

Long Term Conditions

Common Problems, Shared Solutions



Introduction

The purpose of this report is to update North and South Lanarkshire Community Health Partnerships, NHS Lanarkshire's Corporate Management Team, NHS Lanarkshire's Board and the Long Term Conditions National Team on the activities and progress in relation to Long Term Conditions within NHS Lanarkshire.

In 2005 NHS Lanarkshire set out its strategy to manage the current and future challenges of people living with long term conditions. This strategy is consistent with a whole systems way of working and supports the principles within Delivering for Health (SEHD 2005) and Better Health, Better Care (SGHD 2007).

Over the past year the focus on long term conditions has increased. The formation of NHS Lanarkshire's Long Term Conditions Action Team has facilitated the implementation of a comprehensive action plan with a number of objectives which cross reference with the national HEAT Targets and NHS Lanarkshire's corporate objectives. How this programme of work links with the national HEAT targets and corporate objectives can be found in appendix I.

Background

The World Health Organisation (WHO) defines long term conditions as health problems that require ongoing management over a period of years or decades. Long term conditions are not curable and last longer than twelve months (SEHD 2005). Some long term conditions are characterised by acute exacerbations of ill health resulting in repeated admissions to hospital.

Long term conditions include a very wide range of health conditions, ranging from a single condition to multiple and complex conditions which can be physical, mental, behavioural or emotional.

In February 2007 the Scottish Executive issued the Community Health Partnership (CHP) Long Term Conditions Self Assessment toolkit with guidance for completion. Each CHP was expected to complete the toolkit,

score themselves against pre determined organisational standards and develop an action plan to address any shortcomings. NHS Lanarkshire's submission was a joint endeavour reflecting the ethos of whole systems working. A copy of NHS Lanarkshire's completed tool kit and action plan can be found as appendix I.

The toolkit underlines the importance attached to the development of a generic approach to the management of long term conditions and provides the opportunity to address lesser common conditions.



Objectives

In line with NHS Lanarkshire's self assessment toolkit, national HEAT Targets and Corporate Objectives, the objectives set by the Long Term Conditions Action Team for 2007 - 2008 were as follows:

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 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.
5. Align with and influence the condition specific clinical communities.
6. Develop and Implement Directory of Services.
7. Develop Communication Strategy for LTC Action Group.
8. Develop 3 year implementation plan based on LTC Strategy.
9. Create a training & development plan for LTCs and assign budget.
10. Produce LTC Annual Report.
11. Update LTC Tool kit every 4 months.

1 Integrated Care Management

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 assessment in relation to Integrated Care Management did not take place until January 2007.

Considering the nature of Integrated Care Management it was necessary to examine outcomes beyond the agreed pilot timescale 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

A full evaluation has been undertaken and a copy is available on request. Although not statistically significant preliminary data shows that compared with baseline information hospital stays for those admitted and included in Integrated Care Management have reduced slightly.

Anecdotal reports from patients, their families and professionals involved suggest that the quality of care has improved. Full qualitative analysis is included in the final report.

1.1 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 continuing 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 with training ongoing over the next few months.
- ❖ Resource materials and documentation have been developed to support the care managers in their role. These resource materials and the general progress within Lanarkshire has generated a lot of interest from other NHS Boards. NHS Lanarkshire has been and continues to be delighted to assist other NHS Boards by sharing our experience.
- ❖ The latest SPARRA data now includes systemwatch data which predicts risk of admission until January 2009. Due to recent issues with data protection the latest version has been encrypted. This has led to a slight delay however once the appropriate software has been activated this data will be issued to all localities to facilitate the Integrated Care Management process. The previous issue of SPARRA data was used successfully to inform Winter Planning strategies in all localities.
- ❖ Local interdisciplinary/interagency knowledge sharing groups have been convened.

2 Keep well

The Deputy Health Minister launched Keep Well (KW) in Lanarkshire on the 24 October 2006. Lanarkshire was the first area in Scotland to commence delivery of Keep Well, with screening starting in Coatbridge on 23 October 2006.

- ❖ NHS Lanarkshire has 29 practices signed up and delivering KW with a total eligible population of 28 547. The first cohorts of patients were invited to attend by letter.
- ❖ Coatbridge is predominantly delivering KW in practice premises during “office hours”. Eight practices are delivering KW. Four have used fixed appointment letters and the other four have used open letters. The overall uptake was 33.9%. Figures show the Did Not Attend (DNA) rate to be higher using fixed appointments, however the number of appointments made by patients who received open letters were around 20%.
- ❖ Airdrie is predominately using community venues and have screened both in “office hours” and out of hours. All patients were sent fixed appointments. North Lanarkshire Council Call Centre (NLCCC) supported the administration of changing appointments in four out of the eight practices. Their uptake using this model was 40.2%.
- ❖ Wishaw has used a combination of both practice and community venues during “office hours” and patients were invited using a fixed appointment letter. NLCCC was used to change appointments in four of the thirteen practices. Their uptake was 48.5%
- ❖ Near patient screening is used to assess the CVD risk if a patient has of 20% or more as per SIGN guideline 97. If in a risk category, they are referred for further investigations including a full lipid profile.

- ❖ In Coatbridge the Practice Nurse is assessing patients who have a CVD risk of 20% or more. Wishaw and Airdrie have appointed KW Chronic Disease Management Nurses who carry out this role. The differing models of delivery will be evaluated as the pilot progresses.

2.1 Progress to Date

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, developed between North Lanarkshire Council and NHS Lanarkshire. In order to offer a holistic service, the KW pilot is actively linking patients into mainstream activities, such as education, recreational & leisure and the employability programmes.

2.2 Evaluation

Key to the ongoing development of anticipatory care is the evidence of improved outcomes for patients and the sustainability of the services being implemented. Data is being gathered on the patients seen and the outcomes of their KW screen. An interim evaluation has been produced on the implementation phase of KW.



2.3 Screening Activity up to and including 27 Nov 2007

- * **Note:** The interim evaluation report presents the data based on screening activity up until 17th September 2007.
- ❖ Total patients screened = 7664
- ❖ Total referrals to Counterweight = 836
- ❖ Total referrals to smoking cessation = 349
- ❖ Total referrals to exercise programme = 448
- ❖ Total referrals to alcohol team = 13
- ❖ Total referrals to the department of work and pensions = 21
- ❖ Total direct referrals to the GP = 92
- ❖ Total referrals to the P/N/ CDMN = 2982

KW have identified the low level of referrals to alcohol services and are addressing this through education of staff and more robust links with current services.

The evaluation has highlighted that there is an equal balance of male and female patients attending and that without using innovative approaches there is a slight tendency for the more affluent population groups to be over-represented. This tendency is not statistically significant but will continue to be monitored. The next phase of KW will focus on "Reaching the Hard to Reach" using a combination of Community Animators to carry out outreach work, including door knocking and NLCCC to call patients to re-appoint patients and remind patients about their appointment. Using this method will allow us to target our most deprived data zones which should resolve the imbalance of the over- representation of the more affluent population. Early anecdotal evidence has shown the uptake to clinics using the combined approach of phone calls and home visits has increased the attendance at clinics from around 40% to 75%. Because of the early success of this model it will now be implemented in all 3 areas. The model will be evaluated to ensure the intensive "reach strategy" is cost effective (*Keep Well Team*).

3 Telehealth/Telecare: Supported Self Care

NHS Lanarkshire Respiratory MCN, 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.
- ❖ A Project Board has been convened and project manager appointed.
- ❖ It is anticipated that this project will go live in August 2008.

4 Self Management

Self care is all that people do to maintain their health, prevent illness, seek treatment or support, manage symptoms of illness and side effects of treatment, accomplish recovery and rehabilitation and manage the impact of chronic illness and disability on their lives and independence. Self care is a very broad term for this wide range of activities that includes what is also often called self management (www.ascr.ac.uk/selfcare.htm).

In order to facilitate this process people must be fully engaged in their own health and the public health agenda.

People have a distinct role to play in their own healthcare by undertaking a number of strategies to treat minor illness and injuries, preventing disease and by actively managing long term conditions. The recognition of this is crucial to ensuring patient focused healthcare.

It must be acknowledged that most of healthcare is actually delivered by the patient and their family. There is sufficient evidence to support a range of self management interventions with the concept being threaded throughout the Department of Health's Health and Social Care long term conditions model.

These interventions include:

- ❖ Self management education
- ❖ Self monitoring of condition
- ❖ Self help/support groups
- ❖ Having access to personal medical Information
- ❖ The use of Telehealth

NHS Lanarkshire has for many years worked closely with a number of voluntary agencies to provide the necessary support in order to optimise self management of a number of long term conditions. This can range from local support groups to structured education programmes involving patients and their carers. It is our intention to strengthen these partnerships and continue with this example of good practice.

- ❖ The Long term Conditions Action Team has approved a proposal from the Diabetes MCN to implement two programmes to support self management: DAFNE (*Dose Adjustment for Normal Eating*) and X-pert (*structured group education for people living with Type 2 diabetes*). Both programmes will provide participants with the opportunity to study the implications of living with their long-term condition and preparing for the associated lifestyle changes. However, by building in links to various activities and programmes in their local communities (*related to exercise, food provision, community regeneration etc.*) it becomes

much more likely that they will action and sustain the necessary changes. This initiative will reach over 5000 people with diabetes. The evaluation will include comment on the applicability of the findings across other long-term conditions, where possible. This proposal links closely with a similar initiative for COPD self-management.

- ❖ The COPD programme, supported by literature developed by the British Lung Foundation and Chest Heart and Stroke Scotland, aims to provide the necessary confidence, knowledge and skills to patients with COPD enabling them to manage their disease on a daily basis. The introduction of this programme will facilitate potential benefits both to patients and the service. Evidence obtained from other disease specific self-management programmes identify a range of positive outcomes ranging from improved patient autonomy, increased quality of life, positive behavioural change, reduced/rapid management of exacerbations, better utilisation of healthcare services across primary and secondary care including reductions in hospital admissions and length of stay. As COPD is a progressive disease, which often deteriorates significantly with every exacerbation, it is of vital importance to patients and the healthcare system to promote the better day-to-day management of the condition. It will run in conjunction with a structured programme of pulmonary rehabilitation for patients with moderate or severe categories of disease, delivered in a locality setting by a multi-disciplinary team. A modified programme will also be available to those with mild disease and be delivered by practices in partnership with local authority leisure services.
- ❖ Although at the very early stages of implementation, the NHS Lanarkshire Telehealth/telecare project will complement the above programme by offering patients and carers an

interactive method of symptom surveillance prompting appropriate action when required by the most appropriate healthcare individual. Full training will be offered to those who take part in this initiative.

- ❖ Chronic pain self management groups have been provided throughout Lanarkshire for over 10 years by Pain Association Scotland. These groups are professionally led and offer structured training to people to facilitate coping with chronic pain and its impact. Group members are invited to attend the 'Living with Pain' programme. This is a fully validated seven week programme (*one day per week*) based on biopsychosocial principles to maximize the quality of life for both the person with pain and their families. With the redesign of the Chronic Pain Service within NHS Lanarkshire this arrangement will continue as an integral part of the patient pathway.

A subgroup of LTC Action team will be convened to consider the National Strategy for Self Management and how this can be applied to NHS Lanarkshire. Draft Terms of Reference have been prepared for approval.

5 Clinical Groupings

Whole systems clinical models provide the whole spectrum of care for patients with specific types of disease and are underpinned by disease specific pathways/algorithms and evidence-based practice to improve clinical outcomes. A clinical model defines the overall approach to prevention, assessment, diagnosis, treatment, rehabilitation, and management of long-term conditions through to palliative care. It is based on need/demand and provides optimised clinical outcomes for patients regardless of where the service is provided.

It describes what should happen, which is the essential step prior to description of 'Service Provision'

- ❖ The Long Term Conditions Action Team is working with the clinical communities and Managed Clinical Networks (MCNs) to ensure LTC's are integral to the emerging clinical models and that the models 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.

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 NHSL. 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 is a clear desire to ensure that the DoS is resilient and meet the needs of a range of services with NHS Lanarkshire.
- ❖ It was agreed that there would be a need to commence gathering the DoS information to populate the Directory. Dr Vijay Sonthalia has developed a template for this and will continue to work with Information Services to develop the project plan
- ❖ Consideration will be given to provide a specific level of access for patients, carers and members of the public.

7 Communication Strategy

- ❖ The Long Conditions Action Team acknowledge the range and sheer volume of people and organisations involved in the long communications arena. Every effort has been made to ensure the most effective routes of communication. Work in progress.

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 LTC agenda. The 3 year implementation plan is currently being considered with development of the plan commencing shortly. Work in Progress.

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, a series of clinical knowledge update sessions is currently being offered to practitioners utilising all available resources. In the first instance this programme is being offered to Nurses and AHPs 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:
 - Asthma
 - COPD
 - Heart Failure
 - Dementia
 - Neurological Conditions
- ❖ The principles of the proactive management of long term conditions are 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.
- ❖ The LTC Action Team has 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.

9.1 Aims and Objectives of Sub Group

The LTC Learning and Development group will act as a sub group of the LTC Action Team and carry out the following functions:

- ❖ Map out current learning and development activity in relation to LTCs.
- ❖ Identify current gaps in learning and development activity for LTCs.
- ❖ Scope out and prioritise future learning and development needs.
- ❖ Provide a structure within which new learning and development initiatives can be considered and delivery coordinated.
- ❖ Prepare learning and development plan in line with long term conditions strategy and self assessment toolkit.
- ❖ Identify specific budget to support learning and development plan.
- ❖ Provide the LTC Action Team an overview of learning and development activity.
- ❖ Provide the LTC Action Team linkage to learning and development initiatives.
- ❖ Advise the LTC Action Team on local and national developments or issues.

10 Annual Report

In line with the commitment made within the Long Term Conditions Self Assessment toolkit this document will be submitted as evidence of the progress made within NHS Lanarkshire.

11 Update tool kit

It was acknowledged that the SGHD self assessment toolkit was and continues to be a working document subject to version control. The most up to date version has been reissued on a quarterly basis indicating progress. This allowed progress to be identified and the outcome score recalculated.

12 Miscellaneous

The Long Term Conditions Action Team has 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.
- ❖ 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 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 which included an event to explore and map the patient's journey through current services. A larger stakeholder event is planned for later this year.
- ❖ A copy of the Neurological Nursing services report is available on request.

Chronic Fatigue Syndrome/Myalgic Encephalomyelitis (CFS/ME)

- ❖ 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 CMT 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 related voluntary organisations 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.
- A draft version of the tender document has been issued to a small group for comment with the overall project on target.

Chronic Pain Management

Recently, NHS Quality Improvement Scotland published “**Getting to GRIPS with Chronic Pain in Scotland**” (NHS QIS 2007). This report has been described as the most comprehensive stocktake of chronic pain services ever produced and highlights many deficiencies.

The Cabinet Secretary for Health and Wellbeing announced recently that she wants chronic pain to be recognised as a long term condition and expects NHS Boards to implement the recommendations made within the report.

For the past year NHS Lanarkshire has been developing and taking forward plans to completely redesign chronic pain services. The new service which was launched on 1st May 2008 involves a two phased approach incorporating the principles of whole systems working.

Phase one addresses the supporting infrastructure within secondary care services. A new Lead Consultant, Dr Sabu James, has been appointed as has a Chronic Pain Support Nurse. Clinical sessions are also being provided by the Nurse Consultant for Long Term Conditions. Job descriptions for a specialist chronic pain physiotherapist and clinical psychologist are currently with agenda for change for approval.

To complement this service and support phase two implementation, the shift to Primary Care, funding for a chronic pain training programme was secured with the programme now underway. Six GPs and a number of Practice and Community Nurses have enrolled in this year long programme aimed at improving knowledge, practice and services for people with chronic pain in Lanarkshire.

Long Term Conditions Collaborative Programme

In April this year the National Long Term Conditions Collaborative was launched. The overall aim of the Long Term Conditions Collaborative Programme is to improve the quality and range of care and experience for patients in particular allowing patients to manage their conditions more effectively. The resulting goal is to improve health outcomes for these patients, reduce their requirements to use secondary care services and as a by product reduce unnecessary demands on acute services so optimising the use of resources. Reflecting upon what has already been achieved within NHS Lanarkshire over the past year it is clear that opportunity for direct synergy exists within this initiative.

Programme Objectives

- ❖ Improve the management of care in the community
- ❖ Shift the balance of care where appropriate from hospital to community led service
- ❖ Optimise quality of life for patients, carers and families
- ❖ Reduce preventable hospital admissions and length of stay
- ❖ Increase concordance of medicine regimes

- ❖ Increase the involvement and influence of patients in the decision making process
- ❖ Generate empowerment and ownership of their condition
- ❖ Develop informed and supported unpaid carers
- ❖ Ensure efficient and effective delivery of care
- ❖ Improve communication and seamless care
- ❖ Improved local access to quality services

NHS Lanarkshire's Long Term Conditions Collaborative Programme (LTCCP) will support the delivery of Better Health, Better Care and delivery of HEAT targets, and will be part of the strategy for development of continuous quality improvement across NHSScotland. It will also support a smooth transition from the action plan generated from the self assessment tool kit to more tangible person-centred outcomes.

The LTCCP is an essential component of the national strategy to ensure an integrated approach to the delivery of service improvement programmes that also includes 18 Weeks Referral to Treatment Time (RTT) and Mental Health Collaborative Programme. In addition, it links with the Scottish Patient Safety Programme, the Patient Experience Programme (*Better Together*), Rehabilitation Framework, Audit Scotland Report LTC (2007), and the emerging Performance Support Programme for Efficiency and Productivity.

NHS Lanarkshire has developed an infrastructure that supports a whole system approach to modernisation and continuous service improvement. A Modernisation Board is supported by Service Improvement Boards (SIB) as outlined:

- ❖ Health Improvement SIB
- ❖ Primary, Community and Acute SIB
- ❖ Maternity and Children Services SIB
- ❖ Learning Disability SIB
- ❖ Mental Health SIB
- ❖ Older People SIB
- ❖ Regional Planning SIB

The Long Term Conditions Collaborative Programme and 18 Week RTT Programme link directly to the Primary, Community and Acute Service Improvement Board (PCASIB). NHS Lanarkshire will establish an Emergency Access Programme Board that will ensure an integrated approach to the emergency element of the Long Term Conditions Collaborative, 18 Weeks RTT, and the transition of the Unscheduled Care Collaborative Programme. The Executive Sponsor, Alan Lawrie, Director of South Lanarkshire CHP, will also chair the Emergency Access Programme Board.

Conclusion

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.

The activity within NHS Lanarkshire has generated a lot of interest from other NHS Boards and other organisations. An abstract of activity was submitted to the European Nurse Researchers Committee. As a result of this submission NHS Lanarkshire has been invited to hold a dedicated symposium at the 13th European Nurse Researchers Conference in Vienna later this year.

To deliver the commitment made to the Long Term Conditions Reference Group the LTC Action team will hold a seminar to showcase achievements and progress made within the Long Term Conditions Strategy. This event will take place in the early autumn.

Over the coming years NHS Lanarkshire will continue its commitment to the Long Term Conditions agenda, the Long Term Conditions Collaborative and associated workstreams.

References

Better Health, Better Care (2007)

Scottish Government Health Directorate
Edinburgh

Bagnall AM., Hempel S., Chambers D., Orton V., Forbes C (2007)

The treatment and management of chronic fatigue syndrome (CFS)/Myalgic encephalomyelitis (ME) in adults and children.

Centre for Reviews and Dissemination
University of York

Delivering for Health (2005)

Scottish Executive Health Department
Edinburgh

Getting to GRIPS with Chronic Pain in Scotland (2007)

NHS Quality Improvement Scotland
Edinburgh

National Institute for Clinical Evidence (2007)

Chronic Fatigue syndrome/Myalgic Encephalomyelitis (or encephalopathy): Diagnosis and Management of CFS/ME in Children and Adults

NICE
London

Acknowledgements

The Long Term Conditions Action Team would like to thank all those individuals and organisations involved for all their hard work over the past year and their continuing support. We look forward to making even more progress over this year.



Long Term Conditions

Action Plan



CHP's: Lanarkshire
Executive Lead: Alan Lawrie
Lead Clinician: Anne Armstrong
Manager: Alan Lawrie

Date Completed: 23rd July 2007
Version 5.0: Last updated 31st March 2008

Key Objectives for 2007 - 2008 DRAFT

Objective	HEAT Targets/ LTC Standard	Responsible	Initiated	Complete by	Status
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)	Roll out of ICM underway
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	March 2009	Progress continues
3. Telehealth/telecare proposal approved & implementation commenced.	A.05T T.02T LTC 2.6	R. Wright	May 07	March 2008	Goes live in June 2008
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	Diabetes, COPD, Chronic Pain programmes underway Inaugural meeting of the Self management subgroup to be held

	Objective	HEAT Targets/ LTC Standard	Responsible	Initiated	Complete by	Status
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	To be confirmed	The Clinical Community groups continue to develop the clinical models with the first batch of models currently being reviewed by the LTC Action Team
6.	Develop and Implement services directory	LTC 1.6 LTC 2.1 LTC 2.4 LTC 2.7	VJ Sonthalia & A Hendry	August 07	March 08	Ongoing
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	Ongoing
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	Ongoing

	Objective	HEAT Targets/ LTC Standard	Responsible	Initiated	Complete by	Status
9.	Create a training & development plan for LTCs and assign budget Specific tasks: <ul style="list-style-type: none"> • Set up LTC training & development subgroup • Link with Practice Development board • Link with Workforce/workload planning 	LTC 4.1 LTC 4.2 LTC 4.3 LTC 4.4	M Cerinus	June 07	December 07	The first meeting of the Learning and Development take place on 5th May 08
10.	Produce LTC annual report using self assessment tool kit	LTC 6.7 LTC 6.8 LTC 6.10	A Armstrong	April 07	April 08	Publication costs First draft submitted
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	Self assessment toolkit updated on a quarterly basis

Standard 1 - Organisation of Long term Conditions Management

	Objective	Evidence	Current 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, with sub groups for Supported self care, education & training to follow.	3	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.	3	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	Achieved - however progress continues

	Objective	Evidence	Current 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.	3	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	Achieved
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.	3	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.	<p>Organisationally we are committed to assessing service/strategy development through the Equality Diversity Impact Assessment process. Partnership commitment exists with ongoing engagement at a locality level through the Health & Care Partnerships, Joint Future, and Public Partnership Forums in both CHP's.</p> <p>North Lanarkshire Carers together has representatives on the Health & Care Partnerships and the four North Lanarkshire Partnership Boards, North Lanarkshire Public Partnership forum Reference group.</p>	3	<p>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.</p>	Stephen Kerr	TBC

Objective	Evidence	Current Value	Action	Responsible Person/Lead	Timescale
1.8	<p>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.</p> <p>Where opportunities currently exist to co-locate and integrated we provide e.g. consultant outreach clinics, physiotherapy services and co-location with Integrated Day Care Services.</p> <p>As clinical models are developed in all clinical development groups the service modelling will be implemented. All of the capital development programmes have the facilities incorporated to facilitate more integrated working, outreach models of care and multi-disciplinary approach to the delivery of care. Work has commenced in developing the service models for the planned capital developments.</p>	1	<p>Implement the organisations long term conditions strategy ensuring that all future premises are developed to meet requirements.</p> <p>This has been factored into the design of both of the building and of the service modelling with more integration, more whole systems working which will be driven through some on the existing groups ie Clinical Service Groups and Programme Boards.</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 fit for purpose of multi disciplinary working.</p> <p>Currently on hold</p>	<p>Robert Peat</p> <p>Property Services/ Capital Planning</p> <p>Robert Peat</p>	Ongoing

Standard 1: Current Values sub total: 22

Standard 2 - Patient information and Supported Self Care

	Objective	Evidence	Current 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.	2	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. Undertake stakeholder event, agree definition of requirements, undertake scoping exercise to inform development of the directory.	Anne Armstrong	August 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. A five person carer support team was recommended and approved.	3	Link LTC action team membership to implementation of the strategy	Anne Armstrong/ Bob Shorter	April 2007

	Objective	Evidence	Current Value	Action	Responsible Person	Timescale
2.3	<p>The specific information needs of people with visual and communication impairments and from minority ethnic groups are addressed.</p>	<p>This is currently achieved through the translation services with information available in a range of formats and languages on request.</p> <ul style="list-style-type: none"> - Accessibility addressed in Written Patient/carer Information policy - Core generic Information already translated/ available in alternative formats (<i>Acute Division</i>) - other information can be translated/reformatted on request - Information can be sourced upon request via various networks - i.e PIF. <p>Limited Information also available for people with learning disabilities</p> <p>The specific needs of people with visual and communication impairments is currently being achieved through the already established Translation Services.</p> <ul style="list-style-type: none"> • Core service information and HAI information is currently available in alternative formats/other languages • Other information can be translated/reformatted upon request • Information in alternative formats /other languages can be sourced through the Patient Information Manager 	2	LTC Action team to link with Stakeholder Engagement process	Shona Welton/ Arlene Campbell	Ongoing

	Objective	Evidence	Current Value	Action	Responsible Person	Timescale
2.3 cont		<ul style="list-style-type: none"> • Disability Engagement Group - Communications Sub Group (<i>Chaired by the Patient Information Manager</i>) established February 2008 to explore and address the communication requirements of people with additional communication needs. • Action focussed workplan includes - <ul style="list-style-type: none"> • Development of an accessibility guide for staff (<i>forms part of the NHSL Customer Care Standards</i>) • Hint's and Tip's guide for staff • Development of a Firstport site which will become essentially a toolkit for staff engaging with people with different communication support needs • Database of information for people with a learning disability and their family/carers • Staff awareness and training. • NHSL Customer Care Standards (<i>Final Draft</i>) which includes guidance on all aspects of outgoing correspondence <ul style="list-style-type: none"> - Written information & posters - E-mail correspondence - Briefings/ bulletins • Web based information 				

	Objective	Evidence	Current 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.	2	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.	2	To recognise carers as 'partners in care' and continuously improve practice and documentation, and include in training needs analyses for LTC's to be undertaken by LTC Action team.	Janette Barrie	Ongoing
2.6	Patient-held care plans are used and include individualised self management tools.	Some disease specific examples exist for Diabetes and Stroke. Patients under care & treatment orders.	2	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

	Objective	Evidence	Current Value	Action	Responsible Person	Timescale
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, Pain Association Scotland, Arthritis Care, Lanarkshire Links, Cumberland Action for Care of the Elderly. Carer support via Princess Royal trust for Carers, Carer's network South and Carers Together North.	2	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
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. Work with the Carers organisations is ongoing - community outreach Key Workers, coordinators in the Acute setting etc Community projects - i.e Well Man/ health bus also promote a number of self management strategies. See appendix III Introduction of Carers support team will identify Carers, their individual needs and ensure continuity and consistency of information.	1	Review current approach, undertake an accessibility review and stocktake to develop a strategic approach for implementation across organisations. 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 (<i>Big Lottery bid</i>) and co-ordinate with the Public Health Practitioners and MCN activities.	Shona Welton/ Arlene Campbell	March 2008

Standard 2: Current Values sub total: 15

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

	Objective	Evidence	Current 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. The evaluation of the Care Management pilots will provide valuable learning in this regard and will inform future practice in Lanarkshire.	2	Develop frameworks, policies and clear specific role descriptions to ensure seamless care such as keep well and integrated care management.	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 Carlisle, 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.	2	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 & Helen Edmond	Commence Sept 07
3.3	The CHP has a range of services include; 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.	2	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

	Objective	Evidence	Current 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.	3	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	Completed by 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.	2	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 & Cathy Dunn	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. Roll-out of care management underway.	2	Evaluate & roll out successful elements such as the implementation plan for the Winter planning.	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.	2	Medical Service to Care Homes being established and piloted in EK. A Review of Early supported discharge and rapid response teams is underway by Mr Roy Garscadden.	Dr Shiona Mackie	May 2007

Objective	Evidence	Current Value	Action	Responsible Person	Timescale
3.8	<p>Clinicians use common functional outcome measures</p> <p>AHP's use a variety of outcome measures e.g. Elderly mobility score, functional reach, modified river mead.</p> <p>The Rehabilitation Framework group is now underway Chaired by Peter McCrossan and has as a sub group Chaired by Jim Wright and Senga Cree developing a Falls and Bone Health Strategy for consideration at NHSL. This will detail the pathway of care for falls and bone health and bring a consistent, high quality and evidence based service across Lanarkshire.</p> <p>The Intermediate Care Capability framework is currently out for national consultation. This will guide development of intermediate care services and associated multi-agency teams</p>	3	<p>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.</p>	Peter McCrossan/ Anne Hendry	March 2008

Standard 3: Current Values sub total: 17

Standard 4 - Interdisciplinary Education and Training

	Objective	Evidence	Current Value	Action	Responsible Person	Timescale
4.1	Generic approaches to management of long term conditions are included in condition specific CPD programmes.	<p>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.</p> <p>A Primary Care Practice Development Practitioner and a Nurse Consultant for Long Term Conditions have been appointed. Each of their roles encompasses practice development in long term conditions ensuring that all training and development programmes that are developed and delivered focus appropriately on long term conditions. In addition the NES project on intermediate care mentioned above has been incorporated within the umbrella of practice development.</p>	3	Review current approach and develop a CPD strategy to continuously improve the management of Long Term Conditions.	LTC Action Team, Practice Development Centre/NHSL Organisational Development Team	Ongoing
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 District Nurse/Homecare staff interface.	3	In developing a CPD strategy this will ensure a whole systems approach is utilised including interagency and interdisciplinary CPD requirements.	As above	Ongoing

	Objective	Evidence	Current Value	Action	Responsible Person	Timescale
4.2 <i>cont</i>		<p>While the practice Development Centre focuses its education and training provision on meeting the needs of AHPs, Midwives and Nurses (<i>and their support workers</i>) these are usually on a multidisciplinary basis with uni-disciplinary approaches taken when absolutely necessary. The Practice Development Centre has recently collated a return to NES on interagency training which indicated a wide range of interdisciplinary learning occurs across long term conditions.</p>				
4.3	<p>There is affiliation with learning networks to support best practice, which includes NHS Health Scotland, NHS Education for Scotland and academic centres.</p>	<p>The Practice Development Centre continues to link with the Scottish Executive, NES, NHS QIS and NHS Health Scotland in national education projects such as the review of the role of the Charge Nurse and support worker regulation all of which have implications for improving services to patients including those with long term conditions. In addition links are made as required with Further and Higher, and other education providers to maintain or establish learning programmes pertinent to long term conditions (<i>for example support worker development, CPD modules in pain management, advanced physical assessment, care management</i>)</p>	3	Further develop the network within a long terms conditions context.	As above	Ongoing

	Objective	Evidence	Current Value	Action	Responsible Person	Timescale
4.4	<p>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 term conditions that includes improvements in access to education and training.</p>	<p>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.</p> <p>The Practice Development Centre continues to support actions identified within long term conditions learning plans. This may be through advice and guidance on nature and design of programmes (<i>eg care management</i>), direct delivery (<i>eg clinical skills</i>), or commissioning (<i>eg advanced physical assessment</i>). In addition the Practice development centre procured a major investment from NES in respect of a practice development strategy for primary care that included long term conditions (<i>to support eg, minimal intervention training, suicide prevention training, and nurse prescribing</i>)</p>	2	<p>Once established the Long Term Conditions Action Team will do a Training Needs Analysis and further develop the training plans in partnership with key stakeholders and the Practice Development Centre.</p>	LTC Action Team	Ongoing
4.5	<p>Patients and carers participate in the development of educational material and in the planning and delivery of training.</p>	<p>Through the MCN patient groups work has commenced to review and audit patient information and education materials. Appendix III</p> <p>The Practice Development Centre actions do not draw directly upon patient and public feedback but are based on indirect feedback gained from other fora, surveys, complaints and incident reporting to ensure responsiveness to patient and carer need at all times.</p> <p>Values based training is being planned for Mental Health Nursing.</p>	2	<p>Extend current approach to include the planning and delivery of training.</p>	<p>MCNs</p> <p>Practice Development Centre</p>	Ongoing

	Objective	Evidence	Current Value	Action	Responsible Person	Timescale
4.6	The plan includes training which equips staff to empower patients and carers in self management.	Values based training is being progressed nationally and we will work within that development ensuring all targets are met.	1	Implement values based training for key staff to support patient and carer empowerment. Develop and implement a carers education programme to support self management.	MCNs	Ongoing
4.7	Training covers issues of diversity and capacity, and the promotion of psychological, mental and emotional wellbeing.	The Practice Development centre does not offer specific training in these areas but all are underpinning principles of all practice development interventions, witnessed through the recognition of the need to address improvement in therapeutic relationships with patients, including those with long term conditions.	1	Continue to implement values based training mentioned above, for key staff to support patient and carer empowerment.	MCNs Practice Development Centre	Ongoing
4.8	The CHP participates in local and collaborative research to evaluate models of care for managing long term conditions.	Links have been maintained with the Research Consortia and priorities for research established through NMAHP R & D group which included reference to long term conditions. Work is also underway to evaluate Care Management, COP Team and Keep Well pilots.	2	Link outcomes of the research generated by the Consortia into the implementation of the Long Term Conditions strategy.	As above	Ongoing

Standard 4: Current Values sub total: 17

Standard 5 - Information and Intelligence

	Objective	Evidence	Current 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	a) Information systems identify people with specific diseases b) and with multiple long term conditions.	a) SPARRA data is currently being utilised to target those most in need of Care Management. GP information technology systems such as GPASS currently recording disease registers as per the GMS contract. b) No GP IT system is capable of identifying Co-morbidity.	2	Continue to work closely with the Delivering For Health Information Programme to establish local mechanisms within GP IT systems to under take this task.	a) Anne Armstrong b) E health clinical delivery group	a) Achieved b) 2009/10
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 purposes.	Joint documentation and protocols exist for Single Shared Assessment, Integrated Day Care Centre, accessing services such as Home Care and the Joint Equipment Store.	2	Further develop a pan Lanarkshire approach based on examples of current good practice. Continue as outlined	Data Partnership Board	March 08

	Objective	Evidence	Current 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. See Appendix III	3	Through Carers organisations raise awareness of this process within the Community. Continue to include in Single Shared Assessment process.	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.	2	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.	3	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: Current Values sub total: 16

Standard 6 - Quality and Delivery

	Objective	Evidence	Current 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.	3	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, incorporating emerging best practice / evidence i.e. Care Management pilots will be rolled out, Keep well. Practice will be guided by SIGN guidelines, NHS QIS, best practice statements, Peer reviewed research, and patient opinion and experience.	3	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,	3	Make the necessary links; form the Long Term Condition Action Team into reporting mechanisms.	Roy Watts/Stephen Kerr with links to LTC Action Team	Ongoing
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

	Objective	Evidence	Current Value	Action	Responsible Person	Timescale
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.	3	Continue to utilise current system/mechanism 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 Team 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 - April 08
6.7	The CHP long term conditions action team prepares an annual report, using the self-assessment tool kit, against their plan.	Reporting into the Modernisation Board and the CMT through the Primary and Community Care Modernisation process and the strategic redesign project on Long Term Conditions.	3	Produce annual report. This work will become integral to the CHP Management Committees as they utilise the new nursing structures and reporting systems.	Anne Armstrong	April 2008
6.8	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.	This will feature through Modernisation, CHP Management Committees and NHS Board Level.	0	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

	Objective	Evidence	Current Value	Action	Responsible Person	Timescale
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.	2	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.	3	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: Current Values sub total: 25

Long Term Conditions: NHS Lanarkshire Profile

	Maximum Value	Subtotal Year 1	Progress to 31/07/07	Total Year 1 31/03/08
Standard 1: Organisation of Long Term Conditions Management	24	15	21	22
Standard 2: Patient Information and Supported Self Care	24	9	12	15
Standard 3: Service Design and Multi-disciplinary/ Multi-agency working	24	8	15	17
Standard 4: Interdisciplinary Education and Training	24	8	11	17
Standard 5: Information and Intelligence	24	12	13	16
Standard 6: Quality and Delivery	30	15	23	2
Total Score	150	57	95	112

Terms of Reference:

NHS Lanarkshire Long Term Conditions Action Team

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
- ❖ NHS Lanarkshire Carer Information Strategy

Chairperson

Anne Armstrong: Nurse Director Community & Primary Care

Membership

- ❖ CHP Lead GP - Long Term Conditions
- ❖ Change and Innovation 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 - Intermediate Care
- ❖ Project Lead - Anticipatory Care
- ❖ Clinical Effectiveness Representative
- ❖ Local Authority Representative - North
- ❖ Local Authority representative - South
- ❖ Associate Director - AHPs
- ❖ Children's Services Representative
- ❖ NHS Lanarkshire acute Division Representative

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 Strategy Programme Board, (*Programme Board 2*) providing regular progress reports as required. This will include endorsement and review of the Groups work programme. Sub Groups established to progress work streams will provide a regular report outlining progress at each of the Action Teams meetings. This will include exception reporting outlining activity to ensure timeous implementation of the strategy.

MCNs will provide the Long Term Conditions Action team with one page updates on work progress on a regular basis.

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.

Update on NHS Lanarkshire Long Term Conditions Action Plan



The following comments are an update on the Long Term Conditions Action Plan with a focus on the meaningful involvement of North Lanarkshire Carers Together.

<p>Objective 1.7</p>
<p>NLCT has representatives on the Health & Care Partnership and the four North Lanarkshire Partnership Boards. We are also represented on the North Lanarkshire Public Partnership Forum Reference Group and our Development Manager is currently planning Health Issues in the Community Training with this group to ensure involvement is focussed on a community development approach.</p>
<p>Objective 2.2</p>
<p>As part of the Carer Information Strategy a five person Carer Support Team was recommended. The post within South Lanarkshire Carers Network was filled in January 2008. The part time seconded post with our organisation has been advertised on NHS Lanarkshire intranet and the three part time Carers Coordinator posts are currently being advertised. These posts are now for four days per week.</p> <p>Due to the delay in implementing this initiative “once off slippage money” became available and North Lanarkshire Carers Together has been successful in accessing funding for a Carer Coordinator/Trainer to identify, train and support carers to become actively involved in this joint work with NHS Lanarkshire and North Lanarkshire Council and to train “Expert Carers” to take this work forward when this funding ends.</p>
<p>Objective 2.5</p>
<p>NLCT is truly focussed in ensuring that carers are recognised as “key partners in care” and welcome any initiative that encourage and support this practice.</p>
<p>Objective 2.7</p>
<p>NLCT and our colleagues in South Lanarkshire Carers Network ensure that any information relevant to carers is disseminated throughout the relevant authority therefore it is important that both organisations are kept up-to-date on developments and new initiatives.</p>
<p>Objective 2.8</p>
<p>Ensure that, while undertaking a review of outreach services, there is a link with NLCT as we have input in various rural areas of North Lanarkshire.</p>

**Update on NHS Lanarkshire
Long Term Conditions Action Plan *cont'***



Objectives 4.5 & 5.3

NLCT has current input to Single Shared Assessment and Carer Awareness training as well as GP Clinical Fora. We are also involved in social work student induction training and have “signed up” to take student placements for four days within our organisation thus ensuring staff are aware of the key role of carers and the benefits of including them at all levels of the planning, consultation and assessment process.

Objective 5.5

It is planned that the seconded worker with NLCT will develop good links with the person in each GP surgery responsible for the Carers Register and link with the Carers Coordinators within each of the Acute Hospitals to provide a seamless approach to the identification of carers and the provision of good quality and up-to-date information.

Since the initiation of the Scottish Enhanced Service, and carers being one of the three priorities in this initiative, this will further enhance and support the initial work undertaken by our organisation as a result of the Direct Enhance Service.

