Step One: Context

Overview
When introducing CCSP it is essential that certain components are in place to ensure successful implementation. These are described by Think Local Act Personal and include:

1. Identifying the cohort of people to whom you are going to offer CCSP
2. Identifying individuals and generating a comprehensive database
3. Proactively inviting individuals
4. Developing robust call/recall system
5. Quality assurance of the process

The role of surgery MDT meetings is important to ensure the whole team contribute to deciding who might benefit from the process, along with clinical acumen. When beginning the process of CCSP it is important to start small and don't be afraid to go around the loop more than once.
**Identifying the cohort**

RCGP’s [Stepping Forward](#) suggests five methods for identifying participants (p.24-27).

**Resources for risk stratification of population**

- [Next steps for risk stratification in the NHS](#) by NHS England
- [Reducing emergency admissions: are we on the right track?](#) looks at the larger cohort of people lower down the risk triangle who have fewer problems and represent an opportunity to prevent more complex problems arising providing greater benefits to both the individual and the system.

In addition, there is the added complexity of information governance requirements when applying risk stratification tools to populations. Providing a practice can demonstrate that this is for direct patient care, that sufficient fair processing has been undertaken (e.g. posters in the waiting area, leaflets and that patients have had the chance to opt out) these issues can be overcome. However, it is essential that practitioners and practices seek advice from local experts within their Clinical Commissioning Groups to ensure that they are working within their local information governance frameworks.

**Segmenting into specific cohort**

This involves identifying groups of people who share similar characteristics, e.g. frailty as measured by the [Timed up and Go test (TUG test)](#), the frailty index, or people with one or more LTCs. This approach allows for an incremental increase in the number of people benefiting and represents an easy place to start. However, it risks excluding people who are not in the cohort and also treats single conditions rather than offering a holistic approach.

**Organic identification by practices**

Clinical judgement plays a key role in identifying people who would benefit from being offered a proactive approach to their care and members of multidisciplinary teams and general practice staff are well placed to know their population better than anyone. However, this does not take a whole population view, so may exclude people who aren't known to the MDT, practice or practitioner and so introducing inequity of access to care.

**Identifying and working with people with either higher or lower activation**

`Activation`, an individual's level of knowledge, skills and confidence to self-manage, measured by completing the Patient Activation Measure (PAM) survey, can be used to tailor interventions, as well as a measure of success of an intervention. Those with higher levels of activation are more likely to access health and wellbeing inventions and undertake behavioural change activities, while those with lower levels of activation, are more likely to have higher utilisation of unscheduled care in both a primary and secondary care settings. By working with those with lower levels of activation, there are greater opportunities for improved outcomes for individuals and the system as a whole. However, by targeting those with low activation, this may exclude people with higher activation who have greater complexity and associated risk.
The PAM tool can be completed by sending the survey out to specific cohorts or by asking people to complete the survey when attending for the CCSP consultations. Codes for PAM level and score are now available within most GP electronic health records (EHR) so allowing for systematic coding of this data and subsequent data collection and database creation.

**Identifying individuals and generating a comprehensive database**

The database to be generated will depend on the context within which you want to start offering CCSP and what outcomes you plan to achieve. The database should be easily accessible, updated regularly and be accurate.

**Proactively inviting people for review**

Individuals may not previously have been invited for a CCSP consultation and so it is important to ensure the invitation provides clear, easy to read information about the care being offered. Letters of invitation will need to reflect the context within which the CCSP consultation is being offered.

A record should be kept when the initial invitation and any subsequent invites have been sent. IT systems that automatically link the invitation to the EHR will ensure that the health and care team are aware that an invitation has been sent and so can proactively encourage individuals to book their CCSP consultation (e.g. Patient Chase).

Using text messages to alert people that an invitation has been sent and encouraging them to respond to the invite can increase uptake and so improve outcomes.

**Developing robust call/recall systems**

Since the inception of QoF, general practice has introduced processes to ensure people with specific health conditions were systematically invited to attend for their annual health checks. Typically checks were disease specific and focused on the biomedical model. However, there is evidence that this approach has not impacted on prevention, health and wellbeing and has not promoted self-management.

Yet these robust call/recall systems, established in response to QoF, provide an excellent foundation by which people identified, by either/or a combination of the above processes, can be invited proactively for their collaborative care and support planning consultation.

In order to identify people for direct patient care easily, IT systems that are interoperable with existing GP EHRs will need to be available via GP systems of choice (GPSoC) and seen as part of the core GP IT service offer.

**Quality assurance of the process**

1. System used to identify the chosen cohort is robust
2. Database is comprehensive
3. Invitation accessible and user friendly, agreed percentage invitations reach individuals, agreed percentage people respond to invitations after agreed number of attempts
4. Once attended for CCSP consultations each stage of the process has been delivered and audited