collate data and feedback to commissioning body.	Use collated unmet need to feed into future commissioning rounds such as JSNA via Health and Wellbeing Board
Patient outcomes	Pre and post interventions scores on Outcomes Star or similar tool.	Patient brings their copy of Outcomes Star to annual care planning appointment to discuss progress. HCP records scores on IT template (on GP electronic record system). Admin staff feedback collated data to commissioning body.	Use collated information on outcomes to expand local evidence base of effective interventions and use to inform commissioning.
NHS cost efficiencies		Admin staff pull off data for patients' NHS use* - data required for 6 months before the NTP intervention and 6 months after the NTP intervention. *Patients' NHS use could include the number of GP or A&E attendances, prescriptions, unplanned admissions etc	Commissioner (and Steering Group) use anonymised information on individual patient usage and cost of NHS interventions (i.e. £x per GP appointment) to analyse extent of NHS cost efficiencies.

Appendix 6

On-line health directory

The on-line health directory is a critical part of the lead provider model described in this guide. The lack of easily accessible and up to date information on local NTPs is a key barrier cited by health care professionals as to why they do not refer people with long term conditions (LTCs) to local NTPs.

The following key facts and questions are a useful starting point when establishing an on-line health directory to support people with LTCs.

Key facts for web designers

- The overall purpose of the on-line health directory is to facilitate access to local information on services that can help patients with the self care of their LTCs
- Key audiences are health care professionals, people with LTCs and the public
- Lead NTP is responsible for engaging local NTPs to initially populate the website and to ensure information is kept up to date going forwards
- The website will be concentrating on activities relating to 6 key areas; physical activity, healthy eating/cooking, arts/health, befriending, welfare rights/benefits, volunteering opportunities
- Multiple lead NTPs may be commissioned to cover smaller geographical localities in the local area. However, only one of these lead NTPs will be commissioned to host and update the on-line health directory, which will encompass activities for the whole of the local area
- The lead NTP will be responsible for purchasing the website so normal NHS tendering process will not apply
- The website provider will be expected to advise on such areas as website hosting, security, performance, maintenance, data storage and security, SLA for website availability etc.

Key questions

- How will the major stakeholders be bought into the idea of the website?
- Will this be a two tiered site, i.e. one for the public and one for health professionals or a one size fits all site?
- Is this a new website or will it be hosted as part of an existing website?

- How and when will we communicate the new website and implementation progress to the major stakeholder groups?
- How do we ensure NTPs and other organisations agree to sign up to the website and periodically update the information stored? (Consider a monthly free prize draw where every NTP that updates their entry is entered for a £100 prize)
- What security checking needs to be carried out on the NTPs or any new organisations coming onto the website? How is this security checking kept up to date and who is the responsible owner of the security checking? (Consider building this responsibility into the SLA/ specification for the lead NTP that is commissioned to develop the on-line health directory)

SLA questions

- How often will a check be made to ensure all providers on the site are fully up to date?
- What do you do if a service is not up to date on the website?
- SLA for IT to be agreed once website provider has been allocated to the project

Key resource requirements

- Lead provider manager: critical to have agreement that they will potentially create the website and most importantly support it ongoing once it is a live system
- Commissioning leads, PCT and eventually GP consortium lead(s) who will be acting as the commissioning body and as a liaison with GPs and the lead service providers
- Clinicians and lead NTPs to monitor patient outcomes and whether the service / website have provided tangible benefits and report back to commissioning body
- A small selection of people with LTCs used to derive user opinion regarding the usefulness and accessibility of the website, both during the development phase and once the system is live
- Relationship between lead NTP and local NHS communications team to ensure professional marketing campaigns are created and managed

Appendix 7

Scoping exercise for non-traditional providers

A useful initial scoping exercise would be to interview key people in your local health economy. The key questions below could be used to identify the range of local NTPs currently providing services, any gaps and also whether or not there are organisations that might take on the role of lead non-traditional provider.

People to interview could include:

- Chief Officer from local Council for Voluntary Services
- Local GP (with specialist interest in LTCs)
- Local health trainer
- LTC nurse
- NTPs who are currently providing services that support people with LTCs
- Officer from a user engagement forum or similar
- Local authority lead for LTCs*

* Interviewing the local authority lead for LTCs can help to identify any existing services or similar work that may already be in place and will improve communication channels.

Key questions

1. Which non-traditional providers do you know of that provide physical activity services?
2. Which non-traditional providers do you know of that provide nutrition/healthy eating/cooking services?
3. Which non-traditional providers do you know of that provide arts for health services?
4. Which non-traditional providers do you know of that provide befriending services?
5. Which non-traditional providers do you know of that provide welfare rights/benefits advice services?
6. Which non-traditional providers do you know of that provide signposting to volunteering opportunities?

7. Where and how do health professionals, people with LTCs and members of the public find out about existing non-traditional provider services to support people with LTCs in XYZ geographical area?
8. Who keeps this information up to date?
9. Other than the six areas of activities detailed above, can you think of anything else that should be included in a menu of activities to help with the self management of people with LTCs? Is this already provided in XYZ geographical area? By whom?
10. Are there any organisations that could act as one of the lead non-traditional providers in XYZ geographical area?
11. Are you aware of any non-traditional providers that are effectively demonstrating health outcomes for their clients and/or are effectively feeding this information back to patients' GPs?

Appendix 8

Financial flows for lead non-traditional providers

Better Services Enterprise is one of the lead non-traditional providers (NTPs) in Anytown. They perform the functions described in the model on p13. They work from three buildings, and as well as their work with people with LTCs they run two community gyms, a community cafe, two crèches and a community garden open to the general public. They also hire out space within their buildings on a sessional basis and rent out parts of their buildings on long term leases.

Their role as lead NTP counts for approximately 10% of their workload and income. Their funding flows are described in Table 1 below to show how the lead NTP work fits in with their overall work:

Table 1: Income streams for **Better Services Enterprise:**

Source	Type	% of overall annual income
NHS	Block contracts	2.5%
NHS	Grants	30%
NHS	Tariffs per patient – graded according to level of need/complexity (see table 2 overleaf)	
Local authority	Block contracts	Nil
Local authority	Grants	20%
Local charities	Rental income for use of space in lead NTP's buildings	20%
Charitable trusts	Grants	10%
Income from paying customers	Members of the public and patients	15.5%
Fund raising events		1%
Miscellaneous income		1%

Tariffs

Table 2, below, attempts to differentiate between the cost of providing services to people with different levels of need. The table also attempts to show how incentive payments could be included to incentivise long term maintenance for both the person with LTCs and the lead NTP ([Better Services Enterprise](#)).

The figures given in the table are approximate and for services only i.e. they do not include management costs which will need to include monitoring and feedback costs together with costs/risk of managing sub-contracts. It is important to bear in mind the fact that **the tariff can only work if the lead NTP ([Better Services Enterprise](#)) is already in existence**, and if the core functions are funded through other mechanisms.

Table 2: Examples of rationale for differing tariffs:

Tariff	PATIENT HEALTH ISSUES			RESOURCE IMPLICATIONS FOR LEAD NTP		
	Co-morbidities	Mental Health	Mobility	DNAs*	1:1 initial assessment meeting	Ongoing meetings or other input
Low level >< £70 pa	One or two	Low mood	Mobile	No	Up to 60 mins	Minimal – one meeting at end of intervention with follow-up motivational phone call at 6 months.
Medium level >< £150 pa	Two or more	Low mood anxious	Some limitations	Can be one or two	> 1hr	Medium – will require limited additional face-to-face motivational support and follow up phone calls.
High level >< £260 pa	Multiple	Depression anxiety	Limited mobility	Yes ++ Multiple attempts to re-arrange appointments	>1.5hrs	High – intense face-to-face motivational support with buddying into activities and frequent follow-up in order to embed and maintain changes in behaviour.
Incentive payment for long term maintenance £24	Patient receives 6 free sessions with the lead NTP			Lead NTP receives a fee (£24) from the commissioner to cover the 6 free sessions		

*DNA = Patients who do not attend the lead NTP, which may well be as a result of inappropriate referral from Primary Care Team. High DNA is very resource intensive as it means the health link workers need to spend time chasing the patients. Addressing the issues around high DNA will be of benefit to primary health care teams, commissioners and NTPs and would be a key issue for the Service Delivery Steering Group to address.

Key features of services provided by Better Services Enterprise

- Services range from universal to targeted
- Services spill over into one another to avoid silo provision - this makes for messy economics but is designed around people, not accounting systems
- The variety of funding streams reflects the need to avoid being overly dependent on any one funding source
- Surplus from any funding stream that is not ring fenced goes into the central pot to manage any minor shortfalls in particular budgets
- The lead NTP takes on a high level of risk but it is within their remit to ensure quality standards expected of the sub-contracted agencies, and manage the complicated finances that go with non traditional services

Key issues that need to be taken into account

The sub-contracted funds go to small, local agencies, part of the social assets Marmot mentions in his report (8). These agencies are vital pieces in the local service jigsaw; a focus for local volunteering and social networking, delivering a wide range of activities at low cost. The sum of the parts is often much greater than the whole and yet these organisations are vulnerable to funding cuts and local policy changes.

Appendix 9

Lead provider model commissioning checklist

Issues to consider include:

- Have you assessed need (including unmet need), and considered the needs of hard to reach patients?
- What are the performance measures required and who will collect and collate the data? What will be the frequency of data collection and reporting? Who will performance measures be reported to?
- Are GP practice staff geared up to collect and collate data from the patient record? Will the data collected be able to demonstrate impact on NHS service use to support long term sustainability of the model?
- What will your procurement approach be (pilot or straight to tender)?
- What will the funding mechanism be (block funded, tariff based or hybrid of the two - or alternatively, grant in aid funding might be more appropriate)?
- Does the funding mechanism build in strong incentives for both NTPs and people with LTCs, for long term maintenance?
- Have you considered specifying a % of overall annual funding that the lead NTP should be sub-contracting out to ensure transparency and avoid the perception that the lead NTP is taking all NHS funds?
- Have you considered any pooled budget opportunities with, for example, local authorities? How would the governance arrangements work?
- Does your NTP market need developing and/or supporting prior to or during the procurement phase? How will you approach this?
- Have you established a steering group for this development? Have you ensured membership has the correct balance of commissioner and provider representation? Have you developed terms of reference? Who will facilitate/give management support to the group? Who will the steering group report to?
- Do you want to fund a GP/clinical champion to support the work?
- Have you focused sufficiently on putting measures in place to ensure negative patient flow from secondary care? How will this be monitored? What action should be taken if this doesn't happen?

- What contractual levers are available to support the development (eg CQUIN, QOF)? How should/could these be deployed effectively?
- What IT systems are available to support data reporting? What compatibility is there between systems?
- How will patient feedback and user involvement be ensured?
- What happens if the NTP(s) commissioned are forecasting an overspend (due to increased costs or increased patient throughput)? Are financial contingency arrangements available or should measures be put in place at the outset to ensure activity levels and costs are well managed?
- Have you developed a service specification? Does it include the critical success factors, governance arrangements and a risk analysis?

Appendix 10

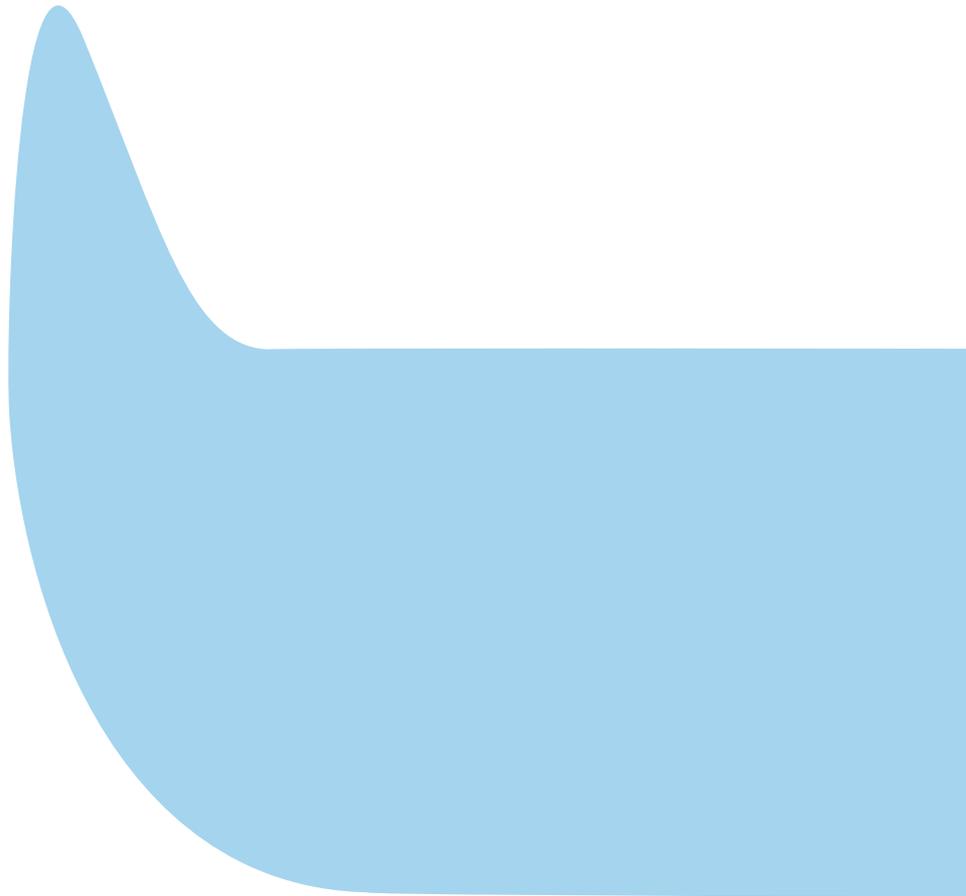
Risk analysis of implementing lead provider model

A risk analysis of this area of commissioning strategy implementation is suggested as below:

Implement- ation indicator	Evidence	Likelihood of not achieving: 1. High 2. Medium 3. Low	Review and comments
Financial Impact	Full analysis of pre and post implementation care pathways (by volume and type of care provider) on a person by person analysis		This will give thorough and authentic financial assessment of new care pathway as compared to traditional care pathway Where the service development costs are off track, pre-considered actions and/or penalties should be deployed
Health Outcome Analysis	Improvement in clinical quality of life and patient outcomes (e.g. Outcomes Star scores) Better adherence with and appropriateness of drug regimen		This area must be built into the performance management framework with appropriate reporting and analysis timescales
Patient/User Perception	Patient/user perception of involvement in care planning Patient/user perception on how they are managing their condition Patient/user perception of effectiveness and wider health and social benefits of using non-traditional providers		This area must be built into the performance management framework with appropriate reporting and analysis timescales

Implementation indicator	Evidence	Likelihood of not achieving: 1. High 2. Medium 3. Low	Review and comments
Commissioning approach	Effective procurement strategy which complies with procurement rules and guidelines		It is likely that a formal procurement exercise will need to take place for letting contracts to lead non-traditional providers. The merits of a pilot approach should be fully considered at the outset
Robustness of service specification	Robust service specification setting out expectations, outcomes, governance arrangements and risk management approach		The service specification is key in setting out how the service should be delivered and managed (both by the provider and the commissioner). A comprehensive and robust service specification at the outset can mitigate against service or contractual issues further down the line
Sufficient NTPs within the marketplace to meet need	Sufficient NTPs available with appropriate skills and acumen to deliver effective service Stimulation of the marketplace by the commissioner leads to a positive response		Naturally as this service is an emerging model, NTPs may not be available or have sufficient skills to engage in service delivery models such as this. The commissioning body must be mindful of this and have considered market stimulation and support thoroughly at the outset in order to mitigate against this risk
Effective performance management	Comprehensive data sets and reporting requirements agreed at outset Responsibility for data collection, collation and reporting fully agreed		

Implementation indicator	Evidence	Likelihood of not achieving: 1. High 2. Medium 3. Low	Review and comments
Effective planning to realise strategic benefits	Effective plan to realise strategic benefits as part of wider commissioning strategy		Management capacity and affordability of any potential proposed pathway changes are potential risks
Effective leadership to realise strategic benefits	<p>Movement of plan to time. Full involvement, engagement and participation from required stakeholders</p> <p>Establishment of a steering group with appropriate representation and accountability to be fully considered</p>		Leadership style will need to be delivered effectively and authentically and a patient/user involvement approach should be incorporated from the outset
Sufficient commissioner and provider capacity and competence in place	Sufficient staff with relevant experience and resources committed to achieving all aspects of this commissioning strategy area within the deadlines set out in the commissioning strategy/project plan		Capacity and experience of staff should be fully considered
Evidence of care pathway change	Care delivery is significantly changed from the traditional model		Healthcare is not sustainable based on current secondary/ specialist care dominant pathways. Therefore a 'do nothing' position is not financially viable and significant shifts both in care pathway delivery/mechanisms and in patient expectations/ input needs to be fostered





For further information go to:
www.diabetes.nhs.uk/year_of_care