

NHS SCOTLAND

NATIONAL FRAMEWORK FOR SERVICE CHANGE

LONG TERM CONDITIONS ACTION TEAM REPORT

Final

The Long Term Conditions Action Team was one of 11 Action Teams set up by the National Framework Advisory Group. The Action Team was asked to consider the health care of the people of Scotland with one or more chronic diseases. It was composed of a multi-professional group involved in Scottish health care (see appendix 1) and it consulted with a range of lay organisations representing patients. It also invited submissions from Chief Executives of Health Boards giving examples of current innovations in long term conditions management. It met on five occasions between August 2004 and January 2005.

EXECUTIVE SUMMARY

BACKGROUND

Long term conditions require ongoing medical care, limit what people can do, and are likely to last longer than one year. They are common in the Scottish population, more common in people living in deprived circumstances, more common in older people and, because Scotland's population is ageing, they will become even more common. If we do not continue to improve our management of long term conditions at a local level, demand on acute services will continue to increase.

VISION

Our challenge is to provide the best quality of care within our finite resources for our citizens who may suffer from long term conditions now and in the future. The aim is to keep people as well as possible for as long as possible.

Our vision is that by 2025 many long term conditions will be being prevented by health education measures as well as advances in preventive health care but it is likely that the proportion of our population who will suffer from long term conditions will increase because of the anticipated increase in older people.

Those citizens who develop long term conditions will have their problems identified early, will be fully informed and involved in decisions about their care and will receive proactive, structured care based on clear evidence of effectiveness.

Our staff will be well trained in patient centred approaches and will be working in strong multidisciplinary teams that span the current divides between primary and secondary care and health and social care.

Communication and monitoring of care will have been greatly enhanced by advances in information technology and will be facilitated by a single electronic patient record linking all care providers.

The care needs of our population at a national and local level will be predictable and services will be tailored to those needs.

Most care will be available in local settings but specialist opinion will be rapidly accessible when required. In-patient care will rarely be required because more specialised local teams will respond rapidly when people develop acute problems with their long term condition. When someone is admitted to hospital for acute care, their discharge will be rapid and supported by further specialised local teams with access to a range of resources to facilitate recovery and rehabilitation.

KEY RECOMMENDATIONS

The following are the key recommendations that the Action Team believes need to be followed now to achieve our vision.

A. INTELLIGENCE AND INFORMATION

1. All care agencies should use a single electronic record system utilising the CHI as the unique patient identifier. As a first step all health care records

- (primary, secondary, pharmacy, nursing homes, hospice etc) should be converted to use the CHI.
2. National and local protocols should be agreed to ensure appropriate access to the single electronic record for healthcare, social care, education, independent sector carers etc.
 3. Information systems that support the day to day management of patients should be developed for use with the single electronic record.
 4. The role of the Scottish Intercollegiate Guideline Network in developing national guidelines for the management of single long term conditions should be strengthened. Their work should include assessment of the resource implications of their implementation and how to implement them better at a local level. Evidence for optimal management of people with more than one long term condition should be sought.
 5. Intelligence systems that support the predictive modelling of our services should be developed in partnership between Health Boards, Information and Statistics Division Scotland, Academic Centres, Workforce Planning Groups etc. to ensure that the right data are collected, properly analysed and fed back to Health Boards to ensure that the services that are required are available when needed.

B.QUALITY OF CARE

6. A framework of audit standards, guidance and best practice statements that will support the management of long term conditions should be developed by NHS Quality Improvement Scotland. As a first step, a series of outcome indicators for successful long term condition management should be developed which may include: quality of life measures; use of hospital beds; outpatient attendances; GP consultations; admissions due to drug related problems; pharmacy consultations; chronic disease management clinics; indicators in the GMS contract; and shift of care closer to home.
7. The Quality and Outcomes Framework (QoF) of the GMS contract should be reviewed to assess its impact on long term conditions management and revised if necessary.
8. An Assessment Tool should be evaluated as a means of establishing baseline performance in long term condition management in Community Health Partnerships (CHPs).
9. Outcomes should be established for long term condition management in CHPs. These will build on the indicators described under Quality of Care but will be tailored to individual CHPs by taking account of local circumstances such as levels of deprivation.

C.COMMUNITY HEALTH PARTNERSHIPS

10. Clinical leaders should be more fully engaged in CHPs
11. Each CHP should be directed to designate a clinical lead for long term condition management who will sit on the CHP management board. The clinical lead will work with a professional manager and will be supported by a local working group to take a whole systems approach that will include liaising with Managed Clinical Networks, developing a long term condition plan for the CHP that takes a population approach, developing systems for collecting and sharing appropriate clinical data and offering staff appropriate training opportunities to enable them to work more effectively.

12. CHPs should establish more formal links with the voluntary sector at a local level and introduce initiatives to provide more support for carers.
13. Dedicated resource should be identified to ensure equity of access and provision of good long term conditions management in deprived communities.
14. CHPs should introduce a series of initiatives for working with patients as active partners in their own health.

D.EVALUATION AND RESEARCH

15. The culture of research and evaluation in the NHS in Scotland should be strengthened so that our health and social care resources are used to produce proven maximum benefit for our citizens. Innovative partnerships between the Scottish Executive Health Department, Health Board R+D departments, the Chief Scientist Office and Academic researchers in higher education should be developed.
16. New initiatives or initiatives not previously tried in NHS Scotland should be rigorously evaluated for effectiveness and cost-effectiveness. Areas where further research and evaluation is required include the cost-effectiveness of different case management approaches and the impact on areas such as prescribing of implementing guidelines for long term condition management

E. EDUCATION AND TRAINING

17. Closer working between the Scottish Education Department and the Scottish Executive Health Department should be encouraged.
18. Health Boards, Royal Colleges, Universities and other partners should ensure that staff are appropriately trained to meet the changing needs of the NHS in Scotland.
19. Training and continuing professional development should be balanced between uni-professional and multi-professional activities where necessary and should focus on breaking down traditional barriers between professions.
20. NHS Education for Scotland should develop training programmes for health professionals as patient educators.
21. Local, innovative partnerships in training between the NHS in Scotland and Higher Education should be encouraged.
22. Health Boards should provide appropriate opportunities for development of new ways for professionals to work in the service.

1.BACKGROUND

1.1.Definition

A long-term condition is a “condition that requires ongoing medical care, limits what one can do, and is likely to last longer than one year”¹. We have used the terms “long-term condition”, “long-standing illness” and “chronic disease” interchangeably throughout this report. We have considered very carefully which term to use as a header for our report and have agreed for maximum clarity to use “long-term conditions”. This includes a range of medical disorders including some cancers, some psychological disorders (while realising that the expectation is for the majority of psychological problems to resolve) but not physical and learning disabilities (although we recognise that some of the general principles of care outlined in this report may apply to people with long-term disabilities).

1.2.Impact of chronic disease

At a UK level, patients with long-term conditions account for 80% of all GP consultations (although we recognise that consultations by these patients may not always be about their long term conditions). They are twice as likely to be admitted to hospital and experience longer hospital stays when they are admitted². In the UK, 60% of hospital bed days are devoted to chronic disease or its complications³. It is claimed that, of the 11 leading causes of hospital bed use in the UK, 8 are due to conditions that with strengthened community care would lead to a fall in bed use³.

In the 2001/2002 Scottish Household Survey, 31% of all households in Scotland contained at least one person with a longstanding limiting illness, health problem or disability⁴. Scottish Practice Team Information (PTI) data are available for GP contacts for the 10 chronic conditions that are part of the new GP contract and two additional categories of depression/anxiety and osteoarthritis². This has demonstrated that more than a quarter of those aged 65 or over are seeing their GP or other member of the primary care team for hypertension. Coronary heart disease, diabetes, respiratory problems, depression, anxiety and osteoarthritis are the other main reasons for contact.

1.3.Influence of age

People of all ages can be affected by long-term conditions. While recognising that there are additional problems relating to children and young adults with long term conditions, the general principles of care outlined in this report are relevant at any age.

Scotland’s population is ageing. The proportion of Scots aged over 65 is predicted to increase from 15.9% in 2001 to 26.6.% in 2031². As age increases, the proportion of people experiencing long term conditions also increases. (The

¹ Partnerships for solutions (2002). Multiple Chronic Conditions: Complications in care and treatment www.partnershipsforsolutions.org/DMS/files/2002/multiplecoitions.pdf

² Kendrick S. *Drivers for change*. Scottish Executive 2004.

³ Department of Health. *Chronic Disease Management: A compendium of information*. Department of Health 2004.

⁴ www.scotland.gov.uk/library5/finance/spv7-00asp

context of Scotland's ageing population is more fully outlined in the report from the Care of Older Peoples' Action Team which this report complements).

1.4. Influence of co-morbidity

In the UK, of those people with a long term condition, around a quarter have 3 or more problems³ and 42% of people with 3 chronic diseases have activity limitation. Most people with long term medical conditions also have other complex needs leading to disabilities that require care from other sources such as social care.

The number of long term conditions an individual may experience also increases with age. From PTI data, in the 65 to 74 age group, 57% of the population had a primary care team contact for at least one long-term condition and 18% were seeing the primary care team for two or more². In the 75 to 84 age group, 61% had a contact for at least one long term condition and 22% for two or more. These figures are likely to be an underestimate of the true contact rate because these data do not include all longstanding illnesses, and practices serving the most deprived populations are underrepresented in PTI data.

1.5. Influence of deprivation

To achieve long term health gain for the entire population of Scotland, we must take account of socio-economic deprivation. At every age, people who live in deprived circumstances have higher rates of chronic disease. For example, in 2001, 21% of women aged 16 to 64 in deprived areas reported they had a limiting long-standing illness or injury compared with 8% in the most affluent areas².

2. VISION

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Our vision is that by 2025 many long term conditions will be being prevented by health education measures as well as advances in preventive health care but it is likely that the proportion of our population who will suffer from long term conditions will increase because of the anticipated increase in older people.

Those citizens who develop long term conditions will have their problems identified early, will be fully informed and involved in decisions about their care and will receive proactive, structured care based on clear evidence of effectiveness.

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3. GENERAL COMMENTS

3.1. The management of chronic diseases has been improving in Scotland in recent years. For example, mortality from coronary artery disease is falling and, despite an increase in the prevalence of asthma, rates of hospital admission and sickness absence due to asthma have been decreasing. This improvement is largely due to the significant efforts made in the organization of chronic disease management in primary care as well as closer working between primary and secondary care and health and social care. This report, therefore, focuses on how we can build on these improvements rather than recommending a change in the direction of travel.

3.2. The Long Term Conditions Action Team recognizes that most long term conditions are managed almost entirely in Primary Care and care is usually based in general practice. This report seeks to support and strengthen this role for general practice and the extended primary care team while at the same time promoting better working across the entire health service and between health and social care to support patients and their carers to manage their conditions.

3.3. Prevention of chronic disease is crucial. The Action Team's remit, however, and the focus of this report, is the management of established chronic disease and the prevention of its complications.

3.4. "Effective prevention and management of chronic conditions requires an evolution of health care, away from a model that is focused on acute symptoms towards a co-ordinated, comprehensive system of ongoing care."⁵ This includes continuing to move away from episodic to continuous support in Primary Care for people with long-term conditions. It also presents us with an opportunity to look at our acute services and how we might provide them more effectively for people with long term conditions.

3.5. Effective long term condition management should be based on generic approaches to managing specific conditions, rather than condition specific approaches i.e. the basic principles of long term condition management are the same, irrespective of the specific condition. Using individual separate approaches for the management of every possible long-term condition would be unworkable at a local level, would not address the issues raised by co-morbidity and would be confusing and inconvenient for patients and their carers. This does not preclude

⁵ Epping-Jordan 2003

using locally developed protocols for common long-term conditions where these are found to be effective.

3.6. The generic needs for good chronic disease management are: a systematic and holistic approach to patient care; patient and carer engagement; adequate resources; supporting tools – clearly defined roles and responsibilities, referral protocols, self-management tools for patients; communication systems; progress monitoring and follow-through arrangements; teamworking; and an appropriately trained and competent workforce.

3.7. Intelligence is central to the delivery of care. This allows practitioners to make the most appropriate decisions about patient care on a person to person basis and will also enable us to predict what is required of our services. This means that evaluation and research needs to be firmly embedded within the system, requiring collection, analysis and utilisation of appropriate data. Research topics could include finding out what works and what doesn't, how best to use current knowledge and resource, monitoring ongoing trends e.g. admission rates for chronic conditions, hospital utilisation by particular groups, number of GP consultations related to chronic disease, level of use of care pathways, patient experiences of their care, and the effect of the new GMS, Consultant and Community Pharmacy contracts.

3.8. There is some evidence from North America that good chronic disease management improves outcomes for patients and reduces admission to hospital³. The Veterans Health Administration in the USA reduced bed use by 50% between 1994 and 1998. The rates of medical-clinic visit rates and visits for testing and consultation increased moderately and rates of urgent care visits fell by 35% at the same time as an improvement in care. Some of this shift is believed to be due to the focused attention on chronic disease although some may be due to introducing more primary care based approaches. The intervention was not tested in a randomised controlled trial and it is not yet clear if similar patterns of improvement would occur in Scotland if the same methods were used (as there is already a strong culture of primary care in Scotland).

3.9. In the UK, it is believed that the key to reducing unplanned admissions lies in primary care. Small changes in primary care can have a large impact on secondary care. For example, it has been estimated that if each GP made one fewer referral every three months, there would be a 5% reduction in emergency admissions to hospital. Providing more facilities at a primary care level such as access to a range of diagnostic services could support better long term conditions management.

3.10. However, the Action Team, strongly believes that it is essential to take a whole systems approach to long term conditions management and that the traditional boundaries between primary and secondary care and between health and social care need to be removed. In future, the use of terms such as primary and secondary care may not be useful. We have used these terms within our report, however, so that colleagues are clear about what we mean.

3.11.The new General Medical Services (GMS), the Consultant and the Community Pharmacy contracts provide opportunities to put in place appropriate incentives for improving long term conditions management. In particular, the GMS contract rewards practices for achieving specified quality outcomes in the treatment of patients with chronic conditions. This contract needs to continue to be responsive to service change and the need to deliver more and better treatment of long term conditions at the local level. The new Pharmacy Contract complements the GMS contract in helping people manage their long term conditions.

3.12.In order to continue to make significant improvements in outcomes of long term conditions management and address inequalities, we need to concentrate our efforts in areas of socio-economic deprivation.

3.13.Community Health Partnerships (CHPs) offer significant opportunities to co-ordinate systematic management of long term conditions and efforts should be directed at supporting them in doing this. In particular, strong engagement is required from clinical leaders who recognize the potential gains from this approach on a local basis.

3.15.The whole system will be dependent upon having a well-trained workforce. Training must include aspects of clinical leadership and chronic disease management approaches e.g. patient centred approaches, tailoring information, surveillance and management.

3.16.Finally, but not least, patients should be empowered to become partners in their own care.

4.EVIDENCE

An extensive review of the literature was carried out and key references appear at the end of this report. Much of the work has been based in the USA and, although not directly applicable to the NHS in Scotland, it still provides useful insights and lessons regarding long term conditions management. Although a systematic literature review was not possible, within the time and resources available to the Action Team, our reading of the literature allowed us to conclude that there are key principles regarding the management of long term conditions:

4.1.Good long term conditions management will:

- Focus on the whole person i.e. holistic care
- Involve people in their own care
- Provide care in the least intensive setting
- Aim to minimise unnecessary hospital visits and admissions
- Be co-ordinated in Primary Care
- Be provided by a multi-disciplinary team.
- Integrate generalist and specialist care
- Integrate health and social care
- Use a population approach
- Use good information systems and intelligence
- Identify people with long term conditions and place them on a general practice based register with their appropriate consent/authorisation

- Use a structured approach to call and recall
- Review care using evidence based protocols and guidelines
- Focus on improving medicines management

4.2. In Scotland, we also suggest that it will use community and voluntary resources well and provide support for carers.

4.3. There is some evidence from abroad of benefit from stratifying people for risks of complications, hospital admissions etc. and co-ordinating the care of those identified as being at very high risk using case managers. We believe that there is not yet sufficient evidence of benefit or cost-effectiveness to recommend this approach in Scotland and we recommend that initiatives using it should be evaluated using a research design that incorporates an appropriate control group before making a firm recommendation about it.

5. RECOMMENDED SHAPE OF LONG TERM CONDITIONS MANAGEMENT

Using the principles outlined above we recommend that Long Term Conditions Management in the NHS in Scotland should be:

- Patient centred
- Integrated and coordinated by Community Health Partnerships
- Systematic

5.1. Patient centred:

What does this mean?

- It means that every patient is treated as an individual.
- Each patient is informed about their health.
- Each patient is helped to be responsible for, and manage their own care, as far as they are able to do this.
- Each patient is fully involved in all aspects of decision making about them

How is this achieved?

- Practitioners use every consultation to discuss and negotiate with the person.
- People have their self-management needs assessed.
- Tailored advice and self-management resources are provided for individuals.
- People are helped to set goals and produce action plans that are followed up
- Treatment regimes are developed by patients and practitioners together.
- People are helped to take their medicines by their community pharmacists.
- Peer support and psychological support will be provided for people when needed including some support in group settings with other patients.

What do we need to do?

Ensure that:

- Basic and continuing health professionals' education stresses the central role of the patient.
- All health professionals are encouraged to see themselves as patient educators.

- NHS Education Scotland provides courses for e.g. nurse educators, pharmacy educators etc.
- There is a Long Term Conditions Lead (discussed later) in each Community Health Partnership with responsibility for patient education
- Appropriate information and education resources in a range of formats (web based, written, taped etc) are kept and maintained for distribution by the Long Term Conditions Lead in each CHP who will work with patients in relation to self-management and psychosocial support.
- Written, CD-Rom and other formats are produced in accessible (e.g. taped material, low reading age, other languages used in Scotland) for distribution in CHPs
- Resources available in local further and higher education are made available to patients.
- We look at the role of patients as educators of health professionals, other patients and the public.

Examples of current initiatives in Scotland

One project involves a partnership between North Ayrshire Carers Centre, the 3 Towns Healthy Living Centre and James Watt College to provide additional care for people with mental health problems. It offers placements for students on the Stress Management Course. It provides a valuable referral route for primary care and the Community Mental Health Team and also provides valuable community placements for students whose employment prospects have been enhanced.

Another project involves a patient focused and improved service for the diagnosis and management of acute exacerbations of COPD and was designed jointly by primary and secondary care. This project led to a reduction in admissions from 500 per year in 1998, to 213 in 2001 and readmission rates from 20% to 7% saving almost 2000 bed days. Patients were empowered to cope with their condition, felt supported in their own environment and had improved quality of life. There was improved communication between primary and secondary care and health care professionals' knowledge of COPD through education provided by respiratory specialists. The service is provided by a respiratory nurse specialist, 0.8wte nurse and 0.5wte physiotherapist.

Another area has piloted four formal patient education programmes consisting of three sessions per programme using a package of written materials developed by the patient education and information sub-group of the Managed Care Network for diabetes.

5.2. Integrated and coordinated by Community Health Partnerships.

What does this mean?

- It means that CHPs are recognised as the main locus for coordinating improvements in the standards of Long Term Conditions management.
- CHPs will link with appropriate Managed Clinical Networks (MCNs). This includes both established MCNs and potentially new MCNs e.g. chronic pain and palliative care. (Further discussion of the relationship between CHPs and MCNs is contained in Scott. W. Managed Clinical Networks and Chronic Disease Management. Scottish Executive 2005).
- It means that the extended primary care team is the main source of delivery of care.

- It means that care is provided in the least intensive setting.
- It means that all professionals (GPs, specialists, AHPs, nurses, pharmacists, dentists, optometrists, social care professionals etc.) are involved.
- It means that the wider local community resources are recognised and involved e.g. voluntary agencies, education, housing etc.
- It means that specialist advice is accessed and used when required. This specialist resource should be highly responsive and easily accessed when required.

How can this be achieved?

- All professionals in health and social care will have appropriate access to, and use, a single electronic record using the CHI.
- A service led group within each CHP should develop a Long Term Conditions action plan.
- The patient care pathway will be adequately resourced and resources will follow the patient.
- Local strategic partnerships will be developed between healthcare, community, local authorities, voluntary, charitable and independent sector organisations.

What do we need to do?

- Immediately provide resources to convert all health and social care records in Scotland to a single electronic record utilising the CHI.
- Invest in information development and support.
- Each CHP should be directed to designate a clinical lead for long term condition management who will sit on the CHP management board. The clinical lead will work with a professional manager and will be supported by a local working group to take a whole systems approach that will include liaising with Managed Clinical Networks, developing a long term condition plan for the CHP that takes a population approach and developing systems for collecting and sharing appropriate clinical data.
- The CHP long term conditions management lead should be responsible for making available resources to patients and carers of educational materials in collaboration with local education departments, colleges and universities.
- The CHP long term conditions management lead should co-ordinate training opportunities for staff in collaboration with local education departments, colleges and universities and NES.
- The CHP long term conditions management lead should hold up to date data on e.g. waiting times, and a library of guidelines and protocols.
- The Scottish Executive should create a National Forum of Lead Clinicians for Long Term Conditions Management so that expertise can be shared and support provided for Long Term Conditions lead clinicians.

Examples of current initiatives in Scotland

One partnership includes: North Lanarkshire Council; the Voluntary Sector; NHS Lanarkshire; Strathclyde Police; Strathclyde Fire Brigade; Communities Scotland; Jobcentre Plus; and Scottish Enterprise Lanarkshire. It uses community planning in action within a Chronic Disease Management project.

In several areas, there are “one stop” diabetes clinics that allows people with diabetes to be reviewed by a doctor, practice nurse, podiatrist and dietician at one appointment.
In one CHP, the Chronic Disease Management nursing team consists of 2 x 0.4fte G grade nurses. It is part of a larger multi-disciplinary unit including a dietician, a physiotherapist and a podiatrist covering 32 practices (250,000 population). They liase with practice nurses, nurse practitioners, GPs, practice managers, consultant physicians, secondary/primary care specialist nurses, pharmacists, allied health professionals and community nurses. They set up CDM clinics, facilitate best practice administration, data entry and coding, train staff and develop and update evidence based protocols.
In several areas, anticoagulant monitoring is provided in primary care in conjunction with pharmacy staff using a computerised dosing system maintained within the acute hospital. GPs arrange for blood sampling in their practice, the sample is sent to the lab, the INR calculated and the dosage and time to next blood test determined by computer. The report will be sent to the GP via the web server and the GPs contact patients with treatment details.
Three general practitioners in one area were trained in the special diploma in dermatology to deliver intermediate care dermatology jointly with Consultants in 3 sites. Practical equipment and reference texts were supplied to all 14 practices in the LCHP. Waiting times for dermatology in the area have declined to 14 weeks from 20 weeks in 7 months.
Pulmonary rehabilitation classes have been set up in the local sports centres in one area by Physiotherapists and sports centre staff. They have reduced the frequency and duration of stay of hospital admissions, exacerbation rate, GP home visits and bronchodilator usage.

5.3.Systematic:

What does this mean?

- This means that chronic disease management will be:
 - population based
 - proactive
 - structured
 - evidence based
- These principles will be common across Scotland.

How can this be achieved?

- People with chronic disease will be registered in general practice based systems
- People will have care plans that will include regular recall by their practice, using prompts and reminders, to have their condition checked.

- Their health will be reviewed using evidence based national and local guidelines and protocols that will be available to professionals and patients.
- If the current study proves it is feasible and useful, CHPs will determine their baseline level of performance in chronic disease management using an assessment tool⁶.
- There will be regular audit and feedback with open sharing of performance at the level of the CHP.
- There will be ongoing monitoring and review of the outcome of services that will take account of population factors such as deprivation, rurality, ethnic minority, hard to reach groups, disabilities, case-mix etc.
- Incentives will be provided for improvements in the process of care including greater freedom to redirect resources at a local level using a programme budget.
- Case management approaches will be researched for people identified at high risk utilising an appropriate control group methodology.

What do we need to do?

- Incorporate evidence based guidelines into IT systems.
- Strengthen the role of the Scottish Intercollegiate Guideline Network in developing national guidelines for the management of single long term conditions. This should include assessment of the resource implications of their implementation and how to implement them better at a local level. Evidence for optimal management of people with more than one long term condition should be sought.
- Monitor the performance of the system using the quality and outcomes framework of the new GMS contract.
- Use the new GMS contract to produce locally enhanced contracts for chronic disease management.
- A framework of audit standards, guidance and best practice statements that will support the management of long term conditions should be developed by NHS Quality Improvement Scotland. As a first step, a series of outcome indicators for successful long term condition management should be developed which may include: quality of life measures; use of hospital beds; outpatient attendances; GP consultations; admissions due to drug related problems; pharmacy consultations; chronic disease management clinics; indicators in the GMS contract; and shift of care closer to home.
- Generate locally owned outcomes beyond the minimum standards.
- Exploit the potential of the new pharmacy contract to provide a broader range of services in the community.

Examples of current initiatives in Scotland

A pilot study was carried out to implement guidelines about the medicines management responsibilities that could be undertaken by appropriately trained personal home carers. The service involved pharmacists, community nursing teams, social work home carers

⁶ A tool to assess baseline level of performance is currently being assessed for use in Community Health Partnerships using a small grant funded by the Scottish Executive.

and home care supervisors, and local GP practices with links to community hospital ward staff and the local dementia team.

All 14 practices in one LCHP have lead teams and nurses and GPs with enhanced training in diabetes (all have a practice nurse qualified to diploma level in delivering care for patients with diabetes). The LHCC also appointed podiatrists and dieticians with a specialist interest in diabetes. As part of the Diabetes Managed Care Network, secondary care consultant staff are aligned to each locality team lead. The percentage of patients receiving practice only care (instead of joint or hospital only care) has increased from 24% to 65%. The average HbA1c at the beginning of the project was 8.3; this is now 7.5.

In one area, community pharmacists visit “housebound” patients to optimise their medication and patient/carer understanding and compliance with medication.

In another area, a CCI Outpatient initiative aims to extend the introduction of evidence based guidelines for back pain management, offer a single access route to treatment via a specialist physiotherapist in primary care and promote direct access for MRI of lumbar spine from primary care and ensure an appropriate pathway for patients with abnormal results who would benefit from seeing an orthopaedic consultant.

In another area, all 12 practices in an LHCC meet regularly to share and compare their data relating to chronic disease management.

6. KEY RECOMMENDATIONS

The following are the key recommendations that the Action Team believes need to be followed now to achieve our vision.

6.1. INTELLIGENCE AND INFORMATION

6.1.1. All care agencies should use a single electronic record system utilising the CHI as the unique patient identifier. As a first step all health care records (primary, secondary, pharmacy, nursing homes, hospice etc) should be converted to use the CHI.

6.1.2. National and local protocols should be agreed to ensure appropriate access to the single electronic record for healthcare, social care, education, independent sector carers etc.

6.1.3. Information systems that support the day to day management of patients should be developed for use with the single electronic record.

6.1.4. The role of the Scottish Intercollegiate Guideline Network in developing national guidelines for the management of single long term conditions should be strengthened. Their work should include assessment of the resource implications of their implementation and how to implement them better at a local level. Evidence for optimal management of people with more than one long term condition should be sought.

6.1.5. Intelligence systems that support the predictive modelling of our services should be developed in partnership between Health Boards, Information and Statistics Division Scotland, Academic Centres, Workforce Planning Groups etc. to ensure that the right data are collected, properly analysed and fed back to Health Boards to ensure that the services that are required are available when needed.

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6.3.COMMUNITY HEALTH PARTNERSHIPS

6.3.1.Clinical leaders should be more fully engaged in CHPs

6.3.2.Each CHP should be directed to designate a clinical lead for long term condition management who will sit on the CHP management board. The clinical lead will work with a professional manager and will be supported by a local working group to take a whole systems approach that will include liaising with Managed Clinical Networks, developing a long term condition plan for the CHP that takes a population approach, developing systems for collecting and sharing appropriate clinical data and offering staff appropriate training opportunities to enable them to work more effectively.

6.3.3.CHPs should establish more formal links with the voluntary sector at a local level and introduce initiatives to provide more support for carers.

6.3.4.Dedicated resource should be identified to ensure equity of access and provision of good long term conditions management in deprived communities.

6.3.5.CHPs should introduce a series of initiatives for working with patients as active partners in their own health.

6.4.EVALUATION AND RESEARCH

6.4.1.The culture of research and evaluation in the NHS in Scotland should be strengthened so that our health and social care resources are used to produce proven maximum benefit for our citizens. Innovative partnerships between the Scottish Executive Health Department, Health Board R+D departments, the Chief Scientist Office and Academic researchers in higher education should be developed.

6.4.2.New initiatives or initiatives not previously tried in NHS Scotland should be rigorously evaluated for effectiveness and cost-effectiveness. Areas where further research and evaluation is required include the cost-effectiveness of different case management approaches and the impact on areas such as prescribing of implementing guidelines for long term condition management

6.5.EDUCATION AND TRAINING

6.5.1. Closer working between the Scottish Education Department and the Scottish Executive Health Department should be encouraged.

6.5.2. Health Boards, Royal Colleges, Universities and other partners should ensure that staff are appropriately trained to meet the changing needs of the NHS in Scotland.

6.5.3. Training and continuing professional development should be balanced between uni-professional and multi-professional activities where necessary and should focus on breaking down traditional barriers between professions.

6.5.4. NHS Education for Scotland should develop training programmes for health professionals as patient educators.

6.5.5. Local, innovative partnerships in training between the NHS in Scotland and Higher Education should be encouraged.

6.5.6. Health Boards should provide appropriate opportunities for development of new ways for professionals to work in the service

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Members:

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Professor Jimmy Hutchison	Professor of Orthopaedic Surgery, University of Aberdeen Medical School
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Dr Bill Mutch	Medical Director, Primary Care Division, NHS Tayside
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