Leodis Healthcare LLP

Commissioning a Chronic Disease Management 'Early Adopter' Programme

'Project Initiation Document'

September 2008

Version 1

Draft 2

Contents:

Appendices:

A person centred approach

The following 'vignettes' have been used to identify some of the key characteristics of the local Chronic Disease Management model as it relates directly to the needs of individuals. They should act as a constant reminder of the focus of this programme.

1 Mr K

Mr K is a 46 year old who lives alone in a high rise block. He is unemployed and drinks alcohol to excess. He was last seen in surgery for a sick note 5 years ago. He smokes roll up cigarettes all day every day. He is admitted to hospital acutely with pneumonia, the discharge letter also contains a diagnosis of underlying COPD.

The system now:

Mr K doesn't respond to any attempts to call him in for review. He is not on any regular medication so there is nothing in the system to generate a regular call in. He is not coded as having COPD as he has not had and will not attend for spirometry. As time goes by his health will deteriorate and his contact with health services will increase these will tend to be acute presentations to A&E and emergency admissions.

As it might be:

Mr K is picked up by the surgery as being a 40 plus year old who has not be seen for 3 years he is called in for a "health check". He doesn't attend but he is recognised as being at risk and so he is visited at home by the outreach health assessor (HA). Although he isn't keen on this "interference" and was drunk when the HA first visited as he is having housing problems and he may not be receiving all his benefits he agrees to the worker coming back another day in the morning when he might be a little more sober.

He is assessed as having alcohol dependence, raised blood pressure, a smoker and increasing breathing problems. He agrees to an appointment being made for him to attend surgery for further assessment. He fails to attend. The HA goes back out to see him to see why he didn't turn up, he "just forgot". It is apparent that Mr K is reluctant to engage.

Although Mr K will not at this stage attend surgery, he does agree to the HA visiting to monitor how he is. The HA works on a harm reduction model with Mr K trying to help him reduce his smoking and drinking. When Mr K becomes unwell the HA picks it up before a hospital admission is necessary and he can be cared for in the community by the GP and Primary Care outreach team.

2 Mrs H

Mrs H is an 84 year old lady who lives alone; her family live some way away. She lives in sheltered housing. She has a number of medical problems including ischaemic heart disease, diabetes, COPD and her memory is poor. She was a heavy smoker for over 40 years stopping in her 60's. She is on all the usual medication which she gets a dose monitored system delivered weekly by the chemist. She has home care on a daily basis to help her with her meals, washing, cleaning and shopping. She is housebound only managing to walk from room to room slowly with a zimmer.

Current system:

Mrs H is on QOF registers for IHD, Diabetes and COPD. She is visited by her GP when she calls, or when her family y or homecare call on her behalf because she is unwell. She is also visited at least annually to have her QOF checks completed. She is beginning to struggle living independently with frequent hospital admissions with falls, chest pain, chest infections and increasing breathlessness. She has now developed heart failure in addition to her COPD.

She is referred to the falls clinic so she if her mobility can be improved. She is followed up in the Medicine for the Elderly clinic. She was last admitted under the cardiologists so has a cardiology OPD appointment and she is being monitored in the community by the heart failure nurse.

She doesn't like taking her tablets she is on so many she decides to take just those that she thinks do her good. The chemist reports partially used boxes being returned. She feels unwell so is unable to attend any of her outpatient appointments.

She becomes unwell over the weekend and the Out of Hours GP visits to find her in bed very frail and unwell, her family "want something sorted out" and she clearly can't manage at home at the moment so she is admitted to hospital.

As it might be:

Mrs H is recognised as an elderly person with multiple long term conditions and who requires intense case management. Her care is integrated so she only attends the community clinic, taken by transport when she needs monitoring. Everything is done on a one stop basis-echo, CXR, bloods etc. She is seen by her GP/community physician and her medication monitored and changed as appropriate.

Her day to day medication is supervised by her home care team so when she decides she doesn't want to take her tablets her medical team is contacted to review her medication and discuss with her how it might be minimised.

She is monitored by home monitoring coordinated by the community nurse; this includes video monitoring of how she is managing at home. When it is apparent that she is not well she is visited at home and an intensive care package put in place.

3 Marjorie

I finished morning surgery and was pleased to see that I only had one visit. I looked at the name and the term 'heartsink' seemed very appropriate at that moment. I can never remember a time when Marjorie came to the surgery despite her uncontrolled diabetes, hypertension and asthma. The excuse she gave was always that she was too ill to come down with the arthritis in her knees and the problems in her mobility due to gross obesity.

We see her daughter at least once or twice a week with her psychosomatic disorder for which no-one has given her any help.

On arrival at the house, a quick perusal of the notes revealed she had only had three hospital admissions in the last six months (quite good for her really) to do with diabetic control, chest infections and a DVT.

Going past the broken gate into the jungle of a garden with empty pizza boxes, the obligatory settee and a rusty old motorbike, a few rustles of an animal close by makes me hope it isn't of the rodent variety. The smell of dog droppings hits you at the gate

and then a concern about Marjorie babysitting grandchildren came to mind (I need to have another word with the health visitor).

I wonder how long I can hold my breath for on this occasion because of the stale stench of urine and old cigarette smoke with a background of animal. I decide to practice my extreme shallow breathing.

Marjorie's bed is now downstairs. She is much bigger than the last time I saw her and I am not sure she could even walk across the room. She is watching the shopping channel and a lot of delivery boxes in the lounge support the fact that her previous debt problems may be creeping back. The smoke in the air is heavy but it is a cool day and the usual smells are not too bad. I decide I might try and stop longer today and see if we can sort her out. She tells me about her bad chest. She frantically uses her inhalers for which I reminded her about the spacer device she was meant to use. I don't really know if she has asthma or COPD, we have never managed to get spirometry with reversibility performed for her. I ask her about her stress incontinence. Nobody was prepared to operate until she had lost lots of weight. She didn't like the ring pessary and has taken it out.

The consultation with Marjorie is continually interrupted by her health obsessed daughter raising issues about her own multiple fictitious disorders.

We go through with Marjorie the importance of her attending her diabetic clinic appointments at the hospital and the usual bizarre excuses are given. I talk to her about her HBA1C and her chronic kidney disease of stage 3 and the importance of her diet along with blood pressure controls. She tells me she is hardly smoking anything though the ashtrays she tries to hide speak otherwise. She tells me about the fresh fruit and veg that Jason, her son, brings in and she is eating really sensibly. In fact, eating like a mouse but still manages to put the weight on. I ask about her arthritic knees, again no-one will touch her until she has lost a load of weight.

She tells me how the anti-depressants haven't been working and she would really like those sleeping tablets back again. She has another bitter tirade against that psychologist that came out to see her.

I check her blood pressure with the largest cuff I have with me, it is raised and I ask about her taking her tablets regularly. She swears to me that she is but the dosset boxes nearby tell a different story.

Eventually the usual antibiotic for her bad chest is dispensed and I offer the prescription to the immobile Jason (he must have put 3 stone on since the last time I was here). He grunts about "can't it be delivered" although the chemist is literally 100 yards away.

I don't think Jason has ever worked.

I offer to do Jason's blood pressure which is marginally raised and ring the surgery to arrange a follow-up appointment to see him to investigate further and offer help on weight management and smoking cessation. A little visit to the kitchen to wash my hands is, as usual, difficult due to the sink full of rancid pots and pans and a look at the hand towel/tea towel induces a minor gag.

On leaving the house I pass the pizza delivery boy with six pizzas in his hands!

A few days later I sit in the surgery awaiting Jason's attendance. He never came….

The words brick wall, banging and head spring to mind….

1 Introduction

1.1 Introduction

This document 're-launches' the Leodis Chronic Disease Management (CDM[1]) Early Adopter Programme. It sets out:

- The context and programme goals;
- The characteristics of the CDM model;
- The action plan and specific projects that will be coordinated as part of this programme.

The document will have been signed off by the Programme Board at its meeting on the 16th September 2008.

1.2 Background

An exploratory meeting between Leodis, the PCT and the Local Authority concerning the development of an early adopter programme for Chronic Disease Management across Leodis practices was held in July 2007. A further 'project meeting' was held in December 2007 at which priorities were set to develop an understanding of the local patient cohort, develop a 'picture' of what a good system would look like and identify measures of success. Without a formal process for managing these pieces of work, however, there has been limited progress in these specific areas.

However, some key 'underpinning' areas of work have been progressing, namely:

- Ongoing Long Term Conditions needs analysis co-ordinated by the PCT (Sue Kendal, Mark Hannigan, Noreen Metcalf, Paul Morton);
- The development of a focus on Vascular disease as key to reducing health inequalities and analysis for Bellbrooke surgery;
- Proposals for a Locally Enhanced Service to support the programme has been drafted;
- Local data validation processes;
- The Combined Predictive Tool for 'stratifying' need in a practice population has been explored with presentations by Health Dialogue and consideration being given to this by the PCT.

In this context it was agreed to seek a 're-launch' of the Leodis CDM Early Adopter Programme through a facilitated process that would culminate in the production of this Project Initiation Document.

1.3 Programme goal

The programme goal is described as:

- To develop and deliver a chronic disease management programme in partnership with the PCT and the Local Authority that is effective at a practice/locality level – starting with Bellbrooke & Shaftesbury practices but with the potential to roll-out across Leodis practices through a clear commissioning process over the next 3 to 5 years;

[1] The language of Chronic Disease Management is used in this document although it is closely related to that of Long Term Conditions. Any implied distinction is in maintaining a slightly broader concept of needs that are not necessarily confined to specific diagnosed conditions. The language should be considered as broadly inter-changeable.

- To achieve this through local engagement – a model that harnesses, co-ordinates and where appropriate integrates existing service 'interventions' in partnership with service users and local voluntary groups;
- To evidence outcomes in a 'controlled' programme of evaluation using quantitative and qualitative measures reflecting the nature of local engagement and therefore influencing wider application of the model across the City and beyond.

1.4 Programme approach – commissioning the service

The nature, roles and functions of a Practice Based Commissioning Group such as Leodis are evolving nationally and locally. The commissioning process is fundamental to this piece of work, albeit with the additional role of 'enabler' that Leodis can adopt with member practices. To undertake such a commissioning role Leodis will need to work closely with the PCT and the Local Authority to identify the extent to which commissioning functions and resources (human and financial) are devolved and supported at a Leodis-wide, locality and practice level.

Examples of the commissioning functions that Leodis will need to develop in partnership with the PCT and LA and in the context of this programme include:

- Development of needs analysis alongside locally focussed market analysis based on clear practice/geographical footprints and engaging with stakeholders at this local level;
- Development of a comprehensive commissioning strategy (building on the programme re-launch) that sets out the full extent of the vision, service model and implementation approach emerging from the early adopter stage;
- Developing ongoing review and feedback of service impact and effectiveness including service user and patient engagement.

The extent to which these functions are devolved will be part of the ongoing dialogue necessary for the successful implementation of the CDM programme.

1.5 National and local context

This programme will be undertaken in the context of a wide range of other initiatives that are relevant and should inform the development and implementation of the local CDM model. It is not intended that this programme should encompass these pieces of work but rather that the Programme Board should be appropriately formed to provide strategic links and therefore facilitate the alignment and/or integration of outputs from these areas into the local work programme, and visa versa. The major programmes of relevance to this work are:

- The national and local Darzi Next Stage Review reports[2] and in particular pathway development in areas such as Long Term Conditions (with its emphasis on Diabetes), staying healthy, acute episodes and end of life;
- 'Year of Care' pilots and the commitment to providing a care plan for everyone with a LTC;
- Vascular checks for all >50 yr olds;
- The development of a 'DARZI practice' @ Burmantofts (in close proximity to the Early Adopter sites);
- The local Diabetes service model building on the regional work;

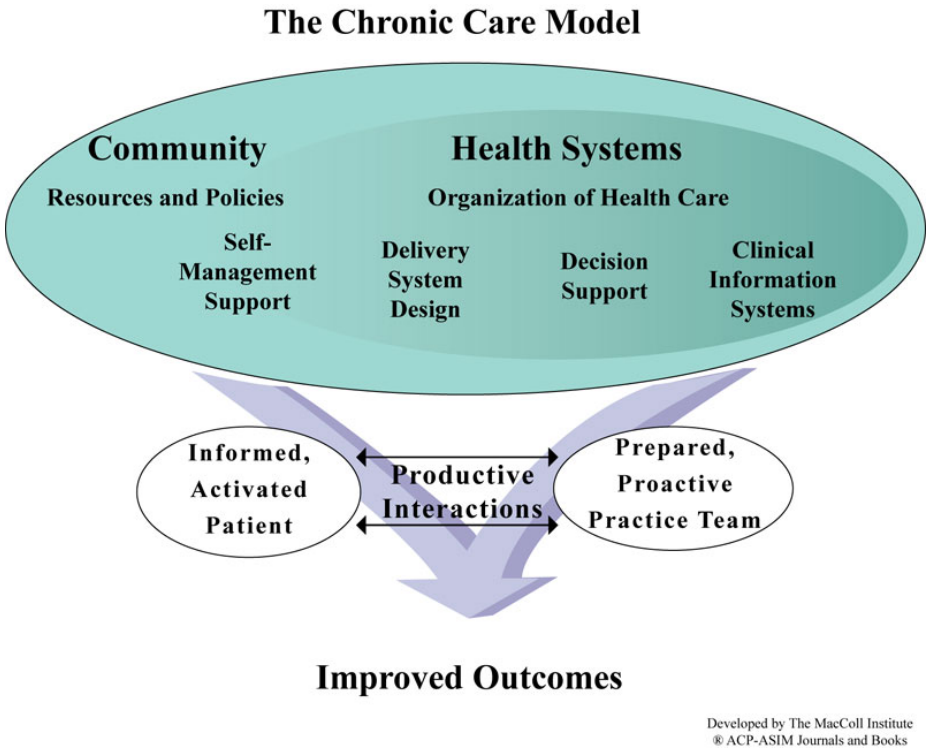
[2] Healthy Ambitions (May 2008) – www.healthyambitions.co.uk

- The imminent launch of PCT Intermediate Care Strategy;
- Existing 'Expert Patient' programmes and Health Trainers operating in the local area (and others …);
- Social Services re-organisation and the new emphasis on Personalisation, Self Directed Support and enablement;
- LINkage Plus network development, particularly in the Gipton area;
- Neighbourhood networks and their support to the prevention agenda;
- Third Sector development initiatives.

2 The Chronic Disease Management Model

2.1 Overview of the model

The diagram below provides an overview of the Chronic Care Model. It illustrates the inter-relationship between the informed patient and the proactive practice team in the context of both community and health system design and organisation.



The CDM model consists of 6 elements, namely:

- Creating a culture, organisation and mechanisms that promote safe, high quality care;
- Assuring the delivery of effective, efficient clinical care and self-management support;
- Promoting clinical care that is consistent with scientific evidence and patient preferences;
- Organising patient and population data to facilitate efficient and effective care;

- Empowering and preparing patients to manage their health and health care;
- Mobilising community resources to meet needs of patients.

The Leodis early adopter programme will need to reflect activity at each of these levels in order to inform future roll-out of the model. It will also need to reflect 'what works' in delivering on this model, namely:

- Involving people and their families;
- Self management and monitoring;
- Group/lay education;
- Identifying people at high risk;
- Nurse-led strategies;
- Integrating health and social care;
- Integrating primary and secondary care;
- Broad managed care programmes.[3]

2.2 Characteristics of a local CDM model

In order to ensure the programme has wide ownership a stakeholder engagement process has been undertaken leading up to and including a stakeholder workshop on the 1st September (see Appendix 1). The initial focus of this engagement has been on commissioning partners with Leodis LLP.

From this process has emerged what are believed to be the key characteristics of a local CDM model, which in turn is consistent with the overall CDM model described above. Whilst some of these characteristics might be 'destinations' rather than first steps they represent a development of the 'vision' for a local CDM model, initially in the identified practices. In summary the characteristics identified are:

- A person centred culture that starts with the individual, ensures ***engagement*** in the process and encourages self empowerment focussed on realistic goals;
- A ***pro-active*** response at all levels of need including preventative and healthy options initiatives;
- A response that recognises and engages with the individual's ***carer***(s) or family through either pro-active health improvement work or by informing and engaging these carers in the co-ordinated care necessary for the individual;
- An assessment culture that ensures a ***holistic*** response by a range of professionals from different organisations, with staff that have the necessary skills as well as access to the means to address a broad range of needs, including health, social care, mental health and housing etc;
- Person centred care that is based on a single overall ***plan of coordinated care*** with the necessary case/care management from complex needs;
- An integrated or ***networked response*** to an individual's need from a range of agencies such that unecessary duplication, overlap or gaps in the system are avoided;
- A service that is underpinned by good quality and timely ***information*** that can be shared when appropriate between agencies.

[3] Singh D (2005) 'Transforming Chronic Care', University of Birmingham – as quoted at December '07 event.

2.3 Benefits and outcomes

A key characteristic of this programme has been identified as the ability to evidence change in such a way as to inform ongoing development and roll-out of the service model across the Leodis practices. This programme has a unique opportunity to develop a bespoke 'evaluation' framework that, whilst feeding into the performance management requirements such as QOF, will focus primarily on outcomes for patients.

3 Action planning

3.1 Local views

During the course of the engagement process to identify the content of this programme a range of stakeholder views were invited. Whilst not comprehensive (i.e. they represent primarily a 'commissioner' perspective at this stage) they do provide a useful steer to the programme. The following factors should therefore be taken into account in the development and implementation of this programme:

The service user experience and contribution:

- The need for an engagement strategy with patients, service users and citizens to effect change;
- The need to 'do with' people – 'Experts by Experience' programme;
- The need to work with existing services and patients that have a CDM with a preventative focus;
- Complement this with an 'outreach' type model, for example with people known to regularly DNA.

Developing the CDM model:

- Need to explore concepts such as the Virtual Ward and links to Intermediate Care services/strategy;
- Need to understand the 'dynamics' of the system – e.g. ability to release resources and re-invest, and understand the overall impact of the model on the 'burden of need', timing/delay of benefit etc;
- Should the model reflect a 'hub and spoke' approach and how do we determine the optimum size for a practice to act as a hub – 10,000, 15,000 etc? What is the relationship between a hub practice and the spokes?

The organisation and impact of CDM services:

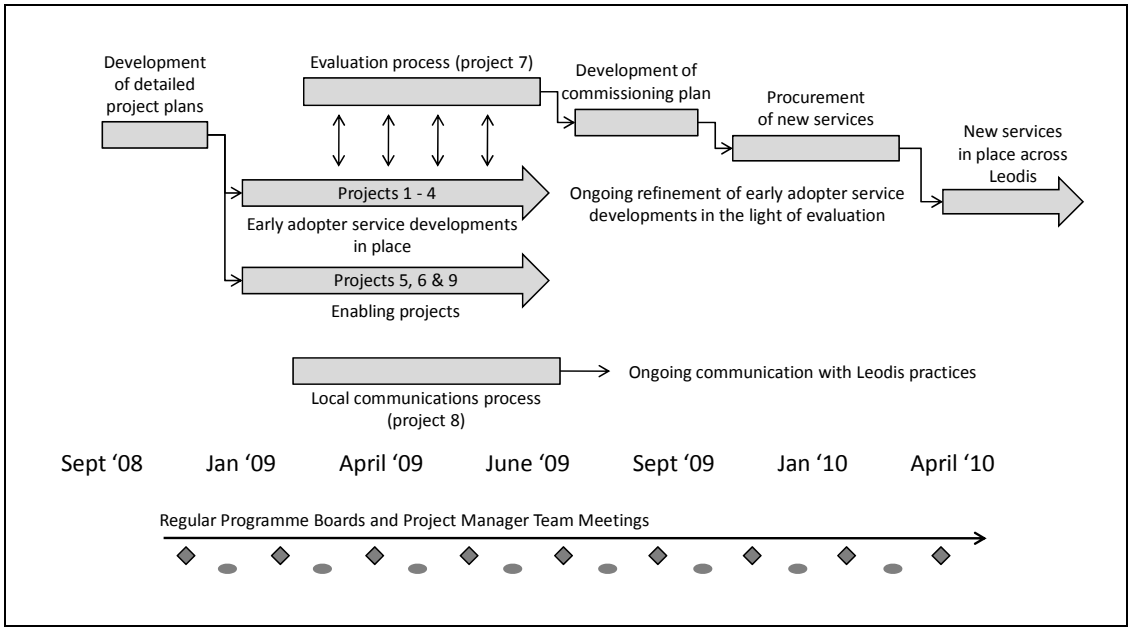
- Understanding how the development of the CDM model will impact on the daily working patterns and priorities of key staff groups – GP's, practice nurses, social workers, voluntary sector workers etc?
- Ensuring social care and local voluntary group contributions and partnerships;
- Need to take account of the wide range of skills and competences within the workforce to meet the needs of people with LTC;
- Understanding the organisational issues arising from there being multiple providers in a given locality?
- How do different services operate at a practice level if we are to develop an integrated system?

The approach to developing and rolling out the programme:

- The importance of ensuring evidence and clinical validation of effectiveness;
- Need to understand and balance the short and long term benefits of CDM;
- A focus on developing evidence to make real change through commissioning in future years;
- Ensuring that the use of tools and processes to risk stratify patients in a practice contribute directly to practice based initiatives and service developments as part of this programme;
- Need to ensure emphasis is on more that just saving hospital admissions;
- Need to identify the added value that Leodis brings;
- Build the momentum over the initial 6-9 months with a focus on (for example) virtual ward, local service directories, integrating health trainers into local model etc;
- Need to target people with a Chronic Condition before their behaviour becomes 'set' – i.e. emphasis on low and moderate risk clients;
- Service model needs to support/feed into the delivery of QOF targets.

3.2 Overview of proposed programme

An outline ***road map*** for the programme is illustrated below.



The key stages in this process are:

- To develop and sign-off specific project plans for service developments and enabling activities for sign-off at an early Programme Board meeting;
- To undertake individual service development projects that exemplify key characteristics of the local CDM model in the 'early adopter' practices commencing from January 2009 at the latest;
- To ensure that the service development projects have a robust evaluation framework running alongside them and that initial outputs from this evaluation process should be available by June 2009 at the latest;

- To develop, by April 2009 at the latest, a communications and networked learning programme of events across Leodis to share the overall model, approach and early feedback from the service development projects;
- To encourage further adoption of service development models that reflect the learning from the initial projects across Leodis practices and to underpin this, where necessary, with resources and enabling structures;
- In parallel to develop key areas of the Commissioning process that would need to be undertaken by Leodis, in partnership with the PCT and the Local Authority, including resource mapping and the analysis of need;
- To develop a 3 year Leodis CDM Commissioning Plan for 2010/11 to 2012/13, which should be completed by September 2009 at the latest, which will be supported by service specifications that build on the lessons learnt from the early adopter phase;
- To undertake a commissioning process, in partnership with the PCT and the Local Authority, for a first phase of CDM services across Leodis practices to be in place from April 2010 in line with the agreed and available resource identified in the earlier phase of this work.

To enable this process to happen, in addition to the Programme Board and governance arrangements described below, it will be necessary to ensure the following resources are available to Leodis and the individual practices taking part:

- Dedicated project management time for each of the projects identified below. Early scoping of the projects should identify the nature and extent of the involvement but it is likely that project managers will require protected time each week to deliver on their role, and that other Project Team members will require permission and priority to be given to specific tasks as they are required within the project plan;
- Overall programme co-ordination and facilitation to provide the link between the individual projects and the overall programme, with particular emphasis on providing regular updates and information to the Programme Board and other key stakeholders;
- Specialist input where necessary that cannot be obtained from within the respective project teams, for example in undertaking independent evaluation of the projects. This is potentially a role for an academic partner.

3.3 Proposed projects

3.3.1 Introduction

Each of the suggested projects in this section, once signed off by the Programme Board, will need to move quickly to a phase of team building and project definition under the leadership of a designated Project Manager for each project. This process should be facilitated to ensure appropriate sharing of methodology, project management stationary and reporting mechanisms to the Programme Board.

3.3.2 Service development projects at a practice/locality level

Project	**Outline project brief**	**Project lead and core team members**
1) People with complex needs	Develop a local mechanism to identify a 'caseload' of people with multiple chronic conditions, or people who are 'hard to reach', and co-ordinate regular multi-disciplinary practice meetings with the purpose of adopting a pro-active approach to their care.	Should be led by a practice nurse or similar professional.
2) Diabetes	Implement the PCT diabetes pathway at one of the two practices in a comprehensive and co-ordinated way to act as a test bed for wider dissemination.	Should be led by a practice nurse or similar professional with PCT involvement.
3) Development of local service networks	To develop those services that support people with long term conditions across the locality (i.e. both Shaftesbury and Bellbrooke) into a more effective network with agreed mechanisms for referral and joint working through: • Convening a local 'provider fair' to enhance people's awareness of what exists; • Undertaking 'research' and networking activity to identify and capture information about the services that exist; • Working with the Project Team to develop agreed referral and joint working arrangements using a pathway model and case study material; • Making recommendations to the Programme Board about future models for a sustained improvement in local networks of services for people with chronic conditions.	Should be led by a practice manager with a core team including social services, health providers and local voluntary sector representation.
4) Information and prevention	Develop in both practices a rolling programme of health promotion information fairs and engagement with other agencies (housing, benefits, leisure etc) with a targeted intent on increasing uptake of healthy lifestyles and greater engagement of the practice population in such activities.	Led by a practice manager with involvement from relevant agencies drawn from the local service mapping project.

3.3.3 Enabling projects at a Leodis level

Project	Objectives	Project lead and core team members
5) Risk stratification	Continue and complete the risk stratification of both practice populations as a basis for targeting specific initiatives and to inform the evaluation process.	PCT lead with support from Leodis and both practices.
6) Resources	To identify resources (human and financial) that supports the delivery of services for people with chronic conditions by each agency. (Needs to link into, but not be dependant on, the PCT Programme Budgeting exercise.)	Leodis lead with PCT (including provider services) and Local Authority involvement plus representation from one of the practices.
7) Evaluation	To develop (potentially with an academic partner) a consistent evaluation framework for measuring the impact of projects on the overall outcomes for people with Chronic Conditions in the two practices.	PCT lead with close involvement from both practices and all relevant project managers.
8) Communications	To develop a communications plan for Leodis practices initially with a focus on sharing the CDM model and Programme approach but subsequently to engage practices in the development of the Commissioning Strategy and procurement process.	Leodis lead with involvement of all relevant project managers.
9) Workforce	Identify training and development needs emerging from the service development projects and/or from existing knowledge about competencies necessary for effective delivery of the CDM model (potentially working with an external partner such as Skills for Health/Skills for Care).	Leodis lead with involvement from PCT provider services and social services.

3.4 Governance of the programme

The suggested Programme Board is as follows:

- Andy Taylor (Independent Chair);
- Helen Alpin (GP) & Tom Roche (Practice Manager) – Bellbrooke;
- Nick Koslowsky (GP) & Jenny Taylor (Practice Manager) – Shaftesbury;
- Chris Reid (CE Leodis);
- Gordon Tollefson, Leodis PPI lead;
- Hilary Philpott, Leeds PCT Commissioning Lead;
- Paula Dearing, Leeds PCT LTC Lead;
- Jon Fear, Leeds PCT Public Health Lead;
- Alastair Cartwright, Leeds PCT IM&T Lead;
- Jemima Sparks, Leeds City Council;
- Dennis Holmes, Leeds City Council;
- Brian Ratner, Leeds City Council.

The responsibility of individual members of the Programme Board and terms of reference for the group are:

1. To provide overall management of the Leodis CDM Early Adopter Programme and review progress relating to individual projects.
2. To sign-off individual project plans for delivery as part of the programme.
3. To agree any changes in individual Project Plans and consider implications for other areas of the programme.
4. To advise on factors that may help or hinder progress in the programme.
5. To resolve disputes between project areas or organisations that cannot be resolved at a project level.
6. To oversee any generic or specific support deployed to ensure delivery of the programme.
7. To act as champion for the project within their own organisations.

The Board will meet at approximately 6 weekly intervals (end of October, mid-December, early February, late March etc). In addition it is expected that Project Managers within the Programme will meet regularly to review progress, prepare reports, ensure links between projects are recognised and maximised and to resolve any conflicts or challenges that emerge.

Appendix 1: Stakeholder involvement

1 One-to-one discussions

Involvement in 'one-to-one' discussions prior to the stakeholder workshop.

- Tom Roche (practice manager, Bellbrooke);
- Helen Alpin (GP, Bellbrooke);
- Jenny Taylor (practice manager, Shaftesbury);
- Nick Koslovsky (GP, Shaftesbury;
- Jemima Sparks & Noreen Metcalf, Leeds County Council.
- Paula Dearing (LTC lead for the PCT) & Mark Hannigan;
- Hilary Philpott, PCT lead on PBC;
- Sue Kendall, Public Health, PCT;
- Alastair Cartwright, Jane Ishawood & Paul Marton, IM&T, PCT.

2 Stakeholder workshop, 1st September 2008

The purpose of this workshop was:

- To describe and agree the broad outline of a service model for Chronic Disease Management and to describe what this would mean for individual patients.
- To review early progress and assess opportunities and obstacles emerging to date.
- To provide the raw material for a 'Project Initiation (re-launch) Document' (PID) that will serve to identify clear milestones, deliverables and the means of deriving evidence from the early adopter sites to facilitate widespread uptake.
- To agree the Programme/Project Board arrangements, terms of reference and membership.

Participants were:

Andy Taylor, Independent Chair	Jemima Sparks, Leeds City Council, Adult Social Care
Norma Thompson, Health Inequalities – Neighbourhoods, Leeds PCT	Simon Harris, Leeds PCT
Elaine O'Brien, Strategic Partnerships OP & DP, Leeds PCT/Adult Social Care	Mark Hannigan, Leeds PCT
Chris Reid, Leodis Chief Exec	Susan Blundell, Leeds PCT
Jon Fear, Health of Healthcare Effectiveness, Leeds PCT	Sue Kendall, Leeds PCT
Noreen Metcalfe, Project Manager, Leeds City Council, Adult Social Care	Jenny Taylor, Practice Manager, Shaftesbury Practice
Paula Dearing, Leeds PCT	Dr Nick Koslowsky, Shaftesbury Practice
Alison Sarmiento, Leeds PCT	Brian Ratner, Leeds City Council, Adult Social Care
Tom Roche, Practice Manager, Bellbrooke Surgery	Hilary Philpott, Leeds PCT
	Peter Lacey (facilitator), Whole Systems Partnership

Appendix 2: Potential project areas identified

The following potential project areas were identified in the run up to, and during, the stakeholder workshop held on the 1st September 2008. They provide a 'reference point' for future consideration alongside those projects selected within the document for initial development and implementation.

- Identify programmes/services in place across the locality and initiate information sharing between professionals (e.g. Expert Patient, Health Coaches, Community Matron, Mental Health, Social Care);
- Hold a local voluntary sector 'provider fair' for all agencies to facilitate sharing, liaison and relationship building;
- Explore and scope the development of an 'expert' central referral point for people with a LTC in a locality with ability to co-ordinate and refer on to the most appropriate service;
- Focus on specific disease group(s) and roll-out programme, e.g. diabetes or COPD;
- Provide new and more appropriate access points in primary care for people with known long term conditions and skill-up staff to support 'low-level', ongoing care needs (exploring impact on GP workload);
- Consider development of 'assertive outreach' model for people who are 'chaotic' users of services;
- Undertake 'live exercise' to map pathways, identify trigger points and describe what needs to be done differently;
- 'Integration' of health and social care at a practice/locality level;
- Communications plan concerning the early adopter project;
- Programme budgeting approach to follow the work being undertaken by the PCT;
- Mapping of all current interventions and projects across health, social care and the voluntary sector;
- Identify a small cohort of high risk patients (e.g. 20 people) and undertake case reviews, agreement to a care plan, mapping of pathways and feedback on learning;
- Apply the CDM model 'levels' to current local services to identify gaps and boost activity where appropriate;
- Develop a training module for staff including 'who does what' and holistic training – multi-agency commitment;
- Further cohort identification;
- Undertaking a gap analysis and forming a view about what actually works;
- Implement year of care plans in the context of CDM model roll-out.