SCOTTISH EXECUTIVE

Health Department

Dear Colleague,

COMMUNITY HEALTH PARTNERSHIPS (CHP) LONG TERM CONDITIONS TOOLKIT

A large number of people have helped to develop this self-assessment Toolkit. By completing this Toolkit, we expect every CHP to develop an Action Plan that will ensure services and care are integrated, responsive and of a high quality. The Action Plan should build systematically on the evidence base for the management of long term conditions, and demonstrate how continuous quality improvement will be achieved for those living with long term conditions and their carers and dependants.

CHPs are the key mechanism for integrating the management of long term conditions because of their partnership arrangements and role within the NHS and with community planning partners. Completion of the Toolkit therefore needs to be recognised as involving a wide range of partners across the health and social care systems, led by Local Action Teams.

The Toolkit underlines the importance we attach to the development of a generic approach to the management of long term conditions, instead of the creation of a national strategy for each and every condition. Use of the Toolkit also offers an opportunity to look afresh at all long term conditions, especially those which may have had less attention in the past.

Actions

CHPs should complete the Toolkit by the end of April 2007, so that the resulting Action Plan can inform NHS Local Development Plans and Local Authority planning processes, and NHS Boards' Annual Reviews. We are allocating £10,000 to each CHP on a one-off basis to help in the initial stages of completing the Toolkit. CHPs may pool this resource should they wish.

The Department wants high quality evidence and learning to emerge from the process, and will therefore arrange for independent evaluation of the implementation of the Toolkit after the first year, particularly its effectiveness in practical terms, by looking at 2 'marker' conditions: Chronic Obstructive Pulmonary Disease (COPD) and rheumatoid arthritis.

Yours sincerely,

KEVIN WOODS
Head of Health Department and Chief Executive, NHSScotland

30 January 2007

Addresses

For action
Chief Executives, NHS Boards
CHP Clinical Leads
CHP General Managers
Medical Directors, NHS Boards
Directors of Public Health, NHS Boards
Chief Executives, Local Authorities
Directors of Social Work/Chief Social Work Officers
Long Term Conditions Alliance Scotland

For information
Chief Executives, Special Health Boards
Chief Executive, Scottish Commission for Regulation of Care
Carers' organisations

Enquiries to:

Long Term Conditions
Will Scott
Healthcare Planning Division
St Andrew's House
EDINBURGH EH1 3DG
Tel: 0131-244 2420
Email:
will.scott@scotland.gsi.gov.uk

Shifting the Balance of Care / CHPs
Kathleen Bessos
Primary Care Development Division
St Andrew's House
EDINBURGH EH1 3DG
Tel: 0131-244 2242
Email:
kathleen.bessos@scotland.gsi.gov.uk

Community Health Partnership Long Term Conditions Self-Assessment Toolkit

1. A long term condition is broadly defined as one that requires ongoing professional care, limits what the person with the condition can do and is likely to last longer than a year. The definition does not relate to any one condition, care group or age category, and includes people with learning disabilities and mental health problems such as dementia.

2. The Department is aware that there are variations on the name 'Community Health Partnerships', such as 'Community Health and Care Partnerships' and 'Community Health and Social Care Partnerships'. In accordance with the legislation, however, the term 'Community Health Partnership' (CHP) is used throughout this HDL.

The Role of the Toolkit

3. The Toolkit has an essential role in promoting the approach to services which is at the heart of *Delivering for Health*: services that are integrated, of high quality, are fully responsive to the needs of those living with a long term condition and their carers and dependents, which treat them as equal partners in the management of their care, and which are delivered as close to home as possible by the NHS and local partners.

4. The model for developing systematic support for people living with a long term condition is set out in section 2.2 of *Delivering for Health*. The Long Term Conditions Toolkit ('the Toolkit') is referred to in that section as 'an effective way of introducing generic approaches to long term conditions in a way that helps to promote consistency of approach across the whole of Scotland. The use of the Toolkit will therefore be mandatory for Community Health Partnerships.'

5. The Toolkit is intended to recognise and build on existing initiatives and good practice in relation to the services and care provided for those living with ***any*** long term condition and their carers and dependants, in order to promote broad consistency of approach across Scotland while allowing local priorities to flourish.

6. Implementation of the Action Plan derived from completion of the Toolkit will support the overall aims of continuously improving access to care and treatment through a general shift in the location of services and care and building the capacity of communities to enable self-management of long term conditions. An example is the wider range of diagnostic procedures and specialist services which are being provided in communities through CHPs, with greater levels of joint working between the NHS, local authority and voluntary sector partners. This involves multi-agency teams working with 'at risk' individuals, providing the best possible support for people at home, improving their quality of life and helping them to maximise their potential.

7. The Toolkit must therefore be used in the context of a wide range of other work, and this is listed in the Annex.

Completing the Toolkit

8. Completion must be on an annual basis, in order to give each CHP the opportunity to identify their baseline position and then through implementation of an Action Plan to track progress in filling service gaps over time.

9. The Department is aware that some of the information required to complete the Toolkit is already included in other documents, such as the Joint Performance Information and Assessment Framework (JPIAF) and NHS Quality Improvement Scotland clinical standards. The Toolkit should be seen as a way of bringing this information together with a specific focus on long term conditions. CHPs should draw on existing sources of information as far as possible, but will also want to develop, over time, the most efficient ways of completing all of these documents and prioritising actions.

10. In drawing up the Action Plan, the CHP should take account of the views of its Public Partnership Forum, as the main mechanism through which CHPs maintain a formal, effective dialogue between local service users and carers in relation to service planning and quality improvement. It should also take account of the views of the Long Term Conditions Alliance Scotland and other key partners.

11. The criteria in each section of the Toolkit are intended to be measurable, and not prescriptive. They reflect the fact that different CHPs have different arrangements, and that issues such as leadership and support may vary to suit local circumstances. They indicate that CHPs' arrangements for the management of long term conditions should build on existing structures and Board-wide strategies such as those developed through Managed Clinical Networks (MCNs).

Using the results of the completion of the Toolkit

12. Each CHP must submit the completed Toolkit and Action Plan to its CHP Committee, NHS Board and planning partners. The Action Plan will need to inform the Board's arrangements for prioritisation, objective setting and resource allocation within the local health system. Thereafter, the NHS Board is expected to reflect the prioritised elements of the Action Plan, with the support of the service redesign plans where appropriate, in its Local Delivery Plan, linking it to the Community Planning structures and processes.

13. To enable the Department to identify innovative and effective practice NHS Boards must submit their CHP Action Plans to the Department, together with, in the first year, any observations they might wish to make about the Plans, their intentions for implementing them and assessment of any financial implications. The Action Plans may also be used to inform the 2006-07 Annual Review.

14. The Department is arranging for independent evaluation of the implementation of the Toolkit in 2007, in order to ensure that we learn from the process. To test the effectiveness of the Toolkit in practical terms, the evaluation will include 2 'marker' conditions, and we will recommend to those undertaking the evaluation that these should be Chronic Obstructive Pulmonary Disease and rheumatoid arthritis. The Department will keep the Toolkit under review, to ensure that it remains valid in the context of future developments.

Annex

Related Policies

- The 'shifting the balance of care' workstream in *Delivering for Health*;
- Implementation of *Changing Lives*: *Report of the 21st Century Social Work Review*, and in particular the self assessment tool which local authorities have completed and submitted to the Executive;
- National Strategy for the Development of the Social Service Workforce;
- The work of the Joint Futures Unit, especially in relation to the single shared assessment and the care management training framework;
- Guidance on Care Management;
- The Executive's priorities for supporting carers, as set out in the response to *The Future of Unpaid Care in Scotland* and guidance on Carer Information Strategies;
- *Better Outcomes for Older People* and the *Strategy for a Scotland with an Ageing Population*, due to be published in January 2007;
- *Developing Community Hospitals: A Strategy for Scotland*;
- *Visible, Accessible and Integrated Care*, the review of community nursing;
- The Rehabilitation Framework;
- Delivery of the actions in *The Right Medicine: a Strategy for Pharmaceutical Care in Scotland* and the new pharmacy contract;
- *Improving Frontline Services, a framework for supporting frontline staff*;
- Workforce developments such as the Skills for Health Career Framework;
- SPARRA (Scottish Patients at Risk of Readmission and Admission), the risk prediction algorithm which ISD published in June 2006, towards which NHS Boards' own risk prediction tools should be converging;
- The work plan on quality improvement in Community and Primary Care Health Services which NHS Quality Improvement Scotland is developing; and
- The national strategy for long term conditions which the Chief Medical Officer is taking forward, one of the essential principles of which is the need to ensure that the experience of those living with a long term condition acts as an influential driver of service change.

Long Term Conditions Management

CHP Self Assessment Tool

CHP:

Lead Clinician:

Manager:

Date completed
Signature

Introduction

The Toolkit forms an essential part of the approach to the management of long term conditions set out in *Delivering for Health*, which aims to develop systematic approaches to the provision of services for those with one or more long term conditions as close to home as possible. Use of the Toolkit is therefore part of the process of shifting the balance of care into the community and improving the responsiveness of service to the needs of each individual. The key outcome will be to improve the quality of life for those with a long term condition and their carers. A long term condition is broadly defined as one that requires ongoing medical care, limits what one can do, and is likely to last longer than one year. Because the Toolkit is generic, it does not relate to any one condition, care group or age category.

This self-assessment should be completed annually by the CHP Long Term Conditions Action Group in line with the approved Quality Assurance Programme.

This tool is not designed to be used for benchmarking with other CHPs or other NHS Boards. The purpose of the self- assessment tool is to support the CHP in evaluating and improving its long term conditions care. The CHP will have the opportunity to improve services by identifying areas of good practice which could be replicated elsewhere, acknowledging service gaps and considering what actions or improvements are required to meet each criterion. This process will support the CHP in constructing an Action Plan for implementation of the required changes.

Indicators of performance need to be measured over time to reflect the continuous quality improvement process. To facilitate serial measurement of quality improvement at annual re-evaluation the self-assessment tool invites CHPs to assign a numeric value (0-3) for compliance with each criterion. At the end of each section there are Subtotals of values for each standard.

Values should be assigned in line with the following position statements:

Value	Position Statement
0	Criterion not met at all.
1	Criterion met in part or Criterion met in full but only for a minority of CHP practices / staff / people
2	Criterion predominantly met or Criterion met in full for the majority of CHP practices / staff / people
3	Criterion fully reflected across the CHP or Criterion met in full for all CHP practices / staff / people

Standard 1 – Organisation of Long Term Conditions Management

	CRITERIA	EVIDENCE	VALUE	ACTION TIMESCALE RESPONSIBLE PERSON
1.1	**The Community Health Partnership has a designated clinical lead for long term conditions management.**		3	
1.2	**The long term conditions clinical lead is a member of the CHP committee or clinical executive.**		3	
1.3	**The clinical lead has senior managerial support and the CHP has a multidisciplinary Long Term Conditions Action Team, which includes all the members of the wider team, to operationalise agreed actions.**		3	
1.4	**The CHP, through the Long Term Conditions Action Team, engages with the local Managed Clinical/Care Networks which relate to a specific long term condition.**		3	
1.5	**The CHP, through the Long Term Conditions Action Team, has clear links with older people's and integrated children's services, and services for learning disability and mental health.**		3	
1.6	**The CHP has shared objectives for long term conditions with acute**			

	CRITERIA	EVIDENCE	VALUE	ACTION TIMESCALE RESPONSIBLE PERSON
	hospitals to deliver a range of integrated services which shift the balance of care to community settings.		3	
1.7	**The CHP engages with community planning partners and with representatives of those with a long term condition, voluntary sector, carers organisations and representatives of cultural and religious organisations in planning and developing services for long term conditions.**		3	
1.8	**The CHP maximises the effective use of premises which are fit for purpose in the delivery of long term conditions management, e.g. through co-location, disability access.**			

Standard 1 Values Subtotal 24

Standard 2 – Patient and Carer Information and Supported Self care

	CRITERIA	EVIDENCE	VALUE	ACTION TIMESCALE RESPONSIBLE PERSON
2.1	**An identified member of the CHP long term conditions action team is responsible for updating and distributing information resources of high standard and evidence-based about long term conditions, adding local information as necessary, which is easily accessible to all.**		3	
2.2	**The CHP follows the Carer Information Strategy which has been developed by the Board and its partner agencies. Unpaid carers are recognised as partners and providers of care.**		3	
2.3	**The specific information needs of people with visual and communication impairments and from minority ethnic groups are addressed.**		3	
2.4	**The CHP has links with the independent local advocacy services established by the Board and partner agencies for patients and carers, and informs patients and carers about advocacy support, including issues associated with incapacity.**		3	

	CRITERIA	EVIDENCE	VALUE	ACTION TIMESCALE RESPONSIBLE PERSON
2.5	**Individual care providers and multi-disciplinary teams involve people and their carers in developing individual care plans. The active involvement of service users and their carers in the provision of care is encouraged.**		3	
2.6	**Self-held care plans are used and include individualised self management tools.**		3	
2.7	**There are peer support groups for people with long term conditions and their carers.**		3	
2.8	**The capacity of services to provide information and support self care is enhanced to meet the needs of people from the most deprived communities, including those who are homeless.**		3	
		Standard 2 Values	24	

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

	CRITERIA	EVIDENCE	VALUE	ACTION TIMESCALE RESPONSIBLE PERSON
3.1	**Operational policies clarify the roles of health professionals, unpaid carers, local authority services, voluntary sector, volunteers and independent contractors in long term conditions management, but are flexible enough to facilitate new ways of working, within regulatory frameworks.**		3	
3.2	**Joint care plans reflect optimum outcomes for individuals and their carers, based on the single shared assessment and carer's assessment.**		3	
3.3	**The CHP has a range of services including prevention, diagnosis and treatment, rehabilitation and palliative care (taking account of the Gold Standards Framework Scotland) which are designed to deliver care more quickly and closer to home by the appropriate mix of local primary care practitioners and multidisciplinary specialists working in community settings.**		3	
3.4	**Long term conditions management is supported by inter-agency protocols for management, e.g. referrals.**		3	

	CRITERIA	EVIDENCE	VALUE	ACTION TIMESCALE RESPONSIBLE PERSON
3.5	**Condition-specific pathways signpost people with long term conditions and professionals to the appropriate intervention / clinician.**		3	
3.6	**The CHP delivers case / care management programmes, based on the risk stratification tool, which target people with the most complex needs.**		3	
3.7	**The CHP provides an inter-agency model of care to support the specialist health needs of people in care homes/sheltered housing.**		3	
3.8	**Clinicians use common functional outcome measures.**		3	

Standard 3 Values 24

Standard 4 – Interdisciplinary Education and Training

	CRITERIA	EVIDENCE	VALUE	ACTION TIMESCALE RESPONSIBLE PERSON
4.1	Generic approaches to management of long term conditions are included in condition specific multi-agency CPD programmes.		3	
4.2	Practitioners and managers from partner agencies participate in Interdisciplinary CPD and share learning and skills.		3	
4.3	There is affiliation with learning networks to support best practice, which includes NHS Health Scotland, NHS Education for Scotland and academic centres.		3	
4.4	The Long Term Conditions Action Team is responsible for access to education and training about long term conditions. It develops a training plan for long term conditions that includes improvements in access to education and training for all members of the team.		3	
4.5	Those with a long term condition and their carers participate in the development of educational material		3	

	CRITERIA	EVIDENCE	VALUE	ACTION TIMESCALE RESPONSIBLE PERSON
	and in the planning and delivery of training.			
4.6	**The plan includes training which equips staff to empower people with long term conditions and their carers in self management and carer-awareness training.**		**3**	
4.7	**Training covers issues of diversity and capacity, social deprivation and the promotion of psychological, mental and emotional wellbeing.**		**3**	
4.8	**The CHP participates in local and collaborative research to evaluate models of care for managing long term conditions.**		**3**	

Standard 4 Values 24

Standard 5 – Information and Intelligence

	CRITERIA	EVIDENCE	VALUE	ACTION TIMESCALE RESPONSIBLE PERSON
5.1	All health care records use CHI as the unique patient identifier.		3	
5.2	Information systems identify people with specific diseases and with multiple long term conditions.		3	
5.3	Single shared assessment policies, including carers' assessment, are implemented and the aggregated data, which should be gathered electronically where possible, used to inform joint planning.		3	
5.4	Protocols for documentation and exchange of information are used and there is shared recording of goals, with data recorded once being used for multiple purposes.		3	
5.5	Unpaid carers and their caring role are systematically identified and recorded, with consent, and linked to the patient record.		3	
5.6	Levels of population risk derived from the CHP population are used in the organisation of local services for long		3	

	CRITERIA	EVIDENCE	VALUE	ACTION TIMESCALE RESPONSIBLE PERSON
	term conditions.			
5.7	**IM & T systems are structured to support ongoing care / case management for individuals with long term conditions and their carers, and are consistent with the eHealth programme.**		**3**	
5.8	**The CHP has performance arrangements, including those in the JPIAF and LIT, which are clear and through which they can demonstrate outcomes that deliver continuous improvement.**		**3**	

Standard 5 Values

24

Standard 6 – Quality and Delivery

	CRITERIA	EVIDENCE	VALUE	ACTION TIMESCALE RESPONSIBLE PERSON
6.1	**The CHP has an Action Plan for long term conditions which specifies outcomes, milestones, and measures to demonstrate continuous improvement in services.**		**3**	
6.2	**In its development of services, the CHP incorporates evidence from sources such as pilots, demonstration projects, good practice, research, guidelines, NHS Quality Improvement Scotland reports on reviews of performance against its standards and Ombudsman's reports.**		**3**	
6.3	**The CHP adopts a systematic approach to monitoring delivery of Health Improvement targets.**		**3**	
6.4	**All agencies involved in providing services for people with long term conditions participate in audit of the management of long term conditions.**		**3**	
6.5	**The CHP monitors long term condition outcomes, as part of overall CHP objectives and JPIAF/ LIT outcomes.**		**3**	

	CRITERIA	EVIDENCE	VALUE	ACTION TIMESCALE RESPONSIBLE PERSON
6.6	Systematic provision is in place for feedback from service users and their carers regarding information on the condition and access to quality of care provided locally.		3	
6.7	The CHP long term conditions action team prepares an annual report, using the self-assessment Toolkit.		3	
6.8	The annual report is submitted to the CHP Committee, the NHS Board Clinical Governance and Redesign Committees, to the Joint Future Committee, to the Board as part of the annual review process and to relevant local authority committees.		3	
6.9	The self-assessment information is considered as part of the process in the NHS Board's ongoing performance review.		3	
6.10	Annual reports are communicated through multi-professional clinical effectiveness meetings and the Public Partnership Forum.		3	
		Standard 6 Values	30	

Long Term Conditions: CHP Profile

Standard	Maximum Value	Subtotal Year 1	Subtotal Year 2	Subtotal Year 3
Standard 1 – Organisation of Long Term Conditions Management	**24**			
Standard 2 – Patient Information and Supported Self Care	**24**			
Standard 3 – Service Design and Multi-disciplinary/Multi-agency working	**24**			
Standard 4 – Interdisciplinary Education and Training	**24**			
Standard 5 – Information and Intelligence	**24**			
Standard 6 – Quality and Delivery	**30**			
Total Score	**150**			

Criteria and standards have not been weighted.
Performance against each standard should be considered independently to identify priority areas for actions. The total score should increase year on year as the CHP implements systems of care to manage long term conditions more effectively.