Long Term Conditions Collaborative
Improving Care Pathways

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Long Term Conditions Collaborative
Improving Care Pathways

Ten approaches to help you deliver better outcomes and an enhanced experience of care for people living with long term conditions

A collaborative resource to support partnerships

Sharing Solutions for a Shared Challenge

The increasing number of people with long term conditions is a major challenge for health, social care and housing services in Scotland. *Improving the Health & Wellbeing of People with Long Term Conditions in Scotland: A National Action Plan* sets out our collective response to that challenge.

The Long Term Conditions Collaborative (LTCC), building on the excellent progress made by Managed Clinical Networks (MCNs), aims to support you to develop clearly signposted pathways for high quality person centred care that is effective, safe, timely and reliable, makes best use of the skills of the multi-professional team, and is supported by good communication and sharing of information across teams and care settings.

High Impact Changes and Improvement Actions

The Long Term Conditions Collaborative developed a set of clear and tangible improvements that we expect to make a big impact on the way people with long term conditions manage their own care and experience care provided by others. These *High Impact Changes* apply across the long term conditions pathway from diagnosis through self management, living for today, change in condition and transitions of care to palliative and end of life care.

Each High Impact Change has a bundle of Improvement Actions, all of which need to be implemented to successfully deliver the change. These improvement actions are based on changes that have been tried and tested by health and social care practitioners in the UK and beyond and reflect what people have said should be done to improve their experience of living with a long term condition. They give some solutions to what can seem like a complex and overwhelming challenge.

Improving Care Pathways

From our published LTC *High Impact Changes* and our Improvement Actions we have identified approaches that enhance care pathways for people with long term conditions (Figure 1). These approaches reflect learning from the many condition specific standards and pathways developed by NHS Quality Improvement Scotland and by MCNs across Scotland.

Our focus is generic support for improvement rather than condition specific. We share learning from NHS Board teams across Scotland and provide tools, techniques and a range of practical resources so that partnerships achieve better outcomes for people with long term conditions and an enhanced experience of care. We equip staff with tools to use at different times and in different situations along the pathway.

All our improvement tools focus on ensuring value for the individual. They include Plan Do Study Act (PDSA) cycles/Model for Improvement; lean-thinking; Value Stream Mapping (process mapping, 6S and 7 Wastes that identify steps and activities that don't add value); DCAQ (Demand, Capacity, Activity, Queue) addressing capacity and flow to streamline pathways and reduce delays, and Poke Yoke to prevent errors thereby increasing reliability, productivity, safety and value across the whole system. Sometimes these techniques are delivered through Rapid Improvement Events.

There is growing interest in the use of the Logic model to illustrate the links between service inputs, outputs, activities and intended outcomes. This approach sets improvement and change in the context of the bigger picture and provides a road map to communicate the vision and to focus and improve its implementation. It offers a useful framework to integrate planning, delivery and evaluation, helps you identify what service approaches and resources are needed and what to measure for short term, intermediate and longer term outcomes. An example of a Logic Model is shown in Appendix 1.

Driver Diagrams are a project tool to breakdown the primary outcome (or main broad aims) into your system components and processes. In other words, to simplify it into increasing levels from primary objectives, then into detailed actions. These all contribute to achieving the overall aim. It allows the team to expand their thinking and to see the logical links at each level whilst always keeping in mind the overarching outcomes. In this case in relation to condition management and how we achieve best practice care for people with long term conditions. An example of a Driver Diagram is shown in Appendix 2.

Designing LEAN Pathways

Innovation and use of lean thinking will be critical for success in making sustainable improvements to pathways for long term conditions. Lean thinking has spread well beyond its birthplace in the realms of post-war Japanese manufacturing industry to secure a firm evidence base in the public sector.

The five principles of LEAN should underpin our improvement work
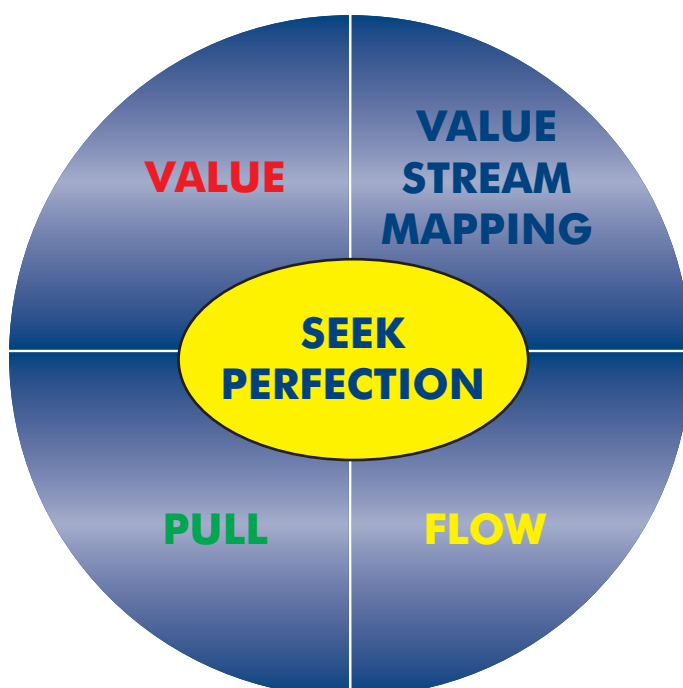
1. VALUE
To truly understand what the person wants (**not** what we *think* they want)

2. VALUE STREAM MAPPING
To really understand what our current service delivery is and what the problems are.

3. FLOW
To link together all the steps, activities and processes in the most efficient way we can (maximising value), eliminating waste and blockages to deliver a better service.

4. PULL
To consider the demand that drives the service, plan for, and better manage it.

5. SEEK PERFECTION
Improvement is a journey without end. There is *always* room for improvement.

Empowerment and Momentum
Lean seeks to empower and motivate frontline staff to make the changes that they feel will improve the system and process, all the time focussing on the needs of the person receiving services. Frontline staff own the process and it is their innovations that will bring the gains required to deliver and sustain a quality service.

Support for Improvement

This document aims to provide you with practical steps to help you improve the health and wellbeing and the quality of care for people with long term conditions.

It is part of a series of LTCC resources:

- High Impact Changes

- Improving Complex Care

- Improving Self Management Support

- SPARRA Made Easy

- Proactive, Planned and Coordinated: Care Management in Scotland

- Anticipatory Care Planning: Frequently Asked Questions

- Making the Connections – Food For Thought, Anticipatory Care, Self Management and Community-led approaches to Health Improvement

These resources and other tools are available to download from the LTCC Community of Practice website: www.knowledge.scot.nhs.uk/ltc

This website provides access to published resources on the NHSScotland e-library and is complemented by local resources provided by members of the community. The aim of the site is to develop knowledge and share long term conditions related good practice.

The website enables members to:

- Access education and learning resources

- Locate and contribute information and evidence

- Collaborate with colleagues

- Access information to support evidence-based practice (e.g. guidelines and policy documents).

Other websites that have useful information about improvement tools:

http://www.nodelaysscotland.scot.nhs.uk/ServiceImprovement/Tools/Pages/IT194_lean.aspx

http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_andservice_improvement_tools/lean.html

http://www.institute.nhs.uk/building_capability/general/lean_thinking.html

http://www.bqbvindicators.scot.nhs.uk/

Ten actions that make a difference

Where it's happening … and who can help

Figure 1

QUALITY CARE

SAFE
EFFECTIVE
EFFICIENT
TIMELY
EQUITABLE
PERSON CENTRED

INFORMATION SYSTEMS
WORKFORCE DEVELOPMENT
COMMUNITY
DELIVERY AND PERFORMANCE
QUALITY IMPROVEMENT

PRIMARY CARE
HOSPITAL
SOCIAL CARE
HOUSING
VOLUNTARY

INFORMED AND EMPOWERED
PREPARED AND PROACTIVE

SUPPORTED SELF MANAGEMENT

MCN: MANAGED CLINICAL NETWORKS

GENERIC APPROACH

MCN: MANAGED CLINICAL NETWORKS

⭐ COORDINATED TEAM BASED CARE

⭐ REHABILITATION/ENABLEMENT APPROACHES

⭐ ACCESS

⭐ TELEHEALTH SOLUTIONS AND TELECARE SUPPORT

⭐ CARE CLOSER TO HOME

⭐ PHARMACEUTICAL CARE

⭐ REGISTRATION, RECALL AND REVIEW

⭐ SHARE INFORMATION AND REAL TIME DATA

1. APPLY GENERIC AND INTEGRATED APPROACHES

Improvement Actions:

- Include generic approaches in condition specific CPD programmes
- Develop integrated patient pathways for long term conditions
- Embed evidence-based guidelines in integrated care pathways

BACKGROUND

Many people live with more than one long term condition. A holistic approach to care frames evidence-based practice for each condition in the context of the individual's life circumstances. It also balances condition specific approaches with generic principles that apply to the management of all long term conditions. These principles include provision of information, advice and support to make appropriate lifestyle choices and changes; to adjust to the loss of mobility or manage chronic pain; to maintain psychological and emotional wellbeing; and to deal with employability and financial health issues. Underpinning these principles is the need for good quality information and clear signposting to care pathways so that the person and their carer can access the appropriate service at the right time and in the most appropriate setting, irrespective of their specific condition(s).

Most people self manage their long term conditions with help from family, community and voluntary sector and with some support from health and community care services. Community Health Partnerships (CHPs) and MCNs need to fully involve service users and their carers if they are to promote a culture change that empowers supported self management and access to community-led health.

Formal care and support, when required, is largely delivered at home through services provided by primary care teams together with social care and housing partners as well as independent contractors such as community pharmacists. The capability and potential of community-based services is maximised through an effective extended primary and community team that in turn collaborates well with more specialist services. This extended community team and its specialist support has a key contribution to the delivery of care in community hospitals and in care homes.
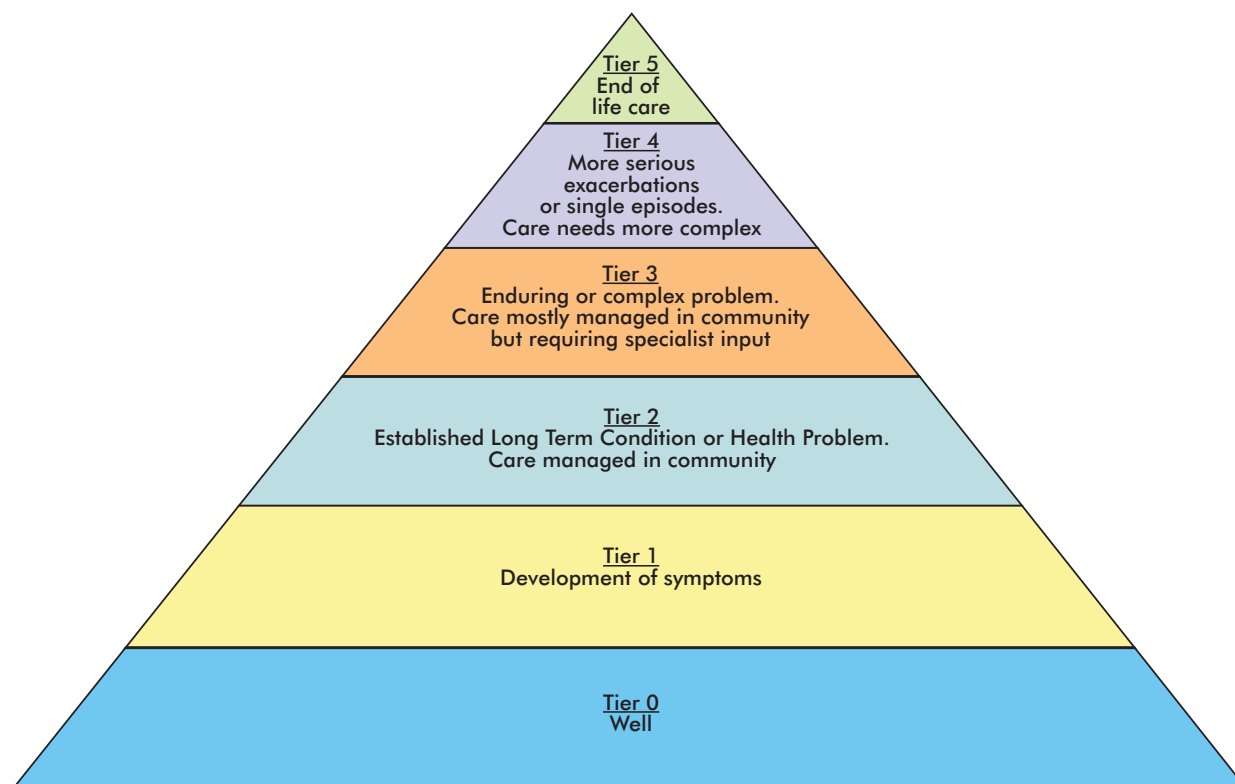
This model requires an integrated approach to skills mapping, workforce development and support for ongoing education and development of the multi-professional team. It also requires defined pathways that support effective care, avoid needless delays, duplication and waste, reduce inappropriate variance in practice and improve access, coordination and continuity of care across teams, agencies and settings.

Pathways need to be viewed as a continuum and considered from the point of view of the person not the condition. They need to be well signposted so that they are easy to navigate for patients, their families and for staff providing care.

Good quality pathways ensure a timely, smooth and coordinated journey across the whole system and a better experience for all. They support care that is safer, more efficient and effective by making it easier for us all to do the right thing.

Tier 0: Well

Describes services provided at home and in community settings with and for people who are well. Services aim to inform and educate the general public about lifestyle choices and self management, raising awareness of how to access services if needed. They may include targeted health improvement for those with risk factors for long term conditions as well as population wide prevention and health improvement.

Tier 1: Development of symptoms

Identifies those first level services provided to help people who are now developing symptoms of ill health. The purpose is to enable speedy access to an informed first point of contact, usually in primary care but including access out of hours. The aim is to facilitate accurate early diagnosis and appropriate management and to inform and support people to manage their condition with help from family, community and voluntary sector partners.

Tier 2: Established long term conditions with needs met fully in the community

This applies to the majority (70-80%) of people with long term conditions. The aim of Primary Care services, with community and voluntary sector partners, is to support people to manage their conditions and maintain their health and wellbeing. Maximising quality of life and independence at home may require additional support from outreach rehabilitation, diagnostic, social care and housing services.

Tier 3: Long term conditions mainly managed in the community but requiring specialist input

This reflects the needs of people supported by the primary care team but who require additional, usually intermittent, specialist support delivered mainly in the community or in Community Hospitals. There is a greater need for effective coordination across teams with multi-disciplinary and multi-agency working. It may be appropriate to consider introducing Anticipatory Care Planning and to explore carer support needs.

Tier 4: Frequent exacerbations and people with more complex care needs

This applies to people with serious acute conditions and/or exacerbations of long term conditions. Services need to be well coordinated with timely access to a range of professionals across care settings and agencies. As well as increased involvement of acute hospital services there is a need to deliver effective packages of care and equipment that proactively and continually support people with complex needs. This requires an integrated approach to planning, workforce development and care delivery as well as an effective use of telehealth and systems for information sharing.

Tier 5: End of life care

Coordinated multi-professional and multi-agency care that supports informed choice for the individual and those close to them. It is generally more appropriately delivered in community or hospice settings as opposed to an acute hospital.

An example of an integrated care pathway from NHS Lanarkshire

NHS LANARKSHIRE

| Diagnositc | Self management | Early intervention | Post care | Specialist Home Support |

COPD
Whole System Service

Outreach & Training Service

MKKD CCPD Self management & Signposting to Exercise for Health

MKKD CCPD Self management & Pulmanory Rehabilitation

Severe to very severe COPD: Domicillary Self management & Home Exercise Diary

CCPD Supported Self Care

H A&E

Respitory Hospital @ Home

Respiratory Home Support Service

Long Term Oxygen Service

CCPD Palliative Care

Consultant Respiratory Physician

Inequalities Targeted Case Finding

Through systematic targeted approaches to case finding, people who have long term conditions not yet identified on GP disease registers, or other related systems, can be identified and more effectively managed. This may include secondary prevention, pharmaceutical care, lifestyle advice and signposting to local supports for self management. At the same time those who do not yet have a long term condition but are at risk of developing one can benefit from primary prevention activity, lifestyle advice and supports for health behaviour change.

Ambulatory Care Sensitive Conditions

Ambulatory care sensitive conditions are illnesses, mainly long term conditions, for which hospitalisation is thought to be avoidable and where adequate care can safely be provided in primary care. This requires careful assessment and decision-making, supported by alternatives to bed based acute care for people whose illness severity does not or no longer requires an acute hospital bed. The NHS Institute for Innovation and Improvement developed a *Directory of Ambulatory Care for Adults* that identifies conditions that may be amenable to primary care provision and where efficiency and productivity gains and improved experience are possible through service redesign. There are essentially four groups to be considered:

1. Diagnosis exclusion – referral for the purpose of exclusion of a specific diagnosis. Individuals can be discharged with a zero length of stay.

2. Low-risk – people with conditions for which senior review with 'risk stratification' can enable early discharge.

3. Specific procedure – people who require a specific procedure or treatment.

4. Infrastructure required – people who can be managed as an outpatient with the appropriate infrastructure.

Long term conditions where effective ambulatory care can prevent flare-ups include asthma, COPD, diabetes and heart failure. These are the principle conditions that make up the current HEAT Target T6:

To achieve agreed reductions in the rate of hospital admissions and bed days of patients with a primary diagnosis of COPD, asthma, diabetes or CHD from 2006/07 baseline to 2010/2011.

Complexity through Multiple Morbidity or Inequalities

Where possible, we should design services that can support the needs of people with multiple morbidities. Many people will have additional social, psychological and economic factors that increase the complexity of their needs. This requires a fully integrated response across health, social care, housing, employment, benefits and voluntary sector partners. Health inequality remains one of our biggest challenges in Scotland. People living in the more deprived communities are likely to have greater complexity of needs and are more likely to be high users of health and social care services at a younger age. Poverty is also a risk factor for late presentation with long term conditions. Those most disadvantaged are least likely to be able to make best use of available health services and support for self management.

2. INVOLVE MANAGED CLINICAL NETWORKS

Improvement Actions:

- Use MCNs as improvement champions

- Share learning from patient and carer participation developed by MCNs

- MCNs should engage with the relevant local Voluntary Sector groups to oversee quality of disease specific and generic patient information

BACKGROUND

Managed Clinical Networks (MCNs) have been around for over 10 years and although each one is different, they all comply with the same core principles. The purpose of a Managed Clinical Network is to link people across boundaries to improve services for the people using them. Very few people are employed in Managed Clinical Networks, rather they achieve results by enabling participants to come together to work through what needs to change.

MCNs have a key role in the work to develop and support the LTC model of care. They have wide functional and system wide membership and include the interest groups relevant to a particular condition. They have a particular role and responsibility for:

- Provision of disease based clinical leadership – promoting clinical excellence

- Identification and promotion of best practice to improve disease based care

- Provision of a focus for various stakeholders to contribute to improvements in both service and care

- Making change happen – acting as change agents

A large proportion of LTC patients have co-morbidity and, if we are going to be truly person centred, then we need to shift the service towards generic pathways. We need to move away from our current fragmented service needs to be more effectively integrated.

Can we develop one stop 'LTC' clinics to address more than one condition, e.g. Diabetes and CHD – so that people have one visit rather than many, and tell their story once? Clearly this benefits both the person and the service.

The person with a long term condition experiences support from a range of professionals and agencies. All too often there are gaps, overlaps, and poor communication across these individuals and agencies. The MCN takes an integrated approach both within the NHS and across the range of partnership agencies with whom it engages. We all need to recognise that our service is part of a bigger whole. We need to build common goals and clarify our roles and those of our partner organisations to ensure that the journey and processes experienced are truly "seamless".

In a whole systems approach there is a need to give due emphasis and recognition to people's social care and support needs as well as their health needs. Good examples of integrated multi-agency approaches include:

• Integrated care management

• Condition management and paths to employability

• Anticipatory care work on health literacy and financial exclusion issues

• Multi-agency care networks for older people and learning disability

In any customer improvement programmes, companies focus on obtaining customer input and feedback. The same principle applies to our service improvement. If we genuinely believe in placing the patient at the centre of the service, then we have to actively support patients and carers to

provide feedback and ideas. MCNs have been working with people to identify what problems they commonly face. They have great ideas on how to improve care for long term conditions – get their contribution.

There are recurring issues and common themes faced by all MCNs. We need to get better at identifying and sharing success and promoting best practice both within and across MCNs.

Have you fully engaged the energy, expertise and reach of your local MCNs?

The majority of MCNs focus on long term conditions such as diabetes, coronary heart disease, respiratory disease, stroke and palliative care at local NHS Board level.

There are a number of regional networks for cancer, learning disability, epilepsy and child protection.

A number of national networks address paediatric conditions, pathology, diagnostic imaging and acquired brain injury.

There are now 134 MCNs listed on the SHOW website www.show.scot.nhs.uk. All are happy to be approached for further details. Please note that the SHOW list is currently being updated. For the most recent version, please contact Helen.Alexander@lanarkshire.scot.nhs.uk

Here are some ways that MCNs support quality improvement. Full details can be accessed at: http://www.nesc.ac.uk/action/esi/contribution.cfm?Title=1011

Sharing Resources and Experiences

MCN Function	Example
Change Agent group Quality Improvement Champions	MCNs have a quality assurance framework. They work with local improvement programmes, rehabilitation coordinators, PFPI structures and clinical governance groups and provide regular quality audit reports
Balance the evidence base with user experience	In developing their COPD guidelines, Lothian's Respiratory MCN involved people with COPD and their carers to advise on the issues they felt needed to be addressed
Engage a wide range of stakeholders	The National Paediatric MCNs support the whole family under difficult circumstances. They do this in innovative ways through facilitated family days, information roadshows and family evenings with invited expert speakers
Improve equity of care	Tayside respiratory MCN champions telepulmonary rehabilitation to increase access for rural communities
Develop generic pathways across related conditions	Lanarkshire's MCNs are working collectively with council leisure services to widen access by introducing generic cardio and strength & balance classes, replacing some existing condition-specific classes
Design pathways to enable faster diagnosis/management plan	Diagnostic pathway for heart failure currently being piloted in Victoria Infirmary for GPs in SE Glasgow CHP. See Appendix 4 for full details of the pathway
Develop as multi-agency care networks	The South East and Tayside Learning Disability MCN operates across four NHS Boards and nine local authorities. It produced accessible communication guidance to support setting up a new regional forensic unit
Involve and support carers	Lanarkshire's Palliative Care MCN is training unpaid carers to explore the support needs of other carers, anticipating that the interviews will be qualitatively different when carried out by someone with a shared caregiver identity
Focus on the service user	The Young People's Involvement Group of the West of Scotland Child Protection MCN produced leaflets (pitched at two levels of understanding) on what young people need to know about a forensic medical – not what the professionals think they need to know
Amplify the voice of people who use services	Voluntary organisations have supported many CHD, Stroke, Diabetes and Respiratory MCNs to deliver VOICES training, which supports lay representatives to effectively contribute to MCNs and influence service improvement
Deliver structured education for staff and patients together	The Respiratory network in Ayrshire and Arran is engaged in the Co-creating Health programme where staff and people with COPD learn together
Share and spread good practice	The National Acquired Brain Injury MCN led the development of standards of care for Traumatic Brain Injury and developed underpinning educational competencies to share and spread across Scotland
Collaborate with other organisations to improve services	NHS GG&C's Heart Disease MCN are working with Chest, Heart and Stroke Scotland and British Lung Foundation to set up a heart failure/COPD support service

3. SYSTEMATIC REGISTRATION, RECALL AND REVIEW

Improvement Action:

- Embed care and review prompts and protocols in information systems

BACKGROUND

Registers

An accurate, complete and current register is the crucial starting point to improve care with and for people with long term conditions. By ensuring the register is complete, information is correct and people are being treated to target, practices will ensure better outcomes for their patient population.

The use of agreed protocols to code patient information ensures consistency within the practice team. Standardised templates ensure a systematic, consistent approach to recording accurate and complete information. Once the register has been established and validated it is essential that its validity is maintained by ensuring that information on new and existing patients is gathered and recorded accurately.

Recall

The ongoing management of people with long term conditions depends on having a system for call/recall that ensures people are invited for review *at least* annually and that attendance and follow-up of people who do not attend is tracked.

The use of birth date or recall dates allows the practice to spread the reviews over the year. Use of a multi-disease register means the person will attend only one or a minimum number of clinics thus saving appointments for the practice and time for the individual.

Review

A template or checklist for the annual review should include:

- Physical examination
- Laboratory tests and investigations
- Lifestyle issues for discussion
- Support for Self Management

Lifestyle issues may include topics such as smoking, alcohol, stress, physical activity, sexual problems and healthy eating. This extends to conversations about supporting well being, understanding current treatment and medication, managing symptom control, identifying personal goals and anticipatory care planning.

A system of short appointments, disease specific clinics, and practitioners with specialist interests may suit people with acute illness, single conditions or need for brief episodic contacts. For people with multiple morbidity, lifestyle challenges and comorbid mental health problems it is helpful to schedule planned holistic reviews that address the individual's overall support needs and allow a more integrated approach to anticipatory care and support for self management. This is particularly important where people have low levels of literacy. Practices participating in the Scottish Primary

Care Collaborative (SPCC) have used the following ideas to improve outcomes for people with long term conditions:

Registers

- Agree definitions for the disease description and define the Read codes to be used to ensure consistency of coding
- Identify missing key indicators from register
- Cross reference people on register with people receiving repeat prescriptions to ensure that everyone is on the register
- Ensure that everyone on the register has had their diagnosis confirmed by the appropriate test e.g. spirometry, kidney function or blood glucose
- Make one person responsible for coding and updating register

Recall

- Use the patient's birth date or recall date and invite patients to attend for a review by sending a personalised letter or telephoning the patient
- Use repeat prescription note to inform patients that a review is due and that no further scripts will be issued until the review takes place

Review

- Ensure that blood results are available at the review
- Identify people with suboptimal results and review treatment
- Develop practice protocols for staff use to ensure consistency of treatment and advice
- Improve patient education through the use of leaflets regarding medication and results
- Construct systematic coordinated recall for people with multiple morbidity

Did Not Attends

- Use prompts in patient notes or the computer system for the patient to be reviewed at next visit or telephone the person to ascertain why they did not attend and arrange alternative date

SHARING RESOURCES AND EXPERIENCES

- Armadale Medical Practice validated their diabetes register and introduced a managed programme of care for people with diabetes
- Thornhill Health Centre, Dumfries and Galloway – Practice Nurse Janette McQuarrie redesigned her diabetic clinics to ensure that laboratory results were available in time for the clinics
- Sleet Medical Practice on the Isle of Skye applied Improvement Methodology across the extended practice team to develop systematic recall for people with diabetes
- Dr Lorna Dunlop, Riverview Practice, Johnston, Renfrewshire developed an IT solution to coordinate the recall of people with multiple morbidity and established the role of a complex care nurse (DRM Dunlop Recall Management)

Further information can be found in this Scottish Primary Care Collaborative Report
http://www.scotland.gov.uk/Publications/2008/01/14161901/7

4.   IMPROVE ACCESS

Improvement Actions:

- Develop an information directory
- Provide a single point of contact to help access services
- Provide as much care as possible in the community

BACKGROUND

Understanding the services and support available and navigating the complex health and social care system can seem daunting both for professionals and for the person/carer living with the condition. Access can be enhanced by applying improvement techniques to understand service needs, match capacity to demand, streamline care processes by identifying and signposting people to the most appropriate person to meet their needs, and by adopting a single point of contact approach for access to services.

Demand, Capacity, Activity, Queue (DCAQ)

To maximise patient flow, services must be able to manage and flex their capacity and activity to meet changes in demand. To achieve this we need to look at the whole patient journey and, through process mapping and flow analysis, assess the service capacity, overall demand, backlog and activity issues wherever there are queues, waiting lists or capacity bottlenecks. Demand, capacity, activity and backlog need to be measured in the same units for the same period of time. The goal is to redesign the pathway to manage capacity and demand effectively and sustainably.

Referral to extended MDT

Explicit pathways can ensure that people are streamed to the right person, in the right place, at the right time. This may be the doctor, practice nurse, community nurse, CPN, pharmacist or allied health professional as well as the homecarer, social worker or voluntary sector support. Extending the scope of practitioners, introducing a skill mix to the team and involving the support of third sector and volunteers will enhance access and increase the productivity of the extended multi-professional primary and community care team.

AHP/Nurse Led Clinics

AHP/nurse led clinics have a valuable role in the management of people with long term conditions. AHPs and senior nurses undertake assessment, diagnosis, treatment and review for people with a range of long term conditions including diabetes, chronic pain, asthma, COPD, heart failure and stroke. These arrangements allow safe and effective care to be delivered more quickly and closer to home.

Directory of services and support

Staff and people with long term conditions need up-to-date information for effective decision making and signposting to available services. Pathways need to be supported by local protocols and service directories that include hospital and community based services as well as community and voluntary sector supports.

Single point of contact

There are benefits to be gained where health/social care professionals and/or people living with a long term condition can access services through a single point of contact which directs them to the most appropriate services to meet their needs. This minimises delays and duplication in assessments and enables earlier access to interventions. Examples include outpatient referral management centres, systems for direct access to simple equipment and referrals to community rehabilitation teams.

SHARING RESOURCES AND EXPERIENCES

- The Emergency Access Delivery Programme supports NHS Boards in shifting the balance of unscheduled care so that people will receive emergency care at the most appropriate level of the care system, as quickly and conveniently as possible. For further information visit the Shifting the Balance of Care website: www.shiftingthebalanceofcare.scot.nhs.uk/initiatives/sbc-initiatives/emergency-access-delivery-programme/

- Many Boards operate an Emergency Response Centre (ERC) as a single point of telephone contact for GPs to refer patients with urgent medical need. The call advisor takes the patient details and advises the GP of appropriate alternatives to hospital assessment or arranges hospital assessment where appropriate including transport if required.

- LTC Community Nursing Teams and Service Development Managers in NHS Lanarkshire and in Clackmannanshire have used DCAQ and LEAN methodology to review their processes. They have improved access by planning and allocating their caseload visits more efficiently and releasing time to care. A weekly Nurse Consultant led clinic extends specialist access for people with chronic pain and supports the training and development of community staff to hold local clinic. A Chronic Pain Self Management Toolkit supports people with chronic pain to manage their condition and reduces the need for follow up appointments.

- Glenrothes and North East Fife have a Single Point of Access service linked to a range of community rehabilitation services through a single phone number or e-referral. This minimises steps in current systems of referral and allocation, reduces inappropriate referrals and minimises delay in assessment and intervention for patients.

- Many teams have introduced ereferral forms for protocol led access to homecare and equipment provided by local authority partners. This reduces avoidable delays and improves the handover of information across teams and agencies.

- NHS Forth Valley have developed a **Service Information Directory (SID)** as a web based information resource providing easy access to information for patients and staff on what services are available and how to access them. www.sid.scot.nhs.uk

- 'Borders Health in Hand' www.bordershealthinhand.scot.nhs.uk supports people with local information and advice on health and self management.

5. PROVIDE COORDINATED TEAM-BASED CARE

Improvement Actions:

- Build effective working relationships with colleagues in other agencies
- Ensure case/care managers have the appropriate skill-set and experience
- Review and develop roles and enhance skill mix
- Give bespoke care to those with complex needs
- Clarify who has 'responsibility of care'

BACKGROUND

Integrated delivery systems such as the Veterans Health Administration and Kaiser Permanente achieve good outcomes for people with long term conditions. In these systems care is organised around multi-specialty medical groups incorporating primary physicians, nurses, allied health professionals and specialists.

In Crossing the Quality Chasm the Institute of Medicine endorsed the contribution made to quality through collaborative working and coordinated and integrated team-based care and support. Key principles are:

- Effective multidisciplinary team working and optimal skill mix
- Integrated working across care settings and agencies
- Anticipatory approach to assessment, care and support planning and review
- Signposted pathways that deliver coordinated care and support
- Clarity about responsibility through named case/care manager/key contact
- Good communication with patient, carer, care team and all agencies
- A workforce with the appropriate skills and capability

Effective pathways for long term conditions should deliver quality and value, maximise opportunities for independence and deliver person centred care and support closer to home. To achieve this we need multi-agency collaborations to respond to the increasing interdependency of partner organisations aspiring to deliver more personalised services, meet increasingly complex needs and rising public expectations.

Developing Workforce Capability

Sustainable improvement will require significant transformational change within and across partnerships. Developing the workforce is vital for modern, safe and sustainable services. This includes exploring new and extended roles for staff, greater collaboration and more development opportunities across disciplines and care settings.

Appropriate skill mix generates a capable, efficient, flexible team that works productively to achieve better outcomes. Achieving the right staffing and skill mix balance can free skilled practitioners from inappropriate duties and enhance capacity for direct care. It is difficult for educational programmes

to keep pace with all the changes taking place in health and social care services. The current emphasis is on developing a capable workforce that can adapt to future challenges.

- Competence describes knowledge, skills and attitudes at a point in time
- Capability describes how an individual can apply and adapt learning from experience and continue to develop their potential

SHARING RESOURCES AND EXPERIENCES

A Force for Improvement: The Workforce Response to Better Health Better Care (2009) identifies five over-arching workforce challenges for the 21st century: tackling health inequalities; shifting the balance of care; ensuring a quality workforce; delivering best value across the workforce; and, moving towards an integrated workforce. In the context of demographic pressure and legislative and regulatory frameworks for staff, leadership development is seen as essential in tackling these workforce challenges, in particular aligning service needs with the shape of the current and future workforce.

Co-producing Integration

- Whatever the organisational structure or resource framework in place, the first step to lever rapid improvement in team based care is through integrated approaches at practitioner level and with people who use services.
- Integrated community services may include one stop shops, day hospitals, local specialist outpatient clinics, models of care management, intermediate care and local urgent care services. They may also provide augmented care in people's homes and into care homes.

A range of integrated services are described at
http://www.shiftingthebalance.scot.nhs.uk/improvement-framework/high-impact-changes/multi-disciplinary-extended-community-teams-including-carers-and-users/

Essential Shared Capabilities

The ten essential capabilities, first developed for Mental Health, describe the capabilities that staff of all grades and professional backgrounds should have or should develop. These have resonance for the multi-professional team caring with and for people who have long term conditions. The ten capabilities are:

- Work in partnership
- Respect diversity
- Practice ethically
- Challenge inequality
- Identify needs of people and their carers
- Provide safe person centred care
- Make a difference
- Promote rehabilitation approaches
- Promote self-care and empowerment
- Pursue personal development and learning

6. DEVELOP REHABILITATION/ENABLEMENT

Improvement Actions:

- Develop intermediate care
- Build effective working relationships with colleagues in other agencies
- Lead and support a shift in culture for health professionals from paternalistic to one that empowers and enables
- Review and develop roles and enhance skill mix

BACKGROUND

Rehabilitation/enablement is a *continuum of enabling interventions*. These may include early anticipatory interventions, or targeted preventative work such as falls and fracture prevention. It also includes assessment, diagnosis and enablement through specific treatment (eg building effort tolerance) as well as support for self management and symptom management of long term conditions. It always involves **maintenance or recovery of function** including social participation and work.

Why does rehabilitation matter?

- It promotes safety and independence at home for high risk, vulnerable people including those with dementia – preventing avoidable admissions to hospital and to long term institutional care

- It delivers safe, supported and timely discharge from hospital – especially for people with complex needs – reducing hospital length of stay

- It makes effective use of 'first point of contact practitioners' and offers alternative pathways that reduce waiting times

- It reduces dependency on health and social care support and associated costs

- It delivers significant cost savings through alternative pathways of care and reduced longer term support costs

The Delivery Framework for Adult Rehabilitation aims to make rehabilitation services more accessible, delivered closer to home and an integral part of a care pathway. Rehabilitation Co-ordinators are working across health and social care services to support improvements in the patient journey through mapping and service redesign.

Rehabilitation is a key component of all pathways for long term conditions. It has an established role in pathways for people with cardiac disease and heart failure, chronic lung disease and chronic neurological conditions.

Three focused and measurable areas of work have been identified as new national priorities for rehabilitation services:

- Musculoskeletal Rehabilitation
- Rehabilitation/Enablement Services for Older People
- Vocational Rehabilitation

These focused areas will deliver radical re-design of rehabilitation services providing safe, cost effective and sustainable care for patients.

SHARING RESOURCES AND EXPERIENCES

National Musculoskeletal (MSK) Programme

This programme has a tiered approach. Key components are:

- Self management support via web-based access to new innovative services throughout NHSScotland, eg the Working Backs Scotland site and home based back pain rehabilitation are to be made available over the internet.

- Self referral through a centralised referral management system to expert physiotherapy advice to reduce GP consultation rates and speed up referral for orthopaedic surgery – work in Lothian is being evaluated.

- Integrated multi-disciplinary teams working within community settings carry protocol led triage with onward referral to the most appropriate service.

Chronic Pain

The MSK programme will be a key component of the tiered model for the management of chronic pain in Scotland. The pathway for chronic pain addresses themes, gaps and priorities identified in the 2007 report *Getting Relevant Information on Pain (GRIPS)*. For more information contact pete.mackenzie@scotland.gsi.gov.uk or visit www.nhshealthquality.org/nhsqis/7350html

A service model for chronic pain has been developed by the Chronic Pain Steering Group. Please see Appendix 3.

Vocational Rehabilitation/Fit for Work Services

These services aim to reduce longer term sickness absence and assist individuals within the workplace through rapid access to support and specialist advice from a dedicated vocational rehabilitation team. A 'fit for work' service, funded through Department of Work and Pensions and the Scottish Government, adopts a case management approach, focusing mainly on small and medium-sized businesses that lack their own occupational health service, and on workers in low-paid employment.

Pulmonary Rehabilitation

Pulmonary rehabilitation, delivered by a multidisciplinary team and including support for self management, can improve the health-related quality of life, exercise capacity and breathlessness of people with COPD. Recent innovations include delivery outwith hospital and through telehealth support. There is good evidence to support the benefits exacerbation and it is an essential criterion within QIS Standards for COPD.

Cardiac Rehabilitation

Comprehensive cardiac rehabilitation is exercise training together with education and psychological support that encourages people to make lifestyle changes to prevent further cardiac events. It is inexpensive, saves lives, helps people return to normal living and is being adapted for people with heart failure. The Braveheart project in Falkirk connects older people who have participated in cardiac rehabilitation with new entrants to the programme. This has produced considerable benefits for participants, mentors and health professionals alike.

Neuro rehabilitation

QIS Clinical Standards for Neurological Health Services includes a criterion around rehabilitation services. The Neurological MCN in Forth Valley has embedded rehabilitation within their pathway for neurological conditions.

Contact Derek Blues, Palliative Care and Neurological Disease MCN Manager:
derek.blues@nhs.net

7. DELIVER CARE CLOSER TO HOME

Improvement Actions:

- Provide as much care as possible in the community
- Make home care flexible, responsive and enabling
- Develop community hospital role
- Develop intermediate care

BACKGROUND

Shifting the Balance of Care aims to achieve better outcomes for people by delivering care and support at home, or closer to home in community facilities. This may involve shifting the location of care, sharing responsibility by empowering a different member of the multi-professional team, or shifting the focus of care through an anticipatory approach that prevents or delays dependency and need for more intensive support.

Community hospitals and local care centres

Community hospitals are as diverse as the communities they serve. In the last decade, community hospitals have moved away from the traditional inpatient model towards being a hub for community health services. Community heath services are key to providing more care closer to home, ideally integrated or co-located with social care, housing support and third sector organisations.

Care at home with support for carers

Most people want to be cared for safely in their own home for as long as possible. Maximising care at home shifts the focus from institutional care to flexible and responsive care and support provided at home. To achieve this, paid and unpaid carers need greater education and support to manage care at home, including better access to respite care. They are important members of the extended community team, alongside partners from community and voluntary sector organisations.

Intermediate care

Intermediate care is a range of integrated community based services to prevent avoidable hospital admission, support timely discharge from hospital, maximise independent living and avoid premature long term care. Some services are condition specific (eg COPD hospital at home/stroke supported discharge) but most are generic services for frail older people delivered by integrated community teams with timely access to specialist expertise. Some services also support people in care homes, bridging the gap between home and hospital. For more information refer to the Joint Improvement team website: www.jitscotland.org.uk

Falls Prevention

The Prevention and Management of Falls Community of Practice has a number of active sub-groups and a wider, online Falls Community to share knowledge, information, good practice and resources to support the development of services to identify older people at greatest risk of falling and ensure timely access to comprehensive falls management programmes delivered at home or close to home. For more information refer to the Falls Community Website – www.fallscommunity.scot.nhs.uk

SHARING RESOURCES AND EXPERIENCES

Releasing Time to Care

Productive Community Services (PCS) is an organisation-wide change programme developed by the Institute for Innovation and Improvement. It systematically engages front-line nursing and therapy teams in improving quality and productivity. It is a practical application of Lean based techniques that empowers staff to challenge practice and use their experience and knowledge to develop local solutions to:

- Create a stable and organised working environment
- Predict and plan work
- Promote effective team working
- Remove waste and reduce frustration
- Increase patient facing contact time
- Deliver high quality, safe and consistent care for each patient
- Connect more closely with the patient experience

Through Releasing Time to Care in Community Hospitals, teams in NHS Borders and Lanarkshire are improving access and flow to their community beds, increasing opportunities for rehabilitation by greater capacity from allied health professionals, taking a more streamlined approach at handovers and team meetings and releasing GP and nursing time to directly care for people. Through action learning sets and networking the learning is shared with teams from other clinical areas and Boards.

Augmented Care at Home Service

Invergordon County Community Hospital, Ross & Cromarty. This service is integrated with the practice and community hospital and facilitates early discharge and unnecessary admission to hospital. Recently, supporting joint working with Local Authorities and Health, the service aims to prevent Delayed Discharges for those patients waiting for home care provision.

Contact: Isobel Clayton, Team Leader isobella.clayton@nhs.net Tel. 01349 855670

East Ayrshire CHP – Partnership Working Step-up, Step-down Care

Ross Court in East Ayrshire is an example of partnership working between the CHP and East Ayrshire Council to develop a locally based service that will benefit older people in the community. It provides a flexible, needs led service within a homely environment where individuals can receive time limited support covering a range of complex needs which may be physical, emotional, social or recreational and which may include nursing and medical interventions. This provision is a step-up, step-down support and is used to reduce the likelihood of acute hospital admission, enabling the person to return home.

NHS Dumfries and Galloway – Short Term Augmented Response Services (STARS)

STARS provides early input to patients in order to avoid unnecessary hospital admission and supports early discharge by providing intensive rehabilitation in the person's own home.

Contact: Gail.edgar@nhs.net

Evaluation of 'Closer to Home' Demonstration Sites

A report from the National Primary Care Research and Development Centre summarises the experiences of 30 demonstration sites:

http://www.npcrdc.ac.uk/Evaluation_of_Closer_to_Home_Demonstration_Sites.htm

8. PROVIDE PHARMACEUTICAL CARE

Improvement Actions:

- Improve delivery of pharmaceutical care
- Use independent and supplementary prescribing, where appropriate, to make medicines more accessible to people
- Work with local community pharmacies

BACKGROUND

Pharmacists are ideally placed to support people to manage their conditions. Poor adherence is known to occur in about 50% of people on multiple drugs and is particularly common in people with lower health literacy. Associated healthcare costs and premature morbidity/mortality are now at epidemic proportions. Medicines are frequently not taken as prescribed, due to multiple and complex reasons including adverse drug reactions (ADR). ADR are often implicated in hospital admissions. These issues can be addressed through proactive medication reviews which include checking control of symptoms, side effects and concordance with prescribed drugs. Pharmaceutical Care is already delivered successfully by pharmacists working within CHCPs/Practices and through joint working with community pharmacies.

With the advent of the Chronic Medication Service, people with long term conditions will be registered with an individual pharmacy with a view to their pharmaceutical care needs being identified and supported. Serial prescriptions will be issued by the GP with plans for the pharmacist to carry out monitoring in between.

Many pharmacists currently run clinics as supplementary and independent prescribers. They work with patient groups with long term conditions like diabetes and COPD, and those with obesity and substance misuse problems. Pharmacists can play a key role in reviewing these patients medication and contributing to their treatment plans. Prescribing allows them additional flexibility to adjust as well as review the treatment plans and to prescribe for acute exacerbations where appropriate.

Reconciliation of medication at times of transfer in and out of hospital is important for safe and effective pathways. Medication management has an essential role in the care management for many people with complex conditions, for example in relation to multiple medication with high risk of adverse events and emergency admissions to hospital. Medication is also an important element of anticipatory care planning – ensuring that the person has access to 'just in case' drugs for anticipated flare ups. Providing a supply of antibiotics and steroids for patients with COPD is such an example of anticipatory prescribing.

As all these roles develop it is essential that pharmacists are seen as part of the healthcare team. They need access to relevant clinical data and need to be included in education and development programmes about long term conditions, self management and behaviour change to help people better manage their symptoms. Long term conditions commissioners should seek to engage pharmacists in managing long term conditions.

SHARING RESOURCES AND EXPERIENCES

Falls prevention

In Edinburgh and in Glasgow people prescribed multiple medication and who are at risk of, or have had a fall, now routinely benefit from a medication review. In Edinburgh the reviews are provided by integrated care pharmacists or primary care pharmacists with communication with the community pharmacist. The NHS Greater Glasgow & Clyde (GG&C) pharmacy team link with community pharmacists to refer people who require ongoing support. The community pharmacists are provided with training, remuneration, standardised intervention checklists and are supported by the practice or Falls team.

Community heart failure service

The GG&C heart failure nurse liaison service (HFNLS) provides community-based structured education over eight weeks to stable newly diagnosed heart failure patients. This service also offers the opportunity for sessions with the community Heart Failure pharmacist in a choice of local community pharmacy premises. The session is designed to enable people to manage their condition better and includes basic education on heart failure medication, adherence support, symptom recognition and non pharmacological management issues (diet, salt intake etc).

COPD

The pathway in Forth Valley allows patients improved access to antibiotics and steroid medication through community pharmacy.

Contact: Katrina Kilpatrick, Forth Valley.
Katrina.kilpatrick@fvpc.scot.nhs.uk

Targeted support for people in areas of deprivation

In three GG&C CHCPs, community pharmacists identify patients within the Keep Well programme who have multiple co-morbidities, polypharmacy and struggle to take their medicines regularly. The pharmacists carry out a structured intervention when the person collects their medicines from the pharmacy. Evaluation demonstrates improved prescription collection, and onward referrals to other services or professionals as necessary.

Home carers

Dumfries and Galloway's 'Care at Home' and Grampian's Carers' Medicines Management Project provide guidelines, training packages and support for home care workers and others assisting people to manage their medicines.

Contacts: catherine.smith4@nhs.net and wendyrobertson@nhs.net

Tackling Health Inequalities in South Asian Diabetic Patients (NHS GG&C)

MELTS (minority ethnic long term medicines service) is an open referral service for any minority ethnic person who wishes a medication review. The referral route can be self referral, or by a family member or any primary or secondary care healthcare professional.

Contacts: Alia Gilani/Richard Lowrie, NHS Greater Glasgow & Clyde Pharmacy Prescribing Support
alia.gilani@ggc.scot.nhs.uk
richard.lowrie@ggc.scot.nhs.uk

9. OFFER TELEHEALTH AND TELECARE SUPPORT

Improvement Actions:

- Provide telehealth and telecare support for self management

- Offer telehealth solutions

- Provide telecare support

BACKGROUND

Telehealth is the provision of healthcare at a distance using telephony and broadband digital technologies to support videoconferencing and remote physiological monitoring. Telecare is the use of assistive technologies to support those in a home or community environment who would otherwise be at increased risk of coming to harm from a range of causes. Clinical involvement is not necessarily part of that package.

There is increasing convergence between telehealth and telecare with the introduction and expansion of remote monitoring as part of the 'telehealthcare' package available in a person's home. **Encompassing physiological monitoring, safety and security, information and support services and home based medical applications, telehealthcare solutions maximise independent living and minimise the risk to people remaining at home (including people with dementia).** They help to alleviate inequalities of service provision due to geography. This is particularly important for access to very specialist advice (eg for neurological services) and for delivery of rehabilitation in a model that maximises skill mix and remote mentoring.

Telehealth and telecare add much to the care and support of people with long term conditions and their carers and should become 'standard' components of our care pathways. Telehealthcare can improve the experience of care by reducing the need for travel to receive care and treatment. It supports self management, promotes confidence, reduces anxiety and decreases social isolation. It can facilitate better prevention, anticipatory care and earlier intervention and allows people the opportunity to receive care safely and effectively at or closer to home. Community hospitals need to be supported by technology that improves connectivity and diagnostics. This supports networks of learning for clinicians and connects GPs and specialists remotely to share knowledge, skills and avoid unnecessary referrals.

Telehealthcare is applied in a variety of ways in pathways for dermatological, cardiac, respiratory and neurological conditions. A first step in designing a telehealthcare service for a specific care group is to segment the population. For example a tiered approach to telehealthcare for people with COPD may be:

1. Web-based support for self management – widely available to all in the most appropriate media for the learning needs

2. Digital prompts for people with mild to moderate COPD and little additional limiting illness. Advice and prompts may be delivered by centralised call handling

3. Home-based physiological monitoring – targeted at people with moderate to severe/unstable disease and delivered with close supervision of the clinical team

4. Care management +/- telecare for people with complex/palliative care needs

SHARING RESOURCES AND EXPERIENCES

Access

Telehealth solutions can be email based such as the photo triage services for dermatology in Lanarkshire or Forth Valley. This has reduced costs and waiting times, speeded up skin cancer diagnoses and enabled 93% of patients to have definitive treatment at their first visit to hospital.

The specialist service from Quarriers, the National Tertiary Centre for Epilepsy for people with Learning Disability is a highly innovative service. Without access to the new video conferencing clinics, people and their carers would have to travel some 330 miles. For most people, this is out of the question due to the severity of their epilepsy or physical disabilities.

Contact: Scottish Centre for Telehealth Cathy.dorrian@nhs.net

The Scottish telestroke programme is a group of projects that aim to improve access to hyper acute stroke care by providing thrombolysis decision support and TIA assessment remotely, using video consultation and PACS imaging. Telestroke project groups will now be a vehicle to support telehealthcare proposals throughout the stroke pathway, building on the established IT, MCN and patient and public links.

Contact: Anne.duthie@nhs.net

An audio-visual video link-up with Ninewells supports clinical decision-making in the minor injuries site at Crieff so staff can safely see and treat more people closer to home, especially during out-of-hours periods.

Contact: Claire McCormack, NHS Tayside Communications, 01382 424138

Monitoring

In Lothian people with COPD are being supported through technology in their homes with information about changes in symptoms being fed back to healthcare professionals, supporting and prompting self management and enabling early intervention when necessary.

Contact: Sandraauld@btinternet.com

Self Management

The Met Office Healthy Outlook® service forecasts weather and viral conditions which are likely to increase COPD exacerbations. It is a telephone prompted self-management programme which empowers people to take preventative action. Moray CHCP developed a centralised model to extend the reach of this project in partnership with their community based telecare project.

Contact: Lorna Bernard, Moray Telehealthcare Project Manager lorna.bernard@moray.gov.uk

TeleRehabilitation

Tele-pulmonary rehabilitation is being delivered in Perth & Kinross where patients and a physiotherapy assistant in Pitlochry community hospital are linked using videoconferencing to a physiotherapist in Perth Royal Infirmary. In NHS Highland a research project is studying the delivery of pulmonary rehabilitation to patient's homes. The successful Tayside model is a template for tele-pulmonary rehabilitation throughout Scotland and is being looked at as a model for other rehabilitation e.g. Cardiac.

Contact: Anne.duthie@nhs.net

More details are available on the SCT website http://www.sct.scot.nhs.uk/

10. SHARE INFORMATION AND REAL TIME DATA

Improvement Actions:

- Share information and communicate real time patient data to relevant people.

- Be Out-of-Hours smart – understand your Out-of-Hours pathways

- Build long term solutions into existing tools like the Emergency Care Summary, Palliative Care plans and Out-of-Hours Special Notes

BACKGROUND

For any professional delivering care in-hours or out-of-hours, whether face-to-face, by telephone or on-line, up-to-date, accurate, relevant information specific to the individual is critical to the successful outcome of the encounter. Such information must be accessible and meaningful and its sharing must be secure. Undoubtedly, the professional's experience, training and consultation skills and competencies are equally important. With this in place information sharing contributes to all six dimensions of quality of care.

Role of eHealth to support the pathway

Current eHealth objectives contribute to the Long Term Conditions Action Plan and to improvements in the pathway. eHealth aims to improve access to health information, to join-up GP and hospital information services and enable quicker access to results for lab tests and x-rays.

A key priority is the Clinical Portal Programme. A clinical portal is an electronic window that will allow clinicians to access different pieces of information about individual patients in a 'virtual' electronic patient record derived from various databases. NHS Tayside and NHS Greater Glasgow and Clyde are already implementing portal technology. Their experience is being used to inform the programme, support the delivery of portal technology across Scotland and highlight how it will benefit both work process and patient care. Easier access to information will support improved care delivery and decision making. Patients can be reassured that staff have the necessary information to be able to manage their care safely.

Unscheduled and Out of Hours Care

NHS 24 frontline staff report definite benefits from accessing patient-specific Special Notes and the Emergency Care Summary (ECS), including the ePalliative Care Summary. This information, of vital importance in unscheduled care, improves decision making with and for people with long term conditions. The ECS is available Scotland wide to NHS 24, Out of Hours Services, A&E departments, some acute receiving units and pharmacists. It is currently being piloted with the Scottish Ambulance Service. Its dataset has been expanded to include a Palliative Care Summary which will support the Gold Standards Framework Scotland. A paper process is already in place and an electronic version is now being rolled out. This will provide an electronic platform to share anticipatory care plans that contain details of carer and key professionals, diagnosis and current treatment, preferred place of care, current care arrangements, patient and carers awareness of their condition and advice for Out of Hours services.

SHARING RESOURCES AND EXPERIENCES

Primary and Community Care

The Multidisciplinary Information System (MiDIS) demonstrator project is currently live in NHS Tayside and NHS Lanarkshire and NHS Dumfries and Galloway are testing the system to support Community Nursing Teams, Mental Health Teams and AHPs share information. A single forms library to support care plans and assessments can be shared across the various service groups enforcing common data standards and improving data quality. There are also plans in Tayside to link MiDIS to the GP record. To support GPIT in all Boards, a framework contract for GPIT will be in place in February 2010 and Boards can move over to these relevant systems from then.

Integrated Care

NHS Tayside is implementing a clinical portal that provides patient centric information for both primary and secondary care clinicians, with much of the information originating from a significant sub-set of the GP record. The portal presents this information as a virtual electronic patient record divided into logical panels or portlets.

NHS Ayrshire and Arran have developed an effective system for identifying and tracking people with long term conditions who are at high risk of readmission to hospital. When people are admitted to hospital, their GP Practice is informed within 24 hours, meaning that the person's care can be better coordinated and their discharge from hospital better planned. People have had their length of stay reduced and been able to safely and quickly return to their care at home.

Ambulatory Care

NHS Greater Glasgow and Clyde has implemented a clinical portal in their new Ambulatory Care Hospitals. It supports the whole patient pathway by removing information silos and provides easier access to information. The portal will be combined with a scanning and electronic document management solution to provide a "paper-light" environment.

Patient eHealth

This will support the long term conditions work through better involvement of people in their care, better access to information to support self management and to provide education support for staff to improve health literacy. Projects include; NHS Inform, which is being led by NHS 24 and will support improved access to trusted sources of Health Information via the internet. NHS Education for Scotland have also been developing educational support approaches for the knowledge worker role.

NHS Ayrshire and Arran is developing a portal for people with long term conditions. The project aims to develop a model for engagement and secure access, to meet the functional requirements identified by patients to support them to manage their health, identify the benefits and share lessons learned. The main capabilities encompass access to information both from NHS records and trusted sources on health, diseases and their treatment options, as well as the ability to access services and utilise electronic communication channels. The priority is for people to be able to personalise their own portal. The patient portal project will include a pilot of eCorrespondance in order to support improved communication with patients.

Learning from these and other established projects such as the Renal View patient portal, will help to shape future direction of patient eHealth.

REFERENCES AND LINKS TO FURTHER INFORMATION

Generic Choice Model for LTC, Department of Health (England), 13 December 2007

Highlights how the care planning process feeds into the commissioning of more personalised services for people with LTC.
http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH_081105

A Force for Improvement: The Workforce Response to Better Health, Better Care (2009): The Scottish Government, Edinburgh

The framework contained in this document highlights the role the workforce can play in delivering better care and the work to improve the investment in staff training, development and wellbeing.

NHS Institute

This provides access to the Institute's document on Multidisciplinary Team Working which can be downloaded once registration is complete.
http://www.institute.nhs.uk/index.php?option=com_joomcart&Itemid=194&main_page=document_product_info&products_id=432

NHS South Birmingham

This link provides access to a webpage describing the core integrated multidisciplinary team and virtual team supporting people with long term conditions.
https://www.sbpct.nhs.uk/YourServices/ServiceChange/Integratedmultidisciplinarycommunityteam.aspx

NHS Innovations

This document provides information of the Pulmonary Rehab Training Programme in NHS Innovations South East
http://www.innovations.nhs.uk/downloads/120_Pulmonary_Rehabilitation_Training_catagory.pdf

Stroke MCN Scotland

This link provides information on the Framework for Adult Rehabilitation together with a list of high impact changes and recommendations.
http://www.nhsgstrokemcn.scot.nhs.uk/wp-Content/uploads/2009/08/frameworkforadultrehabilitationsummaryofhic1.pdf

University of Birmingham/NHS Institute for Innovation

This document is a review of UK and international frameworks for improving care for people with long term conditions.
http://www.improvingchroniccare.org/downloads/review_of_international_frameworks__chris_hamm.pdf

Australian Public Health Information Development Unit

The information in this atlas adds to a convincing body of evidence built up over a number of years in Australia on the striking disparities in health that exist between groups in the population. People of low socioeconomic status (those who are relatively socially or economically deprived) experience worse health than those of higher socioeconomic status for almost every major cause of mortality and morbidity.
http://www.publichealth.gov.au/publications/atlas-of-avoidable-hospitalisations-in-australia

Remote daily real-time monitoring in patients with COPD – A feasibility study using a novel device

The study involved remote monitoring and spirometry by patients and resulted in reduced hospital admission based on parallel data from the previous year.
http://www.resmedjournal.com/article/PIIS0954611109001000/abstract

Sheffield PCT

Article on the Sheffield Telehealth Project for people with lung conditions. The team involved won an award in the Innovative Information and Communications category in the Health and Social Care Awards.
http://www.sheffield.nhs.uk/news/award040408.php

Hampshire Community Health Care

Web article about the introduction of Community Hospital Releasing Time to Care projects undertaken in Gosport, Petersfield and Hythe and how direct time to care has increased as a result.
http://www.hchc.nhs.uk/component/content/article/75-press-releases/74-hampshire-wards-to-get-productive

Strengthening The Role of MCNs, HDL (2007) 21, Scottish Executive Health Department

Royal Pharmaceutical Society

Copy of the Executive Study for integrating community pharmacy into long term conditions care.
http://www.rpsgb.org/pdfs/ltcondintegcommphsumm.pdf

The Scottish Government

Link to the guide for implementing supplementary prescribing for pharmacy practitioners in Scotland.
http://www.scotland.gov.uk/Publications/2004/06/19514/39164

Loughborough 2007

An expert group established a series of priorities for improving care for those with long term conditions such as asthma, Chronic Obstructive Pulmonary Disease (COPD), diabetes and Parkinsons disease.
http://www.inloughborough.com/news/000412/A%20seamless%20service%20for%20long-term%20care

Northumbria Healthcare NHS Foundation Trust

This links to a presentation by Dr Simon Eaton, Consultant Diabetologist on 'Partners in Care: How to make care planning a reality in your service.
http://www.diabetes.nhs.uk/document.php?o=73

Information and Communication of Real Time Data

Information about The Clinical Portal:
http://www.ehealth.scot.nhs.uk

ECS http://www.scimp.scot.nhs.uk/clinical_ecs.html

ePCS http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/LivingandDyingWell/ePCS

Further reading can be found by visiting the LTCC Community of Practice website:
http://www.knowledge.scot.nhs.uk/ltc

APPENDIX I: LOGIC MODEL

NHS FORTH VALLEY

Multiple Sclerosis Logic Model

Input	Process		Outcomes

Input
- GPS
- Nurses
- AHPs
- Social Workers
- Voluntary Organisations
- Consultants
- Patients
- Carers
- HB, LA, SG

Process
- Engage with all organisations to principles, process and philosophy of care
- Strategic buy in/ Operation buy in from all organisations
- Match workforce to need & demand
- Map of current service
- Integrated workforce
- Define need
- Provision of undisciplinary and multidisciplinary training by informed expert trainers
- Ongoing review of service provision
- Engage key stakeholders (TNA & Map)
- Joint education training & review by workforce
- Discuss pathways with all relevant stakeholders
- Clarity of roles within workforce
- Use of best model care by integrated workforce
- ACP developed as mainstream – part of patients care
- Patient/carers informed & educated re ACP & self management plan
- Align services with need
- Informed Patients managed to quality standards

Outcomes
- All patients managed to best practice guidelines
- Shift in balance
- Effective partnership
- Holistic community based care
- Patients & carers partners in care

APPENDIX 2: DRIVER DIAGRAM

NHST Community Strategic Improvement Plans

Aims:

Reduce bed days for people with complex needs.

Outcomes: (by Nov 09)

Increase number of people with complex needs being case managed by DNs in each CHP

Housebound people to have an anticipatory care plan

Increase direct care hours

Test virtual ward model

Increase number of people with LTCs completing generic self management courses

Reduction in number of emergency admissions from care homes

Reduction in number of multiple admissions for people aged 75+

Primary Drivers

- Community Nursing – patient contact time/ anticipatory care
- Patient focused management plan approach to reducing multiple admissions in over 75s
- Scope and Implement Virtual Ward
- AHP – Increase Capacity in Community Settings
- Promote self management

Secondary Drivers

- Case Management
- Anticipatory Care Plans
- Care offered at home
- Access
- IT Systems
- Communication
- Integrated Care
- Proactive management of care
- Staffing / Skill Mix
- Training / Education
- Rehabilitation

APPENDIX 3: SCOTTISH SERVICE MODEL FOR CHRONIC PAIN

APPENDIX 4: SUSPECTED NEW HEART FAILURE PATIENT DIAGNOSTIC PATHWAY

This Diagnostic Pathway for heart failure is currently being piloted in Victoria Infirmary (for GPs in SE Glasgow CHP area). It is designed so that patients with suspected heart failure are given a rapid and accurate diagnosis and management plan, and includes the use of BNP tests as a definite "rule out" for patients that have a normal ECG. Once pilot has been evaluated it is hoped to roll out the pathway across Greater Glasgow and Clyde.
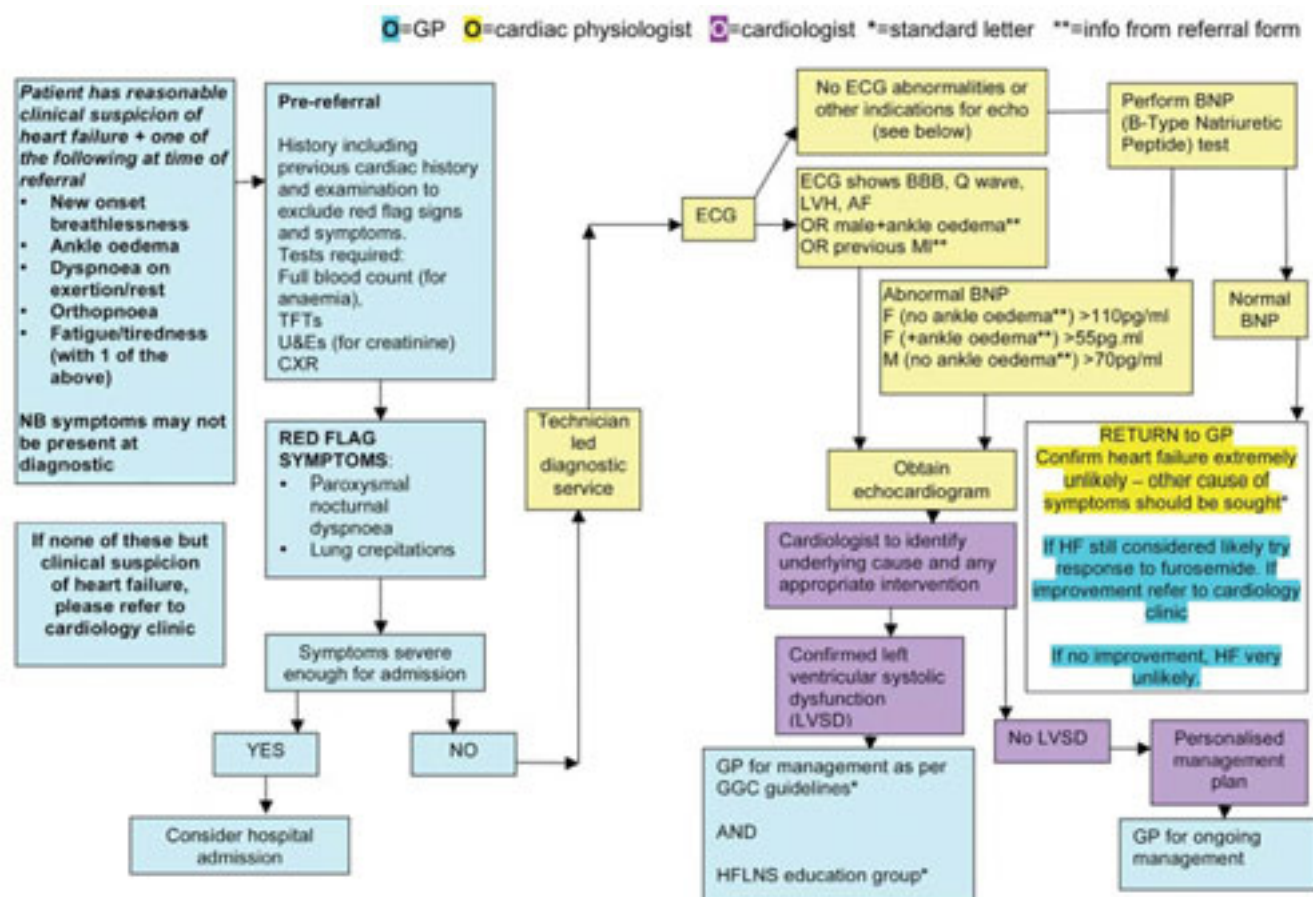
The Scottish Government

This document is also available on the Scottish Gover nment website:
www.scotland.gov.uk

Further copies are available from

Improvement and Support Team
Directorate of Health Delivery
Scottish Government
St Andrew's House
Regent Road
Edinburgh
EH1 3DG

9 780755 982516