



Improving Complex Care

A collaborative resource to support partnerships

Sharing improvement actions on ten approaches that will help you deliver better outcomes and an enhanced experience of care for older people and for people living with long term conditions

■ ■ ■ ■ **Health Delivery Directorate
Improvement &
Support Team**

jit
joint improvement team

Sharing Solutions for a Shared Challenge

The increasing number of older people with complex needs and multiple long term conditions is a major challenge for health, social care and housing services in Scotland. The Long Term Conditions Collaborative (LTCC) and the Partnership Improvement and Outcomes Division (PIOD) are working together to support health and care partnerships deliver sustainable improvements in person centred services for this care group.

Our focus is to support shared learning and to provide tools, techniques and a range of practical supports to enable partnerships to deliver timely, safe, effective, efficient and equitable services that achieve better outcomes and an enhanced experience of care. Approaches include Plan Do Study Act (PDSA) cycles, lean-thinking, targeting steps and activities that don't add value and addressing capacity and flow to improve pathways, reduce delays and to increase reliability and productivity across the whole system.

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 patients 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.

Supporting Delivery

From our published LTC High Impact Changes and Improvement Actions we identified a set of ten improvements that will support you to manage older people with multiple long term conditions and complex needs most at risk of recurrent emergency admissions and institutional care. The list is not exhaustive, nor is it intended to be a comprehensive evidence base. The set of improvements reflects the experience of partnerships in Scotland and builds on lessons from the **NHS Institute for Innovation and Improvement's** guide '**Focus on Frail Older People**' (*Delivering Quality and Value series, 2006*).

To make a real impact we must move from pockets of innovation and good practice to spreading and sustaining improvements across Scotland. When we implement all of these changes together we will generate an energy and a momentum that will get us to that tipping point where culture, behaviours, practice and performance shifts.

We hope that the following ideas, examples and contacts provide you with practical steps to help you deliver even better outcomes for older people.

Ten things you can do now that make a difference

Where it's happening...and who can help

Improvement Action	Page
1. Stratify your population and identify those at high risk	4
2. Target and deliver a proactive case / care management approach	6
3. Introduce advanced / anticipatory careplans	8
4. Communicate and share data across the system	10
5. Develop intermediate care alternatives to acute hospital care	12
6. Provide telehealth and telecare support	14
7. Develop a falls prevention pathway and services	16
8. Provide pharmaceutical care for older people	18
9. Ensure timely access to flexible homecare and carer support	20
10. Promote mental health and wellbeing in later life	22

It may be Complex but it's Logical

There is growing interest in the use of a 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.

Appendix 1 is a simplified Logic model framework that illustrates the ten Improvement actions for complex care and their anticipated impact on outcomes and performance across the whole system.

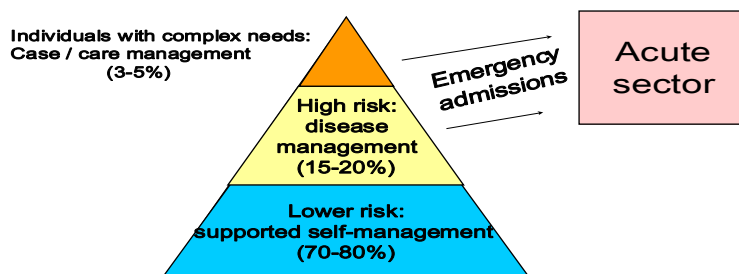
1. Stratify your population and identify those at High Risk

Improvement Action : Identify individuals at high risk requiring complex care by using national risk prediction tools (eg SPARRA) and electronic searches applied to local health and social care datasets (eg disease registers, A&E data, Indicator of Relative Need scores). Then share this information with the people who need it.

Background

We need to shift from a reactive hospital based system of unscheduled care towards one which is founded on a preventive, anticipatory approach to managing long term conditions on a whole-person basis. A first step is to stratify your local population in terms of their pattern, seriousness and complexity of long term conditions to identify those individuals most at risk of future crises.

Population management of long-term conditions



4

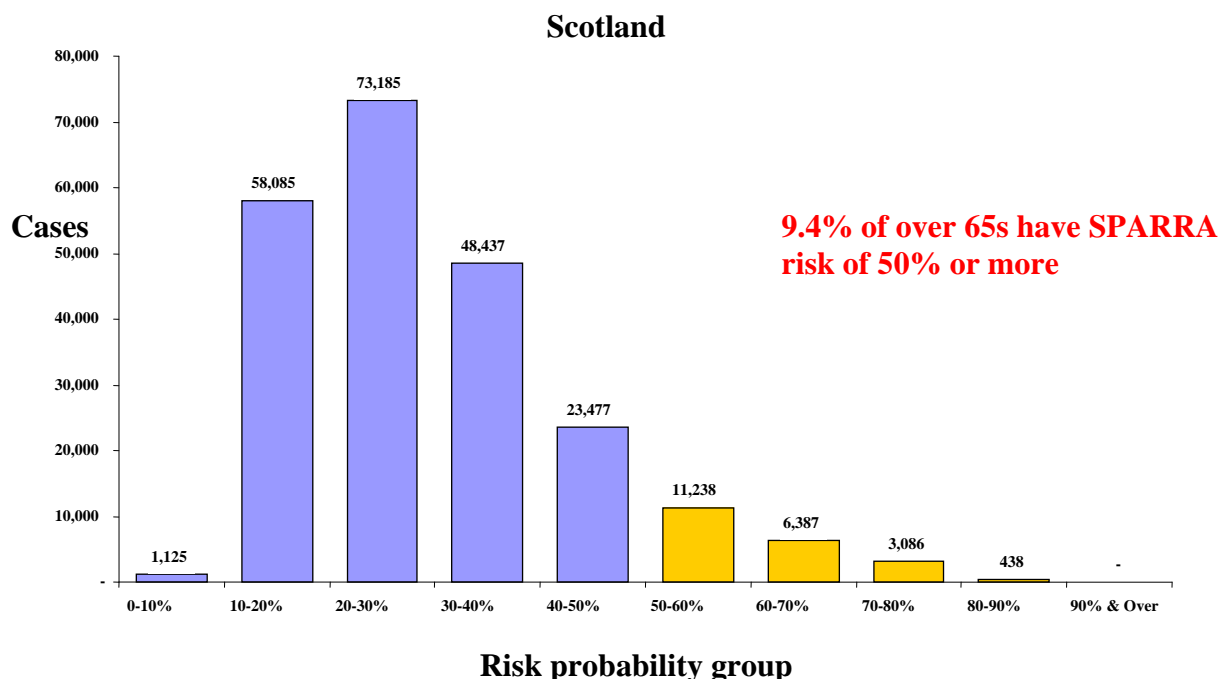
The SPARRA tool, developed by Information Services Division (ISD), identifies patients aged 65 years and over who have entered a cycle of repeat hospital admissions. The SPARRA algorithm predicts risk of future hospitalisation for those individuals who have already had an emergency admission in the previous 3 years.

SPARRA does not identify everyone living in the community with 'Complex' needs. Some CHPs are enhancing the information from SPARRA with community case ascertainment derived from a range of locally held datasets.

Examples of useful available community datasets to complement SPARRA are:

- A&E attenders, ADASTRA / Out of Hours contacts and QOF disease registers - eg Ayrshire and Arran tools
- The Nairn Case Finder tool – NHS Highland
- PEONY – NHS Tayside's tool using CHI generated prescribing information
- Indicator of Relative Need (IoRN) scores for users of social care – demonstrator project by SW Glasgow CHP

SPARRA. Over 65s. Distribution of Predicted Probabilities



Most CHPs use a SPARRA risk score of 50% or more when assigning 'high risk' of future admission. This applies to around 10% of the 65+ population with previous admissions. However at an individual patient level, complexity and intensity of needs and risk are dynamic states which change with time, with fluctuations in disease severity and as family and home circumstances change. When SPARRA data is reviewed at a CHP or practice level, many people with high SPARRA scores will have died, may have improved or already moved into institutional care.

Lanarkshire partnerships established locality groups to review their SPARRA data, share knowledge about these patients across community teams and agencies and to consider the benefit of including these individuals on a case/care managed caseload. Local health and care staff identified people whose health, circumstances or support had stabilised or improved and then targeted for more intensive and preventive support those who remained at high risk.
Contact - Janette.Barrie@lanarkshire.scot.nhs.uk

Where it's happening - Useful Contacts for SPARRA and Risk Prediction Tools

ISD SPARRA Programme – Steve.Pavis@isd.csa.scot.nhs.uk
 Ayrshire and Arran tool – Lyall.Cameron@aapct.scot.nhs.uk
 Nairn Case Finder – abaker@gp55906.highland-hb.scot.nhs.uk
 SW Glasgow CHP use of IoRN data – Margaret Anne Dale
 Tayside PEONY tool – Peter.Donnan@nhs.net

2. Target and deliver a proactive Case / Care Management approach

Improvement Action : Target those identified by risk prediction tools as at high risk then tailor care for individuals through a case / care management approach using multidisciplinary teams that work closely with social services. Develop capability within multi-disciplinary primary and community care teams using personal development plans and learning plans to develop core generic skills and appropriate specialist competencies. Agree and communicate with the patient, carers and across services who has responsibility for co-ordination, overview and review of the care plan.

Background

The terms case and care management are often used interchangeably.

The Department of Health defined Case Management as “a *proactive approach focused on high-risk patients with a combination of medical, nursing, pharmaceutical care and social care needs.*”

The Kings Fund in 2004 described the core elements of case management as case finding or screening, assessment, care planning, implementation, monitoring and review. They may be undertaken as the specific job of a ‘case manager’ or as a series of tasks fulfilled by members of a team.”

Better Outcomes for Older People (Scottish Executive 2005) defined Care management “as a *process whereby an individual's needs are assessed and evaluated, eligibility for service is determined, care plans are drafted and implemented, services are provided and needs are monitored and re-assessed. The individual will usually have complex or frequently or rapidly changing needs*”.

Most published studies of case management originate from the United States where managed care programmes identify potential high resource / service users and deliver case management to reduce resource utilisation costs. Between 2003 and 2005 United Healthcare introduced a case management approach in nine primary care trusts in England. Patients, nurses and GPs reported favourable qualitative outcomes with increased frequency of contact, additional monitoring and psychosocial support. *Evaluation of Evercare: final report. National Primary Care Research & Development Centre, University of Manchester 2006. Available from: www.npcrdc.ac.uk/pr33.*

Before and after comparisons of case / care management are of limited value due to the degree of regression to the mean observed in this cohort of patients. Analysis of outcomes at practice level compared 62 Evercare intervention practices with 6960 control practices. With this caveat, the intervention had no significant effects on rates of emergency admissions, emergency bed days, or mortality for a high risk population aged over 65 with a history of two or more emergency admissions in the preceding 13 months. *BMJ 2007; 334: 31- 34.* With uncertain impact from Community Matrons in England there is little enthusiasm in Scotland for developing new posts to undertake this function as a dedicated role. There are also concerns over the scalability of interventions based on ‘stand alone’ specialist posts.

Develop staff to undertake a case / care management approach

There is intuitive support for a case / care management approach to care and growing interest in building the capability to deliver this through enhanced staffing, skill mix and role development of existing community nursing, allied health profession and social care staff. Some CHPs are progressing case / care management through a local enhanced service while others are building a multi-agency model on opportunities presented by 'Changing Lives' social work review and the review of nursing in the community. Good quality assessment practice is the key to better outcomes and the first step in developing appropriate care and support plans. The recently published **National Minimum Information Standards for all Adults in Scotland (NMIS)** support an outcome focused approach to assessment, care planning and review and provide partnerships with a useful platform for training and development support for case / care management. The NMIS standards also cover guidance on objective and timeous reviews of care plans and support professionals in social care, health and housing to carry out holistic assessments that facilitate user and carer participation.

Emerging experience of case / care management across Scotland suggests tangible improvements in quality and continuity of care and in patient and staff satisfaction but uncertain impact on emergency hospital admissions and bed days. The latter are highly dependent on case / care managers having timely access to alternatives to admission and reflect the interdependencies of interventions delivered in a complex system. Impact of case / care management on emergency admissions depends on the degree to which the local partnership has embraced other improvements in joint working, data sharing, community rehabilitation, intermediate care, ambulatory services and integration with out of hours health and social services.

Where it's happening

Lothian 'IMPACT'. Patients are identified as being suitable for case/care management following screening of high risk individuals highlighted though SPARRA data by GPs, nurse specialists and community respiratory teams. Patients are stratified as red, amber or green for level of input required. Anticipatory Care Plans are drawn up and all relevant parties have access to these.

Contact: Aileen Kenny 0131 5379388.

Tayside CHPs are testing a case management approach and a patient held *My Health Passport* which contains personalised information on health problems, medicines, emergency contacts and red arrow prompts for early interventions at condition flare ups.

Contact: Fiona.Lornie@nhs.net 01738 473131

Lanarkshire partnerships are implementing proactive integrated care management across 6 localities for people identified as at high risk via SPARRA, referral from practitioner or from hospital. There is some early evidence of a reduction in emergency bed days as well as clear qualitative improvements.

Contact: Janette.Barrie@lanarkshire.scot.nhs.uk

Ayrshire and Arran CHPs operate three different models for case management building on SPARRA, real time hospital data and an enhanced service for Intensive Co-ordinated Case Management. **Contact :** Bernadette.Brown@aapct.scot.nhs.uk

3. Introduce advanced / anticipatory care plans

Improvement Action : Create opportunities to explore wishes and choices for the future through advanced care planning for end of life, crisis, respite and rehabilitation needs. Ask the 'surprise question' at case reviews, for emergency admissions and care home residents. Introduce advanced / anticipatory care plans and share information on preferred place of care with out of hours and with NHS24. Embed advanced / anticipatory care plans in special notes and the Emergency Care Summary.

Background

Advanced care planning is a process of discussion and reflection about goals, values and preferences for future treatment in the context of an anticipated deterioration in the patient's condition with loss of capacity to make decisions and communicate these to others. The core elements of advanced care planning are already incorporated within the Gold Standards Framework Scotland (GSF 2006) being used in Primary Care settings for people living with cancer. We have yet to embrace this approach for people with life limiting illnesses and long term conditions.

Understanding the typical illness trajectories for cancer, organ failure and physical and cognitive frailty can help you plan care to meet patients' and carers' changing needs. Each illness trajectory will have periods of relative stability, of intermittent crisis, phases of changing needs and ultimately end of life care. Critical events and stepped changes in disease progression should be recognised as triggers for a palliative approach. Triggers include:

- critical events or significant deterioration indicating the need for a 'change of gear' in clinical management and / or support
- yes to the 'surprise question' (clinicians would not be surprised if the patient were to die within the next 12 months)
- onset of the end of life phase – 'diagnosing dying'.

Frequent unscheduled hospital admissions and readmissions experienced in advanced heart failure or end stage chronic obstructive pulmonary disease (COPD) should trigger further holistic assessment and development of an appropriate care plan for the next phase of the patient's journey. In the prolonged frailty / dementia illness trajectory, key events that indicate the need for further comprehensive assessment, including consideration of palliative and end of life care needs, may include significant irreversible deterioration in function and / or admission to a care home.

Advanced / anticipatory care plans

There is no blueprint for an advanced care plan / anticipatory care plan but it should generally address the following :

- *What happens if your carer becomes unwell?*
- *What to do if your condition flares. How to access help, advice and treatment*
- *What would you like to happen if you became acutely unwell with?*
- *Preferred Place of Care - home, community hospital, care home, acute hospital*
- *Resuscitation status*

The purpose of advanced / anticipatory care planning is to promote greater choice, control and communication of care preferences across the team, across agencies and across care settings. Advanced care plans should be shared with out of hours services through inclusion as special notes. Where consent has been given for sharing, they should be included in single shared assessments.

Some examples of advanced / anticipatory care planning in practice

The Palliative Care Summary (PCS) is an advanced care plan that includes:-

- Medical conditions – as agreed by GP and patient
- Current care plan, including preferred place of care
- Patient and carer understanding of diagnosis and prognosis
- Resuscitation status and Out of Hours contacts

The Gold Standards Framework IT Project, currently being piloted in Grampian, uploads the PCS Out of Hours to the Emergency Care Summary (ECS). The PCS-ECS is then available to NHS 24, A&E and emergency admissions units.

Contact – Peter.Kiehlmann@nhs.net

NHS Highland: Anticipatory Care Project demonstrated a reduction in admissions, readmissions and occupied bed days for 110 patients followed through for 8 months. The “top 1%” most at risk of admission in the practice had an “Anticipatory Care Plan” which includes patients wishes should their condition deteriorate or change dramatically. The main areas discussed are

- what happens if the carer becomes unwell. Who to contact and how?
- capacity issues, Power of Attorney , Welfare guardianship, wills etc
- what if there is an acute medical, surgical or psychiatric problem?
- preferred Place of Care – home, hospital, care home
- resuscitation status and how that information is communicated

The project was qualitatively evaluated by the University of Stirling and the full report is available on the website www.cancercare.stir.ac.uk

Contact : Adrian Baker abaker@gp55906.highland-hb.scot.nhs.uk

NHS Forth Valley Checklist for embarking on End of Life Treatment (CELT)®

CELT® is a decision making framework designed to facilitate a smooth transition from active treatment to end of life care and links the GSF (Gold Standard Framework) and LCP (Liverpool Care Pathway).

Contact : Elizabeth.Ireland@nhs.net

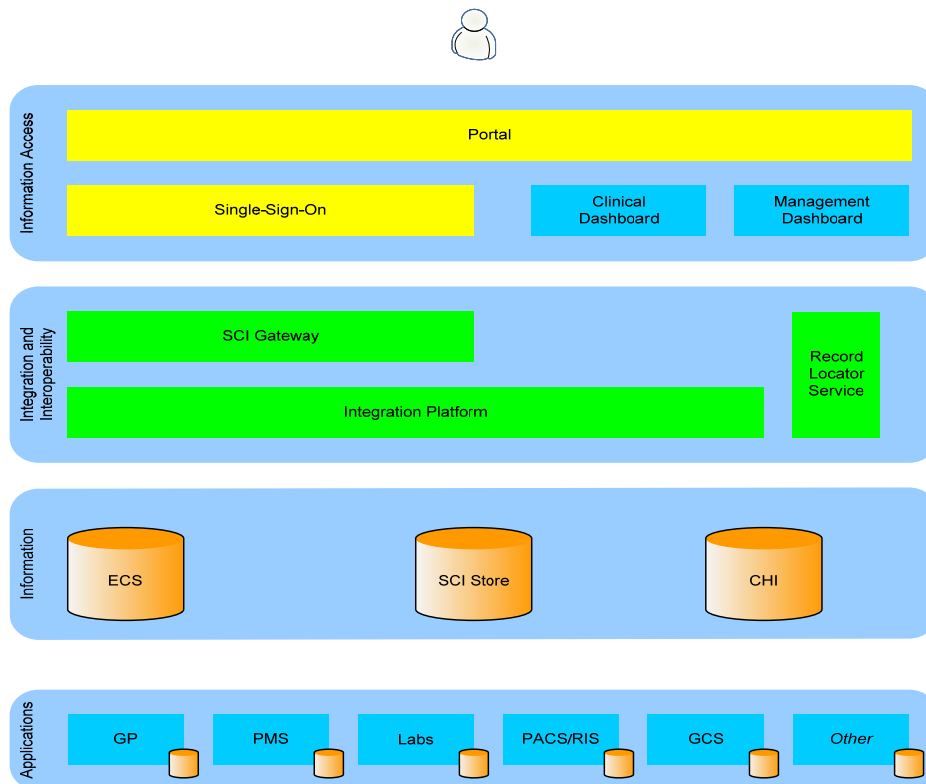
NHS Dumfries and Galloway - Annandale & Eskdale LHP - Development of End of Life Choices questionnaire to people living in care homes. Patient and carer preferences are flagged onto ADAstra out of hours notes and held as an advanced care plan in the care home.

Contact: mary.sherrie@nhs.net

4. Communicate and share data across the system

Improvement Action : Share information and communicate real time patient data to the relevant people; it's vital to improving care. Do PDSAs to help you understand how information is shared across partner agencies, between primary and secondary care, and with SAS, Out of Hours and Community Pharmacy. Use ISD and national IT systems as enablers. Strip out non value added steps. Make data sharing real time by use of flags and Business Object tools to improve continuity of care.

NHSScotland is progressing an incremental and pragmatic eHealth strategy based on access to an integration platform through a single clinical portal. Access will be supported by SCI Gateway using tools to deliver integration and ensure interoperability. An integral part of this Strategy will be to design, develop, and implement a system which supports a personal health record or electronic care plan and the sharing of information to support practitioners working across sectors and agencies.



Contact : Alistair.Bishop@scotland.gsi.gov.uk - ehealth Benefits Programme lead

An ongoing Information Governance study will take stock of where we are now and build on current best practice to identify how NHSScotland can best move forward with information access, consent, clinical and patient engagement and information governance frameworks. Troy Johnson is working alongside Nessa Barry from the Scottish Centre for Telehealth, supported by subject matter experts from NHSScotland.

Contact : Troy Johnson: troy.johnson@logica.com

Make use of the Emergency Care Summary and Special Notes

The Emergency Care Summary contains key clinical information for over 5.1 million patients and is used in around 25,000 care episodes per week, if the patient explicitly consents to its access. Having access to key details such as current medication and allergies makes care safer at transition from home to hospital and out of hours. Including special notes fields can inform the Out of Hours Service that the patient has an advanced / anticipatory Care Plan (ACP), Palliative Care Plan or is being case / care managed.

Adastra Software Ltd, an Advanced Computer Software Plc Group company, provides a specialist case management, data distribution and clinical recording system now used by more than 95% of UK unscheduled primary care operational hubs.

<http://www.adastra.co.uk/>

Share information across health and social care

The process of Single Shared Assessment is essential to the provision of both health and social care. Some partner agencies are beginning to use the eCare Framework technology. Benefits for practitioners are 24/7 access to information, more secure and faster transfer of information and less paper! eCare programme board papers and minutes can be found at

<http://www.scotland.gov.uk/Topics/Government/DataStandardsAndeCare/DSPB>

National Practice Forum

The National Practice Forum ensures that practitioners from across Scotland can contribute their perspective on aspects related to data sharing. The June 08 event on 'Consent & Confidentiality and it's influence on electronic Information Sharing' featured Mr Ken Macdonald, Assistant Commissioner for Scotland, from the Information Commissioner's Office (ICO). Presentations and workshop outputs are available from

http://www.nationalpracticeforum.org/event_details_past.aspdirectoryid=&eventID=39

Where it's happening

NHS Dumfries and Galloway - Annandale & Eskdale LHP – Advanced Care plans for care home residents are flagged onto ADASTRA as special notes for Out of Hours services to access.

Contact: mary.sherrie@nhs.net

Aberdeenshire CHP is using Business Objects tools to link acute and primary care team patient information so that community nurses can identify in real time people who have had emergency admissions to Aberdeen Royal Infirmary. This helps with proactive discharge planning, care pathways and flow through to community services.

Contact : adustan@nhs.net

Ayrshire and Arran have case alerts shared between A&E, Out of Hours, primary care and acute services to identify case managed patients and provide contact details of their case manager. **Contact :** lyall.cameron@aapct.scot.nhs.uk

5. Develop Intermediate Care alternatives to acute hospital care

Improvement Action - Develop intermediate care services that enable people to improve their independence and provide a range of enabling, rehabilitative and treatment services in community settings. Provide effective primary and specialist health care services for residents in care homes and develop the role and contribution of community hospitals.

Background

Intermediate care is a range of enabling, rehabilitative and treatment services delivered through an integrated approach and in community settings to shift the balance of care from hospital to the community. They act as a bridge at key points of transition in the patient's journey from home to hospital and back home again and from illness to recovery. Services can be provided in:

- Individuals' own homes, sheltered and very sheltered housing complexes
- Day hospitals, day care and integrated day services
- Designated beds in local authority or independent provider care homes
- Designated beds in community hospitals

Across the UK there are several definitions for Intermediate care. The Department of Health's Change Agent Team defined Intermediate Care as "A service provided on a short term basis at home or in a residential setting (usually about 6 weeks) for people who need some degree of rehabilitation and recuperation. Its aims are to prevent unnecessary admission to hospital, facilitate early hospital discharge and prevent premature admission to residential care" (Making Connections 2006)

The Joint Improvement Team (JIT) supports an Intermediate Care Learning Network and has a section on Intermediate care on its website: www.jitscotland.org.uk. This has examples, local contacts and reports of Intermediate care learning events in Scotland.

Developing Community Hospitals : A Strategy for Scotland (2006) describes the unique relationship between community hospitals and their local population and sets out their contribution to delivering community-based primary care led services. Key strengths of community hospitals are that they provide local access to a wide range of services on a 24-7 basis and they promote a multi-disciplinary, multi-agency approach to healthcare that maximises the opportunities for partnership with the local community and voluntary sector.

The role of the community hospital varies across Scotland. Some provide community diagnostics, consultant and shared care clinics, day hospital services, rehabilitation and palliative care as well as acute care in a local environment as an alternative to secondary care.

For further information on the strategy and the Scottish Association of Community Hospitals visit www.scotcommhosp.org.uk

Where it's happening

NHS Lothian – Edinburgh CHP – Community Respiratory Physiotherapy Service. Referrals from GPs of patients at high risk of admission. Potential for home visit within 2hrs of receipt of phone call. By end of June 2008 the service had reduced hospital admission by 77% with further evaluation about to start.
Contact: Mairi McCrae 0131 337 4981

NHS Lothian – East Lothian CHP – Elder Project. Reduces emergency hospital admission for frail elderly patients by offering a next day appointment at the day hospital. Early results to July 08 showed admission was avoided in 64 of 83 (77%) patients managed through the project
Contact: Dr Peter Lange 0131 536 8312

Dumfries and Galloway - Short Term Augmented Response Service (STARS) provides early input to complex needs patients to avoid hospital admission and supports early discharge by providing intensive rehabilitation in the patient's own home.
Contact: gail.edgar@nhs.net

NHS Grampian: COPD Early Supported Discharge Project - successful in achieving its aims of reducing bed days and improving quality of patient care. Under this project patients can be discharged early to be looked after by their carer and Health at Home (private agency).
Contact: jain.small@nhs.net; or Gordon.Christie@arh.grampian.scot.nhs.uk

South Lanarkshire has an intermediate care rehabilitation service across Clydesdale and its 3 community hospitals with links to integrated evening care.
Contact: Fiona.Andrews@lanarkshire.scot.nhs.uk

North Lanarkshire has a basket of intermediate care services delivered at home, in local authority and independent care homes and in an integrated day unit
Contact: TaylorF@northlan.gov.uk or Rose.Letham@lanarkshire.scot.nhs.uk

Smithfield Court in Aberdeen and Dollar Court in Dunfermline provide Intermediate care models in sheltered housing. Contact : Anne.McAlpine@faht.scot.nhs.uk

Moray home from hospital service has improved the transition from hospital to home in Elgin & Lossiemouth. Contact : Elena.Geddes@moray.gov.uk

Glasgow have IRIS and DART rapid response and early supported discharge services for older people and a specialist service for people returning home after stroke.
Contact : 0141 201 3210

Fife has Integrated Response Teams and an Enhanced Healthcare Team
Contact : Fiona.McKenzie3@nhs.net

Angus has an Intermediate care service at home and in housing settings
Contact : Philip.Gillespie@angus.gov.uk

6. Provide telehealth and telecare support

Improvement Action: Do tests for change on remote and near patient monitoring for COPD and diabetes and work in partnership with the Scottish Centre for Telehealth. Work with the National Telecare programme to spread the use of remote monitoring packages to help maintain people with complex needs in their own home.

Background

Telecare and telemedicine are the two components of telehealth.

Telemedicine is the provision of healthcare at a distance using a range of digital technologies, including videoconferencing, with clinical professional involvement.

Telecare is the use of a range of 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. Professional clinical involvement is not necessarily part of their 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.

'Telehealthcare' offers a range of care options remotely via phones, mobiles, broadband and videoconferencing. It can improve the patient's experience of care by reducing the need for travel to major cities and hospitals to receive care and treatment. It has been used successfully to provide treatment for dermatological, cardiac and neurological conditions. It enables care to be delivered in remote communities, allows GPs to consult specialists remotely to avoid unnecessary referrals and enables networks of learning for clinicians and maximisation of skill mix for teams.

Case Study

Scottish Centre for Telehealth (SCT) and Perth & Kinross CHP developed an out-of-hours service linking minor injury/illness services at three community hospitals in Blairgowrie, Crieff and Pitlochry with the out-of-hours service hub in Wallacetown, Dundee. Service benefits will include :

- Rural GPs being able to see patients from the urban hub via the link when they have spare, out-of-hours capacity.
- Links to other areas of Tayside.
- Expanded educational opportunities and nurse to nurse support/advice.
- Reduced GP travel by using the service for consultations during normal surgery hours for minor illness and community hospital support/advice.

The CHP and SCT carried out accelerated PDSA cycles to test and roll out the service.

Contact : Sandra Auld, Scottish Centre for Telehealth sandraauld@btinternet.com

Visit the **Scottish Centre for Telehealth** website at www.sct.scot.nhs.uk

Telecare support is as much about the philosophy of dignity and independence as it is about equipment and services. Telecare equipment and detectors can provide continuous, automatic and remote monitoring of care needs using information and communication technology to trigger human responses or shutdown of equipment to prevent hazards. Telecare can be used in a variety of ways, for example to inform an assessment of need, as a direct service provision to manage individual or environmental risks more effectively or as part of a wider package of care and support.

The National Telecare Programme is supporting telecare developments in all 32 partnerships across Scotland. Independent evaluation of the programme shows that, in its first two years (to March 2008), 13,800 hospital bed days were avoided through the use of telecare. More importantly, the evaluation also shows that users and carers are overwhelmingly positive about the benefits of appropriate telecare packages.

Properly used, telecare does not substitute for direct personal contact services. It does provide for greater confidence and security and can ensure that direct contact services are appropriately targeted and available when required. This is not only better for patients and service users and carers, but helps ensure optimum use of staffing, skillmix and clinical time.

Housing Demonstrator Projects – Highland, Inverclyde and West Lothian

These three distinct projects all aim to support service redesign and redevelopment by promoting housing-based models of care, supported with telecare. West Lothian is focusing on a campus style development; Inverclyde is reviewing and remodeling sheltered housing; and Highland's focus is a mixed development centred around the redesign of a community hospital and other local facilities.

Contact: Moira Mackenzie, National Telecare Programme Manager

Moira.mackenzie@scotland.gsi.gov.uk

NHS Dumfries and Galloway: Telecare Project- Funded project to expand the use of telecare across Dumfries and Galloway. Two show flats are available in Dumfries and Stranraer showcasing available technology. Since April 2007, 156 additional people have received complex care packages.

Contact: Marion Glover 01387 272754

Lothian – Met Office Project – East Lothian CHP. Co-ordinated COPD health forecasting and anticipatory care service to improve patients' quality of life and reduce the risk of unplanned NHS contact, including emergency hospital admissions. About to be rolled out following successful pilot. **Contact:** Carol Lumsden 0131 536 8030

Lothian Telehealth Project will extend telecare to include telehealth home monitoring of key signs / symptoms in 400 patients. There is early evidence of benefits for the first 30 patients with COPD but a more substantial evaluation and randomised control trial is ongoing. The project will extend to include people with diabetes and heart failure.

Contacts – Brian.McKinstry@ed.ac.uk or Paddy Corscadden@edinburgh.gov.uk

7. Develop a falls prevention pathway and services

Improvement Action - Embed care and review prompts and protocols in information systems. Improve patient safety by building decision support tools into information systems to support evidence based practice according to agreed pathways and protocols.

Background

One in three people over 65 and half of those over 80 fall each year. A quarter to one third of these falls could be prevented, with lives saved, suffering avoided and costs reduced. Almost half of A&E attendances for people aged over 65 years can be the result of a fall and 50% of those who fall will have another fall within the next 12 months. Hip fractures account for 50% of injury related hospital admissions and 66% of bed days for people over 75. Hip fracture has a mortality of over 20% within three months, and of those who previously lived independently just over half recover their previous independence. Of those discharged home from hospital, 42% will require additional carer support.

NHS QIS is developing a '**Pathways for the Prevention and Management of Falls and Fragility Fractures in the Community**'. **Contact:** Ann.Murray3 @nhs.net

The pathway screens and identifies falls risk and signposts to a tiered level of intervention according to need. The journey of care has been divided into 4 stages :

1. Supporting health improvement and self-management to reduce the risk of falls and fragility fractures (maintenance phase)
2. Identifying individuals at risk of falls and fragility fractures
3. Responding to an individual who has just fallen and requires immediate assistance
4. Co-ordinated management, including specialist assessment

Stage 1	Stage 2	Stage 3	Stage 4
<p>Older people and carers:</p> <p>1. have opportunities to engage in health promotion and lifelong learning around active ageing and minimising falls and fracture risk.</p> <p>2. have opportunities to access appropriate services and organisations, which aim to support:</p> <ul style="list-style-type: none"> • the maintenance of health and well-being • a safe home environment • a safe community environment 	<p>Older people:</p> <p>1. who present with an injurious fall (including a fracture) or recurrent falls (two or more falls in the past year) are offered further assessment to identify contributory risk factors for falls and fractures</p> <p>2. reporting a single, non-injurious fall are offered screening to establish their risk of further falls and/or sustaining a fracture</p> <p>3. are asked routinely (at least once a year) whether they have fallen <i>and/or</i> are fearful of falling <i>and</i> are observed for balance and gait deficits (<i>opportunistic case identification</i>)</p> <p>4. who sustain a fragility fracture <i>and/or</i> are diagnosed with low bone density or identified as being at high risk of fracture receive an <i>initial falls risk screen</i></p>	<p>Older people:</p> <p>1. who have received treatment of any injury due to a fall or treatment of any acute medical condition related to a fall, are provided with the opportunity to enter the falls and fracture prevention pathway</p> <p>2. who have fallen but are not conveyed to hospital following the fall, are considered for further assessment and offered this where indicated</p>	<p>Older people:</p> <p>1. identified at high risk of falling +/- sustaining a fracture are offered a multifactorial assessment to identify contributory risk factors</p> <p>2. with suspected or confirmed blackouts and those with unexplained falls, vertigo and dizziness, are offered focused medical assessment</p> <p>3. following assessment, are considered for an <i>individualised</i>, multifactorial intervention programme aimed at:</p> <ul style="list-style-type: none"> • minimising the identified risks for falling +/- sustaining a fracture, • promoting independence • improving physical and psychological function <p>4. have the opportunity to discuss health improvement and the prevention of further falls prior to discharge</p>

Where it's happening

Forth Valley and Falkirk Council's Mobile Emergency Care Service and Housing with Care Service are working in partnership to identify vulnerable people in the community who are falling frequently and offer early access to assessment, therapy, equipment and advice. Social care staff have been trained to deliver strength and balance exercises in four 'housing with care' units with plans to introduce this in the six residential care units. **Contact** Linda.macpherson@falkirk.gov.uk

West Lothian CHCP has 3321 homes with Smart Technology packages installed to covers 4800 residents. Packages can include technology such as voice-activated home alert consoles, falls detectors, chair/bed occupancy sensors, automated reminders, voice prompts and door open alerts. The community response time is on average 22 minutes from the first alert. Referrals come from a range of agencies, self referrals and hospitals should refer people who have had multiple admissions. **Contact** gill.Cottrell@wlt.scot.nhs.uk

NHS Dumfries and Galloway Falls co-ordinators oversee an integrated programme :

- health promotion; advice on falls prevention; community-based exercise classes support programmes for the general population
- A&E staff and all community practitioners, including health and social care staff identifying older people at high risk
- Assessment of risk factors for those identified at high risk with the option for referral to specialist falls and osteoporosis clinics
- Intervention including Tai Chi, strength and balance exercises in a class setting or at home, equipment provision and social care packages

Contact sarah.kirk@nhs.net

Perth and Kinross CHP Single Shared Assessment process triggers assessors to enquire regarding falls history and offers suggestions for staff to follow e.g. advice about environmental hazards, referral for medication review, appropriate falls prevention literature. If the cause of falls is unknown or cannot be rectified, staff can refer directly to a specialist Falls Clinic. Patients who have attended A+E as a result of a fall but do not require hospital admission are screened by telephone triage to identify those who would benefit from further multi-disciplinary assessment. **Contact** : carolynwilson@nhs.net

Lanarkshire's Falls and Fracture Community deliver a Falls Training Package to health, social and voluntary staff in care homes, sheltered housing and at home. This assists with early identification and management of fallers, includes information on causes and consequences of falls, prevention strategies and details of referral and management pathways to specialist falls services. **Contact** Lianne.McInally@lanarkshire.scot.nhs.uk

8. Deliver pharmaceutical care

Improvement Actions

Recognise what pharmacists, pharmacy technicians and other pharmacy staff can do to support and provide care for people with complex needs. The Chronic Medication Service will allow patients to register with a pharmacy of their choice. A shared agreement between the community pharmacist, General Practitioner and patient will improve understanding and support a person to better manage their condition and reduce visits to the GP Practice.

Use independent and supplementary prescribing where appropriate to make medicines more accessible to people

Background

Up to 50% of medicines are not taken as prescribed and adverse reactions to medicines are implicated in 5-17% of hospital admissions. Problems with medicines can be prevented by identifying those at risk, providing proactive medication reviews, monitoring the effects of long-term medication and modifying the medication where necessary. The patient experience is also improved by effective use of medicines.

The average pharmacy provides services to around 450 people with asthma, 80 people with COPD, 80 with heart failure, 160 with diabetes and 35 with rheumatoid arthritis.

Pharmacists can assess the readiness of a person to change their health behaviour, review their medicines, provide education about their condition and medication, help identify trigger factors and key issues and develop an action plan for self management. They offer encouragement and support for the person to participate in decisions and monitor their own therapy.

Polypharmacy is a major risk factor for falls and elderly fallers should be offered a full medication review with reduction, or withdrawal of medicines that may cause falls. Community pharmacists in particular are in repeated contact with hard to reach patients who have fallen including the housebound, those in areas of deprivation and those with language or cultural barriers where the burden of falls is greater. Community Pharmacy staff are ideally placed to ask people if they have fallen, refer fallers for multidisciplinary assessment and make interventions.

There are many opportunities for better integration of pharmacy services and to include pharmacists in comprehensive and co-ordinated packages of care for people with complex needs. Enablers for this include better communication between people providing care and support and development of shared patient records.

NHS Scotland has a **Care of the Elderly Pharmacy Special Interest Group**. This group is working with NHS Education for Scotland to develop resources to support mutliprofessional education and practice in pharmaceutical care and medication reviews.

Community Pharmacy Scotland is the umbrella organisation of community pharmacists. www.communitypharmacyscotland.org.uk

Where it's happening

Ayrshire and Arran - Pharmacy Involvement in Intensive Co-ordinated Case Management. This small, tightly controlled project is designed primarily to test the model of Intensive Co-ordinated Case Management in 20 patients. The role of community pharmacists involved is to provide pharmaceutical care.

Contact: Diane Lamprell, Ayrshire and Arran. Diane.Lamprell@aapct.scot.nhs.uk

Tayside - A pharmacist is based within the Intermediate Care and Assessment Service in Perth. This has demonstrated a decrease in unnecessary re-admissions due to medication problems and has improved continuity of care. The role of the interface pharmacist has been expanded to include domiciliary medication review and compliance assessment. This initiative was commended in the multi-agency Inspection of Services for Older People report.

Contact: Alistair Jack, NHS Tayside alistairjack@nhs.net

Forth Valley - Scottish Enhanced Services Programmes

COPD and Pulmonary Rehabilitation is in place allowing patients improved access to antibiotics and steroid medication through community pharmacy. **Falls prevention and bone health** is in development to allow community pharmacists to identify patients on medication that can lead to osteoporosis or falls and take steps to reduce risks. In addition, appropriate prescribing and effective management of bone protection medicines will be encouraged.

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

Glasgow Community Falls Prevention Programme

A sustainable model for pharmacy involvement in a falls prevention programme has been developed. The focus is on reducing falls inducing medication, introducing bone strengthening treatment and supporting adherence, particularly in relation to anti-osteoporotic therapy. This involves case finding from community pharmacy, pharmacist led medication review and follow up support for fallers from their community pharmacist. Fallers who are prescribed two or more medicines are referred by Community Older Peoples Teams.

NHS Greater Glasgow and Clyde's 'My Medicines' project supports medicines management for patients at discharge

Contact : Richard.lowrie@ggc.scot.nhs.uk

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 Smith, Dumfries and Galloway catherine.smith4@nhs.net
Wendy Robertson, Grampian wendyrobertson@nhs.net

9. Ensure timely access and flexible home care and carer support

Background

Improvement Action : Make home care flexible, responsive and enabling to support people to remain at home with personal care, equipment and adaptations. Encourage flexibility through role blurring and role shadowing opportunities across professions, agencies and across care settings. Unpaid carers play a vital role in supporting people living with long term conditions. We need to support their needs too ensuring access to education and leisure opportunities, and making sure they have the chance to work flexibly so as to combine work with their caring roles.

Prior to 2001, Leicestershire County Council in-house home care service provided services comparable to that of other external agencies at double the cost. Disparities between provider and purchaser were leading to urgent telephone requests for services, a lack of flexibility and a tendency to perpetuate the service package with little or no review, except in emergency situations. In 2001 they implemented a Homecare Assessment and Re-enablement Team (HART), a new model of specialist home care services to make services more flexible, more suitable to service users' preferences, more cost effective and sustainable.

HART provides a re-enablement service to people newly assessed as needing support at home and works alongside community health teams to provide a truly joined up approach. The focus is on maximising independence and rebuilding skills and confidence so people are less reliant on the more formal and traditional types of service in the longer term. For up to 6 weeks, care assistants identify what people can do for themselves and assist them to regain their skills of daily living. Support is tailored to need, focuses on people's strengths and capabilities with a strong philosophy of people setting their own goals. Care staff encourage and support people to do as much as they can for themselves - doing tasks *with* people rather than *for* them. Any residual on-going home care support needed following the team's involvement is commissioned from mainstream services. **Contact :** Jane Dabrowska, Leicestershire County Council

Key Lessons

- Early intervention from HART prevented crises occurring. The service enables people to have more active lives in their own communities, for longer.
- Through HART, the Council is making better use of resources and has reduced its costs for home care and support in the long term.
- Existing staff transferred to the new model on an incremental basis. There were no changes to job descriptions or titles; the substance of the work remained the same.
- Home Care Brokers facilitated the commissioning of packages and made best use of capacity in each locality, ensuring that priority was given to urgent cases such as hospital discharges and prevention of breakdown of carer support.
- Communication was crucial to successful implementation within the in-house service and amongst commissioners and independent sector providers.

Where it's happening

Aberdeenshire : The Forget Me Not Club for people with dementia and their carers in Aberdeenshire is described as 'a lifeline', somewhere carers can relax and enjoy the company of others. Past carers got so much from the service that they sometimes came back to help out although their relative was no longer attending. This service is funded and run by the social work service with the help of volunteers.

Edinburgh City The Council is in the process of redesigning home care to introduce a reablement model based significantly on the Leicestershire County Council approach. All new referrals will be directed to the new 'in-house' reablement team who will work with clients to optimise their skills and capabilities. At the end of a 6 week period they will be reassessed and further (probably lower levels of) continuing support will come from commissioned external services.

Contact: David.Bolton@edinburgh.gov.uk

Clackmannanshire Council provides a mobile home care service for rapid support. Eight mobile units deployed to provide task focused interventions in people's homes between the hours of 7am and 11pm, seven days per week. The service is delivered in partnership with a private home care provider contracted by the council, with community nurses supervising and training home carers in administration of medication, help with personal care, dressings, catheter and pressure care.
Contact: : jaitken@clack.gov.uk

NES and JIT with the Lanarkshire partnerships developed Capable, Integrated and Fit for the Future - a multi-agency capability framework to support the training and development needs of community health and home care staff delivering intermediate care and enablement approaches. The framework will be further developed as an elearning tool mapped to a directory of educational resources and to digital stories that illustrate the learning outcomes.

Contact: Trudi Marshall trudi.marshall@lanarkshire.scot.nhs.uk

ADSW homecare subgroup has a comprehensive awareness of home care models and services across Scotland.

Contact is derek.phaup@eastlothian.gov.uk

10. Promote mental health and wellbeing in Later Life

Improvement Action : Tailor care plans to individual needs and lifestyle. Adopt a bio psychosocial approach to how the condition impacts on the person, their family, job and lifestyle. Take an approach which supports acceptance, learning to live with the condition and acknowledges a need to make choices and adapt certain areas of lifestyle. Make a range of peer support groups available and accessible and ensure that staff are able to signpost these to people with long term conditions.

Background :

Mental health is a crucial component of our health and wellbeing. It is defined as ‘the positive ability to enjoy life and cope with its difficulties’ and is the resource that enables us to grow, learn and experience life as enjoyable and fulfilling.

Depression is the most common mental health problem in later life. One in four people over 65 years have a depression that is severe enough to impair their quality of life. Physical ill health and disability are the most consistent factors contributing to depression in later life. One in three patients with heart failure and one in five patients with coronary heart disease (CHD) experience depression. Depression is also found in 30% of people with diabetes.

The Living Better project aims to improve the mental health and well-being of people with long term conditions such as diabetes and CHD. Partners include the Royal Colleges, University of Stirling, Diabetes UK Scotland, British Heart Foundation and Depression Alliance Scotland. The project team is working with 6 demonstrator CHPs/CHCPs and with GPs, patients and carers to improve the detection of mental health problems and improve the support people receive.

Living Better is developing a Scotland-wide Learning Network to share information, ideas and learning.

Contact details : *Living Better Project* – 0131 555 5959

Up to 60% of people over 65 admitted to hospital have or will develop during admission a mental health disorder (dementia, delirium, depression). These conditions are associated with increased length of stay and high risk of institutional outcomes. Outcomes are better when these patients are managed by a multi-disciplinary team with the appropriate skills. Access to specialist services for frail older people, training of community staff on the detection and assessment of mental health needs and guidance on the appropriate treatment, interventions and support improves outcomes, reduces bed days and the need for institutional care.

Royal College of Physicians and British Geriatrics Society (2006). Concise guidance to good practice. Number 6: The prevention, diagnosis and management of delirium in older people. National Guidelines, RCP and BGS, London.

Where it's happening

Moray CHCP has formed BALL groups in the community that promote the independence and well-being of older people by combining a focus on physical and mental health, well being and self-determination.

Contact ; Tracy.gervaise@nhs.net

North Lanarkshire Council introduced Locality Link Officers to work with older people in local communities and to build opportunities for participation across a wide range of community and voluntary sector resources and facilities to enhance health and wellbeing.

Contact : TaylorF@northlan.gov.uk

NHS Ayrshire and Arran, Dumfries and Galloway, Greater Glasgow & Clyde, Borders, Lanarkshire and Grampian: Self Help Support. Guided Self Help workers attached to each GP practice across the area. The time limited interventions are designed to provide patients with lifelong skills to detect and react appropriately to patterns of negative thinking thus lessening the likelihood of repeated episodes of distress.

Contacts Sharon Hackney sharon.hackney@aapct.scot.nhs.uk, Rosie Isles rilses@nhs.net, Michael Smith michael.smith@renver-pct.scot.nhs.uk, Mike Henderson mike.henderson@borders.scot.nhs.uk, John Coffey john.coffey@lanarkshire.scot.nhs.uk and Lyn Terry-Short lyn.terry-short@gpct.grampian.scot.nhs.uk.

NHS Forth Valley: Moodjuice web resource for professionals, patients, carers covering self management techniques for mild to moderate mental health problems suffered by people with complex conditions such as Anger, Anxiety, Sleep problems, depression and stress. It also provides advice for carers on finding the right support, employment advice and overcoming problems.

Contact: chris.wright@fvpc.scot.nhs.uk

NHS Forth Valley's nurse consultant for the older person is working with Stirling Dementia Services Centre to develop care pathways and implement guidance for managing older people with dementia.

Contact : chris.beech@nhs.net

Lanarkshire has a practice development practitioner for the Older Person. This post leads a multi-agency learning and development programme that includes dementia awareness training, development of a delirium guideline, training for care home staff and for care managers on screening and assessment of mental health needs of older people and signposting to the appropriate community services and support.

Contact : Trudi.marshall@lanarkshire.scot.nhs.uk

Further Reading, Resources and Sources of Evidence

Older People References

Billings, J., Dixon, J., Mijanovich, T. and Wennberg, D. (2006), Case finding for patients at risk of readmission to hospital: algorithm to identify high risk patients, *British Medical Journal*, Vol. 12, No.333, p. 327.

Carpenter, I., Gladman, J.R.F., Parker, S.G. and Potter, J. (2002), Clinical and research challenges of intermediate care, *Age and Ageing*, Vol. 31, pp.97-100.

Challiner, y. (2003), Performance indicators for hospital services for older people, *Age and Ageing*, Vol. 32, pp. 343-46.

Crotty, M., Whitehead, C.H., Wundke, R., Giles, L.c., Bentovim, D. and Phillips, P.A. (2005), Transitional care facility for elderly people in hospital awaiting a long term care bed: randomised controlled trial, *British Medical Journal*, 331, pp. 1110

Ellis, G. and Langhorne, P. (2005), Comprehensive geriatric assessment for older hospital patients, *British Medical Bulletin*, Vol. 71, pp. 45-59.

Green, J., Young, J., Forster, A., Mallinder, K., Bogle, S., Lowson, K. and Small, N. (2005), Effects of locality-based community hospital care on independence in older people needing rehabilitation, *British Medical Journal*, Vol. 331, pp.317-22.

Morris, J., Beaumont, D. and Oliver, D. (2006), Decent healthcare for older people: good, respectful NHS care for older people is still too patchy, *British Medical Journal*, Vol. 332, pp. 1166-8.

National Institute for Health and Clinical Excellence (2004), Falls: the assessment and prevention of falls in older people, *Clinical Guideline 21*, NICE, London (www.nice.org.uk).

Parker, G., Bhakta, P. and Katbamna, S. (2000), Best place for care for older people after acute and during subacute illness: a systematic review, *Journal of Health Service Research Policy*, Vol. 5, No.3, pp. 176-89.

Rockwood, K. and Hubbard, R. (2004), Frailty and the geriatrician, *Age and Ageing*, Vol. 33, No.5, pp. 429-30.

Rockwood, K., Stadnyk, K., MacKnight, C., McDowell, I., Hebert, R. and Hogan, D. (1999), A brief clinical instrument to classify frailty in elderly people, *Lancet*, Vol. 353, No. 9148, pp. 205-6.

Rothschild, J.M., Bates, D.W. and Leape, L.L. (2000), Preventable medical injuries in older patients, *Archives of Internal Medicine*, Vol. 160, No. 18, pp.2717-28.

Royal College of Physicians and British Geriatrics Society (2006), Concise guidance to good practice. Number 6: The prevention, diagnosis and management of delirium in older people, *National Guidelines*, RCP and BGS, London.

Saltvedt, I., Opdahl, E.S., Fayers, P., Kaasa, S. and Sletvold, O. (2002), Reduced mortality in treating acutely sick, frail, older patients in a geriatric evaluation and management unit. A prospective randomised trial, *Journal of the American Geriatrics Society*, Vol. 50, No.5, pp. 792-98.

Department of Health (undated), *8 tips for quick wins: Improving responses for older people*, DH, London (www.dh.gov.uk/assetRoot/04/11/22/24/04_112224.pdf).

Rubinstein, L.Z. (1993), Comprehensive geriatric assessment: a meta-analysis of controlled trials, *Lancet*, Vol. 342, No. 8878, pp. 1032-6.

Young, J. and Stevenson, J. (2006), Intermediate care in England: Where next?, *Age and Ageing*, Vol. 35, No.4, pp. 339-41.

Shared Space – Long Term Conditions

The Long Term Conditions Collaborative has a work area on Shared Space within the e-library. The Shared Space is a 'secure' area to enable:

- The sharing of documents, case studies, conference abstracts and posters.
- Links and signposting to good practice and other resources available.
- On-line discussions and networking to take place between all communities who have an interest in Long Term Conditions.
- To be up-to-date on events and news pertinent to Long Term Conditions.

In order to use Shared Space, you will need to obtain an 'Athens' password. This can be achieved easily and quickly by following the link below:

<http://www.elib.scot.nhs.uk/SharedSpace/ist/Pages/Index.aspx?ContainerID=1438500>
then click on Register Here.

Shifting the Balance

New SBC website which contains SBC evidence review commissioned by Scottish Government <http://www.shiftingthebalance.scot.nhs.uk/>
Email: Sylvia.wyatt@scotland.gsi.gov.uk

DH website on Care closer to home

http://www.dh.gov.uk/en/Healthcare/Ourhealthourcareoursay/DH_4139717

Evidence produced by Birmingham about what works;

http://www.hsmc.bham.ac.uk/publications/pdfs/Making_the_Shift_02.pdf

Long Term Conditions / Improvement resources

Improvement & Support Team Toolkit:

<http://member.goodpractice.net/ContinuousImprovementToolkit/Welcome.gp>

Improvement & Support Team Website:

<http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/Delivery-Improvement>

Department of Health, 2005, Supporting People with Long Term Conditions: An NHS and Social Care Model to support local innovation and integration

Department of Health, 2008, Long Term Conditions, Five Outcomes,:

http://www.dh.gov.uk/en/Healthcare/Longtermconditions/DH_084295

Department of Health, 2008, Raising the Profile of Long Term Conditions Care: A Compendium of Information

Department of Health, May 2004, Chronic disease management: A compendium of information

Greenhalgh T, Robert G, Bate P, Kyriakidou O, Macfarlane F, Peacock R. (2004) How to spread good ideas. A systematic review of the literature on diffusion, dissemination and sustainability of innovations in health service delivery and organisation. NHS Service Delivery Organisation. London

NHS Institute for Innovation & Improvement, 2007, High Impact Changes for Practice Teams

NHS Institute for Innovation & Improvement, 2007, Final Report on the Care Closer to Home: Making the Shift Programme

NHS Institute for Innovation & Improvement, July 2006, Making the Shift, A Review of NHS Experience (H. Parker)

NHS Institute of Innovation, July 2006, Simplifying Pathways, Making the Shift, A Review of NHS Experience, (H. Parker)

Appendix 1 - A Logic Model improvement framework for Complex Care

