A framework for commissioning support for self care

This framework has been prepared for the Working in Partnership Programme (WiPP) and is based on a workshop held at the Self Care Connect Launch Conference on 31st October 2007. The framework was further refined as a result of ten SHA led workshops on commissioning self care support services in April and May 2008.

Summary of recommendations

Self care is under used and self care support is under commissioned. Good self care support services provide benefits to patients and carers and offers systemic benefits in demand and cost management to health economies.

This framework sets out how self care support fits with existing commissioning approaches and includes some additional techniques that should be helpful in commissioning self care support.

The framework starts with a definition of self care and how this affects the way we commission, with the patient as co-creator of health and therefore co-provider. The framework comprises a set of steps, many familiar to commissioners but some new. There are additional sections on building momentum, where the value of self care support is not fully recognised and on designing and adapting to make sure that existing programmes and initiatives are considered in the commissioning process.

Although the language directs the framework at a commissioner audience the framework will also be useful to those looking to develop self care support services as a clinician or manager in a provider organisation. Anyone looking to develop self care support services will need to understand what motivates the commissioners, how self care can deliver commissioner's objectives and the processes that the commissioners follow to purchase services.

It is in the nature of self care that the framework and the commissioning process recognise the person's role as a co-producer of healthcare and in the maintenance of good health.

What is self care?

Defining self care spans across all the seven stages of man. Self care can extend from making lifestyle choices like eating a healthy diet through to administering prescribed medication or using learned techniques to take care of symptoms. The definition set out below is based on work by the Department of Health[1].

Most care in life is self care.

Self care:

- is a part of active daily living
- is the care taken by individuals towards their own health and wellbeing (both physical and psychological)
- includes the care extended to children, family, friends and others in neighbourhoods and local communities recognising and valuing these social support systems (95% of all care is provided in this context of the community).

Some of the ingredients of self care include:

- maintaining good physical and mental health

- meeting both social and psychological needs
- preventing illness or accidents
- caring for minor ailments and long term conditions
- maintaining health and wellbeing after an acute illness or discharge from hospital.

Others emphasise the element of self care by which the patient takes responsibility for decisions about their care. This has to be facilitated by the health care professionals; positively encouraged, and enabled by the provision of information, skills and time to make the decision.

What is self care support?

The depth of involvement needed by the patient / person in self care means that it is not possible to commission self care support from a provider in the way that we would for 'conventional' types of care. In self care the patient or client is co-provider. Of course the professional has a key role to play in providing the necessary support to enable the individual to do enhanced self care. So that we don't keep getting tripped up by the language we need to be talking about 'self care support' and generate a 'values' system that has real meaning to the person and which encourages them to participate in this enterprise while also the professional provides support.

Directed self care is a self care support system with a feedback loop through the health and social care system with people providing regular feedback.

For example people with stable hypertension could be organised to monitor themselves, and have, say, one annual check at which they provide feedback to their care professional. Otherwise the patient would access the GP only if medication changes were needed or they were unwell. In this instance the care system would have provided support for self care by either giving people the necessary tools, information and / or skills training so that they are enabled to monitor themselves.

Self care support can be made available in various ways by different providers in statutory, private and the community sectors. This can be in the form of providing information; skills training courses; self monitoring tools and devices; self care equipment; or access to self care support networks in the community for people who want to receive or give support. Importantly as suggested it would also involve people providing feedback.

Why commission self care support?

Many of us have commissioned, or are commissioning, services that comprise elements of self care support, such as structured education programmes, behaviour modification, smoking cessation, rehab services and so on.

Our starting point for commissioning self care support is to look carefully at care pathways to see where self care has a role in determining outcomes and / or patient experience. This is an important exercise as these areas have to be handed-over to direct ownership of the patient / person, giving empowerment to the person and enabling independence - two key attributes that are fully valued by the public.

Extension of self care into other areas of care, treatment and prevention is backed by a good evidence base. Benefits for the patient can be:

- increase in life expectancy
- better control over symptoms
- reduction in pain, anxiety and depression levels
- improvement in quality of life with greater independence
- reduction in days off work by up to 50%
- increase in social capital (more trainers, active citizens).

For commissioners there are system benefits:

- improved quality of consultations
- visits to GPs can reduce by 40 to 69%
- hospital admissions can reduce by up to 50%
- length of stay or number of days in hospital may decrease by up to 80%
- outpatient visits can reduce by 17 to 77%
- A&E visits can reduce by up to 50%
- medication intake, e.g. steroids, reduced
- medicine utilisation is improved by 30%.

The demand on some services may be fuelled by a lack of personal responsibility for healthy lifestyles. Successful patient care occurs when the patient assumes control of their care, manages and takes responsibility for that care.

Many will be working in environments where key stakeholders and decision-makers have yet to buy-in to the concept of self care support. Colleagues may fail to understand the benefits that it can bring for patients and for the health economy. In such an environment it is hard, but necessary, work to build a new consensus.

Clearly, the opportunity exists for partnership working between health and social care to be able to design generic and integrated self care support programmes or packages irrespective of - but still applicable to - the relative health being experienced by the patient / person. Importantly, these programmes should maximise uptake and enable independency.

Much of the available evidence has been collected by the Department of Health in an Evidence Pack (July 2007), available at www.dh.gov.uk/selfcare this contains references to a large range of studies.

Further resources will be available on the Self Care Connect website at www.selfcareconnect.co.uk.

The framework

The framework is intended to support local commissioning and is aimed at those working in PCTs and as practice based commissioners. It is not a comprehensive textbook for commissioning or service redesign but rather offers a set of tools and techniques that can be used at various points in the commissioning process.

For each of the steps we provide signposts to the extensive evidence available to support the case for investment in self care support.

1 Build momentum

Self care support is not yet part of the everyday language of NHS commissioning.
A PCT may be investing in self care support without giving it that definition. Patient education, the Expert Patient Programme, walking groups or support networks might be funded by the PCT without anyone making the connection. In other PCTs the executive and key clinical leaders may yet to be convinced on the value of investing in self care

Some effort may be required to build a consensus, firstly that self care is a concept that is helpful in commissioning, and then that self care support can help a PCT to achieve its aims. This is likely to require a concerted effort over time and the application of some techniques:

Link to priorities - the most important task at this stage is to review your local priorities for health improvement. The priorities should describe care pathways that the PCT plans to redesign. Reviewing these and working out where self care support can contribute is a key task.

Generate a debate - write articles and papers for use in local communications see www.selfcareconnect.co.uk for information, research etc.

Promote the concept - Get a workshop slot at local commissioning, training or educational event and use the Self Care for Primary Care resources www.selfcareconnect.co.uk to introduce and strengthen people's understanding.

Develop a value proposition - this is a written statement of no more than half a dozen sentences describing the value that investment in self care support will generate. It should be used in all communications and settings to get the message across.

Identify champions at senior level - find clinicians and managers who are prepared to listen to the debate and consider the evidence.

Build alliances - find other organisations, teams, departments that will have an interest in self care support and/or in the benefits that are available- a really useful way of helping to turn the concept into a mainstream idea.

Get self care support included in key work programmes, for example -

Long term conditions projects - all long term conditions programmes should have an element of self care support (although it may not be called this). Working with project leads to get self care support built in these programmes is a quick and easy way to get the concept established at no cost.

Managing unscheduled care - this is a big area for many PCTs who are seeking to keep patients out of hospital. Self care support has a role to play in improving the management of patients at risk of readmission. Working through community matrons, specialised nurses and emergency care practitioners is a good way to get self care support built into managing at risk patients.

When the time comes for decision-makers to consider investing in self care support, work is needed to create the climate for a favourable decision. A few simple techniques will make a huge difference:

1. Talk about it - create expectation and don't try to surprise people
2. Prime your allies - public health, LTC leads, GP leads, primary care commissioners
3. Be a problem solver - use your chance to address the commissioner's problems
4. Present professionally.

Checklist - Build Momentum

- ☐ Establish self care support as a valid concept among local decision makers
- ☐ Demonstrate how self care support will deliver the local priorities and objectives
- ☐ Make sure that the need to commission self care support is recognised in commissioning strategy documents

2 Assess need

Working out who could benefit from self care support, this means where self care has the potential to bring about lifestyle changes for patients at risk of disease the number of people who might benefit might be very large indeed, sometimes tens, hundreds or even thousands of people.

Prioritisation - identifying the care pathways
The starting point is the local prioritisation process. PCTs and practice based commissioners are looking to invest in and redesign services that have been identified as a priority. These priorities will be expressed in the PCT's published strategy, particularly the commissioning intentions.

The prioritisation process should lead to the identification of a number of pathways or disease areas where self care support could contribute. Pathway approaches are useful but should not restrict the opportunity to make the most of the potential to commission services that address more than one disease pathway (e.g. smoking cessation, diet and exercise programmes) through self care support.

Stratification - targeting support
But it is not possible to address all areas of need immediately so some stratification is necessary. A simple approach suitable for most disease areas would entail stratifying the population as follows with one as highest priority:

1. Patients with symptomatic disease who need support in daily living.
2. Patients with disease at secondary risk of complications or further episodes
3. Patients at risk of developing disease

The needs assessment process needs to be rigorous and subject to tests of evidence and effectiveness in the same way as for conventional commissioning. For example non-intervention may be a preferred treatment. The evidence on the efficacy of elbow joint injections, versus self care, is that at six months there is no difference in outcome. With that information an informed decision about a joint injection is possible. Similarly a patient may choose to have or not to have an intervention based on its cost and perceived benefit.

Checklist - Assess need

- ☐ Make sure that your plans to commission self care support are derived from local priorities
- ☐ Stratify the target populations to identify those that will derive greatest benefit from a programme

3 Review provision

In a 'conventional' commissioning framework this section would normally be headed 'data analysis' or something similar. Standard practice entails analysis of the benchmarked activity data in order to understand what is happening. This would be matched to available data on health needs, in order to gain a picture of service gaps.

Self care support is less amenable to this approach. There is no benchmarked data available on current provision and little knowledge about what should be there.

This section starts from the premise that self care support initiatives are already in place, some in the NHS, some in social care, some delivered or supported by charitable or community organisation or other funding bodies, some of which may be wholly voluntary and informal. Commissioners are unlikely to be aware of all of them. Examples of self care support services at local level can be found at www.selfcareconnect.co.uk and www.dh.gov.uk/selfcare. Undertaking a mapping exercise of self care support activities going on in local areas would be a very useful exercise to show commissioners what is already out there and what more may be needed.

Among this diverse provision there will be some great schemes and ideas that can be expanded, rolled out or replicated. Although there is unlikely to be a database that we can interrogate we should still be collecting information in a systematic way.

i. Review sources

You will need to take an investigative approach to data collection. This might entail asking a lot of questions of colleagues and following up 'leads' about services, groups and programmes. Useful sources of information will include:

Finance department - can provide information about grants or funding made available to non-NHS providers. Some of these may be self care support.

Provider services - will often have self care support as part of the service delivery for long term conditions in the community. Talking to nurses, health visitors, allied health professionals and others will yield all sorts of useful contacts and information.

Public and patient Involvement Forums - (to be superseded by Local Involvement Networks, LINks) members are likely to have links with local organisations that support self care. Self care support is also likely to be an area of keen interest.

GP practices - practices may be the venue for many of these services and will often have valuable contact details.

Voluntary services co-ordinators - where these exist they are often well-connected to the networks of formal and informal support. If not, there is an opportunity to do this.

Social care (or joint) commissioners - dealing with the community, voluntary and non-statutory sector is one of those areas that social care commissioners have developed well and they will have all sorts of knowledge about provision. However, the current programmes may be fractured, geographically inconsistent and not fully integrated with 'core' services. This would be an opportunity to review these programmes and create better joined-up thinking.

ii. Follow up leads

Not all of the information will be readily available. You may need to follow up leads from the different stakeholders to get more detail about the service, including contacting the provider directly to get more information.

iii. Capture

You will need to obtain some basic information about each of the projects you find out about. This needs to be done in a systematic way, ideally using a simple database in a spreadsheet so that it can be searched and sorted. Key information will include:

- Contact details
- How many people does the scheme cater for?
- What is the value of the contract?
- Is there information about the quality of the service?
- Is there information about the effectiveness of the service?
- Is there any capacity to grow/develop the service?

iv. Analyse

Although you are unlikely to get a comprehensive, analysable set of data it is important to analyse what you have collected in the context of your overall objectives on self care support.

v. Report and store

Having done all of this work it is important to let others know about the current state of self care support services. This will help to improve commissioning and to create a culture in which self care is a recognised tool for health improvement. You also need to make the data available to colleagues who can make use of it in their own commissioning roles. Make sure it is saved in a place that others can access.

Checklist - Review provision

- ☐ Information about self care support already in place has been sought from all stakeholders in a systematic and comprehensive way
- ☐ Information is used and made available to others for use

4 Design and adapt

Much can be done in the area of self care support through service redesign, and targeting available resources. It is important to have objectives based on a clear patient pathway for a condition or disease with the patient at the centre. The pathway must be developed with patients and service users. Once the pathway is agreed commissioners will look to identify providers for each intervention with the aim of drawing up contracts and making any other changes to the way that the service is delivered.

Service redesign also entails working differently and taking existing resources (workforce, funding, equipment and facilities) and adapting these so that the need for additional investment is kept to a minimum.

Where self care support programmes exist these can be slotted into the patient pathway as they are, or adapted to meet the new service design. Additional investment may be needed to extend or to replicate the programmes to meet patient need. Commissioners also need to look at how other providers on the pathway can support self care.

So there is a range of opportunities for increasing the provision of self care support.

Co-funding or co-sponsoring - with another (often social care) commissioner or with a provider such as a charity or voluntary agency.

Non-NHS provision - again there may be community, charitable or informal organisations that are providing good self care support. These can be supported to extend their service or to improve governance or other aspects that may be needed.

Quality standards in acute contract - the standard contract with acute hospitals contains provision to include local quality schedules. These can be written to place a requirement on providers to support and develop self care in patients that attend for outpatient appointments or are admitted. These will need to be carefully drafted and supported by performance management.

Self care in primary care - primary care is the environment in which most patients receive most of their care. It is essential to work with practice based commissioning groups and GP practices to get self care in to care pathways and to strengthen advice and support delivered in general practice. This can be done through a range of initiatives from training practice staff to commissioning new local enhanced services.

Extra stage - building self care on as an extra service level for behaviour modification programmes such as smoking cessation, cardiac rehab, and pulmonary rehab and so on.

Checklist - Design and adapt

- ☐ Opportunities to adapt and expand existing self care support have been considered
- ☐ Opportunities to use existing contracts to enhance self care support have been considered

5 Specify

It will be crucial to specify the service you wish to commission, regardless of whether you are running a new procurement or changing existing contracts.

Writing a service specification is a skilled job but should not be done alone. Clinical leadership either from current providers or clinicians with a special interest is important and expert advice from colleagues in public health, contracting, finance and so on will be needed. Looking at other examples of service specifications is also extremely useful. Some other things to think about:

Existing models and templates - others may have done the hard work specifying the service that needs to be commissioned. Editing a specification is much easier than writing one from scratch. At the very least local contracting and commissioning colleagues will have examples of specifications to act as a template

Innovation - specifications need to be clear but not so tight that there is only one way of delivering a service. Prescribing everything down to the last detail takes tremendous effort and may squeeze out the opportunity to deliver things in a different way. This has implications for procurement which are explored below.

Inputs, outputs and outcomes - Many specifications are described in terms of inputs (number of nursing hours, etc). This has little direct bearing on patient care and can stifle innovation. The ideal is to describe the service in terms of outcomes - for example a diabetes self care support service could set goals for reduction in weight, blood sugar level or smoking quit rates. If this proves too challenging then outputs may be a happy medium. An example of an output would be 'provision of structured self care support packages to 500 patients with agreed cardiovascular risk factors'.

Autonomy - by its very nature self care support depends heavily on participants recognising the value of the programme and engaging with it in a way that delivers the expected benefits. There needs to be some latitude for participants to be innovative and revise the programme in ways that may not have been thought of before. The challenge for the commissioner is to allow this freedom and feedback while making sure that the programme meets the necessary standards of governance and that the aims of the programme are maintained.

Contracts - keep in mind that the service will eventually require a contract. As the writing progresses ask yourself how the service will be paid for.

Capacity and scale - the requirement for many existing self care support projects will be to move on from pilots to full-scale service delivery. This is akin to the path from what might be called 'artisan' delivery to 'industrial' delivery and the challenges can be formidable.

Peer review - get people to look over the specification and provide feedback at regular intervals to build support and assure quality.

Checklist - Specify

- [ ] A service specification is produced that promotes high-quality, outcome based care
- [ ] The specification is widely supported and has been quality assured

6 The financial case

As with any other commissioning project the financial justification will usually be made in the form of a business case. This will be set against other claims on a commissioner's resource, each of which will have merit and its own supporters.

Note that the business case may come before or after the specification depending on local circumstances. An outline description of the proposed service will be needed at the business case stage in any case.

The business case will need to be professionally set out and presented in a way that allows decision-makers to compare its benefits to other health and social care investments. At the heart of the business case is the statement of costs and benefits. This is where evidence is vital to demonstrate the value of the investment and, where possible, to link to expected outcomes. In

the health service there will always be more calls for investment than there is available funds. The PCT will have to assure itself that money spent on self care support is as effective as money spent on other forms of patient care.

As with other health care interventions there are different types of financial benefit and these need to be separated out in the document. For example admissions prevented through better self care are 'cash releasing' whereas a reduction in visits to a local GP surgery is an efficiency gain but does not result in a cost saving.

It is important to remember that the benefits of self care support are cumulative in that the learning from information provided or skills training will stay with patients/individuals year on year and may get even better with support from peer networks over time.

Good sources of evidence for cost effectiveness include:

Department of Health Evidence Pack (July 2007), available at www.dh.gov.uk/selfcare

Self Care Connect website at www.selfcareconnect.co.uk

Checklist - The financial case

- [ ] There is clear and robust evidence of the financial benefits of making the investment in self care support

- [ ] Different types of costs and benefits are clearly articulated

7 Contracting and Procurement

The procurement and contracting phase of commissioning is challenging in any circumstance. The nature of self care support - new modes of delivery, new types of provider, smaller library of best practice and evidence - means that the challenge is even greater. It might be worth assigning a new role of self care support co-ordinator within an existing primary care or public health role in the PCT or commissioner organisation. The new function will help integrate the self care support resource/package whether from one or more providers.

Use of the available flexibilities and application of some core principles should help to reduce the uncertainty.

Core principles

Context

The World Class Commissioning programme launched in 2008 gives PCTs the responsibility to shape the marketplace for NHS services in order to achieve their stated objectives. This is expressed in 3 of the 11 competencies.

> **7. Influence provision to meet demand and secure outcomes**
>
> PCTs are will need to have a clear strategy that helps commissioners (and providers) to determine when to use the range of different procurement and contracting techniques. This is one of the most difficult challenges for PCTs and, at the time of writing, most do not have this in place.
>
> **8. Drive continuous improvement in quality and outcomes through innovation**
>
> Linked to procurement methods PCTs are required to use the range of contracting options in a way that delivers improvements in health, not just contract compliance.
>
> **9. Deploy procurement skills that ensure providers have appropriate contracts**
>
> Having the right skills and capacity in place to achieve step changes in the health of the population is also a core competence.

Where a PCT has invested in achieving these competencies the task of the individual commissioner becomes much easier. Where this context is lacking it is an additional responsibility on the commissioner to ensure that the purpose and rationale for the procurement is documented and either communicated to aspiring providers or made available on request.

Defensibility

There is a great deal of confusion about when and how to use formal procurement methods such as advertising in the European Journal and having sealed tender offers. This is not always the best way to approach procurement, especially where the providers are small and/or

inexperienced. PCTs can use a range of techniques including.

Restricting competition to certain types of providers - e.g. existing providers, those with strong, existing community links.

Competitive dialogue - where complex service requirements are addressed by first identifying providers then working with them to develop specifications, contracts and prices.

Encouraging collaboration between providers - strictly forbidden in traditional procurement but may be appropriate in some circumstances.

If you take any of these routes it is essential that there is a clear rationale behind the approach and that this is documented. You need to ask yourself at every stage 'could my chief executive defend our approach in the face of a challenge from the media, from bidders or other stakeholders?'.

Transparency

Whatever type of procurement you run your reasons for running it in the way you do need to be transparent. Obtaining clear decisions from those accountable, documentation of decisions, issuing clear, consistent communications to all stakeholders throughout the process are all essential components of transparency.

Proportionality

One of the key flexibilities for PCTs in commissioning is the 'common sense' recognition that your approach should be proportionate. If you are seeking to support existing community groups in delivering non-clinical self care support (cooking classes, walking groups, etc) then you will not need to have comprehensive clinical governance frameworks and a dozen KPIs reported monthly. Similarly, using the procurement approach used for securing a multi-million pound walk-in centre to buy such services will effectively rule out any local groups from bidding.

Supporting smaller providers

The competencies set out in World Class Commissioning place a responsibility on PCTs to help smaller providers to develop themselves as providers and as effective bidders.

This work should be done outside of any formal procurement as this may lay open the PCT to charges of encouraging collusion.

It is worth recognising that, where there are existing small or informal providers, these may not be best placed to respond to a formal public sector tender process. Some thought needs to be given to adapting the process such that it does not discriminate against these groups or organisations. It may be possible to support them in preparing their bid although this needs to be done within the 2006 Public Contract Regulations and the PCTs own standing financial instructions.

Checklist - Contracting and procurement

- ☐ Check the PCT strategy and policy on developing the provider marketplace
- ☐ Consider whether your procurement and contracting procedures may discriminate against small or local providers
- ☐ Put in place programmes to help smaller providers to enhance their skills

8 Performance management

Good performance management is in the interests of the provider as well as the commissioner. Commissioners will want to make sure that monitoring is robust and consistent. As with all commissioning, performance monitoring for self care support should:

- Be inclusive - with all parties and individuals associated with the delivery of the service
- Be conducted in an open and transparent way
- Allow variation within the contracting period
- Help to identify improvements in service delivery
- Review specified deliverables, including outcomes, quality, standards, cost and value for money.

Reporting requirements should be reasonable and proportionate to the contract. There is a tendency to request too much data too often. This is a particular problem for smaller providers.

Every contract should include opportunity for a dialogue between commissioner and provider. This is particularly important in an area like self care support which is evolving quite rapidly. Review and revision will allow both parties to take advantage of emerging ideas and best practice.

There are many performance systems in use. The Birmingham Own Health project uses the OSCAR framework for developing outcomes:

- Organisation
- Patient Satisfaction
- Clinical
- Activities
- Resource utilisation

As far as possible performance should be based on outcomes - measurable changes to health. Where this is not possible - such as when the service is to extend life years into the future -use outputs. Outputs include aspects such as the number and quality of care packages. Try and avoid input measures such as nursing hours as this approach tends to stifle innovation

Checklist - Performance management

- [ ] The performance regime is supported by all stakeholders and accepted as reasonable by the provider
- [ ] The performance regime is based on outcomes as far as possible

9. Evaluation (of Outcomes and Patient / Person Perceptions)

Performance management takes care of many of the questions we would ask of a new service or a new provider. But this approach has limitations. Most tellingly it uses a critical approach that was constructed a priori, telling us only about aspects of performance that we have already considered.

It does not consider any of the consequences of a health intervention that were not anticipated at the outset, such as an unintended increase in health inequalities. This is where evaluation by an independent expert can lead to improvements in a service.

Evaluation goes beyond performance management to look at:

- Whether the objectives of the service are being achieved - that is whether there are detectable health gains among those using it (contrasted with the focus of performance management on specific measurable changes)
- Whether there are unintended benefits or dis-benefits arising from the project that were not originally conceived
- Whether there were intended as well as unintended costs or savings (assessed by carrying out quantitative and qualitative economic analyses)
- Whether any changes could be made that might lead to greater benefits/lower costs.

By its nature evaluation needs to be carried out after sufficient time has been allowed for the project or service to have an effect. This is almost certain to be more than a year from inception and may be several years later.

It should be rigorous and, ideally, carried out by an independent body using a proven methodology. By its nature any evaluation should include a strong component of user perception.

Checklist - Evaluation

- [ ] Evaluation is carried out in a systematic and rigorous way by an independent party

10. Re-commission

Evaluation should be the start point for a fresh round of commissioning utilising the learning from the project and building on evidence and best practice that has emerged in the meantime. Although there are no rules on time periods one would expect a service to be reviewed every three to five years.

References

1. Department of Health, Self Care - A Real Choice: Self Care Support - A Practical Option, (2005)

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