

Chapter 1

Background to the Implementation of Case Management Models for Chronic Long-Term Conditions within the National Health Service

Introduction

Long-term conditions are defined as those conditions that cannot be cured but can be controlled by medication and other therapies. The management of chronic long-term conditions such as diabetes, chronic obstructive pulmonary disease, arthritis and heart failure is not new; for many years, specialist teams of nurses and other professionals alongside primary care generalist practitioners, including practice nurses, have been delivering specifically focused disease management for patients with chronic conditions. It is clear from health statistics that the number of diseases that are now being managed as chronic conditions is increasing as our management abilities for diseases that were once considered life threatening have improved. The patients therefore now live longer with these conditions. However, the effect of chronic diseases on the quality of life of these patients and their carers is significant.

Improving the care provided to patients with long-term conditions has been a key priority for the National Health Service (NHS) since the development of the NHS Plan in 2000 [1] and continues as a main thread through all policy drivers to be high on the Government and Department of Health (DH) agenda. It is also clear that in the NHS in England the ongoing management of these conditions is always likely to cost much more than the elective surgical procedures. There is also an economic impact of chronic diseases on the patients and their families owing to the reduction in earning potential of the younger people who develop chronic diseases and the cost of caring. Evidence suggests that the prevalence and impact of chronic diseases are greater in areas of high deprivation, and primary care trusts (PCTs) are currently attempting to improve this by focussing on behaviour change to aid prevention in these areas. The depth of evidence of inequalities in health is currently focussing the minds of commissioners on defining service needs based on real health needs, so that the services are appropriately targeted and include the provision of health promotion and prevention of disease starting early in life, and then building on this behaviour change across age ranges.

The delivery of care for those with chronic conditions with less complex needs is now clearly focused within primary care. NHS policy sets out clear expectations on commissioners to ensure that care provision is provided nearer to patients and increasing amount of care is delivered outside the acute sector, but it must be noted that other key policy and modernisation drivers aiming to introduce market-style incentives and multiple provider models may inhibit the development of good long-term disease management. The January 2009 DH publication 'Supporting people with long-term conditions: commissioning personalised care planning' [2] clearly defines for commissioners the expectations and ongoing push from a policy perspective in relation to effective commissioning of services in both health and social care for patients with long-term conditions. Each year the operating framework provides commissioners with guidance on the areas they are expected to commission and the services they need to develop, and the recent framework [3] continues to support the push of service development for patients with long-term conditions through increasing choice, commissioning care closer to the patient and focussing on commissioning for improved clinical and patient-reported outcomes.

Primary care management of long-term conditions

Increased primary care functionality in relation to chronic disease has been developed and consolidated through the recent General Medical Services contract [4], which defines the basic outline of service within primary care, and the supporting Quality and Outcomes Framework [5], which sets clear quality targets and indicators in some key areas of chronic disease management, including clinical and organisational areas; all of these domains are set in line with known good practice. The Quality and Outcomes Framework prevalence results for 2006/2007 provide information on the prevalence of many chronic diseases within England (Table 1.1). This information has enabled primary care to define in detail the service needs of the population on a practice and locality basis. The information also allows practice to identify based on national expectations the effectiveness of screening and diagnosis within the practice population. The ability of local health commissioners to use this information intelligently to commission locally based and responsive services is a major thrust to the plans for World Class Commissioning within the NHS [29].

The outcomes for the disease or condition focused services within primary care and specialist teams have improved over the years and in many areas the care has clearly been proved excellent. The publication of National Service Frameworks (NSFs) within some of the chronic disease areas has provided some clear and evidence-based processes of care, but without some supportive processes, guidelines alone could not achieve the impact on quality of care.

Table 1.1 Quality and Outcomes Framework 2006/2007 Prevalence Counts (Department of Health Data)

Long-term conditions	Numbers affected
Coronary heart disease	1,899,000
Heart failure	420,000
Stroke and transient ischaemic attack	863,000
Hypertension	6,706,000
Diabetes	1,962,000
Chronic obstructive pulmonary disease	766,000
Epilepsy	321,000
Cancer	489,000
Severe mental health conditions	380,000
Asthma	3,100,000

How management approaches have been developed

Many of the developments in the quality of care for chronic diseases, particularly heart disease, chronic obstructive airways disease and diabetes, in primary care have been assisted via projects and programmes supported through phase III of the National Primary Care Collaborative [6] in which a number of primary care practices across the NHS have taken part. The development of the required knowledge, clinical skills and competencies within practitioners to enable the management of patients with these disease processes is obviously fundamental to ensuring improved outcomes for patients. It is well known that the foundation for delivery of quality care is also based on excellent teamwork between care providers across all sectors (tertiary, acute, primary and community care) and communication between all practitioners and their patients and carers. The high-level competencies for case managers [7] that were published by the DH in 2006, and that form the main focus of the later discussion within this text, reflect many of the same skills and competencies developed by specialists and generalists. It is clear from the evidence that if this higher level of competence is held by the practitioners, they can provide the process of proactive case management and therefore enable the programme of care to provide the expected improvements in outcomes and quality of life.

The development of pathways and models of care based on evidence and good practice that are shared across acute and primary care has allowed not only the ongoing development and dissemination of skills and competencies to primary care and community practitioners but also some progress with improvements in the quality of service delivery. This ongoing development of skills and competence has also enabled the level of patient complexity managed in primary care to continually increase, which has assisted in the delivery of care provision, as outlined in policy documents, in a standardised way

in primary care, in line with defined patient pathways and of course good practice. These developments in care provision have effectively enabled the movement of a reasonable proportion of care out from acute settings nearer to the patient, which is clearly in line with many of the current policy requirements including the recently published report by Lord Darzi 'High-quality care for all: NHS Next Stage Review' [8].

The long-term development of the General Medical Services contract over the past decade has also provided practices with the ability to increase capacity and to develop in their staff the specific skills and knowledge required to provide care in particular disease areas based on the health needs of their practice population. Despite all this good work, the ability to deliver quality management for patients with more than one chronic disease or with complex health needs has not progressed to the same degree, and as is clear from the evidence of the health needs of these patients who are accessing care in increasing amounts from the NHS, this cannot continue.

Developing and delivering care

It is obvious that primary care practitioners and specialist teams, both community and secondary care based, have worked hard to develop the knowledge, skills and competencies required to manage these chronic-disease-specific programmes of care and this has improved greatly the communication between them. However, there remains an overall view within the NHS, which is reported anecdotally by patients and carers, of lack of 'co-ordination' and 'personalisation' of care for those with more than one condition and who are at the more complex end of care need.

Nevertheless, from both the patient and the delivery perspectives, it is clear that as the population becomes older and lives longer with chronic conditions, managing patients with any of these diseases in disease-based silos, particularly when many of the patients have more than one chronic disease, is a recipe for confusion and is unsatisfactory in terms of outcomes. This silo-based process of care delivery very clearly achieves much poorer patient outcomes and lower levels of patient satisfaction. Although the care being delivered is obviously well meant and often of a high standard, the lack of personalisation does in some cases lead to less than successful outcomes for patients and their carers as the care received is often viewed as inflexible and not always based on the patients' wishes, nor does the service delivery always reflect patients' choice. The process of case management and its formalised implementation is now seen by the NHS as a potential way to improve both the outcomes and the effectiveness of care delivery for patients with multiple conditions and complex needs; this patient group is often described in policy and planning documents as 'high-intensity users'. The improved management of these patients is seen as a key process that will reduce their impact on acute services through reduction in emergency admissions.

As outlined previously, the United Kingdom has, alongside most industrialised countries, improved the management of many of the individual chronic diseases through advances in understanding of disease processes, improving non-pharmacological and pharmacological management and setting of good practice standards based on a sound evidence base. The NHS has also, through a number of projects and programmes, aimed to improve the way service is delivered through 'good practice'. A key programme to facilitate improved care models includes the implementation of the National Institute for Health and Clinical Excellence, which publishes a wide range of guidance relating to care delivery commonly known as NICE guidance. NICE guidance, either technology or intervention based, is published to provide healthcare staff, providers and commissioners with a robust review of the clinical effectiveness of treatment practices and interventions including medication appraisals. The implementation of the processes within NICE guidance, though not always popular with the public, professionals or the pharmaceutical industry, does at least provide for the first time a formalised and systematic review of treatments and interventions within the NHS.

Historically, this sort of review and evidence was not always widely or easily available within the NHS despite the work of many academic departments and clinical/research teams across universities and the NHS. A number of teams within UK academic establishments have developed processes and delivered systematic review projects over the years. One of the most established, well known and credible is the Cochrane Collaboration [9], which has defined very clearly the gold standard for processes of reviews, including guidance for the processes that should be utilised to ensure the quality and efficacy of any review. Although at one time it was claimed that very few interventions used routinely within the NHS had been subject to any robust or systematic review of efficacy or effectiveness, it is now seen as an absolutely fundamental requirement that clinical interventions and treatments provided are evaluated for clinical and cost effectiveness and that all services are now subject to appropriately robust review to ensure safe care and value for money. The NHS Centre for Reviews and Dissemination is also a key player in the area of practice and service review and dissemination of learning.

Future of care

The major review of funding completed by Derek Wanless and published in April 2002 [10] provided a number of potential 'scenarios' for the funding of health care up to 2022/2023. The scenarios presented were based on assumptions regarding the effectiveness of the NHS performance and the health status of the population. The report clearly outlines the need for the NHS to improve dramatically the quality and outcomes of care provision as without these improvements any increase in funding would be, in the main, ineffective and care would gradually become more and more unaffordable. For more than a decade, the NHS has undergone a programme of reform and modernisation in

which the NHS budget in England has trebled to reach £93.6 billion, in Northern Ireland there has been a 35% increase in budget and in Scotland the budget has increased by 76% since 1999 [11]. This level of investment has clearly delivered some quality and service improvements, but still there remain concerns regarding the quality and effectiveness of some of the programmes of care for the most vulnerable and, of course, for those with the most complex needs, in particular with chronic conditions.

The investment has accompanied much reorganisation with healthcare delivery including improved commissioning processes via PCTs, payment by results (PBR), world class commissioning, practice-based commissioning (PBC) and foundation trusts. All of these changes are focused on delivering an NHS improvement plan [30] through the implementation of a 'patient-led NHS', in which money follows patients and commissioning decisions are based on clearly defined health needs [12]. The NHS is trying through modernisation to:

- Shift care away from relatively expensive inpatient care to community-based diagnosis and management,
- Achieve economies of scale through integration of institutions,
- Control clinical profligacy through clinical guidelines and evidence-based practice,
- Substitute expensive doctors with less expensive professionals,
- Implement provider performance monitoring to improve quality and accountability.

The impact and cost of chronic disease

It has been estimated that in Britain 17.5 million adults may be living with a chronic disease and that 6 in 10 adults in the household population report some form of chronic health problem [13]. The number of people over 65 is projected to increase across the United Kingdom by between 18% and 23% and the number of people aged 85 or over is projected to rise by nearly 75% by 2025 [11], and it is also likely that 75% of people over the age of 75 are or will be suffering from some form of chronic health problem. The fact is that older people are the main users of the NHS, and although they form only about one-fifth of the population, it is known that they occupy two-third of general and acute beds within NHS hospitals [14]. This activity and cost pressure is not just on the NHS; even the local authorities spent nearly half of their social service budget during 1999/2000 on older people (NSF for older people) [15]. A key target for local authorities is to increase the number of people living independently in their areas. The processes used are direct payments, which can empower clients to choose the care they desire, and improved services, which enable independence with availability of equipment and telecare and care management (assessment and care planning). The requirement for local authorities and the NHS to work in partnership to deliver services is also fundamental to enabling independence.

The figures for chronic diseases in the United Kingdom, reflected in World Health Organisation data across the industrialised world, highlight that some 75% of the total population reports having one chronic condition and 50% reports having two or more conditions [13]. The figures describe very clearly the size of the problem facing the NHS both now and in the future.

Identifying patients who require case management

The development of a process to identify patients who are in need or at risk of readmissions or who require specific service delivery has been carried out in a number of ways across the NHS over the years. The literature review of predictive risk processes by the King's Fund and their partners outlines the rationale for predictive modelling and the successes and failures of some of the processes used [16]. This review concludes that measurement of risk is extremely important and that good predictive models must be adaptable to the context, must be statistically valid and must contain sufficient variables; currently, concurrent modelling is seen as most accurate, but this may change as we utilise more intelligent data. The variables used in the models are seen as interdependent. It is clear from this review that socio-economic data alone have low predictive power, but the power increases when they are linked to other variables including diagnostics, clinical data and pharmacy data. The development of predictive tools, such as the Patients at Risk of Re-hospitalisation (PARR) [17] tool and Dr Foster Intelligence's High-impact User Manager (HUM) system, to assist in the identification of patients at high risk has provided some support to organisations trying to implement case management. The combined PARR tool is an algorithm that merges a number of data variables, including hospital episode statistics (HES) and community data, to identify effectively the patients at high risk of re-admission. The PARR tool [18] developed by a collaboration of the King's Fund, New York Centre for Health and Public Service Research and Health Dialog Solutions has provided to PCTs across England an intelligent analytical tool. The tool has been used successfully in many organisations for identifying and targeting care for patients at the highest risk. The tool has been further developed to provide information on needs across the full chronic disease continuum.

The combined predictive model has provided a process through which organisations have been able to tailor interventions to the needs of the patients and match the expected outcomes. This model enables organisations to focus efforts on areas of need across the full spectrum of the risk pyramid. The PARR tool provides well-validated statistical information on patients and their level of risk in relation to service usage. The DH has also supported the development of predictive tools and provided a data toolkit [19] that aims to assist health and social care partners in understanding the health impact of chronic diseases on their populations. The accessibility of 'intelligent' information allows the organisations to understand which diseases are having the greatest negative impact on the local population and where. The information can then be utilised to inform

commissioning decisions, allowing improved local planning and targeted service delivery to improve outcomes and reduce health inequalities. It should also be noted that though predictive tools based on analysis of data are effective, identification by clinicians and practitioners based on their knowledge of patients has also been used and found to be reasonably effective in outcomes.

National guidelines and evidence-based practice

The development for the NHS of the NSFs [15] for diabetes, mental health, coronary heart disease and older people during the late 1990s initiated standardised, evidence-based care programmes/pathways for the long-term conditions and care groups. The NSFs were developed for clinical areas of high population exposure and outlined care pathways based on robust evidence with proven efficacy. The publication of the NSFs provided for the first time some clear national targets for quality standards and outcomes within service provision and delivery targets to facilitate and enable service improvements across the NHS. Despite these targets, implementation has in some areas been patchy, with greater levels of success in those areas for which implementation funding followed targets. However, the delivery targets within NSFs have provided a framework on which commissioners and providers, including clinicians, have been able to influence improvements and changes in service delivery. The targets within NSFs have in the main been focused on increasing access to service pathways modelled on good practice, by ensuring that standardisation of care is implemented to improve both access to care and the quality of its delivery. The development and implementation of evidence-based guidelines like NICE guidance and NSFs into care delivery is heavily dependent on the credibility of the guidelines and the organisation/group that produces this information. Despite well-disseminated guidelines within the NHS, there remain some areas in which full implementation is challenging.

Embedding evidence in practice

The Institute for Healthcare Improvement in the United States would argue that a delivery infrastructure is required for embedding evidence-based guidance into practice. The areas that they advise as good practice would not be a surprise to anyone working in clinical care as these are seen as absolutely essential to enable effective implementation. The supporting processes can be described simply as:

- Find the guidance,
- Encourage providers to take part in the process,
- Check what you currently do,
- Customise to local needs as appropriate,

- Use simple flow charts and checklists to ensure full understanding,
- Review both effectiveness of delivery and the guideline.

The evaluative process outlined also allows for identification of barriers to implementation, which should then, in theory, allow planning for any other implementation to manage these issues in advance. It is clear from reviews of effective guideline implementation that there are a number of other key principles to enable embedding of guidelines, which are in many ways common sense. Effective implementation will obviously rely on the clinical engagement and the involvement early in the process of those likely to be most negative; winning their hearts and minds will most definitely assist the process. It is also clear from what we know about delivery of project management that implementation of a guideline would be assisted by project management processes. These project management processes allow for clear planning and timescales and also for identification of pressures and problems that might delay or prevent implementation. This does not mean that every guideline needs full project management methodology, but the principles of understanding the aim, knowing the journey and supporting the trajectory of the journey would dramatically improve implementation. Within the NHS we rely, in many instances, on dissemination of guidance to practitioners and their ability and commitment to implementation, and whilst for some this will be an easy and effective process, for others it most definitely is not the most appropriate way to support delivery. All NHS organisations are required to declare compliance with the Standards for Better Health to evidence how they provide assurance of dissemination and implementation of national clinical guidelines and how they develop and implement local clinical pathways as part of world class commissioning.

Making progress in the management of chronic conditions

Improvements in management of chronic conditions are clearly evidenced by the fact that mortality from heart disease had fallen across the United Kingdom by 27% between 1996/1997 and 2001/2003; this is alongside a reduction in death rates from cancer in the under 75 group by 12% in the 6 years up to 2005 [20]. There is therefore evidence of increasing life expectancy of many patients with long-term conditions. The improvements in how the NHS manages these conditions have of course increased the numbers in the population living with long-term conditions across many of the disease areas. Many diseases that were considered life threatening in the past have now become chronic. An added element for the NHS in the delivery of care for patients with long-term conditions is the impact of health inequalities in these disease groups across large portions of the population. The latest information produced by national reports from the results of the Quality and Outcomes Framework in primary care [21] highlights

the levels of difference in terms of both access to care and outcomes for many of the chronic diseases in areas with high levels of deprivation. The prevalence of long-term conditions varies across regions, with the England average on 33.2% with a variation of between 20% in the bottom quintile and 37–48% in the top quintile [22]. A number of factors, including age, socio-economic status and lifestyle choices, are suggested as reasons for this variation. The modernisation agenda for the NHS through PCTs aims to focus the commissioners onto potential ways to improve the health of their local population, reduce health inequalities and improve outcomes for patients.

Modernising care in the National Health Service

The NHS Reviews, like the Darzi Review [8], and modernisation plans are clearly focused on commissioning and providing services that improve the quality of life for patients. The strap line used of ‘adding life to years alongside years to life’ provides a new focus for the NHS, requiring that services work to improve the quality of life for patients, particularly relevant to those living with chronic conditions. It is clearly important that all providers of care focus on both quality and outcomes within service delivery and ensure that there are choices in management approaches for patients, supported with good information to facilitate those choices. The Next Stage Review [8] clearly outlines the requirement for personalised and holistic services, which are flexible in delivery and can deliver good ‘patient reporting outcomes’.

It is also estimated that 45% of those with chronic disease will suffer from more than one condition, which adds complexity to the management of their disease. This can cause major problems for patients with contradictory or confusing processes of care, as these processes could be viewed by patients as narrow and unhelpful. The anecdotal comments of patients and their carers often highlight the sometimes frustrating and confusing processes of care they receive. The key comments reported outline that poor communication, poor co-ordination and lack of information are often at the heart of the problems the patients see with the care they receive.

Developing case management and care delivery

The DH has produced, based on the chronic care models, a pyramid of care that shows risk for service use of the population [18]. Those in the low-risk sector, between 21% and 100% of the population, use less than half of the average access to care (general practitioners, accident and emergency [A&E] attendances and admissions). In service delivery impact, this low-risk group will require little actual intervention but may require lifestyle and other behavioural modifications. Moderate-risk group, 6–20% of the population, uses 1.8 times the average for admissions, 2.2 times the average for outpatient encounters and 1.5 times

the average for A&E attendance. The moderate-risk group will require what is described as information therapy: support and information for self-care. High-risk group, equating to 0.5–5% of population, access 5.4 times the average hospital admissions, 4 times the average outpatients encounters and almost 3 times the average A&E attendances. The high-risk group needs proactive disease management at a moderate intensity. Then there is the very high risk population that forms for most organisations 0.5% of the population. This group uses more than 18 times the average for admissions, 6 times the average for outpatient contacts and 9 times the average for A&E attendances. This is very clearly the group for which care management would be the most effective.

Case management, which is seen as an option for management that can improve the process of care, can be described as a process of proactive management of patients with chronic diseases. In the main, the programme is implemented for patients with complex health needs and focuses on the use of practitioner skills, which facilitate and enable patient-centred and holistic care. The key to the process is to manage across all care environments through proactive interventions and planned programmes of care, which allow flexibility and are also focused on monitoring how the patient's condition is progressing and recognising early signs of change and deterioration. The key processes within the case management programmes in the United States are described as care orchestration, communication, acting as a champion or advocate, high-level clinical skills and acting as a coach [23]. All of these processes or skills are seen as fundamental to enabling the proactive model of care and achieving good outcomes for patients and their carers.

Case management as an advanced clinical role, for mainly nurses, has been developed in the United States. The process is fundamental to the provision of care under many of the United States healthcare providers (managed care organisations), and their aim is to programme and orchestrate care in a managed and outcome-focused way. The model has provided for the United States a cost benefit in terms of reduced admissions and improved cost effectiveness of care; these are of course essential to ensure cost control and reduction within the United States healthcare model.

Case management in the National Health Service

The implementation of case management as a process for the NHS has been encouraged via the DH through support to PCTs pilots of case management models across England. The key pilot for case management was based on the United States models including Evercare programme via the UnitedHealth Group and was completed on 10 sites across the United Kingdom. The work with UnitedHealth Europe started in 1987 and a final report into the pilots was published in February 2005 [23]. The report described some key successes including increased skills and confidence within the nurses trained through the programme, high levels of patient and carer satisfaction and a reduction in hospital

admissions in the biggest group of patients in the programme. However, the researchers were unable to confirm whether the latter was regression to mean or the impact of the interventions.

The DH was clearly impressed by the outcomes evidence from the pilot and set targets for each strategic health authority for the implementation of case management roles in practice. The effectiveness of these roles was measured as a Public Service Agreement (PSA) target on the basis of reduction in emergency bed days used. The PSA for long-term conditions was based on the following target: 'to improve health outcomes for people with long-term condition by offering a personalised care plan for vulnerable people at highest risk and to reduce emergency bed-days by 5% by 2008 through improved care in primary care and community settings for people with long-term conditions.' A PSA target for staff working in community matron roles, providing case management in primary or community care settings for people with complex long-term conditions and high-intensity needs, was set at 3000 nationally based on the population, with each PCT receiving an individual target.

The department has adopted the Kaiser model that stratifies people with long-term conditions into three levels. At level 1 is supportive self-care, aimed at working in collaboration with patients and carers to assist them in developing their abilities to care for themselves. Level 2 is disease-specific care management, providing responsive care for people with complex single needs through multidisciplinary teams and the disease-specific protocols such as NSFs etc. Level 3 is the identification of the most vulnerable people with highly complex multiple long-term conditions and use of case management approaches to anticipate, co-ordinate and join up health and social care.

The development of case management models to deliver improved health outcomes was therefore seen as a wise investment and as an effective way to support delivery of the PSA targets. The founding principle these targets were based on was fairly clear evidence that despite the improvements in disease-specific care through implementation of NSFs, problems persist for patients with multiple long-term conditions, leading to poor health outcomes and frequent admissions. Meeting the different elements of the PSA target required significant changes to the traditional patterns of service delivery.

The NHS data [13] show that 80% of general practitioner consultations are for patients with chronic diseases. Two-thirds of patients admitted as medical emergencies have exacerbation of chronic disease or have a chronic disease and 60% of hospital bed-days are used by patients with chronic conditions. It is also clear from these data that patients with one or more conditions make much higher use of healthcare services, e.g. the 15% of people with three or more problems account for almost 30% of inpatient days and costs for patients with more than one chronic conditions are six times higher than costs for patients with one chronic condition. These findings are no surprise to staff working in the NHS and are supported by the evidence from the United States, where it has been shown that people with chronic conditions consume about 78% of all healthcare spending [13].

The DH has supported the formal development of a case management competencies framework and a supporting educational framework [7] via an academic programme to help case managers develop the set of competencies that are required for providing effective care. The implementation of case management model is also fundamental to organising care around the needs of patients and nearer to where they live, promoting self-care models and improving outcomes of care. It should be noted that in addition to this model of care delivery, there has been an increased recognition of the need to focus on prevention of long-term conditions through lifestyle changes, increase early diagnosis through access to effective screening programmes, improve personal abilities to self-care through robust education on diagnosis and facilitate the delivery of choice.

Promotion of self-management and self-care

The Expert Patients Programme [31] is one of the initiatives aimed at supporting and enabling patients to make informed choices and improving their abilities to self-care. All of these are fundamental principles in delivering improved health outcomes and processes for the management of long-term conditions. NHS targets to enable patients to take personal responsibility for their own well-being and also provide ongoing support for self-care. This will result in delivery of improved outcomes for health through compliance and concordance and an increasing recognition within patients of the importance of lifestyle choices in the ongoing progress of chronic diseases [11]. The principle of personal responsibility is underwritten in the NHS Constitution [25]. The current published constitution outlines for the first time the rights and responsibilities of the public and staff. It not only outlines the need for all users of the NHS to accept their personal responsibilities for working in partnership with care providers but also clearly outlines what a patient can expect from the NHS and its staff.

Partnerships and expectations

There is also a clear recognition that the partnership of care delivery across health and social care is fundamental to managing long-term care in the future, as without collaboration and integration, care delivery will be fundamentally flawed. Health and social care systems must therefore consider the effect of the aging population on the demands for resources.

The best care and support is delivered by professionals working together as part of teams to meet the needs of communities, groups and individuals. There are huge benefits for everyone – NHS, local authorities, third sector, but most of all for all of those people whose lives can be transformed by being given the support that's right for them.

David Behan, Director General for Social Care [22]

It is also clear that, in future, the expectation of commissioners of service will be that service will be delivered through a patient at the centre of care programme [12] and in a co-ordinated and integrated way. In the longer term, commissioners will commission based on patient pathways, which have safe and effective handovers of care responsibility, with proven patient outcomes and delivery nearer to the patients' home. The guidance provided to commissioners within 'Supporting people with long-term conditions: commissioning personalised care planning' [2] clearly outlines the expectations to embed personalised care planning within all health and social care economies. The document provides a clear definition of what personalised care planning should include, the benefits and what it means for the commissioners. The concept is that commissioning patient-centred services will enable improved outcomes for patients through increased service integration and partnerships, improved service user satisfaction, improved efficiency, promotion of independence and choice and reduction in health inequalities through standardised approaches to care.

The NHS White Paper 'Our Health, Our Care, Our Say' [26] and the policy document that followed it clearly outlines the need for the health and social care professionals to work together to deliver 'joined up' services which utilise a holistic view of the needs of individual patients and provide care which ensures quality of care and outcomes. It is also clear from some service reviews in local areas that recognition of the strengths of the care workforce and some development in their skills to enable delivery of ongoing review and supervision of disease management (recording of blood pressure, blood sugar etc within set parameters) could improve outcomes, provide early recognition of deterioration and increase management processes and thereby reduce emergency admissions.

The implementation and delivery of the ongoing modernisation agenda within the NHS clearly defines new and advanced roles for all professionals, alongside the plans and reports already in place, for example those outlined in many policy and strategic papers from the Chief Nursing Officer and other key leaders within the NHS [27,28]. Implementation of case management models and processes is just one of the many new roles required of healthcare professionals to enable these modernisation plans to be delivered. Healthcare provisions and roles across the world are changing constantly to enable the delivery of care based on health needs and improvement in patient outcomes.

The NHS has since its inception constantly striven to improve care quality and access to care. It has tried to deliver this through quality leadership and encouragement of innovation. The NHS Plan published in 2000 provided for all involved in care opportunities to reinvigorate and modernise care delivery. The development of processes for improved management of chronic disease care is just one area in which the opportunities are beginning to be realised.

Across the NHS, provider organisations and their partners (social care and the voluntary sector) are busily developing service to manage and support this

patient group. Each of these organisations is working to manage the following key issues:

- Recruitment, education and training of the workforce,
- Targeting patients: how to identify those who will gain the most benefit,
- Processes and operational tools,
- Interface working and referral processes,
- Information and data management.

This remainder of this text attempts to review how these issues may be or are being managed and how case management can and is making a real difference to the health and social well-being of these patients.

Conclusion

It is apparent that all policy drivers in health and social care are pointing to the need to modernise care delivery. The ability of society to deliver the health and social care needs, both now and in the future, is dependent on this modernisation. The needs of the population in relation to care are increasing owing to lack of improved health behaviours, prevention and improved management of chronic conditions including self-management; therefore, modernisation of service delivery is absolutely essential. Since we now recognise the increasing burden of chronic long-term conditions on the society, this will remain the key focus for service delivery. The enormity of the impact on individuals and society of these disease processes is now well recognised as is the fact that we must prevent these disease from occurring and manage them when diagnosed. If these actions can be implemented effectively, patients/service users are more likely to live longer and healthier lives. The implementation of the recommendations within the 'Darzi Review' alongside other policy recommendations will probably enable new models of care, which are indeed focused on the personal needs and views of the population.

References

1. Department of Health (2000). *The NHS Plan*. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4055783.pdf (accessed on October 2009).
2. Department of Health (2009). *Supporting People with Long Term Conditions: Commissioning Personalised Care Planning. A Guide for Commissioners*. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093354 (accessed on October 2009).
3. Department of Health (2009). *High Quality Care for All: Operating Framework for the NHS 2009/2010*. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_091446.pdf (accessed on October 2009).

4. Department of Health (April 2004). *General Medical Services Contract*. http://www.dh.gov.uk/en/Healthcare/Primarycare/Primarycarecontracting/GMS/DH_4125638 (accessed on October 2009).
5. Department of Health (April 2006/2007). *Quality & Outcomes Framework*. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4088693.pdf (accessed on October 2009).
6. National Collaborating Centre for Chronic Conditions (2004). *Chronic Obstructive Pulmonary Disease. National Guidelines on the Management of Chronic Obstructive Pulmonary Disease in Adults in Primary and Secondary Care*. <http://guidance.nice.org.uk/CG12> (accessed on October 2009).
7. Department of Health (2006). *Caring for People with Long Term Conditions: An Education Framework for Community Matrons and Case Managers*. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4118102.pdf (accessed on October 2009).
8. Department of Health (2008). *High Quality Care for All: NHS Next Stage Review Final Report*. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_085828.pdf (accessed on October 2009).
9. Cochrane Collaboration and NHS Centre for Reviews and Dissemination. <http://cochrane.co.uk/en/index.html> (accessed on October 2009).
10. Wanless D (2004). *Securing Good Health for the Whole Population*. Treasury Office. http://www.hm-treasury.gov.uk/consult_wanless04_final.htm (accessed on October 2009).
11. Department of Health (2006). *Modernising Nursing Careers*. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4138757.pdf (accessed on October 2009).
12. Department of Health (2005). *Patient Led NHS*. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4106507.pdf (accessed on October 2009).
13. Department of Health (2008). *Improving Chronic Disease Management: A Compendium of Information*. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_082067.pdf (accessed on October 2009).
14. 2006 UK National Audit Office. <http://www.nao.org.uk/publications.aspx> (accessed on October 2009).
15. National Service Frameworks Diabetes, Mental Health, Older People, Children. <http://www.dh.gov.uk/en/publicationsandstatistics/index.htm> (accessed on October 2009).
16. King's Fund, NHS Modernisation Agency, Health Dialog and New York University (2006). *Predictive Risk Project Literature Review*. http://www.kingsfund.org.uk/applications/site_search/?term=Predictive+risk+project+literature+review&searchreferer_id=0&searchreferer_url=%2Fapplications%2Fsite_search%2Findex.rm&submit.x=16&submit.y=12
17. King's Fund, Health Dialog Analytic Solutions and New York University Center for Health and Public Service Research September (2005). *Case Finding Algorithm for Patients at Risk of Re-Hospitalisation*. http://www.kingsfund.org.uk/applications/site_search/?term=Case+Finding+Algorithm+for+Patients+at+Risk+of+Re-Hospitalisation.&searchreferer_id=0&searchreferer_url=%2Fapplications%2Fsite_search%2Findex.rm&submit.x=22&submit.y=9
18. Health Dialog (June 2006). *Combined Predictive Model: Executive Summary of Interim Results*. http://www.kingsfund.org.uk/applications/site_search/?term=Combine+Predictive+Model%3A+Executive+Summary+of+Interim+Results.&searchreferer_id=0&searchreferer_url=%2Fapplications%2Fsite_search%2Findex.rm&submit.x=16&submit.y=10

19. Department of Health (2009). *Disease Management Information Toolkit (DMIT)*. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_074921.pdf and http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_074922.pdf (accessed on October 2009).
20. Department of Health (2005). *Supporting People with Long Term Conditions: Liberating the Talents of Nurses Who Care for People with Long Term Conditions*. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4102498.pdf (accessed on October 2009).
21. Department of Health (2008). *Quality and Outcomes Framework Report*. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4088693.pdf
22. Department of Health (2008). *Raising the Profile of Long Term Conditions Care: A Compendium of Information*. http://www.kingsfund.org.uk/applications/site_search?term=Combined+Predictive+Model%3A+Executive+Summary+of+Interim+Results.&searchreferer_id=0&searchreferer_url=%2Fapplications%2Fsite_search%2Findex.rm&submit.x=16&submit.y=10
23. UnitedHealth Europe (February 2005). *Assessment of the Evercare Programme in England 2003–2004*. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4114224.pdf (accessed on October 2009).
24. Department of Health (2006). *Public Sector Agreements*. http://www.hm-treasury.gov.uk/pbr_csr07_psaindex.htm (accessed on October 2009).
25. Department of Health (2009). *NHS Constitution*. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_093442.pdf (accessed on October 2009).
26. Department of Health (2006). *Our Health, Our Care, Our Say: NHS White Paper*. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4127459.pdf (accessed on October 2009).
27. Department of Health (2002). *Liberating the Talents: Helping Primary Care Trusts and Nurses Deliver the NHS Plan*. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4076250.pdf (accessed on October 2009).
28. Department of Health. *The Chief Nursing Officers '10 Key Roles'*. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4101739.pdf (accessed on October 2009).
29. Department of Health (2008). *World Class Commissioning*. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_080952.pdf (accessed on October 2009).
30. Department of Health (2004). *NHS Improvement Plan*. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4084522.pdf (accessed on October 2009).
31. Department of Health (2001). *The Expert Patient Programme: A New Approach to Chronic Disease Management*. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4018578.pdf (accessed on October 2009).