

Meeting of
NHS Lanarkshire Board
28th of November 2007

Lanarkshire NHS Board
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**SUBJECT: Long Term Conditions Action Team Objectives 2007/08 and
Implementation of
The Long Term Conditions Strategy**

1. PURPOSE

- The following report provides the Board with an update on the progress achieved to date in establishing the Long Term Conditions Action Team Objectives 2007/08 and implementing the Long Term Conditions Strategy

2. SUMMARY OF KEY ISSUES

- Considerable progress has been made across a number of areas in relation to achievement of the Long Term Conditions Action Team objectives 2007/08 and the implementation of Long Terms Conditions Strategy.
- The interim evaluation of the Integrated Care Management pilots preliminary data shows that compared with baseline information hospital admissions of those included in Integrated Care Management have dropped slightly, although this is not statistically significant. Anecdotal reports from patients, their families and professionals involved suggest that the quality of care has improved
- Keep Well was launched in Lanarkshire on 24 October 2006. The Lanarkshire model targets all patients between the ages of 45-64 registered with a GP in the pilot sites. As at mid October 18,781 letters have been sent out and 7,235 patients have attended for screening with a variety of referrals being made to both statutory and voluntary services
- Telehealth/telecare - £200,000 was awarded to NHS Lanarkshire to take this forward with the caveat that the development linked with Local Authorities and the project was subject to robust evaluation. The project will require further investment from NHS Lanarkshire; the total anticipated additional funding will be in the order of £350,000. This is being worked through in detail at present. It is anticipated that this project will formally commence early next year.
- Self-Management. The Diabetes and Respiratory Managed Clinical Networks self management proposals have been agreed and signed off by the Long Term Conditions Action Team. Funding has been issued to take forward the proposed self management programmes.

- Long Term Conditions Self Assessment toolkit. It has been acknowledged that the Scottish Governments Health Departments self assessment toolkit is a working document subject to version control. The most up to date version will be reissued on a quarterly basis to those identified as having specific responsibility. This will allow progress to be identified and the outcome score recalculated. Good progress is being made towards compliance. The base line measures identified that the organisation scored 57 out of a possible 150. Latest assessment has identified that this has improved to 95.

3. ACTIONS FOR THE SERVICE

- The Long Term Conditions Action Team will continue to update the self assessment toolkit on a quarterly basis and provide updates as requested to the Scottish Government
- The Diabetes and Respiratory Managed Clinical Network's will take forward the implementation of the Diabetes and Chronic Obstructive Pulmonary Disease Self Management Programmes.
- The Telehealth/telecare Project Board will produce a project initiation document and take forward the project in the new year.

4. RECOMMENDATION

The Board is asked to;

- receive the attached report outlining progress to date on achieving the Long Term Conditions Action Team Objectives and implementing the Long Term Conditions Strategy
- receive a copy of the self assessment toolkit evaluation summary.

5. FURTHER INFORMATION

For further information or clarification of any issues in this paper please contact.

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LONG TERM CONDITIONS

ACTION TEAM UPDATE: NOVEMBER 2007

PURPOSE OF UPDATE

- To inform members of Board of progress in relation to the 2007 /2008 Long Term Conditions Action Team objectives and implementation of NHS Lanarkshire's Long Term Conditions Strategy.

OBJECTIVES for Long Term Conditions Action Team 2007 - 2008

1. Introduce Integrated Care Management within the Wishaw General Hospital catchment area and pilot sites to reduce emergency readmissions of the over 65 age group.
2. Implement Keep Well
3. Develop Telehealth proposal & commence implementation programme
4. Identify Self management subgroup of Long Term Conditions action group to undertake mapping of current self -management resources and make recommendations. Initial emphasis will be on self management of Chronic Obstructive Pulmonary Disease and Diabetes
5. Align with and influence the condition specific clinical communities
6. Develop and Implement services directory
7. Develop Communication Strategy for Long Term Conditions Action Group
8. Develop 3 year implementation plan based on Long Term Conditions Strategy
9. Create a training & development plan for Long Term Conditions and assign budget
10. Produce Long Term Conditions Annual Report
11. Update Long Term Conditions Tool kit every 4 months

CURRENT SITUATION

Objective 1: Integrated Care Management

Integrated Care Management Pilots

Integrated Care Management within Lanarkshire focuses on people who have complex or rapidly changing needs by providing the most intensive care in the least intensive setting ensuring access to appropriate services when required.

This project officially commenced in September 2006. Although the processes got underway, patient contact in relation to Integrated Care Management did not take place until January 2007.

Considering the nature of Integrated Care Management it will be necessary to examine outcomes for six months beyond the life of this project to establish the longer term impact.

Three localities were selected to host pilots of the Integrated Care Management approach:

Coatbridge - selected due to high levels of deprivation
East Kilbride - selected due to an increasing older population
Clydesdale - selected due to rural location.

An interim evaluation report has been prepared. Although not statistically significant preliminary data shows that compared with baseline information hospital admissions of those included in Integrated Care Management have dropped slightly.

Anecdotal reports from patients, their families and professionals involved suggest that the quality of care has improved.

Roll-out of Integrated Care Management

- Roll out of integrated care management to Wishaw General catchment area is on target. Practices that refer patients into Wishaw General have been notified and suitably experienced District Nurses have agreed to take on the role as Care Managers.
- Negotiations are ongoing with South Lanarkshire Council regarding joint care management training however North Lanarkshire Council have given their full support with a training programme being developed specifically to facilitate Integrated Care Management. Other training requirements have been identified and secured, and will be delivered over the next few months.
- Resource materials and documentation have been developed to support the care managers in their role.

- An introduction to Integrated Care Management event was held to fully inform Care Managers of the processes.
- The latest SPARRA data now includes systemwatch data which predicts risk of admission until October 2008. This data has been issued to all localities for cleansing in preparation for Integrated Care Management. For those not currently involved in the roll-out this data may be used for winter planning.
- Local interdisciplinary / interagency knowledge sharing groups have been convened.
- The Roll-out of Integrated Care Management in the Wishaw general catchment areas has now formally commenced.

Objective 2: Keep Well – Anticipatory Care.

- Keep Well is a National 3year phased programme aimed at increasing the rate of health improvement in deprived communities by enhancing primary care services to deliver anticipatory care. 3 Localities within North Lanarkshire (Airdrie, Coatbridge and Wishaw) were identified as having the highest concentration of the most deprived 15% data zones and were selected to be in phase one of the programme.
- Keep Well was launched in Lanarkshire on 24 October 2006. The Lanarkshire model targets all patients between the ages of 45-64 years registered with GP practices in the pilot sites.
- Patients are invited for screening for cardiovascular disease risk by nurse advisors, brief intervention and lifestyle advice. Screening is now underway in all 3 pilot areas with Refer2us (an independent service provider) carrying out patient testing in 19 out of 29 practices. As at mid October 18,781 letters have been sent out and 7,235 patients have attended for screening with a variety of referrals being made to both statutory and voluntary services.
- The innovative practice being delivered by the Keep Well pilot sites is influenced and supported by the strategies set out in The Joint Health Improvement Plan and The community Regeneration Plan developed between North Lanarkshire Council and NHS Lanarkshire.
- The project is actively linking patients into mainstream activities, such as education, recreation and leisure and the ‘routes to work’ initiative led by the Department of Work and Pensions.
- Key to the ongoing development of anticipatory care is the evidence of improved outcomes for patients and sustainability of the services being provided. The results of the ongoing local evaluation will be shared to stimulate quality improvement actions across the localities in NHS Lanarkshire and at a national level.

Objective 3: Telehealth/Telecare: Supported Self Care

- NHS Lanarkshire Respiratory Managed Clinical Network, in collaboration with the Scottish Centre for Telehealth, proposed to implement an alternative approach to the provision of services to patients with Chronic Obstructive Pulmonary Disease (COPD). A proposal was developed and submitted to the Scottish Government Health Directorates Telecare Department for this service development together with a funding request to support the initial period of programme implementation.
- £200,000 was awarded to NHS Lanarkshire to take this forward with the caveat that the development linked with Local Authorities and the project was subject to robust evaluation. The project will require further investment from NHS Lanarkshire, the

total anticipated additional funding will be in the order of £350,000. This is being worked through in detail at present.

- A Project Board has been convened. This group met and agreed that a project Manager be appointed. However in the meantime a Project Initiation Document will be prepared indicating timelines and detailed costings.
- It is anticipated that this project will formally commence early next year.

Objective 4: Self Management

- The Diabetes Managed Clinical Network and Respiratory Managed Clinical Network self management proposals have been agreed and signed off by the Long Term Conditions Action Team. Funding has been issued to take forward the proposed self management programmes.
- A subgroup of Long Term Conditions Action team will be convened to consider the National Strategy for Self Management and how this can be applied to NHS Lanarkshire.
- Work is ongoing.

Objective 5: Clinical Groupings

- The Long Term conditions Action Team are working with the clinical communities to ensure Long Term Condition's are integral to the emerging clinical models and that the models specifically address issues in the Long Term Conditions Strategy. This is linked to the Boards 'A Picture of Health' and through this process all specialties and disease specific groups are currently under review.
- An update of the work and remit of the Long Term Conditions Action Team was presented to members of the clinical communities at a recent event.

Objective 6: Directory of Services

- There was a recognised need and subsequent request from a number of areas to develop a Directory of Services (DoS) concept for NHS Lanarkshire. This would be available via the web initially for GPs and relevant community staff and would roll out to Secondary care once there had been a "proof of concept" and good roadtesting in primary care.
- The DoS would need to be maintained in a robust fashion and this would require the creation of a dedicated resource (at a level yet to be determined) that would sit in primary care to begin with. This resource and function would migrate towards the Emergency Response Centre in due course.

- There was a clear desire to ensure that the DoS was resilient and that as such the cheap and cheerful home grown version would not be sufficiently robust for these purposes, in particular as the Emergency Response Centre became a user.
- It was agreed that no matter which way matters went there would be a need to commence gathering the DoS information. Vijay Sonthalia will develop template for this and work with Alan Lawrie to identify personnel to carry this work out. If we went with the NHS24 Knowledge Management System (KMS) this would not in fact be possible for 6/8 months. This fits the proposed timeline and ensures that we would be getting a product that worked fully and was subject to stringent quality assurance measures.
- Vijay Sonthalia and Barry McAlister will have discussions about what KMS would mean for NHSL in terms of limitations, format etc and advice on the potential options that surround this way forward.
- Consideration will be given to provide a specific level of access for patients, carers and members of the public.

Objective 7: Communication Strategy

- The communications team have been contacted for guidance on the most effective communication routes. Work in progress.

Objective 8: 3 year implementation plan

- The Board has already committed to £3M investment in community nursing over the next few years which is anticipated will go a considerable way to addressing the Long Term Conditions agenda. The 3 year implementation plan is currently being considered with development of the plan commencing shortly.

Objective 9: Training & Development plan

- Whilst acknowledging the various levels of existing knowledge and specialist practice it is evident that practitioners within the generalist arena require access to information on numerous clinical conditions generated from the latest research evidence in order to maintain best practice and support the shift in focus of care to within the community.
- To support this transition and in an attempt to address some of the more immediate requests for training, it proposed that a series of clinical knowledge update sessions be offered to practitioners utilising all available resources. In the first instance this programme will be offered to Nurses and Allied Health Professions within Primary and Secondary care.
- Linking with the Practice Development Centre, a project board has been convened and includes all relevant stakeholders to oversee the development, implementation and evaluation of the Clinical Knowledge Update Programme.

- Based on current intelligence, the outcome of a focus group, clinical activities and developments within NHS Lanarkshire the following clinical conditions have been proposed for inclusion within the planned programme.
- Diabetes
- Chronic Obstructive Pulmonary Disease
- Asthma
- Dementia
- Neurological Conditions
- The principles of the proactive management of long term conditions will be inherent in each session.
- The overall aim of the clinical knowledge programme is to enable health professionals with previous clinical experience to maintain up to date evidence based practice and
 - to provide practitioners an opportunity to access the latest clinical research evidence within specified conditions,
 - to improve and update knowledge to meet the requirements of the knowledge and skills framework,
 - to share and enhance best practice,
 - to increase awareness of the contribution made by multidisciplinary team members,
 - to increase awareness of the contribution made by patients and their carers in the management of their own condition.

Proposed Timetable

Week commencing	Monday	Tuesday	Wednesday	Thursday	Friday
31.12.07					
07.01.08				10.01.08	
14.01.08				17.01.08	
21.01.08				24.01.08	
28.01.08				31.01.08	
04.02.08				07.02.08	
11.02.08				14.02.08	
18.02.08					
25.02.08					
03.03.08				06.03.08	
10.03.08				13.03.08	
17.03.08					
24.03.08					
31.03.08					
07.04.08				10.04.08	
14.04.08				17.04.08	
21.04.08				24.04.08	
28.04.08				01.05.08	

05.05.08				08.05.08	
12.05.08				15.05.08	
19.05.08				23.05.08	
26.05.08				29.05.08	
02.06.08				05.06.08	
09.06.08					

Diabetes		Neurological	
Asthma		Dementia	
COPD		Palliative Care	

- The Long Term Conditions Action Team plan to set up a subgroup to consider the overall training and development requirements in relation to long term conditions and links to workforce /workload planning to ensure a competent, capable and confident workforce.

Objective 10: Annual Report

Work on preparing the Annual report will commence early next year to ensure the report is delivered to the Scottish Government Health Department in April 2008.

Objective 11: Update tool kit

It has been acknowledged that the Scottish Government Health Department self assessment toolkit is a working document subject to version control. The most up to date version will be reissued on a quarterly basis to those identified as having specific responsibility. This will allow progress to be identified and the outcome score recalculated.

Miscellaneous

The Long Term conditions Action Team have responded to a number of enquiries from other sources.

- Following a number of enquiries to NHS Lanarkshire regarding nursing support for people with Neurological conditions, a brief overview was requested by Mrs Joan James, Director of Nursing, Acute Division and Mr Roy Garscadden, Director of Operational Planning.
- The overall aim of this piece of work was to establish the current level of specialist nursing support for people with Neurological conditions within the Primary Care Division of NHS Lanarkshire.
- The approach taken was to establish the number of nurses, their area of specialty, services and support offered, highlight examples of best practice and highlight any

particular challenges / barriers to providing best practice. The following conditions were been included within this report although it must be acknowledged that this does not address the full list of conditions included under the specialty of neurology:

- Multiple Sclerosis
 - Epilepsy
 - Parkinson's Disease
 - Motor Neurone Disease
 - Huntington's Disease
- This piece of work has influenced the more general review of Neurology Services currently underway.
 - A copy of the Neurological Nursing services report is available on request.

Chronic Fatigue Syndrome / Myalgic Encephalomyelitis (CFS/ME)

- The Long Term Condition Action Team was asked to consider a proposal to bring together a multidisciplinary group to establish a pathway and service for people living in Lanarkshire who suffer from Myalgic Encephalomyelitis, with a view to piloting this pathway and service within one locality.
- Considerable concerns were raised in relation to this proposal – raising patient expectations that might not be met, setting a precedent for other sub-specialties, creating potential tensions with Glasgow, cutting across the current neurological services review, and how referrals would be made to specialist services.
- Whilst acknowledging the difficulties and challenges for those living with this condition and their families, the Long Term Conditions Action Team decided they could not support the proposal in its current form.
- With the recent publication of the Health Technology Assessment on the treatment and management of Chronic Fatigue Syndrome / Myalgic Encephalomyelitis (CFS/ME) and subsequent NICE clinical guideline number 53, Chronic Fatigue Syndrome / Myalgic Encephalomyelitis (or encephalopathy): diagnosis and management of CFS/ME in adults and children in August, an opportunity existed to consider how this evidence could be applied within NHS Lanarkshire to aid diagnosis and management.
- Considering current thinking and emphasis on the management of long term conditions and the diverse range of symptoms associated with this condition an opportunity exists to add to the evidence base for the management of this condition whilst improving quality of life.

- Therefore while the review of NHS Lanarkshire's Neurological Service continues and the debate into the cause and treatment of CFS / ME is ongoing, the Corporate Management Team were asked to consider the evidence and the following:
 - To support and fund a number of Master Classes aimed at GPs and Primary Care staff to increase awareness and knowledge of this condition to assist diagnosis and management, with the ultimate view of adopting a diagnostic protocol.
 - To support and fund a time limited research project to identify the structure and content of a specialised self management programme for people with CFS / ME involving Lanarkshire residents and members of MEEK in the development and research process
 - A specialised programme could include areas such as the management of fatigue, managing activity and periods of rest, sleep patterns, diet, etc, based on individual needs. This could be enhanced with the use of a CFS/ME personal symptom management plan.

Reflecting upon activity described within this update it is clear that the Long Term Conditions Action team are progressing and supporting implementation of NHS Lanarkshire's Long Term Conditions Strategy.

To deliver the commitment made to the Long Term Conditions Reference Group the Long Term Conditions Action Team will hold a seminar early next year to showcase achievements and progress made within the Long Term Conditions Strategy.

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12 November 2007

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Long Term Conditions: Action Plan

CHP's:	Lanarkshire
Executive Lead:	Alan Lawrie
Lead Clinician:	Anne Armstrong
Manager:	Alan Lawrie
Date completed	<u>23 July 2007</u>
Signature	

Long Term Conditions Action Team

Key Objectives for 2007 – 2008 DRAFT

	Objective	HEAT Targets/ LTC Standard	Responsible	Initiated	Complete by	Cost Implications
1.	Introduce Integrated Care Management within the Wishaw General Hospital catchment area and pilot sites to reduce emergency readmissions of the over 65 age group	T.02T T.01T A.05T LTC 3.1 LTC 3.4 LTC 3.6 LTC 6.2	J Barrie	02 April 07	December 07 (A number of specific deadlines exist within programme)	£140,000
2.	Implement the Keep Well Pilot and evaluate	H.01T H.02T H.03T LTC 2.8 LTC 3.1 LTC 6.2	G Docherty	July 07	July 2008	As agreed with SGHD
3.	Develop Telehealth proposal & commence Implementation	A.05T	R. Wright	May 07	March 2008	£200,000

	Programme	T.02T LTC 2.6				
4.	Identify Self management subgroup of LTC action group to undertake mapping of current self-management resources and make recommendations. Initial emphasis will be on self management of COPD and Diabetes	LTC 2.7 LTC 2.8 LTC 3.8	J Barrie Respiratory and Diabetes MCN's	August 07 July 07	January 08 To be confirmed	£600,000
5.	Align with and influence the condition specific clinical communities to ensure LTC's are integral to the emerging clinical models and they specifically address issues in the LTC Strategy. This is linked to the Boards 'A Picture of Health' and through this process all specialties and disease specific groups are currently under review	LTC 1.4 LTC 1.6 LTC 3.5	C Dunn	April 07	On Going	NIL
6.	Develop and Implement services	LTC 1.6	VJ Sonthalia &	August 07	March 08	£20,000

	directory	LTC 2.1 LTC 2.4 LTC 2.7	A Hendry			
7.	Develop Communication Strategy for LTC Action Group	LTC 1.5 LTC 2.1 LTC 2.2 LTC 2.3 LTC 2.5 LTC 6.10	J Barrie & Calvin Brown	August 07	October 07	Nil
8.	Develop 3 year implementation plan based on LTC strategy. The Board has already committed to £3M investment in community nursing over the next few years which is anticipated will go a considerable way to addressing the LTC agenda		LTC Action Team	June 07	September 07	TBC

9.	<p>Create a training & development plan for LTCs and assign budget</p> <p>Specific tasks:</p> <ul style="list-style-type: none"> • Set up LTC training & development subgroup • Link with Practice Development board • Link with Workforce /workload planning 	<p>LTC 4.1 LTC 4.2 LTC 4.3 LTC 4.4</p>	M Cerinus	June 07	December 07	TBC
10	Produce LTC annual report using self assessment tool kit	<p>LTC 6.7 LTC 6.8 LTC 6.10</p>	A Armstrong	April 07	April 08	Publication costs
11	Review, refine and update actions in self assessment tool kit to ensure clarity and comprehensive cover of all elements.		LTC Action Team	August 07	October 07	NIL

Scottish Government Health Department: Long Term Conditions Self Assessment Tool Kit.

Summary Analysis.

Standard	Maximum Value	Subtotal Year 1	Progress to date 31/07/07	Subtotal Year 2
Standard 1: Organisation of Long Term Conditions Management	24	15	21	
Standard 2: Patient Information and Supported Self Care	24	9	12	
Standard 3: Service Design and Multi-disciplinary/Multi-agency working	24	8	15	
Standard 4: Interdisciplinary Education and Training	24	8	11	
Standard 5: Information and Intelligence	24	12	13	
Standard 6: Quality and Delivery	30	15	23	
Total Score	150	57	95	