

Long Term Conditions Management

CHP Self Assessment Tool

CHP's:	Lanarkshire
Executive Lead:	Alan Lawrie
Lead Clinician:	Anne Armstrong
Manager:	Alan Lawrie
Date completed	<u>09 April 2007</u>
Signature	

Introduction

The Toolkit forms an essential part of the approach to the management of long term conditions set out in *Delivering for Health*, which aims to develop systematic approaches to the provision of services for those with one or more long term conditions as close to home as possible. Use of the Toolkit is therefore part of the process of shifting the balance of care into the community and improving the responsiveness of service to the needs of each individual. The key outcome will be to improve the quality of life for those with a long term condition. A long term condition is broadly defined as one that requires ongoing medical care, limits what one can do, and is likely to last longer than one year. Because the Toolkit is generic, it does not relate to any one condition, care group or age category.

This self-assessment should be completed annually by the CHP Long Term Conditions Action Group in line with the approved Quality Assurance Programme.

This tool is not designed to be used for benchmarking with other CHPs or other NHS Boards. The purpose of the self- assessment tool is to support the CHP in evaluating and improving its long term conditions care. The CHP will have the opportunity to improve services by identifying areas of good practice which could be replicated elsewhere, acknowledging service gaps and considering what actions or improvements are required to meet each criteria. This process will support the CHP in constructing an action plan to implement the required change.

Indicators of performance need to be measured over time to reflect the continuous quality improvement process. To facilitate serial measurement of quality improvement at annual re-evaluation the self-assessment tool invites CHPs to assign a numeric value (0-3) for compliance with each criteria. At the end of each section there are Subtotals of values for each standard.

Values should be assigned in line with the following position statements:

Value	Position Statement
0	Criterion not met at all.
1	Criterion met in part <u>or</u> Criterion met in full but only for a minority of CHP practices / staff / people
2	Criterion predominantly met <u>or</u> Criterion met in full for the majority of CHP practices / staff / people
3	Criterion fully reflected across the CHP <u>or</u> Criterion met in full for all CHP practices / staff / people

Standard 1 – Organisation of Long Term Conditions Management

	CRITERIA	EVIDENCE	VALUE	ACTION	RESPONSIBLE PERSON/LEAD	TIMESCALE
1.1	The Community Health Partnership has a designated clinical lead for long term conditions management.	Anne Armstrong Nurse Director Community & Primary Care has a lead responsibility and is supported by a Nurse Consultant Long Term Conditions/GP Lead for Long Term Conditions	3	No further action required	Alan Lawrie	Achieved
1.2	The long term conditions clinical lead is a member of the CHP committee or clinical executive.	The Nurse Director Community & Primary Care is a member of the CHP Committee and the Joint CHP Strategic Implementation Group	3	No further action required	Alan Lawrie	Achieved
1.3	The clinical lead has senior managerial support and the CHP has a multidisciplinary Long Term Conditions Action Team to operationalise agreed actions.	Long Term Conditions Action Team forms part of the Primary Care Modernisation Programme Board deliverables. Working Groups have been established to pilot specific elements of the strategy such as Care Management, Keep well	1	Long Term Condition Action Team to report into the Primary Care Modernisation Programme Board. This will require the establishment of a dedicated LTC Programme Management resources.	Alan Lawrie	Achieved
1.4	The CHP, through the Long Term Conditions Action Team, engages with the local Managed Clinical/Care Networks which relate to a specific long term condition.	The MCN managers/clinical leads will be key members of the Long Term Conditions Action Team	1	The Managed Clinical Networks will feed disease specific action plans into LTC Action team. The LTC Action team to explore how services will be prioritised and delivered and consider processes for the LTC's where MCN's do not exist – i.e. Rheumatoid Arthritis.	Anne Armstrong	March 2007

	CRITERIA	EVIDENCE	VALUE	ACTION	RESPONSIBLE PERSON/LEAD	TIMESCALE
1.5	The CHP's, through the Long Term Conditions Action Team, has clear links with older people's and integrated children's services.	This is achieved through the modernisation structure, which includes cross membership of the Primary Care Modernisation Programme Board and the Older Peoples Programme Board. Further work is required in relation to integrated children's services	2	Ensure communication is cross cutting and links are made between LTC/Older People/Children's services and mental health and Learning Disability programmes	The use of role descriptions will ensure explicit responsibilities	June 2007
1.6	The CHP has shared objectives for long term conditions with acute hospitals to deliver a range of integrated services which shift the balance of care to community settings.	A range of clinical communities is being established to ensure a whole system approach to clinical and service models. Through the LTC and Primary Care Strategy and currently through the Unscheduled Care.	2	Agree the objectives and set priorities and timeframes via the Long Term Conditions Action Team gaining endorsement via the Primary Care Modernisation Programme Board	Anne Armstrong	May 2007
1.7	The CHP engages with community planning partners and with patient representatives, voluntary sector, carers organisations and representatives of cultural and religious organisations in planning and developing services for long term conditions.	Organisationally we are committed to assessing service/strategy development through the Equality Diversity Impact Assessment process. Keep well. At a high level partnership commitment exist with ongoing engagement at a locality level through the Health & Care Partnerships, Joint Future, and Public Partnership Forums in both CHP's	2	Firstly audit what we currently do and provide evidence on status of progress for this work. Continue with and further develop current approach at all levels. Focus work on 'Hard to Reach' groups and communities.	Stephen Kerr	TBC

	CRITERIA	EVIDENCE	VALUE	ACTION	RESPONSIBLE PERSON/LEAD	TIMESCALE
1.8	The CHP maximises the effective use of premises which are fit for purpose in the delivery of long term conditions management, e g through co-location, disability access.	Where opportunities currently exist to co-locate and integrated we provide e.g. consultant outreach clinics, physiotherapy services and co-location with Integrated Daycare services.	1	<p>Implement the organisations long term conditions strategy ensuring that all future premises are developed to meet requirements</p> <p>Roll out this model in the new build at Kilsyth, East Kilbride and Hamilton Resource Centres. NHSL Capital Investment schemes will consider this as part of APoH estates developments and the development of our clinical models.</p> <p>A process will set out for matching up opportunities to meet Strategic Objectives of services closer to home with the implementation of the LTC Strategy. This will include a clear understanding of how community premises will identify actual headroom for developments that shift the balance of care, including the need for facilities that are fir for purpose of multi disciplinary working.</p>	<p>Robert Peat</p> <p>Property Services/Capital Planning</p> <p>Robert Peat</p>	Ongoing

Standard 1 Values Sub total

15

Standard 2 – Patient Information and Supported Self care

	CRITERIA	EVIDENCE	VALUE	ACTION	RESPONSIBLE PERSON	TIMESCALE
2.1	An identified member of the CHP long term conditions action team is responsible for updating and distributing information resources of high standard and evidence-based about long term conditions, adding local information as necessary, which is easily accessible to all.	The MCN Health Improvement group concentrates on this area of work. NHSL also have a Patient Information worker concentrating on post discharge information. This is not co-ordinated across the whole system.	1	Review and revise current areas of responsibility ensuring a whole systems approach is utilised through the entirety of the patient's journey. Establish an Integrated and multi formatted directory of services.	Anne Armstrong	May 2007
2.2	The CHP follows the Carer Information Strategy which has been developed by the Board and its partner agencies.	The Carer Information Strategy has been completed and has been approved by the NHS Board March 2007.	2	Link LTC action team membership to implementation of the strategy	Anne Armstrong/Bob Shorter	April 2007
2.3	The specific information needs of people with visual and communication impairments and from minority ethnic groups are addressed.	This is currently achieved through the translation services with information available in a range of formats and languages on request.	1	LTC Action team to link with Stakeholder Engagement process	Shiona Welton	Ongoing

	CRITERIA	EVIDENCE	VALUE	ACTION	RESPONSIBLE PERSON	TIMESCALE
2.4	The CHP has links with the independent local advocacy services established by the Board and partner agencies for patients and carers, and informs patients and carers about advocacy support, including issues associated with incapacity.	Few existing advocacy services for LTC's although this occurs through the Enable group in the North and the Advocacy project in South for LD and Older People Age Concern.	1	Link into the Lanarkshire Advocacy Forum with a view to undertaking an assessment of this area and to scope advocacy services to identify gaps in service priorities and audit of effectiveness.	Stephen Kerr	Oct 2007
2.5	Multi-disciplinary teams involve people and their carers in developing individual care plans.	Patients under the care of community nurses/AHP's will have individual care plans and carers may be involved in developing these. CPA, M.H.C & T Act 2003	1	The need to recognise carers as 'partners in care' is critical. Continuously improve practice and documentation and include in training needs analyses for LTC's to be undertaken by LTC Action team.	Janette Barrie	Commence June 2007
2.6	Patient-held care plans are used and include individualised self management tools.	Some disease specific examples exist fore Diabetes and Stroke. Patients under care & treatment orders.	1	Review current practice with a view to developing a consistent evidence based approach for the organisation and develop an implementation plan linked to the organisations eHealth strategy.	E Health Clinical Delivery Group	2009
2.7	There are peer support groups for people with long term conditions and their carers.	Independent peer support groups exist with the MCN's, the voluntary sector e.g. BLF, BreatheEasy, Diabetes UK, Lanarkshire Links, Cumbernauld Action for Care of the Elderly. Carer support via Princess Royal Carers Trust and Carer's network South and Carers Together North.	1	Added to 2.4 work the LTC Action team will identify current resources to support peer groups to establish generic support groups. NHSL will explore the action to establish a multi agency, mixed stakeholder group to undertake a review of current practice and services.	Stephen Kerr	October 2007

	CRITERIA	EVIDENCE	VALUE	ACTION	RESPONSIBLE PERSON	TIMESCALE
2.8	The capacity of services to provide patient information and support self care is enhanced to meet the needs of people from the most deprived communities.	Keep well pilots have a reach strategy which looks at how information and support can be delivered to those hard to reach groups in the most deprived areas. This will inform good practice across the rest of Lanarkshire. Service capacity in Community Nursing is allocated in terms of need. More work is planned to support self care.	1	Review current approach, undertake a gap analysis and develop a strategic approach for implementation across the organisation. This will include particular focus on the role of voluntary organisations with regard to outreach within remote and rural areas, minority groups and hard to reach groups, education and development as well as information advice and support. Make links to the developing connections project (Big Lottery bid) and co-ordinate with the Public Health Practitioners and MCN activities.	Shiona Welton	March 2008

Standard 2 Values Sub total

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Standard 3 – Service Design and Multi-disciplinary/multi-agency working

	CRITERIA	EVIDENCE	VALUE	ACTION	RESPONSIBLE PERSON	TIMESCALE
3.1	Operational policies clarify the roles of health professionals, unpaid carers, local authority services, voluntary sector, volunteers and independent contractors in long term conditions management, but are flexible enough to facilitate new ways of working, within regulatory frameworks.	All of these are considered as full partners in care, however the ability of service users and carers to contribute is very much dependent on their abilities and the clients needs. Care Management pilots are expected to provide valuable learning in this regard and will inform future practice in Lanarkshire.	0	Develop frameworks, policies and clear specific role descriptions to ensure seamless care	Janette Barrie	Commence 2007
3.2	Joint care plans reflect optimum outcomes for individuals and their carers.	There are isolated examples of Joint Care Plans e.g. Outreach Dementia service; CHIPS project in Carluke, Care Management pilot, but more development is required in this area. Evaluation of Single Shared Assessment both in terms of quality and sharing of data is planned.	1	Review current good practice; develop a consistent approach for implementations across Lanarkshire ensuring staff are supported to achieve this. Scope out resource requirements to achieve this.	Janette Barrie	Sept 07
3.3	The CHP has a range of services incl; prevention, diagnosis and treatment, rehabilitation and palliative care which are designed to deliver care more quickly closer to home by multidisciplinary specialists working in community settings.	These services are under development, however they would all benefit from a more consistent, coordinated approach including the development of more community based rehabilitation. Some of this will be addressed through redesign projects i.e. Gold Standard Palliative Care 80% sign up and SWITCH for Occupational Therapy services.	1	The model of care will be further developed through a whole systems approach which will involve the clinical community to establish the clinical and service model for Lanarkshire.	LTC Action Team	Commence April 2007

	CRITERIA	EVIDENCE	VALUE	ACTION	RESPONSIBLE PERSON	TIMESCALE
3.4	Long term conditions management is supported by inter-agency protocols for management, e.g. referrals.	This is being developed as part of the Care Management Pilots e.g “Proactive Integrated Care Management in Lanarkshire”. This will inform future practice in this area.	1	Interagency protocols will be further developed and refined and will be directed by the Long Term Conditions Action Team i.e. Chronic Medication Services via the new Pharmacy contract.	Anne Armstrong	Dec 2007
3.5	Condition-specific pathways signpost patients and professionals to the appropriate intervention / clinician.	Through MCNs, CHD Post MI the Stroke MCN, Diabetes pathways and clinical model, Care Management and Keep Well this is being met but is not yet fully developed.	1	This approach will be developed for all conditions and will be supported by the Managed Clinical / Care Network Based on evaluation roll out across Lanarkshire	MCN's	Ongoing
3.6	The CHP delivers case / care management programmes, based on the risk stratification tool, which target people with the most complex needs.	Pilot underway in 3 Localities. Will undertake 6 month review by 31st March 2007.	2	Evaluate & roll out successful elements	Anne Armstrong	December 2007.
3.7	The CHP provides an inter-agency model of care to support the specialist health needs of people in care homes/sheltered housing.	Liaison nursing posts currently exist however these are not integrated at present. Falls teams, Rapid Response and Community Nurse interface group. Liaison CPN in each DGH.	1	Medical Service to Care Homes being established and piloted in EK	Dr Shiona Mackie	May 2007

	CRITERIA	EVIDENCE	VALUE	ACTION	RESPONSIBLE PERSON	TIMESCALE
3.8	Clinicians use common functional outcome measures	AHP's use a variety of outcome measures e.g. Elderly mobility score, functional reach, modified river mead	1	Consistency developed through condition specific MCNs and clinical communities. Work is underway to review and redesign the Intermediate Care teams and post acute rehabilitation services to harmonise protocols, functional assessments and outcome measures.	Peter McCrossan/Anne Hendry	March 2008

Standard 3 Values Sub total

8

Standard 4 – Interdisciplinary Education and Training

	CRITERIA	EVIDENCE	VALUE	ACTION	RESPONSIBLE PERSON	TIMESCALE
4.1	Generic approaches to management of long term conditions are included in condition specific CPD programmes.	Training and development programmes have been developed on a wide range of issues such as Care Management and clinical interventions. Strong links to the Nes re intermediate treatment project.	1	Review current approach and develop a CPD strategy to continuously improve the management of Long Term Conditions	LTC Action Team, Practice Development Unit/NHSL Organisational Development Team	
4.2	Practitioners and managers from partner agencies participate in Interdisciplinary CPD and share learning and skills.	Examples of partner agencies include Single Shared Assessment, Addiction services and Managed Care / Clinical Networks for Stroke, Diabetes, PVD, Respiratory and Coronary Heart Disease. The Practice Development Unit focuses on the development needs of Nurses, Midwives and Allied Health Professionals.	2	In developing a CPD strategy this will include ensure a whole systems approach is utilised including interagency and interdisciplinary CPD requirements.	As above	
4.3	There is affiliation with learning networks to support best practice, which includes NHS Health Scotland, NHS Education for Scotland and academic centres.	Links have been established via the Practice Development Unit with Bell College, Paisley University, Queen Margaret University and Glasgow Caledonian University. As have links with NHS NES.	2	Further develop the network within a long terms conditions context.	As above	
4.4	The Long Term Conditions Action Team is responsible for access to education and training about long term conditions. It develops a training plan for long	A training and development plan exists for the care management and Keep Well elements of the LTC Strategy. In addition a Training plan has been developed for District Nursing	1	Once established the Long Term Conditions Action Team will do TNA and further develop the training plans in partnership with key stakeholders and the Practice Development Unit.	As above	

	CRITERIA	EVIDENCE	VALUE	ACTION	RESPONSIBLE PERSON	TIMESCALE
4.5	term conditions that includes improvements in access to education and training. Patients and carers participate in the development of educational material and in the planning and delivery of training.	Through the MCN patient groups work has commenced to review and audit patient information and education materials	1	Extend current approach to include the planning and delivery of training.	As above	
4.6	The plan includes training which equips staff to empower patients and carers in self management.	Values based training is being planned for Mental Health Nursing. This approach which support patient empowerment will be rolled out to include a wider staff group	0	Implement values based training for key staff to support patient and carer empowerment. Develop and implement a carers education programme to support self management.	As above	
4.7	Training covers issues of diversity and capacity, and the promotion of psychological, mental and emotional wellbeing.	As above	0	As above	As above	
4.8	The CHP participates in local and collaborative research to evaluate models of care for managing long term conditions.	The organisation participates in the nursing and allied health profession collaborate research consortia in the West and East regions. A key component is long term conditions. Work is also underway to evaluate Care Management, COP Team and Keep Well pilots.	1	Tie the outcomes of the collaborate research consortia into the implementation of the Long Term Conditions strategy.	As above	

Standard 4 Values Sub total

8

Standard 5 – Information and Intelligence

	CRITERIA	EVIDENCE	VALUE	ACTION	RESPONSIBLE PERSON	TIMESCALE
5.1	All health care records use CHI as the unique patient identifier.	The organisation is working towards full implementation of CHI. Audits are being undertaken to support compliance	2	Monitor progress towards universal use of CHI and continue to support development	Robin Wright	HEAT Target 97% cover Dec 2006
5.2	<p>a) Information systems identify people with specific diseases</p> <p>b) and with multiple long term conditions.</p>	<p>a) SPARRA data is currently being utilised to target those most in need of Care Management. GP information technology systems GPASS currently recording disease registers as per the GMS contract.</p> <p>B)No GP IT system is capable of identifying Co-morbidity.</p>	2	Continue to work closely with the Delivering For Health Information Programme to establish local mechanisms within GP IT systems to undertake this task	<p>a) Anne Armstrong</p> <p>b) E health clinical delivery group</p>	<p>a) Achieved</p> <p>b) 2009/10</p>
5.3	Single shared assessment policies, including carers' assessment, are implemented and the aggregated data, which should be gathered electronically where possible, used to inform joint planning.	Single shared Assessment and Carers Assessment are implemented. SSA Adult group, data being agreed for carers.	2	Implement new systems as they are completed through the work of the data sharing process. IN line with this develop systems to support data aggregation to inform joint planning.	Alan Lawrie	Dates vary for each set of policies – 04/07 to Completion of Getting it right for every child 03/09
5.4	Protocols for documentation and exchange of information are used and there is shared recording of goals, with data recorded once being used for multiple	Joint documentation and protocols exist for Single Shared Assessment, Integrated Day Care Centre, accessing services such as Home Care and the Joint Equipment Store.	1	Further develop a pan Lanarkshire approach based on examples of current good practice. Continue as outlined	Data Partnership Board	March 08

	CRITERIA	EVIDENCE	VALUE	ACTION	RESPONSIBLE PERSON	TIMESCALE
5.5	Unpaid carers and their caring role are systematically identified and recorded, with consent, and linked to the patient record.	This is recorded on an individual bases in GP Carers registers and case records and care plans if disclosed by the patient and or carer. Consent form signed by carers. NLCT - work is currently being undertaken through the work with the DES criteria	2	Through Carers organisations raise awareness of this process within the Community	Bob Shorter	2008
5.6	Levels of population risk derived from the CHP population are used in the organisation of local services for long term conditions.	Demographic profiling of localities has resulted in Community Nursing staff being refocused and aligned into areas of greatest need. In addition the profile was utilised to determine the location of the Keep Well and Care Management pilots.	1	Request information be audited at locality level and reported into the LTC Action team to discuss improved management processes if required	Locality General Managers	Dec 2008
5.7	The IM & T system is structured to support ongoing care / case management for individuals with long term conditions.	Process commenced to put in place project structure to develop systems and best linkages across the whole system	0	Work with the E Health Clinical delivery group, Delivering For Health Information Programme to establish Primary Care and CHP risk stratification mechanisms.	EHealth Clinical Delivery Group	2009/10
5.8	The CHP has performance arrangements which are clear and through which they can demonstrate outcomes that deliver continuous improvement.	The CHPs have established Management Structures, Operating Management Committees to review performance against key deliverables. Also 6 monthly meetings review local performance . A system of objective setting and performance management exists.	2	The LTC Self assessment framework will be utilised within these structures to further manage performance in relation to Long Term Conditions management	Anne Armstrong	As required

Standard 5 Values SubTotal

12

Standard 6 – Quality and Delivery

	CRITERIA	EVIDENCE	VALUE	ACTION	RESPONSIBLE PERSON	TIMESCALE
6.1	The CHP has a delivery plan for long term conditions which specifies outcomes, milestones, and measures to demonstrate continuous improvement in services.	NHSL has a Long Term Conditions Strategy that is currently being linked to the Primary Care Strategy, which will have specific outcome measures to demonstrate continuous improvement linked to timescales for delivery.	2	The resultant action plan from the planning event in March 2007 will act as the foundation for this work.	Anne Armstrong	May 2007
6.2	In its development of services, the CHP incorporates evidence from sources such as pilots, demonstration projects, good practice, research, guidelines and Ombudsman's reports.	The current approach is to model current practice on local pilot work, and emerging best practice/evidence i.e. Care Management pilots will be rolled out, Keep well and the recently published SIGN 97.	2	The LTC action team will work on a CHP action & delivery plan to incorporate all aspects of LTC Management and ensure this is performance managed through the agreed structures.	Anne Armstrong	June 2007
6.3	The CHP adopts a systematic approach to monitoring delivery of Health Improvement targets.	Local Delivery Plan process that develops, delivers and accounts for Health Improvement (HEAT) targets annually. Quarterly monitoring of HEAT targets by Performance Management Committee and DfH. Locality Planning Groups,	2	Make the necessary links form the Long Term Condition Action Team into reporting mechanisms	Roy Watts/Stephen Kerr	Ongoing

	CRITERIA	EVIDENCE	VALUE	ACTION	RESPONSIBLE PERSON	TIMESCALE
6.4	All agencies involved in providing services for people with long term conditions participate in audit of the management of long term conditions.	No current system exists	0	The LTC Action will incorporate this as a key priority to ensure joined up planning and delivery.	Anne Armstrong	Dec 2008
6.5	The CHP monitors long term condition outcomes, as part of overall CHP objectives and JPIAF outcomes.	All aspects of service delivery, design and health improvement that impinge on long term conditions are an integral part of Corporate Objectives and their review. JPIAF processes and outputs are proxies for outcome and are subject to an annual programme of reporting, evaluation and target setting	2	Continue to utilise current system of reporting to CHP Management and Operating Committees	Roy Watts/Stephen Kerr	At regular intervals
6.6	Systematic provision is in place for feedback from patients and carers regarding information on the condition and access to quality of care provided locally.	Care Management pilots have patient satisfaction built into face to face practice and evaluation documentation. Systems exist to record and respond to complaints with clear linkages to processes around PFPI. Carer-Patient satisfaction audits	2	Audit this through the LTC Action and agree a set of standard systems and methods for capturing this information. Ensure this is reflected in the service provision locally post implementation.	Trudi Marshall	July 2007-04-08
6.7	The CHP long term conditions action team prepares an annual report, using the self-	Reporting into the Modernisation Board and the CMT through the Primary and Community Care Modernisation process and the strategic redesign project on Long	1	This work will become integral to the CHP Management Committees as they utilise the new	Anne Armstrong	April 2008

	CRITERIA	EVIDENCE	VALUE	ACTION	RESPONSIBLE PERSON	TIMESCALE
6.8	assessment tool kit, against their plan. The annual report is submitted to the CHP Committee, the NHS Board Clinical Governance and Redesign Committees, to the Board as part of the annual review process and to relevant local authority committees.	Term Conditions. This will feature through Modernisation, CHP Management Committees and NHS Board Level	1	nursing structures and reporting systems. LTC Action Team to agree reporting intervals and establish a schedule of meetings to complete regular updates on progress and final reports.	Anne Armstrong	April 2008
6.9	The self-assessment information is considered as part of the process in the NHS Board's ongoing performance review.	This will be adopted from April 2008	1	Continue to develop our documentation and systems around reporting to widen our consultation and communications.	Roy Watts	April 2008
6.10	Annual reports are communicated through multi-professional clinical effectiveness meetings and the Public Partnership Forum.	Public Partnership Forums are key stakeholders in the Long Term Conditions Strategy implementation. Clinical Communities and the Managed Clinical Networks contribute significantly to this work and are key influencers in terms of effectiveness of approach.	2	Continue with the meaningful involvement if CHP Public Partnership Forums and continue to build the links to the APoH stakeholder engagement process.	Calvin Brown	May 2008

Standard 6 Values SubTotal

15

Long Term Conditions : CHP Profile

Standard	Maximum Value	Subtotal Year 1	Subtotal Year 2	Subtotal Year 3
Standard 1 – Organisation of Long Term Conditions Management	24	15		
Standard 2 – Patient Information and Supported Self Care	24	9		
Standard 3 – Service Design and Multi-disciplinary/Multi-agency working	24	8		
Standard 4 – Interdisciplinary Education and Training	24	8		
Standard 5 – Information and Intelligence	24	12		
Standard 6 – Quality and Delivery	30	15		
Total Score	150	57		

Criteria and standards have not been weighted. Performance against each standard should be considered independently to identify priority areas for actions. Total score should increase year on year as the CHP implements systems of care to more effectively manage long term conditions.

ATTENDANCE LIST

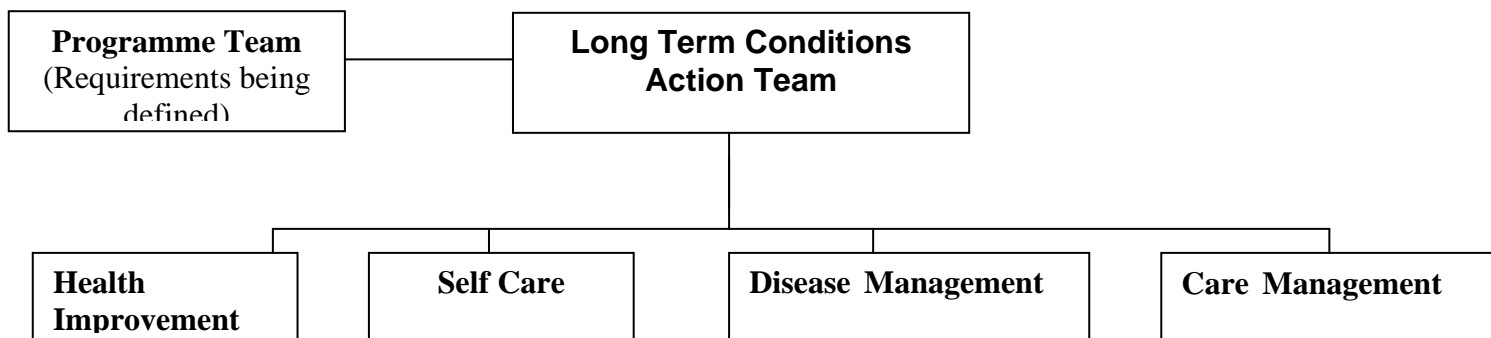
CHP Long Term Conditions Self-Assessment Toolkit Workshop

Law House, Wednesday 28th March 2007

NAME	POSITION	ORGANISATION	ADDRESS	DAY TIME TELEPHONE NO	MOBILE TELEPHONE NO	E-MAIL ADDRESS
John Mitchell	Chairman	South Lanarkshire PPF	141 Vancouver Drive Westwood East Kilbride G75 8NL	01355 231952		johnmvandek@tiscali.co.uk
Stephen Kerr	Head of Planning & Performance (N)	North CHP	Strathclyde Hospital Airbles Road Motherwell ML1 3BW	01698 245266	07748 333576	stephen.kerr@lanarkshire.scot.nhs.uk
Jamie McDermott	Senior Officer	North Lanarkshire Council	Scott House Merry Street Motherwell ML1 1JE	01698 332055	07748 624274	McdermottJ@northlan.gov.uk
Dr Gregor Smith	Lead GP, Hamilton Locality & Respiratory MCN	Hamilton Locality, NHSL	Udston Hospital Farm Road Hamilton	01698 723230	077987 11582	gregor.smith@lanarkshire.scot.nhs.uk gregor.smith@larkhall.lanpct.scot.nhs.uk
Maureen Taggart	SDM Long Term Conditions	NHSL South CHP	Clydesdale Locality Law House Airdrie Road LAW ML8 5ER	01698 377825	07748 622430	maureen.taggart@lanarkshire.scot.nhs.uk

NAME	POSITION	ORGANISATION	ADDRESS	E-MAIL ADDRESS
David Shields	SDM	NHSL	Admin Building Coathill Hospital Coatbridge	david.shields@lanarkshire.scot.nhs.uk
Helen Alexander	Diabetes & Vascular MCN Manager	NHSL	Red Deer Centre Alberta Avenue East Kilbride	helen.alexander@lanarkshire.scot.nhs.uk
Helen Biggins	Chair	East Kilbride PPF	7 Whitemoss Road East Kilbride G74 4JB	To follow
Dr PS Mahal	GP/CHP Locality Lead	NHSL	Central Health Centre Cumbernauld G67 1BJ	pali.mahal@lanarkshire.scot.nhs.uk
Robert Anderson	Chair	South Lanarkshire Carers Network	29 Clydesdale Street Hamilton ML3 0DD	info@slcn.co.uk
Margaret Moncrieff	Development Manager	North Lanarkshire Carers Together	51 Hope Street Motherwell ML1 1BS	margaret@carerstgether.org
Lorraine Smith	SDM	NHSL, South CHP	East Kilbride Locality Red Deer Centre Alberta Avenue East Kilbride	lorraine.smith@lanarkshire.scot.nhs.uk

Programme Infrastructure



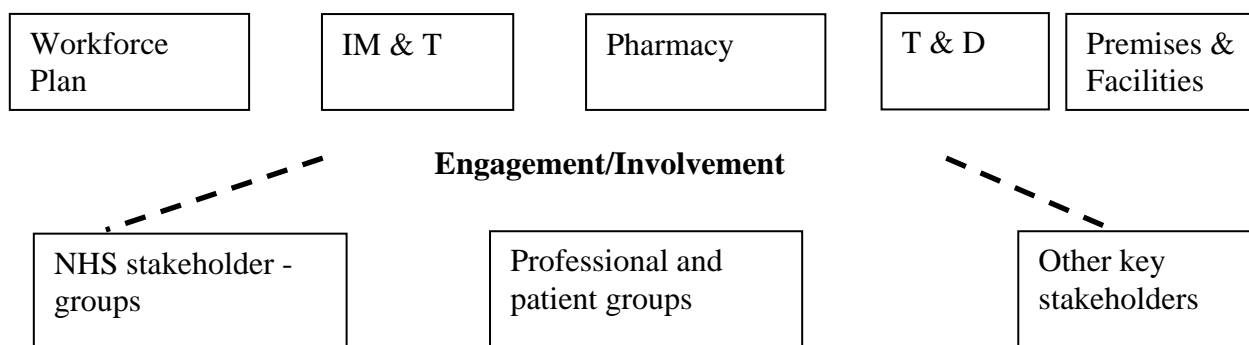
Strategies for Prevention
Health promotion
Patient info
Programmes
Education
New technology

Information & Ed
Condition support
Patient empowerment
Key contacts
Standard single assessment
Meds review systems
Patient held records

Standard data set
Generic CDM QAF
Multi disciplinary working
Nurse led care
Seamless referral/protocols
Integrated care pathways
GMS QOF
Primary Care/SW
MCN's

Consultant led care
Shared definitions
Medicines management
Integrated Team health,
Pharmacy, Social Work
Nurses/AHP's

Cross Cutting issues



NB. The Long Term Conditions Action Team membership and roles and responsibilities will reflect this wide and cross cutting agenda.

Appendix 1

TERMS OF REFERENCE: NHS LANARKSHIRE LONG TERM CONDITIONS ACTION GROUP.

Aim

To systematically and consistently implement NHS Lanarkshire's Long Term Conditions Strategy to meet the needs of the people of Lanarkshire.

Objectives

1. Raise awareness of NHS Lanarkshire's Long Term Conditions Strategy across the Organisation and partner agencies.
2. Scope out the current position ensuring evidence based practice is identified and replicated where appropriate
3. Develop a comprehensive action plan to support the implementation of the strategy utilising a risk management approach to prioritise action where appropriate ensuring key targets such as HEAT targets are achieved
4. Monitor implementation and report on progress to Programme Board 2, (Community and Primary Care Strategy)
5. Evaluate the impact of implementing key aspects of the long terms conditions strategy.

Strategic Documents

In meeting the above objectives the following documents must be considered:

- Delivering For Health
- Lanarkshire Long Term Conditions Strategy
- The National Service Framework For Long Term Conditions,
- Caring For Scotland
- New Pharmacy Contract
- NHS Lanarkshire Community Nursing Review: Future Vision
- Delivering Care Enabling Health
- Visible, Accessible And Integrated Care
- GMS Contract

Chairperson

Anne Armstrong: Nurse Director Community & Primary Care

Membership

- Lead GP – Long Term Conditions
- Programme Manager – Long Term Conditions
- Head Of Planning – North or South CHP
- Nurse Consultant – Long Term Conditions
- Carer Representative
- Patient Representative
- Patient Services Manager
- SDM Long Term Conditions & Lead For Supported Self Care
- General Manager
- Trade Union Representative
- Chief Pharmacist
- Lead Clinician MCN
- Project Lead – Care Management
- Project Lead – Anticipatory Care
- Clinical Effectiveness Representative
- Local Authority Representative – North
- Local Authority representative – South
- Associate Director - AHPs

The Group has the ability to co-opt members on an ad hoc basis as required

Links with Key Groups

- Managed Clinical /Care Networks
- Older Peoples Programme Board
- Children's Services Programme Board
- Community Nursing Implementation Group
- Care Management Steering Group
- Keep Well Project Board

Reporting Mechanism

The Action Team will report through the chair to the Primary Care Modernisation Programme Board, (Programme Board 2) providing progress reports at agreed intervals. This will include endorsement and review of the Groups work programme. Sub Groups will be established to progress work streams will provide a regular report outlining progress at each of the Action Teams implementation plan. This will include exception reporting outlining activity to ensure timeous implementation of the strategy

Communication

The Sub Group is responsible for ensuring that front line staff are involved in their work and are able to influence the shape of the future service within the realms of strategic guidance. Regular updates will be provided via the PULSE.