Strategic Framework
for the Management of Long Term Conditions

Delivering Change to 2015

Health care systems worldwide are faced with the challenge of responding to the needs of people with chronic medical conditions such as diabetes, heart failure and mental illness"

World Health Organisation, 2002

CONTENTS

1. OVERVIEW

1.1 The Imperative for a New Approach to Care

A long term condition can be defined as a condition that:

"requires ongoing medical care, limits what one can do, and is likely to last longer than one year"

The management and care of people with long term conditions has been described by the World Health Organisation as "the health care challenge of this century".

It has been estimated that 78% of healthcare resources are attributable to people living with long term conditions. In the 1988 Scottish Health Survey, 40% of the population of Scotland indicated that they had a long term illness or disability. In addition, around a quarter of people in the UK with a long term condition have three or more problems.

The number of chronic diseases in people with long term conditions increases with age. In the 65-74 age group, the average number of chronic conditions is 1.7. While it is considered to be the case that by 2025 many long term conditions will be prevented by advances in preventative health care and by health education measures, nevertheless because of the anticipated increase in the elderly population, the proportion of the population suffering from long term conditions will increase.

Patients with long term conditions account for a high percentage of all GP consultations - they are twice as likely to be admitted to hospital and experience longer hospital stays when they are admitted.

A further major driver for our focus on long terms conditions is the extent to which their impact is both unequally distributed across our populations, closely related to deprivation, and the extent to which long term conditions also cause inequalities between those with such conditions and those without. Finally, many long term conditions will create access and wider equalities challenges in relation to the way we deliver health services.

Given these inequalities issues, increasing demand, and the societal impact of long term conditions, there are significant implications for healthcare resources. It is imperative that available resources are targeted so as to optimise their effect on long term conditions while simultaneously minimising their impact on other healthcare demands.

1.2 Our Approach

This paper presents the Long Term Conditions Strategy Framework for NHS Greater Glasgow and Clyde (NHSGGC).

The Framework has been developed by the LTC Steering Group and has been subject to wide consultation. It provides a direction for the planning and delivery of change across our organisation and will be developed and implemented in alignment with our Frameworks for Primary Care and Rehabilitation.

The overall aim of our strategy is to improve the health and well being of people with long term conditions; to keep people as healthy as possible for as long as possible and so reduce the incidence and impact of long term conditions. Achieving this overall aim, through this Framework will be critical to achieving our wider organisational purpose which is:

> **"to deliver effective and high quality health services, to act to improve the health of our population and to do everything we can to address the wider social determinants of health which cause health inequalities."**

The core of the Framework comprises:

- a model for the provision and management of care and support for people who live with long term conditions;
- the key components of each level of the model, together with the workforce, information technology and associated implications associated with the implementation of this model;
- setting out the organisational arrangements to deliver the required transformational change.

We have incorporated into this Framework NHSGG&C Long Term Conditions Collaborative programme - our response to the national LTC Collaborative programme.

The diseases the Framework covers are listed in Section 5. Mental health and issues specific to child health were not considered but the Framework provides a foundation that can be tailored to meet the specific needs of child health by the appropriate planning processes. For mental health there is a link into the mental health planning process.

This Framework provides a basis for action across our system with Acute Services, our Partnerships, our Managed Clinical networks (MCNs) and Planning Groups all having a part to play to drive the change which is required and which will need sustained effort over a number of years to achieve the aims which we have set out.

An update of the Framework will be produced each year as part of the wider planning process.

1.3   What we are aiming to achieve through our LTC Model of Care?

Our overall aim is to provide the best quality care within finite resources. The active management and co-ordination of care involving health, local authority and voluntary organisations will enhance the quality of care provided as well as minimising the need for health interventions.

We aim to:

- encourage people to be more in control of their own health and well being;
- shift the balance of care through a reduced and more appropriate access to secondary care and by increasing access to care in community settings. We will encourage greater partnership between all the agencies involved in the provision of care, egg, GPs, pharmacy, patients, carers, social work and the voluntary sector;
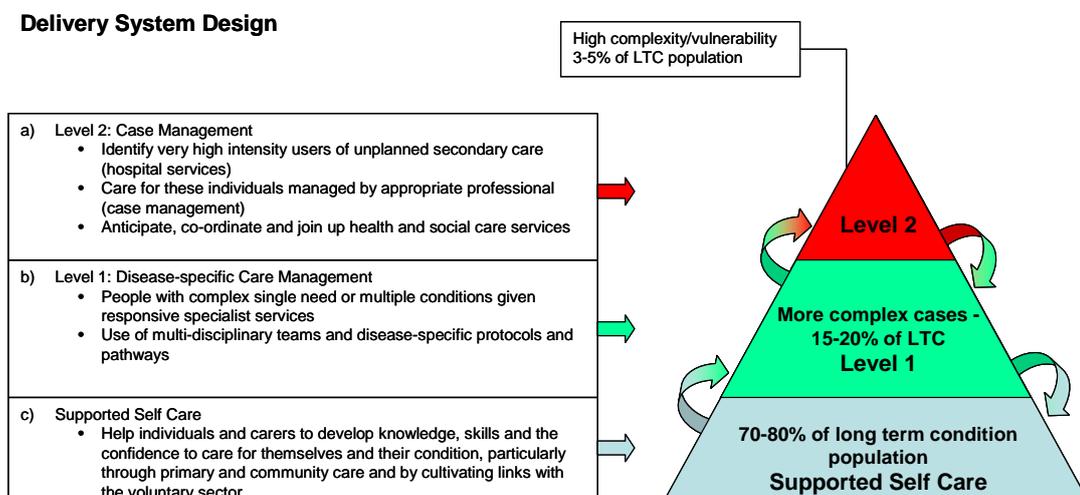
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- reduce the healthcare resource burden, by having fewer and shorter hospital admissions. The incidence and impact of long term conditions will be reduced by an individual linking with the appropriate healthcare person to head off potential crises in their condition. Admissions will be shortened by having links to the appropriate expert services (such as the early supported discharge team for COPD) triggered at admission. A care management approach to the management of long term conditions has been demonstrated to have a positive impact on quality of life, severity of symptoms and reduction in acute bed usage;
- address the social, psychological and emotional aspects of being diagnosed and living with a long term condition, which can be considerable. By encouraging greater partnership between health and social care, the areas of employment, housing, transport and benefits, we will seek to minimise the societal impacts arising from long term conditions;
- reduce the inequalities which are created by long term conditions, address the equality challenge they create in relation to health services and tackle the differential impact of long term conditions on our population.

1.4   Proposed Model of Care

This Framework sets out the direction for the development of services to meet the needs of NHSGG&C resident population affected by long term conditions. It describes the interventions and support required along the care pathway in order to provide the most effective management of care.

The model of care that is proposed, incorporates a "framework" of standards - an overarching approach - and outlines the various elements that contribute to the levels of care needed to care for people with long-term conditions most effectively, depending on their individual circumstances.

The long term conditions model of care, shown below, stratifies the population by risk, and thus by their requirements for care, into distinct levels to identify and match up the appropriate levels of care.

Delivery System Design

High complexity/vulnerability
3-5% of LTC population

a)   Level 2: Case Management
- Identify very high intensity users of unplanned secondary care (hospital services)
- Care for these individuals managed by appropriate professional (case management)
- Anticipate, co-ordinate and join up health and social care services

b)   Level 1: Disease-specific Care Management
- People with complex single need or multiple conditions given responsive specialist services
- Use of multi-disciplinary teams and disease-specific protocols and pathways

c)   Supported Self Care
- Help individuals and carers to develop knowledge, skills and the confidence to care for themselves and their condition, particularly through primary and community care and by cultivating links with the voluntary sector

Level 2

More complex cases - 15-20% of LTC
Level 1

70-80% of long term condition population
Supported Self Care

1.5   Model Components

The Framework incorporates a foundation level of **Supported Self Care** in conjunction with two additional levels of interventions through which care will be delivered:

- **Level 1 Disease-specific Specialist Care Management;**
- **Level 2 Complex Care Management.**

The provision of Supported Self Care is a key underpinning holistic approach to care which involves the encouragement of a greater partnership between health, social work, community partners, carers and the voluntary sectors. The aim is to encourage individuals to cope and live well with their condition by equipping them, and their carers, with the necessary knowledge, skills and confidence.

Level 1 Disease-specific Care Management targets people with complex single need or multiple conditions with information, monitoring and proactive management. The aim is to slow down deterioration and prevent complications necessitating the need for admission to hospital.

Level 2 Complex Care Management involves the identification of the very high intensity users of unplanned secondary care - people with frequent admissions for one or more long term condition. The aim is to identify and anticipate the care requirements of this more complex group of patients and co-ordinate a multidisciplinary, multi- agency if required, care package to prevent emergency situations leading to admission.
Each of these interventions is outlined in more detail in Section 4.

1.6   Delivery of the Framework: How it all Fits Together

Delivering the aims which this Framework sets out will require action and change across our whole system. Section 4 sets out in more detail the responsibilities of the different parts of our organisation. At headline level:

- the LTC Steering Group will monitor the progress on the delivery of the model of care and will ensure that further cross system work is identified and taken forward, particularly in relation to the work streams of information, care management and self care. The group will also initiate any coordinating activity required across our system; will ensure communication and connection of the different strands of work, and will ensure that our planning and priorities guidance provides further and up to date direction;
- the MCNs and planning groups will develop and support the models. These groups have membership from across our system and include the interest groups relevant to a particular condition. Each MCN and planning group is assessing the current management of long term conditions against the key actions required for each tier identified in our LTC model of care. These actions are outlined in detail in section 6 of this document;
- the Partnerships and our Acute services will develop their change and action programmes to deliver the aims in this Framework. These will be reflected in their development plans and performance frameworks.

Each year the LTC Steering Group will create a whole organisation opportunity to review progress and share practise and develop the programme of work further.

1.7   Resourcing the Framework

The Framework does not include a financial plan, the delivery of care to people with long term conditions requires a substantial proportion of NHS resources, in acute and community services and in primary care. Greater Glasgow and Clyde is already a higher spender on elements of these services than is the NHS norm, for example, in our investment in enhanced services provided by GPs. The focus of the Framework is the reshaping and shifting of resources to achieve more effective use. To support that objective we have established a programme budgeting review of three key diseases covered by the Framework. This will enable us to see the full picture of where resources are presently deployed and to plan shifts in those resources to match the changes we want to achieve.

1.8   Information and Information Technology

Having effective communication and information systems in place are absolutely key to deliver effective management of long term conditions. In order to provide co-ordinated care, we need to have real time access to information on care management patients.

We also need ready access to key baseline data and information in order to understand the profile and needs of individuals with long term conditions across our Community Health (and Care) Partnerships (CH(C)Ps). Identifying information needs and issues and areas that need to be developed and strengthened are addressed in Section [10]. Some of these issues are best managed through a generic approach as opposed to within disease specific planning groups and will therefore be taken forward by the LTC Steering Group. A short-life working group has been established reporting to the Steering Group to develop this work programme.

2.   NATIONAL POLICY AND LOCAL CONTEXT

2.1   This section describes the national policy for long term conditions and the local context in which this Framework has been developed.

2.2   **National Policy.** Better Health Better Care, the Scottish Government's Action Plan for health and health services, has a strong focus on long term conditions, building on previous commitments in Delivering for Health.

It highlights the need to improve prevention, identification and treatment of long term conditions and the major contribution this has to improving health and reducing inequalities.   It commits to ensuring that work on long term conditions is driven by the experience of those who live with the conditions or are carers, and in partnership with the voluntary sector.

National policy promotes the continued development of anticipatory care, supported self care and self management and the central role of CH(C)Ps in developing community services and shifting the balance of care. It aims to make integrated care management approaches more consistent and widespread across Scotland. It also highlights the importance of effective patterns of consultation in primary care for those

with one or more long term conditions, and the further development of tools to identify and support those at highest risk of admission to hospital.

Better Health Better Care introduced a number of new HEAT targets relating to long term conditions which are set out in more detail in the performance section of this strategy. The establishment of the LTC Collaborative has further underlined the national importance of improving the management of long term conditions.

2.3 **Long term conditions affect very large numbers of the population.** In Britain, six out of ten adults report having a long-term condition that cannot currently be cured - and people with long-term illnesses are often living with more than one condition, making their care even more complex. 80% of primary care consultations and two thirds of emergency hospital admissions in the UK are related to long-term conditions.

2.4 **The prevalence of long term conditions is set to rise over the next few decades.** Major health gains experienced over the last few decades coupled with ever increasing advances in medical science have resulted in people living longer lives. The population in Scotland is both ageing and declining. The proportion of Scots aged over 65 is predicted to increase from 15.9% in 2001 to 26.6% in 2031. Because there is an association between increasing age and risk of developing a chronic condition, long term conditions are set to place an ever increasing demand on our healthcare resources over the next 25 years. The challenge is to delay the onset of long term conditions with their associated illness and loss of function.

2.5 **Long term conditions have a huge impact on quality of life, independence and economic wellbeing.** Having to deal with a long term condition, often with distressing symptoms or side effects of treatment can place intolerable stress on family, social and work life. Over 2 million people in the UK are dependent on benefits as a result of being unable to work due to a long term health problem. The total effects on the country as a whole are enormous. The World Health Organisation estimates that the UK loses $33 billion as a result of premature death and disability associated with heart disease, stroke and diabetes alone.

2.6 **The psychological aspects** of dealing with a long term conditions can be considerable, varying from dealing with personal response to the disease; coping with treatment; feeling of lack of personal control and handling the responses of others. It is important that the psychological repercussions of long term conditions are factored in to the provision of care for the patient.

2.7 **The effects of long term conditions can be minimised or their impact reduced.** It is estimated by the World Health Organisation that around 80% of premature heart disease, stroke and type-2 diabetes could be prevented by eating a healthy diet, taking regular physical exercise and avoiding use of tobacco products. Helping people to adopt lifestyle changes therefore has enormous potential to reduce an individual's risk of developing a long-term condition or to reduce the impact it has on his or her life.

2.8 **Long term conditions therefore have major consequence for NHS resources** particularly where people have multiple problems. Around 80% of all consultations at GP practices are for care of LTCs. Patients with an LTC or complications of their disease account for around 60% of all hospital bed days. The cost of care increases dramatically once someone has multiple diagnoses - it is estimated that people in this category have care which costs six times as much as people who have one illness.

2.9 **Ageing Population and demand for LTC care**. Major health gains experienced over the last few decades coupled with ever increasing advances in medical science have resulted in people living longer lives. However, gains in life expectancy have not been matched with healthy life expectancy, with the result that people tend to live for a longer period with a limiting long term condition. Public health advances together with social setting improvements linked to better housing, sanitation and diet have resulted in more people surviving longer and moving from infection related morbidity and mortality to conditions associated with ageing. Although the above mentioned public health advances have been momentous, other changes in the public health over the nearer past have resulted in a more inactive, heavier population, consuming more tobacco and alcohol and with higher levels of stress.

The major challenge facing health systems now is how best to support people with long term conditions. In addition, because of the demographic situation in Scotland, with our ageing population, long term conditions are set to pose an increasingly strong challenge to our healthcare systems.

2.10 **Local Context - Setting the local context.** NHS Greater Glasgow and Clyde (NHSGGC) is the largest health board in Scotland (population 5,144,200) and includes some of the most deprived areas in the country. The total resident population of NHSGGC was recorded by GROS as 1,192,419 in mid-June 2007.

Greater Glasgow and Clyde comprises ten CH(C)Ps. Table 1 below shows the GGC CHCP population figures for 2006 (CH(C)P population figures for 2007 not available until Data Zone information is updated).

Table 1: Community Health (and Care) Partnership Populations 2006

9

CH(C)P Name	Total Population	Male Population	Female Population
Scotland	5116900	2469407	2647493
Renfrewshire CHP	169590	80948	88642
West Glasgow CHCP	138856	67339	71517
East Glasgow CHCP	123824	58574	65250
South West Glasgow CHCP	116580	55544	61036
East Dunbartonshire CHP	105460	50859	54601
South East Glasgow CHCP	101476	49538	51938
North Glasgow CHCP	99954	47640	52314
West Dunbartonshire CHP	91240	43223	48017
East Renfrewshire CHCP	89290	42540	46750
Inverclyde CHP	81540	38901	42639

2.11 **The impact of long term conditions.** Information derived from the 2001 Census data indicates that 20% of the population of Scotland reported a limiting long term illness or disability. Table 2 shows that the figures for Glasgow range from 16% to 30%. These figures need to be considered against the fact that Scotland's population is both ageing and declining, predicted to move from its current 5.05 million to 4.75 million by 2030.

Table 2: % Population with Limiting Long Term illness Census (2001)

| CH(C)P	All People	With a Limiting Long-term Illness	
		Number	%
East Glasgow CHCP	127,556	37,977	29.8
North Glasgow CHCP	99,821	27,731	27.8
South East Glasgow CHCP	101,176	23,177	22.9
South West Glasgow CHCP	115,356	30,842	26.7
West Glasgow CHCP	133,960	31,418	23.5
Glasgow City	577,869	151,145	26.2
East Dunbartonshire	108,243	17,938	16.6
West Dunbartonshire	93,378	21,189	22.7
Inverclyde	84,203	19,006	22.6
Renfrewshire	172,867	36,272	21.0
East Renfrewshire (pt)	87,657	13,993	16.0
NHSGG&C	[1,124,217]	[259,543]	

In addition, the numbers receiving attendance allowance/benefits through not being able to work as a result of incapacity from a long term conditions demonstrates the wider socio-economic burden of long term conditions which is immense.

Table 3 below shows the percentage of adults who have indicated that they are unable to work due to illness or disability. Clearly, the impact on the NHS and social care, voluntary organizations and other local authority services for supporting people with long term conditions is very significant.

Note: Limiting long-term illness covers any long-term illness, health problem or disability which limits daily activities or work a person can do.

Approximately 98% of the population of East Renfrewshire CHCP, 5% of North Lanarkshire CHP and 18% of South Lanarkshire CHP are served by NHSGGC

Table 3: Percentage of Adults unable to work due to illness/disability
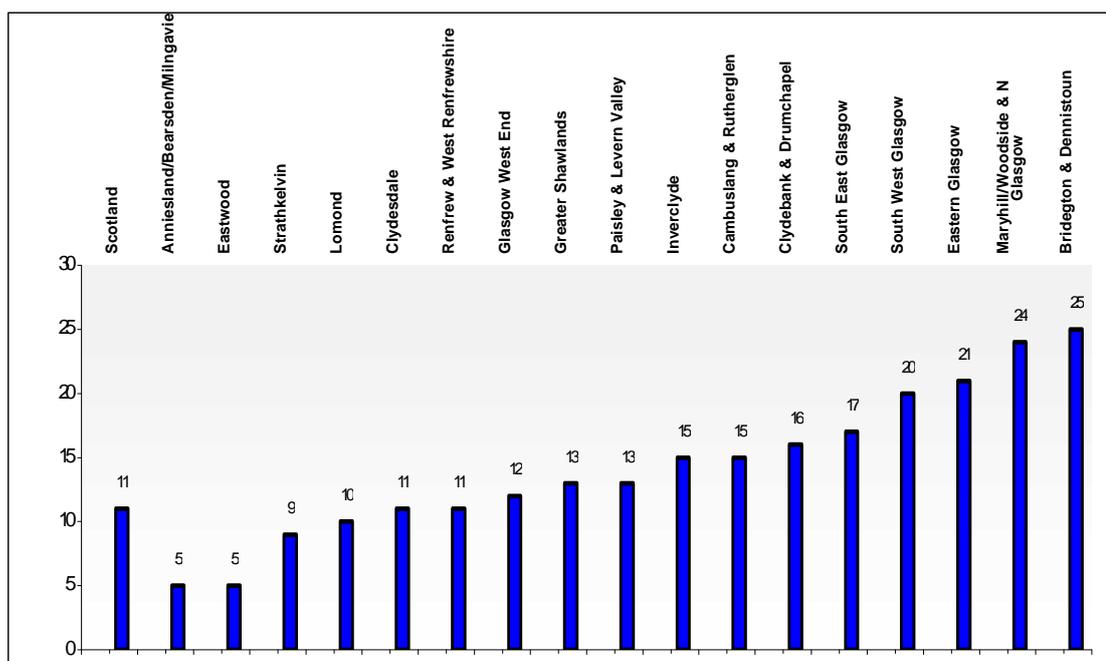
2.12   Mortality and morbidity.   Heart disease, cancer, stroke, chronic obstructive pulmonary disease, kidney disease and chronic liver disease account for some three quarters of all deaths in Scotland.

Smoking, poor diet and lack of activity account for two thirds of premature deaths in Scotland. Tobacco for example is linked to several of the chronic diseases that make up the leading cause of death - heart disease, stroke and chronic respiratory disease. Poor diet and lack of activity are also associated with heart disease, diabetes and stroke. There is also a well studied phenomenon indicating that there is excess mortality in Rheumatoid Arthritis related to premature cardiovascular disease.

An even greater driver of health care costs is morbidity. Long term conditions causes disability and adversely affects the ability to cope with day to day living - very often over long periods of time.   The commonalities of coping across many of the long term condition morbidities demands a more generic approach to long term condition self management, one that provides for the management of co-morbidities**.**

Around a quarter of people with a long term condition have three or more problems. 42% of people with three or more chronic diseases have activity limitation. The number of chronic diseases in people with long term conditions increases with age. In 65-74 age groups the average number of chronic conditions is 1.7.

3.   HEALTH INEQUALITIES AND LONG TERM CONDITIONS

3.1   The health of the Scottish population as a whole has been improving. However the health of some groups of society has either improved more slowly or in some cases deteriorated in real terms.   Health inequalities can be described as differences in health status between different subgroups of a population resulting from differential health needs based on individual circumstance (e.g., gender, deprivation), life stage (i.e. age) or as a result of a significant life event (e.g. homelessness or abuse).

3.2   There are a wide range of interlinked influences on health inequalities. The additional risk posed to an individual's health by lifestyle choices such as smoking, excessive alcohol consumption, poor diet and physical inactivity are widely accepted, however, an explicit acknowledgement of the association between these behaviours and socio-economic factors is required.

3.3   In Scotland in 2001 mortality rates recorded for men aged 20-59 in routine and semi-routine occupations were 3.7 times those in professional and managerial occupations (Ref: 1). These socio-economic effects are mediated not only by occupational status but also by other factors such as low income, poor educational attainment, and low levels of literacy, social exclusion and isolation.

3.4   In 2005 the Greater Glasgow Health and Well-being study recorded that socially excluded people were more likely to attend accident and emergency and to be admitted to hospital and those who felt isolated from family and friends were more likely to access outpatient services than the general population (2). These factors along with their impact on the material environment, such as exposure to hazardous working and living environments and poor access to services and transport, contribute to the impact of deprivation on health. For example those people living in deprived communities, living in housing association accommodation, with no qualifications, who are economically inactive, and feel socially excluded were less likely to feel safe walking around their local area (2).

3.5   In addition to lifestyle choices and life circumstances, ethnicity also has a direct effect on health inequalities. The incidence of type II diabetes has been shown to be as high as 8% in South Asian population of Glasgow compared to 3% in the indigenous population. This figure rises to as high as 40% in the South Asian 70+ age group (5). Diversity involves recognition that everyone is different and has different educational, cultural, physical, psychological and emotional needs.

3.6   The impact of health inequalities on long term conditions closely follows the pattern of the effects on general health. Higher prevalence rates for coronary heart disease, stroke, diabetes and COPD are recorded in areas of deprivation than in more affluent areas. In 2005 (2), it was recorded that those living in the most deprived parts of Greater Glasgow (Deprivation Category 6/7) were almost twice as likely to report that they have a long-term limiting illness (26%) than those living in the least deprived parts (DEPCAT1/ 2: 14%).

3.7   This trend was also evident for other socio-economic measures such as housing type and qualification levels (2). Measures of social exclusion indicate 37% of those in receipt of Income Support reported having a limiting long-term condition or illness compared to 22% of the Greater Glasgow population as a whole (2). These figures have an impact on the demand for health care resources in certain geographical

areas and within certain groups but they also have a wider impact on the economic activity of those areas and communities.

3.8   On an individual level it is important to understand the consequences of the interaction of these factors in order to be aware of the persistent and enduring nature of health inequalities. For example, an individual who lives in a deprived area is more likely to have few or no qualifications which reduces the opportunity to be in well paid work or increases the likelihood of being unemployed, on benefits and experiencing social exclusion.

3.9   These factors in and of themselves may not directly cause ill health but they increase the exposure of that individual to other risks such as hazardous living and working conditions, poor housing and lack of access to transport which in turn will make it difficult to access public or health services.

3.10   Again, those from Black and Minority Ethnic groups, older people, and those with poor mental health or physical disabilities are likely to experience increased levels of chronic disease. In 2005 68% of those with poor mental health reported having a limiting long term condition or illness compared with 22% of the Greater Glasgow population as a whole (2). In some cases these circumstances compounded the individual's ability to engage in a healthy lifestyle therefore increasing the individuals risk of developing a long-term condition.

3.11   Once diagnosed with a long-term condition an individual is more likely to experience further health problems. The link between long-term chronic conditions such as diabetes, heart disease, stroke and cancer and increased levels of depression and anxiety is well documented. This can lead to a negative spiral of ill health, as poor mental health is a determinant of health inequalities. Chronic conditions can also interfere with an individual's ability to work, which in turn may influence levels of income, access to transport and services and lead to social exclusion. Overall long-term conditions can have an adverse effect on an individual's quality of life.

3.12   Planning for long term conditions must therefore consider the needs of:

-        groups with know health needs or subject to discrimination either by - race /gender/ disability/socio-economic/sexual orientation/faith;
-        groups at different life stages - all ages but particularly adults of working age and older people;
-        groups who experience life events that are likely to impact negatively on health - homelessness/bereavement/abuse/trauma or changes in personal circumstances such as divorce or job loss.

4.   ORGANISATIONAL ARRANGEMENTS FOR THIS FRAMEWORK

4.1   This section outlines the roles and responsibilities across our organisation to improve the management of long term conditions. NHSGGC is a very large, complex organisation. To achieve the necessary whole system changes and our aims for long term conditions will require all parts of the organisation to focus on this priority and to work together to achieve those aims. This Framework provides the basis for that whole system working to ensure coherence and consistency.

4.2   The Role of CH(C)Ps

CH(C)Ps have the key role in the delivery of improved management of care for long term conditions. This role is described in Audit Scotland's August 2007 Report "Managing Long Term Conditions" as follows:

CH(C)Ps are expected to bring together all involved in providing long term condition care in their area, for example general practice teams, community pharmacists, hospitals, social work, voluntary organisations, and patients and carers, and take a lead role in:

- taking a systematic approach to long-term conditions;
- easing access to primary care services;
- providing preventative care;
- supporting people at home;
- avoiding hospital admissions;
- identifying opportunities for more local diagnosis and treatment;
- enabling appropriate discharge and rehabilitation;
- improving health and tackling inequalities;
- improving specific health outcomes.

The development of CH(C)Ps across Greater Glasgow and Clyde with responsibility for primary and community services provides a different organisational context for long term conditions delivery and the ability for local joint work to develop services to meet local needs.   In East Renfrewshire and Glasgow City, integrated arrangements with social work provide further opportunities for service redesign and a more comprehensive approach to long term conditions, using a social model approach.

The most effective approaches will be those which respond to local circumstances and the Framework sets a strategic direction but with flexibility to allow CH(C)Ps to develop services which best meet local needs. In responding to this Framework, the CH(C)Ps will also make linkages to the planning and development of primary care and the implementation of the Rehabilitation and Enablement Framework.

4.3   The Role of Acute Services

Acute Services have a key role in the delivery of improved services for, and the management of, long term conditions. This role is in relation to developing a different approach to the direct delivery of acute care to people with long term conditions and working with the rest of our organisation to develop, change and improve the management of long term conditions across the health system.

The development of new models of hospital provision such as ambulatory care centres is a further opportunity for service redesign. Effective management of long term conditions across community and secondary care, and at the interfaces, will be essential to ensure that new acute models are effective and support change. In order to establish a joint Acute and Partnership focus on this Framework a short-life Acute Division/Partnership group will be established.

4.4 Disease-based Planning

Within NHSGGC there are a number of disease-based planning groups and managed clinical networks which aim to achieve services planned, managed and co-ordinated across prevention, diagnosis, treatment and care.

MCNs and planning groups will translate the broad principles of our model into detailed planning outputs to support changes to service delivery in acute and community settings. They will act as improvement champions for long term conditions. They will also ensure:

- **sharing of learning from patient and carer participation developed by MCNs.** The MCN process recommends a four tiered system of public and patient involvement, these being: Patient involvement, Patient Feedback, Patient and public information, Patient and community participation in services and their planning;
- **development of integrated patient pathways for long term conditions.** Integrated Care Pathways determine locally-agreed, multidisciplinary practice based on guidelines and evidence, where available, for a specific client group. It forms all or part of the clinical record, documents care given and facilitates the evaluation of outcomes for continuous quality improvement**.** Change the emphasis from acute episodic care to structured, proactive care using "bundles of care" where clinical evidence supports this;
- **embedding evidence based guidelines in integrated care pathways**. Evidence of good practice, guidelines and standards all provide a basis for assessing and reviewing the quality of care;
- **learning from the approach to supporting patient participation**, e.g., Hearty Voices, Chesty Voices;
- **Engagement with the voluntary sector groups to promote the quality of disease specific and generic patient information**. This can be provided in a number of ways, e.g., leaflets, face-to-face, as part of a support group, web page, peer support group or via telephone help lines. NHS 24 provides telephone and internet information which also contains a link to the on-line Health Library. The Long Term Conditions Alliance for Scotland provides contact details for voluntary sector organisations who can be contacted for disease specific support and information.

4.5 The LTC Steering Group

The remit of the Steering Group, which brings together representatives from across our organisation, is to oversee the implementation and development of this Framework. The Steering Group will:

- provide a focal point for our interface with the Scottish Government on LTCs;
- develop performance management for the Framework's implementation;
- commission specific whole-system programmes of work, for example, on supported care and care management, to support Framework implementation;
- ensure communication and connection across the organisation as the Framework is developed and implemented.

4.6 LTC Collaborative

The National Collaborative Programme for Long Term Conditions is a Scottish Executive sponsored three-year programme. The LTC Collaborative is one of the key elements in the national Better Health, Better Care Work-streams, and is intended to support local healthcare systems to implement improvements in the management of long term conditions. The rationale behind the Collaborative approach is the achievement of whole system change through the application of improvement methodologies in a small and systematic way, applying and testing small system changes along the improvement pathway.

It is intended that the implementation and delivery of our LTC strategic Framework will also deliver the national requirements and expected outputs for the LTC Collaborative programme. There are three national workstreams for the collaborative programme. These workstreams correspond and relate to the identified tiers in our LTC model of care.

The actions, responsibilities and timescales relating to delivery on each of these models of care are identified in the later sections of this document.

The programme management arrangements, the Collaborative workstreams and the links with other Collaborative programmes and NHSGG&C workstreams are shown in the diagram below:

Long Term Conditions Programme Management Arrangements
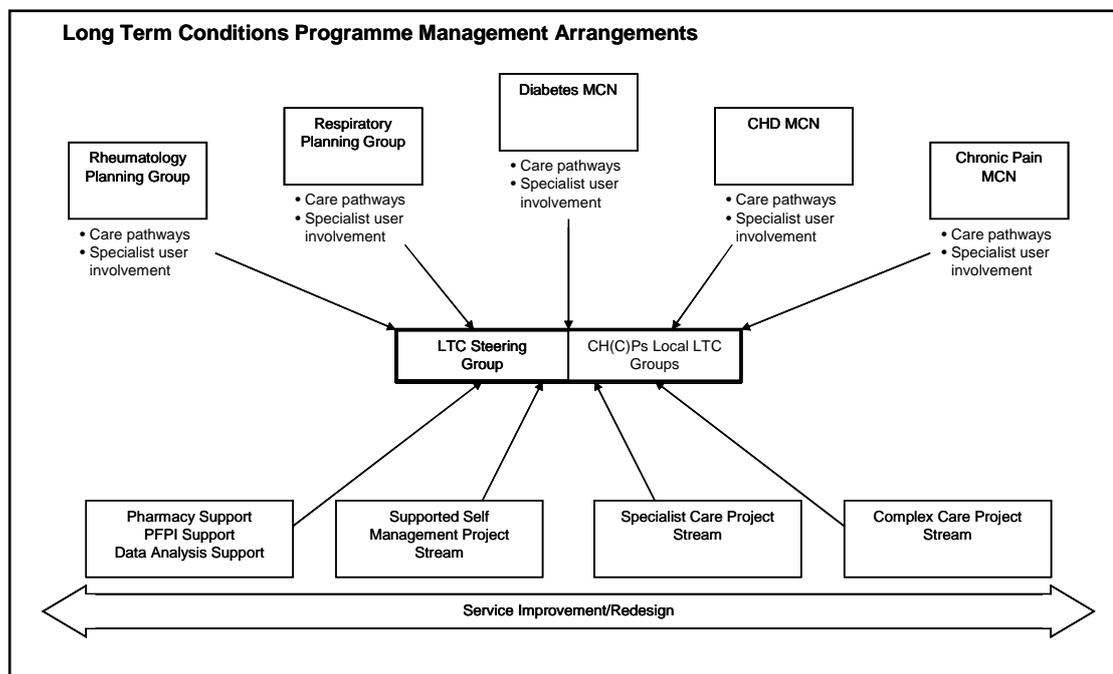
5.   THE AIMS AND SCOPE OF THE FRAMEWORK AND MODEL FOR CHANGE

5.1   NHS Greater Glasgow and Clyde is committed to improving the health of its population over the next 10 years by systematically tackling the effective management of long term conditions. Residents who are living with long term conditions will be supported to take greater responsibility for their own health and wellbeing; be informed about their condition but have access to specialist advice when appropriate. Services will be provided locally by multidisciplinary teams who

will use clear pathways of care. Organisations will work in partnership to ensure that all those with long term conditions are able to realise their potential.

We will achieve this vision by ensuring that the following building blocks of our Long Term Conditions Framework are in place:

- patients and carers as active participants in care; informed and fully involved in decision making about care, fostering a culture of self care and well being;
- decreasing dependency, increasing personal responsibility:
- a greater focus on effective preventative health care and health education measures, leading to better prediction of and responsiveness to care needs of the population;
- the early identification of, and response to, problems or exacerbations of condition;
- the provision of proactive and structured care based on clear evidence of effectiveness;
- staff trained in people centred approaches. Multidisciplinary teams will span the divide between primary and secondary care and health and social care making the change in attitudes, behaviour and culture required to achieve this approach;
- A culture of:-
  - clear signposting to most appropriate services;
  - care available in a local setting where appropriate;
  - specialist opinion readily accessible and responsive;
  - redesigned packages of care.

5.2   Delivering these building blocks will require a transformational shift in the way in which we address long term conditions and a fundamental review of networking and processes including:

- pathways of care focussed on individuals with long-term conditions;
- having a systematic approach that links health, social care, patients and carers;
- identifying everyone with a long term condition;
- stratifying people so they can receive care according to their needs;
- identifying and dealing with frequent users of secondary care services;
- using appropriate resources to provide case management;
- developing ways to identify and manage people who may become very high intensity service users;
- establishing multidisciplinary teams supported by specialist advice;
- developing local ways to support self care;
- expanding self management and education programmes;
- partnership between professionals and people with long term conditions;
- partnership between primary care, secondary care, social care, and other agencies;
- integrated solutions that respond to the needs of people with long term conditions;
- focus on providing care in most appropriate setting whether that be secondary, primary or community care settings;
- focus on self care;
- earlier detection;
- minimising effects of disease and reduce complications;

- more effective medicines management;
- reduction in the number of crises;
- promoting independence, empowering patients and allowing them to take control of their lives, and prolonging and extending the quality of life.

5.3   This Framework is intended to provide a platform for our system to deliver these transformational changes.

5.4   **Scope of Framework**

The Long Term Conditions Strategy group defined the disease groups to be covered within the Framework as follows:
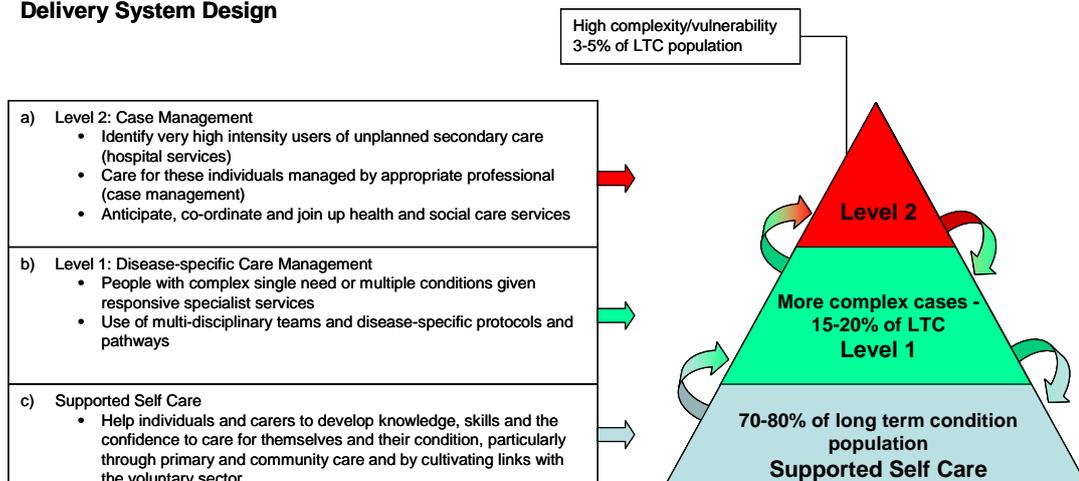
- Coronary Heart Disease;
- Diabetes;
- Stroke;
- Rheumatoid Disease;
- Older People and Disability (Frailty);
- Sensory Impairment;
- Acquired Brain Injury;
- Osteoporosis;
- Chronic Pain;
- Renal;
- Respiratory;
- Epilepsy;
- Disability:
  - Neurological Disease:
    - Parkinsons;
    - Chronic Fatigue;
    - MS;
  - Neuro Muscular:
    - Spina Bifida;
    - Ataxia;
    - Motor Neurone;
    - Muscular Dystrophy;
    - Huntingdon's.

5.5   **Proposed Model of Care**

Achieving fundamental change across a large and complex organisation requires a clear model which can be understood and communicated effectively to all the stakeholders and which can be used as a common underpinning.

The Delivery Model is underpinned by supported self care and has two levels. These levels are however interdependent and a patient may move between levels depending on the level of stability or exacerbations in their condition.

Delivery System Design

a) Level 2: Case Management • Identify very high intensity users of unplanned secondary care (hospital services) • Care for these individuals managed by appropriate professional (case management) • Anticipate, co-ordinate and join up health and social care services	
b) Level 1: Disease-specific Care Management • People with complex single need or multiple conditions given responsive specialist services • Use of multi-disciplinary teams and disease-specific protocols and pathways	
c) Supported Self Care • Help individuals and carers to develop knowledge, skills and the confidence to care for themselves and their condition, particularly through primary and community care and by cultivating links with the voluntary sector	

A brief description of each component of the model is outlined below, expanded with more comprehensive detail on each component in sections 6, 7 and 8.

5.5.1   Foundation Level: Supported Self Care

Core to the management of all long term conditions is the concept of self-care. This involves working collaboratively with individuals and their carers to develop the knowledge, skills and confidence to care for themselves and their condition effectively. This will involve input from a range of health professionals depending on need. An element of supported self care will be fundamental to, and should permeate all tiers of care.

5.5.2   Level 1: Disease-specific Care Management

This requires the provision of ongoing monitoring and review of patients with less severe clinical symptoms or people who have more complex single need or multiple conditions requiring specialist intervention; with responsive, specialist services based on multidisciplinary teams and disease-specific protocols and pathways.

5.5.3   Level 2: Care Management

The provision of intensive, personally tailored care to the 3-5% of people with particularly complex needs that require a more intensive level of care and are at greatest risk of hospital admissions.

This requires the identification of the most vulnerable people; those with highly complex multiple long term conditions, and, using a care management approach, to anticipate, co-ordinate and join up health and social care.

A primary purpose of the model is to inform the "assignment" of patients to the appropriate level at any point in time, acknowledging that assignment should not be static. A series of criteria will need to be developed (and agreed among all stakeholders), to inform this process.

This approach also has significant implications for stakeholder/workforce development. There are significant training requirements involved in changing both patient expectations and healthcare and associated workforce professions' clinical attitudes and approaches.

5.6   This section has provided a high level description of our aims, the scope of this Framework and our model of care. The following sections set out the model in greater detail.

6.   FOUNDATION LEVEL: SUPPORTED SELF-CARE

6.1   The Current Position

Self-care is fundamental in the management of long-term conditions and requires to be a core component in the NHS approach. There is great potential for the further engagement of patients in their own self-care and the patient should be seen as a valuable resource in the management of their own condition by health care professionals. Supporting self-care facilitates individuals to take a key role and responsibility in managing their own care, empowering them and their family and carers to manage their condition as effectively as possible.

Engaging patients in self-care needs to meet the NHS's overall aim of reducing health inequality and this needs to underpin the programme's approach.

Self-care can be defined as the care taken by individuals towards improving or maintaining their own health and well being, including actions to:

-      improve physical and mental health;
-      prevent illness or accidents;
-      care for minor ailments and long-term conditions;
-      address social and psychological issues;
-      maintain health and wellbeing after a discharge from hospital.

Self-management is the process each individual develops to enable them to manage their condition.

Supported self-care refers to a range of support offered to individuals to enable them to improve their knowledge about their condition and develop the skills and ability to enable self-care.

6.2   Principles of Supported Self-Care

Such approaches seek to actively involve the individuals in making decisions about their own care and aim to address the "whole person", not merely the illness or disability, through assisting individuals to:

-      feel confident and in control of their lives;
-      manage their condition and its treatment in partnership with health care professionals;
-      make healthier lifestyle choices, such as stop smoking and becoming more physically active;

- communicate effectively with professionals and are willing to share responsibility on treatment;
- be realistic about the impact of their disease on themselves and their family.

6.3 The Challenge

There is strong evidence that enabling patients to have a greater role in the management of their own care[1] can have a positive impact, including:

- significant impact on the use of services, with fewer primary care consultations, reduction in visits to outpatients and A&E, and decrease in use of hospital resources;
- better symptom management, such as reduction in pain, anxiety, depression and tiredness;
- increase in life expectancy and reduced risk of developing another condition
- improvement in quality of life with greater independence;
- regulated or reduced medicines intake

Patients with one long-term condition can be relatively stable. However, it is estimated that up to 45% of patients with a long-term condition suffer from more than one condition, and in the over 65 years population this figures rises. These patients with multiple LTCs have healthcare costs that are six times higher than patients with only one condition.

We need to develop self-care strategies in order to encourage individuals to develop the knowledge, skills and confidence to care for themselves and their condition effectively, facilitate earlier detection of changes in their condition and seek intervention as required and, as appropriate, access services that are delivered as near to an individuals home as possible. This will be achieved through a combination of:

- supporting earlier detection of deterioration in a condition or perceived health status;
- supporting patients to take control of their disease and lives in order to minimise effects of disease and reduce complications;
- empowering patients through the promotion of independence and allowing them to take control of their lives, leading to a reduction in the number of crises and more effective medicines management.

Supported self-care underpins all other levels of care within the pyramid; approx 70% to 80% of people living with a long-term condition will be supported at this level.

6.4 Supported Self-care Approach

Supported self-care will be delivered across all levels of care. A generic framework is being developed to support planning groups to identify existing standards and approaches and appropriate local delivery vehicles to support self-care. The preferred delivery vehicle should consider the range of local infrastructure and approaches available within acute services, CH(C)Ps and the voluntary sector, recognising a menu of approaches might be the best model to ensure the diverse needs of patients are considered (such as cultural differences, cognitive impairment, low levels of literacy, reluctance to engage with services and those living with multiple LTCs).

All planning groups should review the supported self-care framework to establish existing standards and current activity/delivery vehicles in line with those elements outlined within the supported self care framework.

Five work streams have been identified to further develop the role of planning groups to support patients and carers living with a long-term condition(s).

i)   Information - quality assured accessible information that includes both condition specific and general well-being information.

ii)   Structured Patient Education Programmes - condition specific evidenced based education programmes employing self-care and motivational dimensions.

iii)   Disease-specific Individualised Medicines Advice - formalises a shift in the burden of explanation to patients on medicines (the need for, optimal use, safety and cost effective use) from existing, fragmented approaches to adequately trained, accessible Community Pharmacists across GGC.

iv)   Generic Self-management Skills - training programmes to support individuals living with any LTCs to develop the skills to effectively manage their condition

v)   Enabling Access to Wider Support - providing opportunities for patients and carers to access to health , social care and voluntary sectors services, such as stop smoking services, stress centres, financial inclusion services and peer support.

The outputs of these workstreams will provide a basis for Acute Services, CH(C)Ps and the voluntary sector to respond to the needs of individuals living with multiple long-term conditions and to address underlying factors that impact on individual health status

6.5   Information

Good quality information is an integral part of good quality healthcare and an essential feature of patient centred services, Research has shown that information can improve the medical outcomes[5] and reduce patient anxiety, and that patients want it[7]. Information helps both individuals and their carers:

-       understand the nature of the condition and the outcome of any tests/treatments that may be involved;
-       contribute in a more informed way to discussions or decisions about their care;
-       obtain the knowledge and skills to have confidence in their ability to self-care;
-       know when and where to seek professional health and social care help;
-       identify further sources of information and support services such as structured education programmes, community-based lifestyle interventions, self-help groups;
-       be reassured and feel able to cope.

Planning groups should establish mechanisms to:

- identify existing gaps in patient information;
- ensure locally produced information adheres to good practice guidance to ensure information is in plain English, current, accessible, relevant and in context, respectful, avoiding stereotype;
- ensure people using services are involved in reviewing content development and design of locally produced information resources;
- establish menu of approved information, giving consideration to the point in the patient pathway at which it is given. This should be consistent across all relevant sites.

Information produced by relevant voluntary organisations should be considered to avoid unnecessary duplication.

6.6 Structured Patient Education Programmes

Health professional-led patient education programmes (including group and individual based programmes), offer an opportunity to embed principles of self-care within existing practice in the NHS, and can be delivered within NHS or community setting. Meeting staff training needs through needs assessment and delivery of local education and training programmes should equip health professionals to work with people within the context of their own lives, rather than solely within a clinical model of care.

Many voluntary organisations also offer support for individuals living with specific conditions. Such programmes however do not aim to replace education and advice from health professional, but rather offer additional support to individuals through peer-support initiatives (such as the Diabetes buddy programme, Arthritis Care - challenging arthritis).

Planning groups should ensure:

- existing patient education programmes are evidence based, inclusive and incorporate principles of self-care;
- partnerships are established with relevant voluntary organisations to develop opportunities for volunteer/peer support initiatives;
- training needs of health care staff are identified and addressed to ensure delivery of quality group patient education programmes.

6.7 Disease-specific Individualised Medicines Advice

Around a quarter of people with a LTC have three or more conditions and are more likely to have poly-pharmacy, collected on a monthly/bimonthly basis from local pharmacies. One of the most pressing problems of our growing LTC population is the safe and effective management of poly-pharmacy. Current unstructured approaches to providing patients with understandable, individualised and repeated medicines advice and the resulting poor adherence, is a recognised cause of hospital admissions.

If we can improve medicines adherence among the LTC population through evidence based approaches, there is likely to be a measurable reduction in admissions. We know that self-management programmes incorporating individualised, repeated, structured advice on medicines provided by community based pharmacists are known to improve adherence to medicines. Existing work by Community Pharmacists to

improve medicines self management for patients with Heart Failure, patients in socio-economically deprived areas, patients with falls/osteoporosis and others with complex medicines and needs demonstrate that pharmacy led support in this area is acceptable to patients and integrates with existing processes. The forthcoming Chronic Medication Service component of the Community Pharmacy Contract will enable a shift in Community Pharmacists' priorities to this area.

Planning Groups, CHCPs and Pharmacy Prescribing Support Unit should establish robust mechanisms to:

- ensure all community pharmacists are trained and able to deliver a minimal standard of patient education for priority LTCs (Diabetes, COPD, Asthma);
- enable electronic referral of high risk patients with complex medicine related needs to Community Pharmacies for repeated adherence support by the community pharmacist;
- ensure Community Pharmacists, while delivering medicines adherence support to patients, are aware of and can act upon agreed signs/symptoms of deterioration requiring onward referral;
- encourage Community Pharmacists to take the opportunity to refer patients onto other social care services as required, particularly in areas of deprivation
- enable community pharmacists to use existing learning from Keep Well pilots to engage with some patients;
- embed this work with the other Supported Self Care workstreams.

6.8 Generic Self-management Skills

The development of generic self-management skills training has evolved from condition specific approaches, recognising that individuals living with different long-term conditions face similar challenges in managing their condition and improving their quality of life.

Reviews of the self management programmes are positive and indicate that programmes provide a helpful approach for certain individuals, in particular those who are already managing their condition fairly well. However they may not meet the needs of different cultural groups and those with language or sensory impairment unless targeted specifically[4].

The voluntary sector has a wealth of experience of recruiting and supporting volunteers and delivering volunteer/lay-led self-management programmes. The recently established Long Term Condition Alliance Scotland will have a role in supporting voluntary organisation to work in this area. Community organisations are well placed to target and tailor programmes to meet the needs of local communities and encourage access of hard to reach groups.

Further guidance is required to develop a systematic approach for the commissioning and delivery of generic lay-led self management programmes within CH(C)Ps. The existing models and appporaches[8] should inform this process and will be tailored to fit with NHSGG&C structures and patients needs.

6.9 Enable Access to Wider Support

Supporting people with long term conditions should take into account inequality and discrimination and how this affects people's ability to make healthy choices. The

approach should look at people's economic and social position and how this affects their ability to participate in self care initiatives and how their individual needs can be supported.

Supporting individuals to make changes to their health behaviours (e.g., eating a healthier diet, reducing alcohol consumption, increasing physical activity and stopping smoking), providing support to address wider factors impacting on individuals health status (e.g., housing conditions, poverty and literacy) and mental wellbeing (reducing stress, anxiety and feelings of depression) have been shown to be major factors in improving the health and ongoing wellbeing for those with a long term condition.

Individuals living with long term conditions should be supported to access health improvement, social care and voluntary services, which provide specialist support and advice, such as stop smoking programmes, peer support, employability and financial inclusion services.

Further efforts are required to develop a systematic approach to ensure local service pathways are embedded within patient care and also enable self-referral where appropriate. Such pathways should build on those already developed within Local Enhanced Services Chronic Disease Management programmes and should aim to reduce inequalities in health.

Planning groups should:

- develop approaches which reduce health inequality;
- establish a consistent approach to [assessing individuals health behaviours] across the patient journey in line with national and local guidance;
- identify further opportunities to establish direct referral pathways to community health improvement, social care and voluntary services;
- develop mechanisms to effectively communicate service information to staff and individuals.

The key actions and responsibilities for the delivery of supported self care are shown in Attachment 1 Action Plans.

7.   LEVEL 1: DISEASE-SPECIFIC SPECIALIST CARE

7.1   The Current Position

Disease-specific specialist care management can be defined as the proactive management of care, following agreed protocols and pathways for managing specific diseases. It is underpinned by good patient information; good information systems including patient registries, care planning and shared electronic health records.

Level 1 disease-specific specialist care management involves providing people who have a more complex single need requiring specialist intervention, or multiple conditions with responsive, specialist services using multidisciplinary teams and disease-specific, evidence based protocols and pathways

Disease-specific specialist care management is the most well developed section of the pyramid of care locally. It is dependent upon a systematic approach to disease management and care planning. Disease-specific specialist care management targets patients experiencing an unstable period in their illness who are at risk of

decline in their condition.   Following the provision of short-term input the patient may return to a level of stability.

The General Medical Services Contract (GMS) underpins disease specialist care management with the Quality and Outcomes Framework and the various Local Enhanced Services (LES) focused on reaping the benefits of improved quality management of long term conditions. It is anticipated that this work will provide a solid foundation to build upon.

General Practitioners and their teams have been acknowledged experts in supporting people living with long term conditions for many years. The intention through this strategy Framework is to formalise and develop this existing expertise, joining up initiatives from different parts of the health service. An example of current good practice is the chronic disease monitoring programme, developed and introduced over the past five years in Glasgow.

Local enhanced services (LES) have been developed in a number of disease areas and are aimed at ensuring a structured approach to the best possible clinical care for people with chronic disease including access to health improvement services and support for health behaviour change, addressing mental health concerns and ensuring patients have comprehensive information about their condition and its treatment.

The regular review which is an integral component of this programme offers a co-ordinated approach not only to the medical management of the problem, but also to a variety of other social and behavioural aspects of care provision, across many sectors. It is based on the best evidence available, or expert consensus where evidence is lacking, and ensures a consistent, quality assured patient pathway for the longer term management of a chronic disease.

7.2   Multidisciplinary Teams

New methods for managing and supporting people with long term conditions bring together multidisciplinary teams, working across social care, primary and secondary care and voluntary organisations. The networked teams include GPs, secondary care clinicians, associated healthcare professionals, nurses, pharmacists, health improvement staff, care home staff, health visitors, social workers, administrative staff and voluntary organisations.

These teams need to be co-ordinated for the care of each individual by one senior professional; this could be the practice nurse - or the GP him or herself - or by others outwith the GP practice, e.g., in the heart failure service this function is carried out by the Heart Failure Liaison nurse

Effective practice-based registers provide the cornerstone of patient care and the basis for call and recall, clinical care, prevention, continuous quality improvement, monitoring and clinical audit and a systematic approach to disease management review.   Registers are already well established in NHSGG&C through the QoF of the GMS contract and under the auspices of the chronic disease management programme referred to above.

Modification of lifestyle factors such as diet, alcohol consumption and physical activity have been shown to be major factors in improving the health and ongoing wellbeing

for those with a long term condition. Glasgow's chronic disease management programme provides patients with an annual review in a practice nurse led clinic. The review includes: clinical tests, medication reviews, risk factor modification and referral to health improvement services, such as Hearty Eating, GP exercise referral and smoking cessation programmes. The overall aim is to produce better health outcomes, slow disease progression, reduce disability, ensure better management of the sudden deteriorations often associated with long term conditions and/or onward referral to more specialist services.

7.3 **The Challenge**

The provision of responsive, specialist services in the acute phase of the LTC is a major challenge. Patients within this level need to have a support structure in place and be able to access the care they need at the appropriate level. This may be through having access to a named contact, which could be a member of the practice team, a nurse specialist or other identified health professional.

We need to ensure that we develop a more co-ordinated approach to facilitate joint responsibilities for patients across primary and secondary care in order to allow us to focus on frequent users of services and proactively target them for management.

There are a number of initiatives currently underway that we can build on to allow us to explore and investigate new ways of working, including access to specialist opinion. These include for example looking at the feasibility of introducing telephone clinics, email access for advice and similar initiatives.

For maximum benefit, we need to develop services that are available 24/7. 48 hours over a weekend is too long a time to have no rapid, expert response other than A&E and admission available. Overnight, things often seem worse to patients - reassurance at that point can often avert admission with rapid access to expert care in the morning.

7.4 Key principles and core elements of Level 1 Disease Specialist Care Management:

- pro-active disease management - which involves early identification of needs and prompt response with the right care and support with systematic and tailored programmes for individual patients;
- early identification of and response to problems or deteriorations to identify those at risk of moving up to level 3 to allow an anticipatory approach to disease management;
- clear patient pathways that are integrated between health and social care and development of streamlined pathways where they do not currently exist;
- pharmaceutical care - more effective medicines management;
- well educated patient who can identify the onset of deterioration and respond appropriately;
- services in place to allow rapid response to the call for help;
- good mechanisms of call, recall review, and monitoring using registers for appropriate prompts and reminders;
- managing the interface between secondary and primary care - allowing speedy access to specialist secondary care when required, or other expert care - and allowing speedy hospital discharge, either to home with additional support (medical and/or social care), or to rehabilitation services;
- provision of multi professional peer support for health professionals;

- agreed clinical protocols and care standards;
- community based health improvement support services for patients, e.g., smoking cessation, weight management, exercise classes;
- structured education and support from health professionals in a community setting, e.g., cardiac rehabilitation programme, heart failure nurse community clinics.

7.5   Advantages delivered through this approach are:

- it will be easier to recognise patients with co morbidities and target them, co-ordinating care for those conditions in order to avoid lots of different appointments. Overall workload should reduce as self care improves;
- it has been shown that co-ordination of care by one dedicated professional leads to more appropriate and targeted use of resources within primary and secondary care;
- people with long term conditions will enjoy the experience of more coordinated health and social care provision, much of it at primary level. This will improve their quality of life and should lead to fewer planned admissions, as well as unplanned and emergency acute admissions. There should be a clear understanding by patients and professionals of what will be offered/standards to be expected and providers and where their point(s) of contact are for what.

The key actions and responsibilities for the delivery of disease specific specialist care are shown in Attachment 1 Action Plans.

7.6   Key Interfaces in the Delivery of Level 1 Disease-specific specialist Care:

- CH(C)P LTC local structures;
- Managed Clinical Networks and other related planning groups;
- Rehabilitation and Enablement Framework;
- Chronic Disease Management Programme;
- GMS Contract Work Group - Enhanced Services and Quality and Outcomes Framework.

7.7   The outputs this work will achieve are:

- condition specific pathways identified and made explicit signposting to the appropriate intervention and clinician for our target disease groups - Asthma, Diabetes, RA, COPD and CHD;
- publication of appropriate protocols and guidelines, including referral guidelines;
- pro-active disease management - which involves early identification of needs and prompt response with the right care and support with systematic and tailored programmes for individual patients;
- early identification of and response to problems or deteriorations to identify those at risk of moving up to level 3 to allow an anticipatory approach to disease management;
- clear patient pathways that are integrated between health and social care and development of streamlined pathways where they do not currently exist;
- pharmaceutical care - more effective medicines management;
- services in place to allow rapid response to the call for help;
- good mechanisms of call, recall review, and monitoring using registers for appropriate prompts and reminders;

- managing the interface between secondary and primary care - allowing speedy access to specialist secondary care when required, or other expert care - and allowing speedy hospital discharge, either to home with additional support (medical and/or social care), or to rehabilitation services;
- co-ordinated care for those with more than one specific condition;
- provision of multi professional peer support for health professionals;
- agreed clinical protocols and care standards;
- community based health improvement support services for patients e.g. smoking cessation, weight management, exercise classes;
- structured education and support from health professionals in a community setting;
- referral pathways to financial inclusion and employability advice.

8.   LEVEL 2: CARE MANAGEMENT

The Long Term Conditions Subgroup on Case/Care management has:

- Agreed an Integrated Care Pathway (ICP)
- Clarified that Case and Care Management are essentially the same – they describe a process which ensures the management of care
- Supported this approach by reference to Guidance (National) on Standards of Practice, Data Collection and Data Sharing

 Rationale - This approach is

- Based on the principles of multidisciplinary working
- Starts with Assessment and Care Management Training – National Framework
- Utilises Single Shared Assessment as a universal model for recording and sharing information
- Depends for its effectiveness on local IM&T and information exchange systems

Key principle adopted by the group

'The best approaches are designed locally through relationship-driven joint working which develops new cultures and integrated practices'

Key Benefits of this Approach

- It enables local flexibility – and can be adapted to both generic and disease specific conditions and care group specific models
- Can deliver care through local adaptation towards role and task models if preferred

Conclusions and Recommendations

The group concluded that:- the essential starting point for all LTC care pathways is the definition of a multidisciplinary approach – within which the key elements, or principles and standards which will make it work, are specified, including the agreed relationships between key partners.

The group acknowledged the:- varied documentation in use within different Local Authority areas for single shared assessment and care management, including service and data standards, and considered that the approach recommended is entirely compatible, and complementary to, such local variation.

The Integrated Care Pathway is intended to be:- a **baseline** pathway which identifies the key elements of the integrated care process, and can be tailored to local needs and circumstances

Local flexibility, reflecting local partnership agreements, will therefore be essential in establishing the recommended Long Term Conditions Integrated Care Pathway.

The group recommends :- all disease specific and generic interventions should utilise this Integrated Care Pathway.

Key differences between Long Term Conditions will require to be identified and taken account of in utilising the Integrated Care Pathway within a multidisciplinary approach.

Elements of the Integrated Care Pathway can be varied to reflect target/s being addressed, e.g. reducing bed days etc.

The starting point for local agreements on disease specific and generic work should be the utilisation of risk identification and stratification systems such as SPARRA etc. which identify the appropriate LTC Integrated Care Pathway to be utilised, and the multidisciplinary team member most appropriate for the 'management of care' of each individual.

8.1   Background and Current Position

Care management has been defined as the process of planning, co-coordinating, managing and reviewing the care of an individual. The broad aim is to develop cost-effective and efficient ways of co-coordinating services in order to improve quality of life. Key care management questions involve the decision on who needs, what they need and who leads - how to decide, and is it effective.

The care management approach requires the identification of the very high intensity users of unplanned secondary care, or those patients with particular complex needs that require more intensive medical and/or social care, effectively stratifying the patient population in order to identify those patients at high risk of unplanned admission to hospital.

Care for these most vulnerable people, those with highly complex and /or multiple long term conditions or end stage disease should use a care management approach, to anticipate, co-ordinate and join up health and social care.

The Kerr Report highlighted the fact that 5% of service users account for 43% of overall patient bed days. This group of service users have the most complex needs and often have a number of long term conditions. Once in hospital, this group of service users are likely to account for the majority of delayed discharges.

Intensive care management is viewed as a key activity designed to improve service user outcomes. Care management can be defined as "a collaborative process of assessment, planning, facilitation and advocacy for options ad services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes."

In summary, the aim is to give patients the most intensive care in the least intensive setting. In line with the direction proposed in Delivering for Health there needs to be a move away from a reactive, unplanned and episodic approach to care, particularly for those with complex conditions and high intensity needs.

For the most vulnerable, on-going, co-ordinated support is needed to tackle the cycle of repeat admissions to hospital which emerge when a condition reaches crisis point.

The following objectives underpin the development of a strategic approach to care management:

-        earlier detection;

-        good control to minimise the effects of disease and reduce complications;
-        reduction in the number of crises;
-        promoting independence, empowering patients and allowing them to take control of their lives;
-        prolonging and extending the quality of life;
-        compressing morbidity to as close to end of life as possible.

8.2   The Challenge

In developing this section of the strategic Framework it became clear that the evidence for the effectiveness of an intensive care management approach is at present mixed. Locally and across Scotland and the UK service systems are adopting a wide range of approaches to the issue of how best to support the most vulnerable people with long term conditions. Two examples of the models currently in use are outlined here, followed by a description of some pilot work undertaken in NHSGG&C.

In England the Department of Health have established the role of "community matrons" across the

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Example 1: Evercare Model

The Evercare model is a model of "proactive care for the most vulnerable" which encourages hospital admissions avoidance for older people through the provision of an integrated primary care service with an advanced nurse working collaboratively with a GP. The approach is based on achieving integrated care coordination by developing primary care nurses (Advanced Primary Nurses - APNs) with expanded skills to work as "generalists with special interests" rather than as specialists. The APNs case manage frail elderly patients and work in collaboration with general practitioners, district nurses, consultant geriatricians and secondary care nurses.   The key components of the APN role are described as

- clinician;
- care orchestrator;
- communicator;
- coach; and
- champion.

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system. The aim is to have 3000 community matrons in post by March 2007.

At present, there is a qualitative gain demonstrated through this approach, however the evidence for the overall cost effectiveness and value of this approach is not clearly demonstrated.

Example 2: Castlefield Model

The Castlefield model, based on the Evercare model, which promoted joint working and early intervention by health and social care workers operating in close proximity appears to have been effective. In this model, a nurse, working closely with a social worker, considers patients eligible for case management if they are over 65 and meet at least three of the following criteria:

- four or more active chronic diagnoses;
- four or more medications, prescribed for six months or more;
- two or more hospitalisations, not necessarily as an emergency, in the past twelve months;
- two or more accident and emergency attendances in the past twelve months;
- significant impairment in one or more major activity of daily living;
- significant impairment in one or more of the instrumental activities of living, particularly where there are no support systems in place;
- older people in the top 3 per cent of frequent visitors to the practice;
- older people who have had two or more outpatient appointments;
- older people whose total stay in hospital exceeded four weeks in a year;
- older people whose social work contact exceeded four assessment visits in each three-month period; or
- older people whose pharmacy bill exceeded £100 per month

8.3 Pilot Work - NHSGGC - Local Level

More locally, colleagues are adopting a range of multidisciplinary approaches, both within the acute sector and CH(C)Ps, to the needs of high risk individuals. These approaches range from redefining the role of COPT teams to the establishment of regular multidisciplinary meetings within a primary care setting.

These approaches involve identifying a cohort of patients at high risk of readmission, in some cases utilising the names generated by SPARRA (Scottish Patients at (high) Risk of Readmission and Admission - an IT risk identification tool, developed in response to Delivering for Health) as a means of beginning to focus collective attention on the need to address this most vulnerable client group.

Pilot work - Development of an Alert System

A key feature of successful case management is the availability of the appropriate triggers and alerts for the case manager to be notified that there is a deterioration situation or crisis for the patient.   As part of the East Dunbartonshire project, an alert system for repeat admissions and long length of stays was developed with the support of the Informatics department.

This provides up to date information about high risk patients to enable speedy response/action for discharge, rehabilitation, enablement and ongoing management in a community setting. The alerts work in a similar way to the current coding system used by A&E departments via the patient administration system. An alert can be added to the identified person's record and if they activate an emergency service, this alert will be flagged up. The code attached to this alert is checked and agreed actions follow.

Pilot Work - Renfrewshire

In Renfrewshire, a joint pilot project was developed between Renfrewshire Social Work Department and Primary Care. Inn the White Paper, Caring for People, which identified Care management and assessment as the "cornerstones of high quality care", two different models of care management were identified

- "The Role" - care management as a job in itself;
- "The Task" - care management tasks with other duties.

The Renfrewshire project aims to demonstrate the 'role' model approach to care management. The aims of the project were to test the benefits of the care management model in terms of patient care and to evaluate the impact on community nursing staff and other professionals.   Additional outcomes looked for are the prevention or reduction of inappropriate admissions, and the prevention of delayed or failed discharges.

This pilot demonstrated joint and integrated working with partner agencies to deliver health/social care across agencies, and proactive care management of patients with complex needs and long term conditions in the community.

This project set out to how to achieve greater equity/clarity for patients in respect to access to resources, referral routes and care pathways and a whole systems approach across health, housing and social care. Renfrewshire are taking what is essentially a systems approach to solving disequilibrium or crisis in a patient's condition, bringing a systematic approach to assessment, care planning, implementation, monitoring and review. The various resources and networks of the patient are identified, including deficits and risks, and solutions are sought towards improving the health & well being of the patient.

Who can provide the intensive care manger role? This was considered as part of the review, and the role was felt to be appropriate for any of the following health professionals, with the provision of training and guidance on the competencies required:

- district nurse/health visitor;
- social worker;
- occupational therapist;
- physiotherapist;
- professional providing a specialist service.

 "The Role" model - care management as a job in itself, can be compared/contrasted with other examples of the "task" approach as part of this pilot's evaluation.

8.4 Conclusion of the NHSGGC Pilots

Preliminary results are positive in respect of outcomes, they are not yet at the stage of delivering a full and complete qualitative and financial evaluation. Although the evidence for one approach versus another is currently ambiguous, what is clear is that there are definite guiding principles of systematic screening, assessment, care planning, monitoring and review which underpin all case management.

It is recommended therefore that the strategic direction to be adopted should be for planning groups to build on the evidence based approach being developed in both Renfrewshire and East Dunbartonshire and use these underpinning guiding principles to develop a model of care applicable to that particular disease grouping.

Development of this approach can be facilitated by a review of the findings coming out of the NHSGG&C pilots mentioned above. For example, there is evidence to suggest that in a specialised team situation, the task approach works very well. Whether disease group care management be task based, or role based; care management should therefore be disease group situation specific, and modelled and implemented depending on what the area requires. This will be a decision taken at local level assisted by the relevant planning group/MCN.

To help planning groups/MCNs progress the development of a care management approach for their specific disease areas, key questions, principles, structure outline and elements of case management are outlined in the following sections.

Pilot work East Dunbartonshire

In the local context another approach has involved the NHS and local authority in East Dunbartonshire. The *Joint Vulnerable Older Person's Project* was established in October 2006. The aim of this project was to establish a system for East Dunbartonshire which would enhance the identification of vulnerable people aged 75 years or over and trigger a multi agency collaborative approach to meet their needs within the community setting.

The project team have undertaken a rigorous review of the literature with a view to identifying evidence-based approaches to case management, and have concluded that there is no clear evidence about which interventions work best and that many of the studies have conflicting findings. However, they report that the research does support the following approaches among others:

- ambulatory community based care pathways;
- community multidisciplinary team care;
- care co-ordination (Multidisciplinary team based); especially in persons with mental health difficulties, COPD, CHD and diabetes;
- intensive homecare especially during transition from hospital to home;
- register, targeting and tracking of at risk persons;
- risk stratification.

Other strategies identified within the project considered for further review include:

- enhanced discharge planning - a process which should start at admission - and includes outreach/local teams, e.g., IRIS, COPT, heart failure, ESD, COPD;
- home visits by specialist and non-specialist professionals;
- integration between health and social care;
- multidisciplinary team working especially immediately after discharge;
- telecare - an IT based system of remote monitoring;
- telemonitoring - clinical info recorded and shared via, e.g., telephone lines;
- telephone follow up.

Initial findings of the pilot report a lack of evidence to support

- any one model of identification for vulnerable persons;
- basic discharge planning in very high intensity users of acute services;
- case management on a one to one basis with high grade senior community staff.

8.5 Key Questions

Some of the key questions which need to be addressed will be around the following elements:

- **Care manager or multidisciplinary team model?** There are arguments for the identification of a single responsible care manager to oversee the range of intervention with an individual who requires intensive input from a range of agencies. Proponents argue that the identification of such an individual will ensure that appropriate interventions are taken. Rather the responsible person is likely to take the role of case manager for a particular service user where their skills most closely match what is required. One option would be to utilise a multidisciplinary team approach where there are a number of professional inputs, and one person in the team is charged with responsibility for overseeing the range of inputs required. It must be a key attribute of effective case management that there is both agreement and clarity around which health professional is undertaking the care manager role.

- **Is it cost effective?** Evidence for the cost-effectiveness of the role of the care manager is limited and further evaluation is needed to establish whether the costs of providing are offset by savings from reduced service utilization and by the higher quality gains implicit in the approach.

- **Population Needs?** We need to be very clear about the needs of the population at whom case management is targeted. This will inform decisions about how best to develop it, who should provide it, and the range of services that should be in place to ensure that it is effective.

  It may be that the need for further pilot approaches emerges from the review activity. In that event it is recommended that the case manager approach should be tested through a series of pilot projects in which the benefits of case management delivery can be shaped, tailored to local circumstances, quantified and evaluated.

8.6 Key Principles and Core Elements of Care Management

The recently re-launched care management guidance offered a number of principles and values which inform an approach to care management.

These principles which have been at the heart of care management within social care since 1993 are equally applicable to case management in relation to long term conditions:

Key principles of case management:

- involving service users in a meaningful way in decisions about their care;
- minimum intervention necessary to achieve optimum outcome;
- promoting independence and self care as far as is feasible;
- recognising and supporting the contribution of family and carers;
- matching professional skills to the needs of service users;
- improving outcomes for patients;
- improving patients' ability to function and quality of life.;
- the prevention of unnecessary admissions to hospitals;

-        reducing lengths of stay of necessary hospital admissions.

Core elements of care management:

-        case finding or screening, and managing the transition between levels of care in the pyramid;
-        assessment, including risk weighting;
-        care planning, and management;
-        monitoring and review.

The key actions and responsibilities for the delivery of care management are shown in Attachment 1 Action Plans.

9. PATIENT FOCUS & PUBLIC INVOLVEMENT

9.1 Values

In the context of this Framework, the involvement of patients, carers and the public will be integral to the planning, monitoring, development and delivery of services relating to the management and care of long-term conditions across NHS Greater Glasgow and Clyde. This should be underpinned by the following values:

- service user involvement should be genuine and meaningful and be able to influence outcomes and actions;
- service users should be supported to develop their skills, confidence and knowledge, to ensure they are able to contribute and be involved at a level they are comfortable with;
- service user involvement should be supported by clear communication, where people receive feedback and information on time, and in a format that is accessible;
- service user Involvement should reflect the core principles of community development - participation, empowerment, citizenship, partnership, collective action and preventative action and the National Standards for Community Engagement;
- involvement of service users should reflect a continuous process and not one-off activity.

9.2 Process of Engagement

As outlined in the values above, the involvement of patients, carers and the public should reflect a continuous process and not one-off activity. It is therefore essential that current structures and mechanisms of engagement are utilised, ensuring service users are integral to service developments and the review of Framework outcomes.

Current mechanisms of engagement include Managed Clinical Networks and their related service user fora, and Public Partnership fora within Community Health (and Care) Partnerships. Both mechanisms propose opportunities for engagement with patients, carers and the public, and should be utilised not just as single entities but also as partner fora working together across the NHS system of long-term condition management and care. The role of voluntary sector organisations (both nationally and locally) should also play a key role in the process of engaging and involving people; providing links to a wide network of people. Engaging with and recognising the needs of carers is of particular importance to this work. We will ensure that this is a visible element of local, NHSGG&C wide and disease based planning and implementation related to this Framework.

9.3 Input from Patient Forum

We are keen to get input and feedback from patients and carers to our strategy to ensure the validity of our plans and direction of travel. As partners in developing this strategy Framework, patients and carers have been involved, and will continue to shape the direction of travel and implementation of this Framework. Patient and Carers are represented through the MCN's and Planning Groups and we will continue to solicit input. A programme of events and meetings will be structured to take this forward. An initial meeting was held with the patient forum to elicit their views on the

model of care components and our direction of travel.   The forum expressed enthusiasm for our vision of long term conditions management direction, and are keen to participate and get involved in disseminating the vision through the patient forum in whatever way they can.

10.   WORKFORCE DEVELOPMENT

10.1   This Framework has significant workforce implications.   Its development and implementation will require a different shape of workforce, working in different teams, on different tasks and in different ways.   The changes we envisage will need fundamental shifts in culture, attitudes and behaviours for a wide range of workers within the NHS and partner organisations.   We have illustrated this with a number of examples of development areas in the rest of this section.   The workforce changes will be reflected in the Board's strategic workforce planning and in the workforce planning and development within Acute and CH(C)P services.

10.2   New Patient Pathways and Protocols

It is likely that while there will be some need for training and development, the nature of the proposed strategic change is predominantly about changing working processes and patient management approaches rather than enhancing or changing disease specific knowledge or interventions. Rather, the emphasis will be in generating and ensuring the adoption and implementation of new patient pathways and protocols.

10.3   From Silos to Multidisciplinary Teams

The present workforce have, by definition, gained their experience in environments where the dominant tradition has been working within their discipline "silo". It will be important in our new way of working for healthcare professionals to be able to work across sectors and with other professionals previously not considered to be part of their team. There will need to be clarity about who does what; who has expertise and how to contact them, as well as easy access to such information. Teams will be wider and perhaps more virtual.

10.4   Ensuring Benefit Accrual

In particular, we often lose sight of ensuring accrual of the anticipated benefits from new working processes. Everyone agrees that the ideas are good and even puts them into practice, but somewhere along the line in the change process, the anticipated benefits disappear. If we are to reap the benefits from the proposed strategic change, then it will be imperative that individuals are clearly tasked on helping to measure, obtain feedback on, and take corrective steps to ensure benefits are indeed accrued. We need to include qualitative as well as quantative measures e.g. quality of life, well-being and function, as examples of aspirations of better long term condition management.

10.5   Development Areas

To achieve the proposed strategy, a number of development areas need to be considered.

- **Ensuring organisation and clinical structures are aligned to delivering LTC**. Current structures have evolved over time for a broad range of reasons.

There is therefore a need to review those structures (in conjunction with the process review) to ensure that they are fit for purpose and will maximise delivery of Long Term Condition Care. This will be part of the patient pathway reviews undertaken within the MCNs and Planning Groups.

- **Optimising interagency/inter-discipline interface and handover.** Again, the review of work/patient flow processes should aim to identify those potential areas of patient handover (and conflict), to inform the nature and content of appropriate training and development. Similarly, any internal and external IT/information systems that will develop need to ensure that those operating the systems are fully trained.

- **Attitudes and Behaviours.** No matter how well the systems and processes are defined, the proposed strategy will have little effect unless fairly entrenched ways of working and attitudes which may be counter to the requirements of the proposed approach are fully addressed.

  Fully effective Multi Disciplinary Teams (MDTs) need to ensure that all members of the MDT, irrespective of their seniority, are fully recognised and valued as part of the team.. We need to ensure that appropriate values and behaviours are made explicit and recognised within the team.

- **Breadth of Population being trained and developed.** The proposed strategic change is predicated on the recognition that a much larger number of stakeholders need to have their awareness raised, and receive appropriate training and development as required

  Key in this is the involvement of the patient. We need to address the public at large to raise awareness of the new approach and manage their expectations.

  Equally, once a patient enters the LTC Framework, a raft of awareness raising and educational systems, processes, materials and infrastructure needs to be generated and made easily accessible to patients, carers and healthcare support workers.

  Similarly, in our partnership agencies, we need to ensure that there is an alignment in the training and education of all those workers whose activities may impinge upon the LTC environment.

Key actions and responsibilities for workforce/stakeholder development are shown in Attachment 1 - Action Plans.

11. INFORMATION AND DATA MANAGEMENT

11.1 Introduction and Purpose

The purpose of this Section is to outline the issues and areas that should be developed in order to provide clinicians, patients, and their carers with the information they need when and where they need it in order to transform the management of care of people with long term conditions and to consider this across health care, social care and for carers
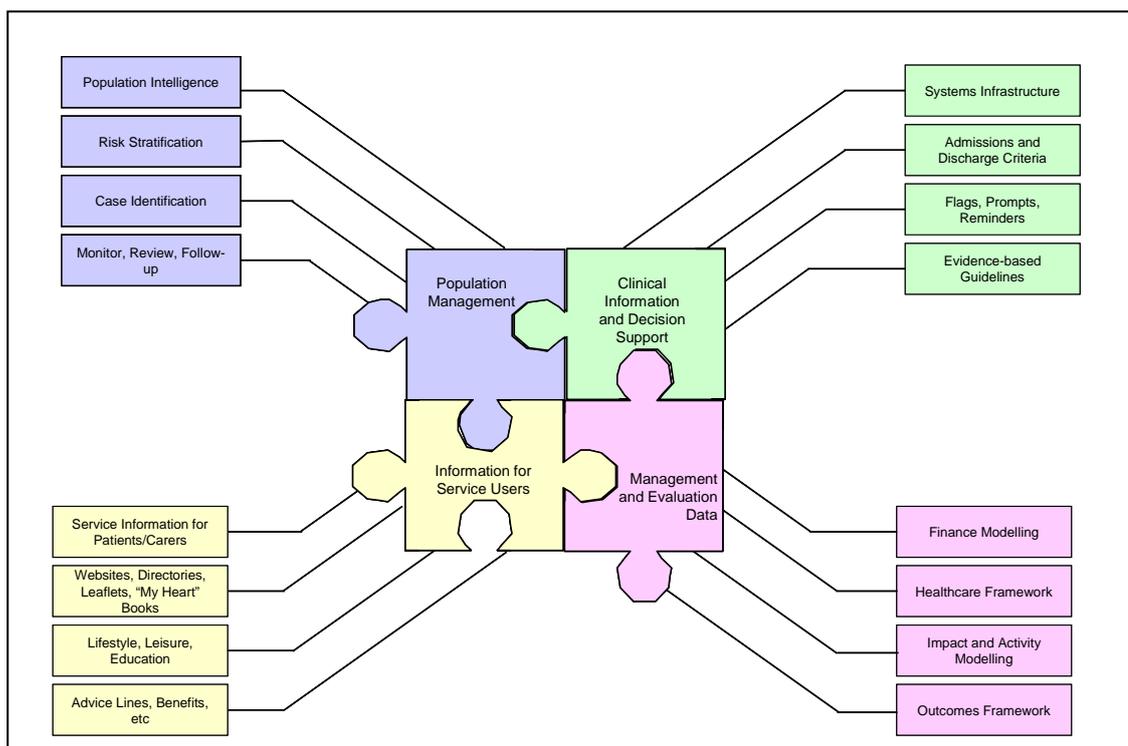
11.2 Common Themes/Issues

We need ready access to and availability of key baseline data and information in order to understand the profile of and understand the needs of individuals with long term conditions across our community health (and care) partnerships. We need ready access to admission and referral data analysis, together with data on local population health status, disease prevalence to allow us to scope provision and uptake of existing services and identify gaps in service provision. This will also allow us to identify gaps in provision and better enable us to align services appropriately to need.

Use of this data will also provide us with a mechanism to underpin evaluation and performance management of our long term conditions Framework.

- information needs to be gathered on functionality, clinical issues and self care Required - information for primary care, secondary care, social care, others, e.g., pharmacy, NHS24, day care;

- all professions currently collect data separately – with minimal sharing e.g. the District Nurse visits in morning and the podiatrist visits in afternoon - often no easy way of communicating between them;
- health and social work need to sort out communication and working arrangements around care packages - for example district nurses using new IT cannot access social work systems to change care packages;
- issue of dependency – there is often a lack of information leading to initial setting up of package and correspondingly related to a requirement to reduce;
- unique identifier needed to underpin sharing of information - universal use of the CHI.

11.3 Sharing of Information

Getting better at sharing information, both between health professionals and between health professionals and our partners outwith the health service is a key challenge for us.

There are a number of initiatives currently underway around sharing of information that will be instrumental in helping us achieve our LTC strategy. One of these will be making the emergency care summary more widely accessible, especially to out of hours services.

Another key area is the Local Data Sharing Partnership project which is a programme of work commissioned through the Scottish Executive Transformation and Technologies Division (TTD) to facilitate data sharing within NHS Board areas.

Currently there are two main initiatives; electronic sharing adult single shared assessments and the provision of child protection messaging. The longer term aim is to integrate the main systems used by health, social work, education, housing etc into a shared Multi Agency Store (MAS) so that agencies can view and contribute to complex shared and integrated processes. These will be underpinned by a robust security and consent models.

The aim is to facilitate an end to end process where staff have access to the latest information enabling more effective planning of care, reporting and coordination to enable seamless acute to community transfers, and potentially reducing delayed discharge.

11.4 Short Life Working Group

A short life working group has been established as a sub group of the LTC Steering Group whose responsibility it will be to identify the overall information needs related to long term conditions and break down into workstreams that can be achievable in the short, medium and long term. This group will also ensure linkages to the other planning and development groups for information, including the Local Data Sharing Partnership and Joint Information Group.

The key actions and responsibilities for information and data management are shown in Attachment 1 Action Plans.

12. ENSURING DELIVERY

12.1   The delivery of the changes this Framework is intended to achieve will be monitored in a number of different ways. Our core arrangement will be through an agreed set of performance indicators for LTCs which will be incorporated, with HEAT targets, into our corporate performance framework. Progress on delivering the Framework will also be assessed through the scrutiny of development plans from the Acute Division and CH(C)Ps and in the Organisational Performance Reviews focused on the delivery of those plans.

ACTION PLAN

Complete agreement on timescales will be reflected in an updated Action Plan.

Key Strategic Actions to Enable Supported Self-care	Responsibility	With support of	Timescale
1. A generic framework describing core elements of supported self-care should be developed to enable the identification of existing supported self-care activity across the system.	Supported Self Care (SSC) Sub-Group		Completed
2. Planning groups should identify specific quality standards and good practice in relation to supported self-care (including information, structured education and voluntary sector programmes).	MCNs and Disease Planning Groups	Supported Self Care (SSC) Sub-Group	To be agreed at October meeting
3. Planning groups should further strengthen the links and develop strategic partnerships in order to use to best effect the expertise available from Voluntary Organisations and associated umbrella organisations through their contribution to planning groups and MCNs.	MCNs and Disease Planning Groups CHCPs	Supported Self Care (SSC) Sub-Group	In process
4. Planning groups should further develop strategies to address the diverse needs of the population including; women and men, people in poverty, minority ethnic groups, disabled people, hard to reach groups; low levels of literacy/English as a second language through the development of tailored information and patient education programmes where required.	MCNs and Disease Planning Groups CHCPs	Supported Self Care (SSC) Sub-Group Equality and Diversity Team	In process To be agreed at October meeting
5. Planning groups should ensure that all information is quality assured and meets a minimum standard.	MCNs and Disease Planning Groups CHCPs	Supported Self Care (SSC) Sub-Group	In process To be agreed
6. Planning groups should establish clear pathways to Health Improvement, social care and voluntary sector services service to maximise health improvement and reduce inequalities in health. This should include provision of information to raise awareness of such services amongst staff, individuals/carer's and communities.	MCNs and Disease Planning Groups CHCPs	Acute Planning Health Improvement Team	In process Draft pathways available Conclude March 2009
7. Planning groups should adopt models of good practice that enable/empower patients/carers to become actively involved both in planning services and development of personal care plans. Ensure that patient voice is heard and views actively solicited in such a way that it reflects a diverse population.	MCNs and Disease Planning Groups CHCPs	Facilitated by MCNs and Disease Planning Groups	In process

ACTION PLAN

Complete agreement on timescales will be reflected in an updated Action Plan.

Key Strategic Actions to Enable Supported Self-care	Responsibility	With support of	Timescale
8. Planning Groups, CHCPs and Pharmacy Prescribing Support Unit should establish robust mechanisms to: - ensure all community pharmacists are trained and able to deliver a minimal standard of patient education for priority LTCs (Diabetes, COPD, Asthma); - enable electronic referral of high risk patients with complex medicine related needs to community pharmacies for repeated adherence support by the community pharmacist; - ensure community pharmacists, while delivering medicines adherence support to patients, are aware of and can act upon agreed; signs/symptoms of deterioration requiring onward referral; - encourage community pharmacists to take the opportunity to refer patients onto other social care services as required, particularly in areas of deprivation - enable community pharmacists to use existing learning from Keep Well pilots to engage with some patients; - embed this work with the other Supported Self Care workstreams.	CHCPs, MCNs Planning Groups and PSU		To be agreed at October meeting
9. Develop a systematic approach for the commissioning and delivery of generic lay-led self-management programmes within CH(C)Ps. This should include guidance on the role of role of community and voluntary organisations.	CHCPs	Supported Self Care (SSC) Sub-Group	In process End 2009 Report evaluation and recommendations
10. Planning groups should identify staff training needs and mechanisms to engage with health professionals to raise awareness/develop skill in relation to principles and practice of supported self-care and adult patient education	CHCPs	Supported Self Care (SSC) Sub-Group OD	To be agreed to take forward

ACTION PLAN

Complete agreement on timescales will be reflected in an updated Action Plan.

Key Strategic Actions to Enable Level 1: Disease-specific Care	Responsibility	With support of	Timescale
1. Know your patient cohort. Identify patients who require disease management. Utilise existing disease registers, and establish new disease registers where they do not currently exist.	CHCPs	MCNs and Disease Planning Groups	In process
2. Ensure that the agreed clinical standards and protocols devised by the MCNs and Planning Groups are adopted and implemented locally.	CHCPs	MCNs and Disease Planning Groups	In process
3. Review existing pathways and protocols to ensure that there are clearly defined stages and measures delineated at appropriate stages in the pathway to help people avoid complications or slow down the progression of their condition.	MCNs and Disease Planning Groups	CHCPs	In process
4. Ensure the measures and defined stages identified in 3 above, are locally known and disseminated to all practitioners with a need to know.	CHCPs	MCNs and Disease Planning Groups	In process
5. Ensure that there is an action plan to implement measures identified in 3 above, with stages and resource shortfalls identified where they exist.	CHCPs	MCNs and Disease Planning Groups	
6. Ensure pathways and protocols are developed where they do not currently exist in the patient pathway.	MCNs and Disease Planning Groups	CHCPs	In process
7. Ensure that there is an system in place locally to update healthcare practitioners and others with information and protocols as they are developed and updated.	CHCPs	MCNs and Disease Planning Groups	
Ensure that appropriate patient information is developed and made available in accessible formats to provide support for this group of patients to manage their own conditions. This will provide an empowering framework geared to improving a patient's experience of services and their health outcomes. Ensure that there is an appropriate update mechanism in place.	MCNs and Disease Planning Groups in conjunction with SSC sub group	Voluntary Organisations CHCPs	In process In process
8. Ensure that patient information is readily accessible to all who require it at a local level. Ensure that there is an appropriate update mechanism in place.	CHCPs -	MCNs and Disease Planning Groups	In process

ACTION PLAN

Complete agreement on timescales will be reflected in an updated Action Plan.

Key Strategic Actions to Enable Level 1: Disease-specific Care	Responsibility	With support of	Timescale
9. Identify ways at a local level to encourage patients to take full advantage of the existing GMC Annual Review/Recall programme patients regularly, to ensure they receive the best evidence based care and are supported to manage their condition.	CHCPs	MCNs and Disease Planning Groups	In process GMC programme annual review
10. Ensure that the services required to support practices in delivering the care required are identified. This will include diagnostic services - laboratory services, imaging, and disease specific clinical services e.g. pulmonary function testing, rapid access chest pain clinics mental health services for anxiety and depression; services to support health related behaviour change.	MCNs and Disease Planning Groups CHCPs	MCNs and Disease Planning Groups	In process
11. Ensure that the services identified as required at a local level to support practices in delivering care required are in place.	CHCPs	MCNs and Disease Planning Groups	
12. Where resource challenges exist to prevent the provision of services locally, ensure that there is a staged action plan identifying shortfalls and what is required to meet the gaps identified.	CHCPs	MCNs and Disease Planning Groups	
13. Key Pharmaceutical Care issues for Level 1 Disease Specific Care Management			
- integrate Pharmacy support into GGC Planning group/MCN strategy to enable a rolling programme of implementation of an adherence support/ Pharmacy Long Term Medicines Service for targeted patients with Heart Failure (2007/8), Osteoporosis and Falls (2007/8), COPD (2008/9) and Diabetes (2010/11);	PPSU, CHCP pharmacy teams		TBC
- agree the key disease and medicine specific messages to be given by pharmacists and other healthcare professionals to patients with targeted conditions, and agree criteria for onward referral to other health and social care services within pathways and protocols;	MCNs and Planning groups	PPSU and CHCP Pharmacy teams	
- provide strategic leadership to ensure Pharmacy clinical support is mainstreamed and integral to disease specific care management pathways;	PPSU	CHCPs	

ACTION PLAN

Complete agreement on timescales will be reflected in an updated Action Plan.

Key Strategic Actions to Enable Level 1: Disease-specific Care	Responsibility	With support of	Timescale
- consider the utilisation of Pharmacists with a Special Interests to contribute to supporting the delivery of pharmaceutical care of patients with specific diseases, helping to address traditional hierarchical structures in line with policy;	PPSU, Lead directorate pharmacists	MCNs and Planning groups	
- support Glasgow and Clyde wide initiatives to prescribe cost effectively for patients with LTCs;	CHCP Pharmacy teams	PPSU	
- encourage innovation in service delivery, e.g., piloting of novel ways to engage and support the hard to reach and those with multiple co-morbidities including socioeconomic deprivation.	CHCP pharmacy teams, Keep Well Pharmacy team	PPSU	

ACTION PLAN

Complete agreement on timescales will be reflected in an updated Action Plan.

Key Strategic Actions to Enable Level 2 Care Management	Responsibility	Care Management Support with support of	Timescale
1. Adopt at local level, a system of identifying prospective very high intensity users of services, (case finding) using a risk identification tool (such as SPARRA). This may be different for different groups, e.g., heart failure and frail older people.	CHCPs	Programme Lead/ Information Support	In process TBC by each CHCP
2. Apply case finding tool; identify high risk groups.	CHCPs		TBC by each CHCP
3. Identify strategies to deal with these risk groups on a prioritised disease by disease basis.	CHCPs	MCNs/Disease Planning Groups	
4. Establish multi-professional teams based in primary or community care with support of specialist advice to manage care across all settings.	CHCPs	MCNs/Disease Planning Groups	TBC
5. Ensure that the Care management approach is developed in close collaboration with social care providers to ensure that an appropriate range of health and social care services is available to prevent hospitalisation.	CHCPs	MCNs and Disease Planning Groups	In process TBC
6. Care management entails a systematic approach linking health, social care, patients and carers. This entails a population based, proactive, structured and evidence based approach. The approach utilised should ensure that staff are competent to assess and manage the potential barriers to care such as poverty, physical access, cultural issues, differential attitudes of men and women. Training/cultural awareness issues to be agreed.	CHCPs	MCNs/Disease Planning Groups Equality and Diversity Team	TBC
7. Effective case management requires health practitioners, not confined to any particular professional group, with communication and collaborative working skills. Ensure that the skillset of the competencies of a care manager, identified in the national training framework, are made available to planning groups, MCNs and CHCPs.	LTC Case/Care Management Subgroup		In process

ACTION PLAN

Complete agreement on timescales will be reflected in an updated Action Plan.

Key Strategic Actions to Enable Level 2 Care Management	Responsibility	Care Management Support with support of	Timescale
8. At an organisational level, we need to ensure that the systems are in place to support case management (IT, training, supervision) as well as the processes to support patient care e.g. out of hours care, availability of the support services identified as required.	MCNs and Disease Planning Groups	CHCPs	TBA
9. In addition to identifying people who will benefit most from intensive case management, we must also ensure that services are in place for people with less severe illness who nevertheless have significant health and social care needs.	CHCPs through use of risk identification tool -	MCNs/Disease Planning Groups	TBC
10. Develop an evaluation framework to assess the impact of care management initiatives on the use of health services (including primary care) and patient satisfaction.	CHCPs	MCNs/Disease Planning Groups LTC Care Management Subgroup	TBA
11. A systematic approach to involving pharmacy in care pathways through formal referral to ensure targeted patients receive clinical medication review then ongoing medicines self management support.	MCNs, Planning Groups, CHCPs	PPSU	Ongoing
12. Increase the capacity of managed service Pharmacists and capability of pharmacy contractors to enable delivery of clinical medication review and pro-active medicines self management support	LTC Steering Group/LTC Collaborative	PPSU and CHCPs	TBC
13. Agree which patients should be referred to Pharmacy in CHCPs for clinical medication review and ongoing medicines self management support	PPSU and MCNs	CHCPs	TBC
14. Press for the establishment of e-transfer of relevant clinical information to and from pharmacy, enabling a stronger focus on medicine management	LTC Information and Data management, GMS IT Group, PPSU	CHCPs, MCNs	TBC

ACTION PLAN

Complete agreement on timescales will be reflected in an updated Action Plan.

Key Strategic Actions for Workforce/ Stakeholder Development	Responsibility	With support of	Timescale
1. Detailed planning for the introduction of the model in terms of workforce development implications. This has been started as part of Glasgow's chronic disease programme which provides a foundation on which to build.	CHCPs	MCNs HR OD	TBC
2. Ensure a genuine Multidisciplinary team working where members respect the professionalism of all other members for the benefit of the patient,	CHCPs	MCNs HR OD	TBC
3. Be clear about benefits accrual - ensure individuals are clearly tasked on helping to measure, obtain feedback on the new LTC approach, and take corrective steps to ensure benefits are indeed accrued.	CHCPs	MCNs Disease Planning Groups	TBC
4. Ensure a process of stakeholder/public/patient awareness raising of the new LTC model of care.	CHCPs	MCNs and Disease Planning Groups	TBC

ACTION PLAN

Complete agreement on timescales will be reflected in an updated Action Plan.

Key Strategic Actions for Information and Data Management	Responsibility	With support of	Timescale
1. Ensure the provision of accessible public health data to model the service needs of the future, relating to provision for long-term conditions, e.g., use of population projection trajectories.	CHCPs	MCNs/Disease Planning Groups Public Health Information Services	TBA
2. Ensure the use of data to enable ongoing risk stratification of patients to identify patients at highest risk of readmission and offer anticipatory care in the form of case management. The development and use of a risk identification tool (SPARRA or equivalent) that will facilitate the analysis of 'recent' information to analyse data for unplanned admissions; lengths of stay; frequent A&E attenders; primary care data linked to social care data (for example multiple medications, functional difficulties other jointly agreed 'qualification criteria' for case management;	CHCPs	ISD Information Analyst LTC Programme	Ongoing
3. Available data is made available and utilised to undertake audit and evaluation of service provision, for example unplanned admissions and why they occur. Changes are made to provision as a result of these analyses	CHCPs Information Services	MCNs/Disease Planning Groups Information Analyst LTC Programme	TBC
4. Available information is shared and accessible across all organisations in the health community.	CHCPs Information Services Public Health	MCNs and Disease Planning Groups	TBC
5. Information needs to be gathered on functionality, clinical issues and self care Required - information for primary care, secondary care, others, e.g., pharmacy, NHS24, day care.	CHCPs Information Services	MCNs /Disease Planning Groups Information Analyst LTC Programme	TBC
6. Information on and mapping of service provision for each client group should be undertaken by disease planning groups. This could be broken down into other areas such as CHCP or care groups.	CHCPs	Information Analyst LTC Programme	TBC

ACTION PLAN

Complete agreement on timescales will be reflected in an updated Action Plan.

Key Strategic Actions for Information and Data Management	Responsibility	With support of	Timescale
7. All professions currently collect data separately with minimal sharing and often no easy way of communicating between them. Health and social work need to sort out communication and working arrangements around care packages - for example district nurses using new IT cannot access social work systems to change care packages.	CHCPs Joint Information Steering Group	MCNs/Disease Planning Groups Information Analyst LTC Steering Group	TBC
8. We need to be able to share emergency details between primary, secondary and OOH providers in order to improve the management of emergency patients - extend the use of the emergency care summary to allow this.	MCNs/Disease Planning Group Information Services	CHCPs LTC Steering Group	TBC
9. Availability of an Integrated Care Record - accessible to all those who require the information, including patients and carers needs to be expedited. Currently many professionals in many settings hold fragments of the record but none have access to the whole record. The Integrated Care Record requires that a common set of information support systems are, as appropriate, available in all care settings to support the clinical care process and to contribute to or be summarised in the Integrated Care Record. These include: - patient administration for inpatients and outpatients; - appointment scheduling systems; - A&E department support systems; - laboratory and radiology support systems ; - online ordering of tests; - online access to laboratory test results; - on-line instant access to clinical images such as X-rays and ultrasound across Scotland; - primary care and shared communication with other parts of the NHS; - electronic prescribing systems integrated with other clinical information systems; - community pharmacy systems linked to other NHS practitioners (e-Pharmacy); - specialist clinical support systems.	Joint Information Steering Group CHCPs	MCNs/Disease Planning Group LTC Steering Group Information Analyst	