

# Many conditions, One life

## Living Well with Multiple Conditions



An Action Plan to improve care and support for people living with multiple conditions in Scotland



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## Foreword

More people in Scotland are living longer, and healthier, lives as we are able to prevent, detect and treat illness earlier and understand more about how long term conditions affect people's lives. We now have a better understanding of the support that people need to live their lives on their own terms and using the many skills that they have.

There have already been many improvements in the way that health and social care services support people to live well with their long term conditions in Scotland. For example, many more people now get the right information, advice and support to understand and to manage their own conditions. But we can still make things better.

Many more people in Scotland are living with more than one long term condition than ever before. This Action Plan aims to improve the quality of support and services for people who live with multiple conditions. It complements other important changes we are making such as the introduction of Self-Directed Support and the integration of health and social care. This legislation contains principles for person centred care. From April 2015, Health Boards and Local Authority Social Work Departments will work together, and with their partners from housing, Third and independent sectors, in a more joined up way. The aim of integration is to support people to live well at home or in the community for as much time as they can and to have a positive experience of health and social care when they need it.

In future, support and care will be planned with greater involvement of people who use services and their unpaid carers, families, and the local community. The GP practice and the team of people who work in and around the practice will be at the heart of delivering integrated care in Scotland. GPs, practice nurses, receptionists and managers will work alongside district nurses, social workers and community mental health teams to provide joined up care and the right support for local people. They will build stronger links with the many local voluntary groups and resources that help people to stay well. Local neighbourhood networks will be part of a locality integrated network of care and support that includes pharmacists, Allied Health Professionals and some hospital specialists – all working together to support people to live well at home.

Listening to the experience and ideas of people who use our services offers valuable insight, advice and support to help improve these services. This Action Plan was developed with people who live with multiple conditions. It describes actions we must take in each GP practice, in all community teams and in every community in Scotland to improve the lives of people with multiple conditions.

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## Acknowledgements

This Action Plan was developed with input from members of the Health and Social Care Alliance Scotland (the ALLIANCE)'s Involvement Network. The ALLIANCE, Scottish Government and the Joint Improvement Team would like to thank the group for their time and invaluable input to this document. In particular we are grateful to those who so generously shared their own stories and experiences.

This work was also informed by the My Condition, My Terms, My Life campaign led by the ALLIANCE and through workshops involving people who live with multiple conditions.

## Living Well with Multiple Conditions

people living with multiple conditions in Scotland

## Why do we need to change?

People with multiple long term conditions often experience disjointed services that focus on a particular condition in isolation. The 'burden of treatment' from the range of services and professionals they interact with can make it very difficult for people to manage their various conditions.

Access to health and care services, and the communication between them, is difficult for people who have to attend many appointments with several professionals, often in different locations. These issues are even more significant for people living in rural areas and for those with mobility issues.

People living with multiple conditions have told us what they expect from health and care professionals.

**“Listen to me and find out what matters to me”**

We have described seven principles that should be at the heart of care and support for people with multiple conditions

**“I am not just my conditions. Take time to understand all about me and my life”**

Practitioners working with people who live with multiple conditions should develop their skills in empathy, listening, having positive conversations



and a 'personal outcomes' approach that focuses on what matters to the person. Time and space should be afforded to build a meaningful relationship with the person and their carer.

**“Support me to help myself”**

People living with multiple conditions should be supported to explore and understand what self management may mean for them. They should be signposted to high quality information, education and resources to help them to self manage, including local support provided by community groups and the third sector. Information should be presented in ways that cater for a range of abilities, in line with our Health Literacy Action Plan, Making it Easy.

**“Help me to understand what is happening to my body and health”**

People should be able to access the health and care information that is important to them if they want to, using new technology where possible. They should be supported to understand the information and to use it to improve the quality of consultations and shared decision making with professionals. People's knowledge and experience of their conditions must be valued and used to inform shared decision making about current and future care and treatment, e.g. anticipatory care planning, pharmaceutical care planning and communication between different professionals and teams.

# Many conditions, One life

An Action Plan to improve care and support for



**“Understand that the challenges of managing one of my conditions can place strain and stress on my ability to manage my other conditions”**

Professionals need to be aware of the ‘juggling’ that people often need to do to manage a range of conditions. Sometimes something required to deal with one condition makes another of their conditions worse. For example medications for one condition can exacerbate another condition, or being less active because of a physical condition can lead to poorer mental health.

**“Understand that I may be struggling with issues that are associated with my condition, but less apparent. Don’t treat my conditions in isolation of these”**

Professionals should be aware of and ask about the full range of emotional and psychological issues and symptoms that commonly affect people, regardless of which conditions they may have. These include pain (often chronic pain), fatigue, depression, anxiety, low self-esteem and distress. Wider issues which can have a significant impact on the person’s ability to manage their conditions include employment, caring responsibilities, family relationships and social life. People should be supported to address these issues as part of a holistic approach that considers all of what matters to them.

**“Understand the value of shared experience and meeting other people who have experienced similar circumstances to me”**

Professionals should recognise that many people living with multiple conditions can benefit greatly from peer support, either in person or online, and that this can help them to self manage and build their personal resilience. Networks to facilitate peer support should be developed locally and nationally in partnership with the third sector.

**“Involve my carer/family member as they have an important role to play too”**

Providing unpaid care to people who live with multiple conditions can also have a significant impact on the lives of those in a caring role. Carers should be involved as equal partners and supported in their own right. Unpaid carers have significant and valuable insight from which health and social care support and services can benefit.

# Living Well with Multiple Conditions

people living with multiple conditions in Scotland

## Taking action to improve lives



This Action Plan describes the changes that we need to make to improve support for people who live with multiple conditions. Why each change is important is explained in personal terms by our experts who live with multiple conditions.

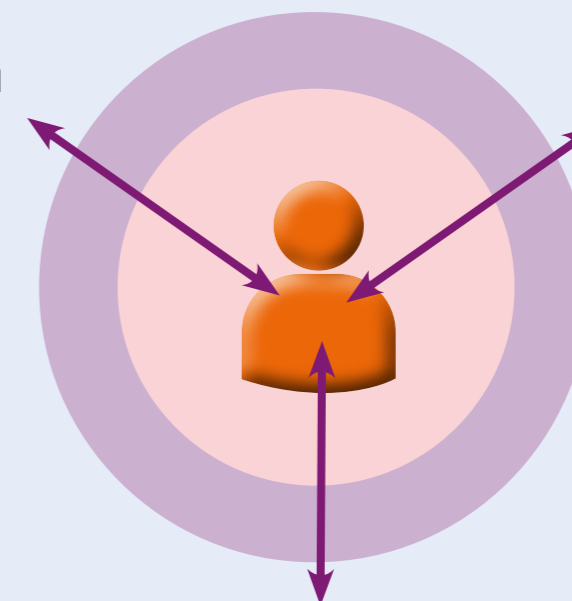
The Action Plan lists ten actions that will deliver these changes. These actions will take place on three levels:

- Whole Person - changing the conversations we have and shifting the relationship between the person and the professional in every consultation;

- Whole Team - new ways for health and care professionals to work together, and with volunteers and community supports, around the GP practice;
- Whole System - improving the way that care and support is planned and coordinated across the whole pathway between home and hospital.

People should be supported by practitioners that help them to be in the driving seat and make choices about their own lives and support.

Conversations between people and health and social care practitioners should focus on what matters to the person.



People should experience smooth pathways through the health and social care system.

Services should help meet the needs of people with multiple conditions and help reduce health inequalities.

Care and support should help people to self manage and to stay well. This includes making sure people can access good support within their communities.

# Many conditions, One life

An Action Plan to improve care and support for

**Action 1:** Make sure health and social care staff really listen to those they provide care and support for and help people to achieve what matters to them.

## George's story

George lives with 17 long term conditions. George believes that it is important that people who live with multiple conditions are truly listened to. Things that matter to the person might seem unimportant to the practitioner. For example, George likes to be called by his first name as this helps him to relax. When this request was ignored it affected the quality of the consultation.

**"I just shut down and answered the questions with yes or no because if they didn't listen about calling me George what was the point in trying to explain about my Diabetes."**

At first George was given no information about the condition he was living with and the ways this would affect his life. He believes that a more person centred approach, longer appointments, and help to make contact with people who have similar conditions, would have helped him to better understand his conditions.

**"We know more about our conditions than anyone else, we live with them 24/7, 365 days a year."**



### What we will do more of

- Building on the learning from *Talking Points* and the *Personal Outcomes Partnership*, spread a multi-agency training and development programme in outcomes based conversations to all localities. The Personal Outcomes Partnership is a collaboration between the Joint Improvement Team, Thistle Foundation, People Powered Health and Wellbeing Programme, NHS Education for Scotland and the Scottish Social Services Council.
- Learn what works from *House of Care* early adopter sites in Tayside, Glasgow and Lothian and spread this approach to every partnership. The House of Care has a strong evidence base and is a simple visual model for all the elements needed to position and sustain person centred care and support planning. Using the model helps patients, carers, professionals and managers work together and become more aware of the contribution people can make towards managing their own long term conditions. It also encourages GP practices to develop better links with community supports, for example peer support groups, lunch clubs and walking groups.

# Living Well with Multiple Conditions

people living with multiple conditions in Scotland

**Action 2:** Make sure that appointments provide enough time for the person to talk about what really matters to them and about their physical, psychological, emotional and spiritual wellbeing.

## Janice's story

Janice is 66 years old and lives with psoriasis and severe psoriatic arthritis. She has recently been diagnosed with an eye problem that is causing significant visual impairment. She feels depressed, worries that her sight might deteriorate and what this will mean for her future. She has limited mobility, cannot wear nice shoes and has problems doing her hair. This affects how she feels about herself as a woman.

Janice feels that a standard ten minute appointment is often not long enough to provide the emotional and psychological support that people may need.

**"I really miss my old family doctor who seemed to be more involved with what was happening in my life and my children's lives."**

She would like more support and information to help her cope. She thinks people need information from the onset of their condition and in a range of formats.

**"No matter what age you are, if you get landed with any long term condition it can be quite devastating."**

### What we will do more of

- Build on the learning from *Productive General Practice*, *Releasing Time to Care* and the *Care Plus study* to support Primary Care teams and community services to identify new ways of working that streamline appointments and release time for longer consultations for people with complex care and support needs.
- Provide the *Emotion Matters* online learning resource for health and social care in every partnership. This resource was developed by the ALLIANCE and NHS Education for Scotland with support from people with lived experience of long term conditions. It is based on a series of films of people talking about the effect that living with long term conditions has on their mental health and about how staff can better support them. It covers issues like the range of emotions that can come with long term conditions, the challenges people face in adjusting to a diagnosis and how individuals and staff can build good relationships. It also talks about how staff can look after their own emotional health.

# Many conditions, One life

An Action Plan to improve care and support for

**Action 3:** Increase the use of Anticipatory Care Planning, Carer support plans and Key Information Summaries. This will mean that people, and those who support and care for them, are better prepared to deal with health problems which may fluctuate or get worse over time.

## Rachel's story

Rachel is a carer for her son who has severe mental health problems. She recognises that some people with conditions such as autism and Asperger's avoid face-to-face contact about their health. She has been told that she is not able to discuss her son's health issues with his GP as he is over the age of 16.

**"The current scenario means parents have to stop work, run up debts, worry that they will die leaving someone who has had no provision made for them."**

Rachel believes that more should be done to help people with mental health needs and their carers to plan for their future and that carers should have their own support.



### What we will do more of

- Embed Anticipatory Care Planning in every locality to help people with multiple conditions to 'think ahead' and to have greater control and choice over their care and support. This enables people to record their wishes and care and support preferences in the event of a future deterioration, or a sudden change in circumstances for their carer.
- Work with hospital and emergency services to increase the number of staff who routinely access the electronic Key Information Summary so that they make decisions based on the person's wishes and preferences.
- Work with the National Carer Organisations and with carers in local partnerships to ensure the carer's support plan incorporates anticipatory care planning. This will help ensure appropriate arrangements can be put in place for the cared for person in the event of the carer suddenly becoming ill.

# Living Well with Multiple Conditions

people living with multiple conditions in Scotland

**Action 4:** Pharmacists more regularly do reviews with people who take many different medicines and support them to understand and to manage their medicines at home.

## Janice's story

When Janice was diagnosed with Psoriatic Arthritis nearly 40 years ago, she was only prescribed anti-inflammatory drugs. She didn't receive any second line medications for many years and feels this led to her becoming a lot more disabled than she might otherwise have been.

She would have liked to know more about the potential benefits from other drugs.

Janice would have welcomed advice and support from a pharmacist to help her to understand her condition and the medicines that she takes and to know how to watch out for possible side effects.

### What we will do more of

Through the implementation of Prescription for Excellence

- Empower and enable people with multiple conditions to understand and manage their medicines. This will involve the pharmacist, and others in the team if relevant, discussing with the person the medicines that they take so that they get the most out of them. This usually involves advice and support on how to take their medicines correctly, checking understanding of how each medicine acts, advising on side effects to watch for and checking that each medicine is still appropriate to their needs and goals.
- Test and spread new models of care and support that have pharmacists embedded in the multidisciplinary team working in and around the practice and part of the integrated community team that helps people with multiple conditions to remain well at home.
- Develop training and support for social care providers that helps them to understand and fulfil their role in helping people with support needs to manage their complex treatments and medicines safely at home.

# Many conditions, One life

An Action Plan to improve care and support for

**Action 5:** Introduce local volunteers and new roles in GP practices to simplify access to local sources of community support, including support for unpaid carers.

## Kathleen's story

In June 2011 Kathleen lost her much loved job serving as a Sergeant in the regular Army. She felt at rock bottom and had no experience dealing with unemployment. She was put on medication and her doctor gave her the number of a local mental health community service. She recalls that a very understanding young lady answered her call and asked her to come to COPE that same afternoon. Kathleen talked about her emotions and feelings with a therapist and was given a relaxation CD and a few work sheets to read and try before her next appointment. She then attended COPE on a weekly basis and used the relaxation room. Later she started to volunteer for COPE then became a part time associate. Now she has a paid job there as a full time administrator / receptionist.



**"Every day is different and I am learning a new skill each day. I can honestly say the day I rang COPE for help changed my life for the very better."**

### What we will do more of

- Implement recommendations from the Improving Links in Primary Care project to link general practices with sources of support in their local community. Support may include local accessible and affordable cafes, safe places to walk, social events, befriending and volunteering opportunities, exercise groups and social activities. The project identified three solutions:
  - mapping local assets as a way to strengthen trusting relationships
  - sharing knowledge of local resources, using an online tool (ALISS)
  - adopting a links worker approach.
- Learn from the experience of 7 Deep End practices currently testing a model of an attached LINKS practitioner and adapt this model so that all practices can benefit from a community connector or a links worker.
- Continue to develop the ALISS (A Local Information System for Scotland) programme that makes information about local sources of support more findable. It helps communities to work together to gather, maintain and share information as well as providing a technological solution to managing this.

# Living Well with Multiple Conditions

people living with multiple conditions in Scotland

**Action 6:** Increase the use of day to day technology to help people to have more information and control over their own health and care. Increase access to digital information, home monitoring and video consultations to reduce the number of appointments they need to attend.

## Jim's story

**"If I can be working in partnership with clinicians I could have much more success at avoiding mistakes, taking action and reducing the negative."**

Jim is 62 years old and lives with Psoriatic Arthritis. In his early 40s diagnosis and treatment for testicular cancer was delayed by 15 months as his test results were overlooked. His cancer has been in remission following successful, albeit delayed, treatment. Jim moved back to Scotland and again experienced poor communication and errors in his care. He did not feel that he was listened to, or that his concerns were taken seriously. Jim's experiences have led him to believe that healthcare could be improved by greater sharing of information like test results and clinic letters with people who use support and services. He feels they can address any factual errors and make sure that problems are picked up right away.

If people are to be fully engaged and informed partners in treatment decisions they need to know and understand the meaning of their test results. Jim is involved in the Scottish Primary Care Information Resource programme (SPIRE), helping to improve understanding of the health and information needs of people in Scotland.

**"Clinicians are full of good intentions and highly trained, but they are never going to be as committed to me and my health and wellbeing as I am."**

### What we will do more of

- Scale up use of home monitoring, videoconferencing and digital platforms like *Living it Up* so that people with long term conditions across Scotland can benefit from every day technology, online and social media support to help them stay well and contribute to the community.
- Build on the success of *Renal View* and *My Diabetes My Way* systems for people to access the health information that is important to them and to develop portals so that people can securely message their clinician, check results, request appointments and prescriptions and upload their home monitoring.
- Expand access to clinical portal for a wider range of healthcare workers so that their clinical decisions are based on the right information that has been securely shared across all sectors.

# Many conditions, One life

An Action Plan to improve care and support for

**Action 7:** Make every health and care contact an enabling experience and an opportunity to improve health and wellbeing.

## Fiona's story

Fiona was diagnosed with bipolar in 1994 and with Multiple Sclerosis (MS) in 2008. She began teaching as a primary school additional support teacher and had a good relationship with her co-workers and employer. Fiona's MS first starting showing itself as double vision and feeling weak when running after the children in her class. She had to be hospitalised many times as she received steroids for her MS that affected her mood. From then on Fiona experienced short-term memory loss. She tried a "phased return" back to work but relapsed and had to accept early retirement.

**"Even though I do work voluntarily now, I never thought that at my age I would have to take a pension."**

Fiona experiences depression and anxiety due to both of the conditions. Fiona now works in a charity shop with Sense Scotland for four hours a week. She can't stand for too long and has to be careful not to bend or do heavy lifting. Fiona holds information only for short periods of time. Fiona also volunteers at Glasgow City Mission. She has to be careful with her balance but she can manage to make toast and talk with the children and her co-workers. She meets up with her co-workers on nights out and has them round to her home. This has given her a lot of confidence and makes her feel included.

**"It's wonderful. I was made to work and I need to be busy, I'm not good at doing nothing. I would rather go out if I can because I spent so long having to stay in hospital."**



### What we will do more of

- Embed the Physical Activity Screening Questionnaire in routine practice and encourage people with long term conditions to be more active.
- Support health and social care Allied Health Professionals to lead an integrated approach to reablement and rehabilitation in every locality.
- Promote a risk enabling ethos around discharge from hospital so that more people are able to recover at home or closer to home.
- Develop Self Management Champions, drawn from professionals and people with lived experience and establish a Self Management Network in every locality, using resources from a range of national and third sector programmes, including the National Self Management Network Scotland and the Self Management Partnership and Practice Programme hosted by the ALLIANCE.

# Living Well with Multiple Conditions

people living with multiple conditions in Scotland

**Action 8:** Support staff to learn from each other so that specialist staff have better general skills, and staff in community teams develop extended roles.

## Ian's story

Ian is married with two children and lives with Crohn's disease and depression. He was made redundant from his first job in manufacturing shortly after he became ill.

He then worked in various short term contracts but struggled because of the effects of his conditions. Eventually Ian had to retire due to ill health at the age of 35. He did retrain in computing, but has been unable to work since because of his conditions.

He struggles a lot with his self-esteem.

**"The 'soundbite' I like to use when I am feeling down is "failing does not make you a failure."**

Ian would like to be more physically active. He has looked into the idea of joining the council-run gym, but even with a disabled person's discount it would be £23 a month and he cannot afford this with his other outgoings. Ian believes that professionals should be mindful when signposting to local community resources that any kind of cost is usually a big barrier for people who are not working.

Ian thinks that he is very lucky to have a good team of professionals around him and that the Inflammatory Bowel disease service at Glasgow Royal Infirmary works well. Most of Ian's GPs have been very understanding about his mental health problems and his gastroenterologist referred him to a psychiatrist. Ian gets a lot of support from his specialist nurse.

### What we will do more of

- Review and refocus the District Nursing role and commission the required education and training across Scotland to prepare District Nurses for their central role in the multiprofessional team who care for people with complex and multiple conditions at home.
- Develop a framework for the Integrated Care Support Worker role and support adoption of this role to improve resilience, particularly in remote or rural areas.
- Encourage job plans that enable hospital clinicians to provide consultations, mentoring and development support for integrated care in localities.
- Increase the awareness, understanding and skills of the primary care team in managing Chronic Pain and ensure effective links with the local specialist Pain service.

# Many conditions, One life

## An Action Plan to improve care and support for

**Action 9:** Managed Clinical Networks work together to develop care and support pathways and guidelines that make sense for people who have multiple conditions. This will help individuals and staff to make the right decisions and ensure people with multiple conditions have the right care, support and rehabilitation, including support to remain in work.

### Robert's story

Robert is 49 and has lived with asthma and eczema since birth, hearing loss since 1995 and Asperger's syndrome was diagnosed in 2006. Robert was able to manage his conditions and worked in electrical engineering and administration but felt like an outsider in social environments and at work, partly due to his hearing impairment.

He was signposted by the Autism Resource Centre to the National Autistic Society (NAS) and took part in the "Prospects programme". He learned how to explain about autism to potential employers and went on an employment scheme. This allowed him to be supported and work part-time in administration in an office. This was a very positive experience until he had difficulties managing a new condition.

Robert developed Ulcerative Colitis and needs to use the bathroom facilities often. When he was in pain he would sit by himself when waiting for his medication to take effect or when he felt too overwhelmed to concentrate. He would panic about how to get home if he was in pain and his co-workers were concerned about his wellbeing. This made him feel more self-conscious and stressed at work.

**"Your workload doesn't change just because you have a new condition."**

**"When you get ill you get emotional and it plays on your concentration and I have a narrow focus because of my other condition."**

Robert sought advice from the Crohn's and Colitis UK website where he accessed a leaflet about reasonable adjustments by employers for people with colitis. His employer sent him to a doctor and Robert suggested small changes that would make a difference to him. However these were rejected by his employer. Robert recommends that employers should act as fast as possible in making adjustments to help the person to remain at work. He says that work is important for people and gave him "self-worth and a sense of identity".

**Managed Clinical Networks (MCNs)** are groups of people and professionals who work together to improve the quality of care and support for a particular condition or care group. They involve professionals and teams from primary care, community care and hospital and often involve community and Third sector support. MCNs aim to streamline care across the whole pathway including support for rehabilitation, self management and employability.

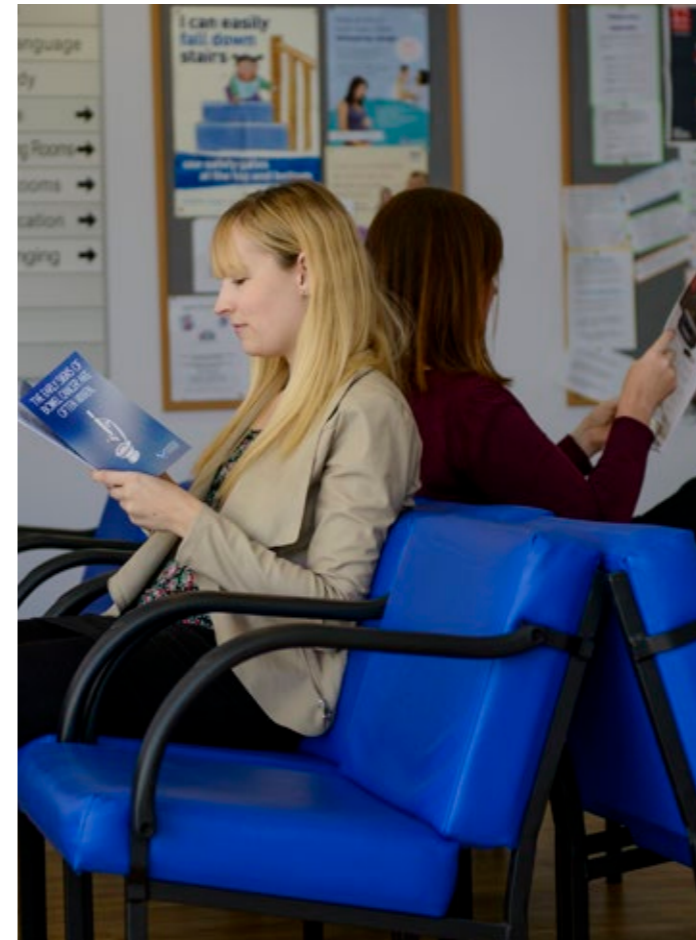
#### What we will do more of

- Encourage MCNs to work with third sector and community planning partners so that people with multiple conditions are offered a holistic assessment and are signposted to advice and support for their emotional, practical and financial needs, learning from examples like the MacMillan Improving Cancer Journey demonstrator.
- Support health and social care staff to routinely ask people who use their services about their work status and develop their knowledge and skills to signpost people to the right support to enable them to remain in or return to work.
- Work with NHS Health Scotland's Healthy Working Lives team to develop resources that will help employers to understand common long term conditions and what they can do to support their employees to remain in work.
- Develop and implement a national framework for generic community-based physical activity that addresses inequalities in current provision and integrates rehabilitation exercise referral services based on the learning from the Person-centred Activities for people with Respiratory, Cardiac and Stroke conditions project.
- Build on the learning from programmes like Walking Towards Better Health that support communities to establish accessible walking groups for people with long term conditions.

# Living Well with Multiple Conditions

## people living with multiple conditions in Scotland

**Action 10:** Identify people with multiple conditions so that they can access the right level and type of care and support as their needs change. This should include coordinated health and care services, along with support from peers, third sector and use of technology.



### Pam's story

Pam is 67 and lives with advanced osteoarthritis and high blood pressure. She has also been a carer for her mother-in-law who developed dementia three years ago.

Pam feels she missed out on having a 'head start' on treatment as diagnosis was delayed and she did not receive information from health professionals about how to manage her conditions. She found what she needed online and from the third sector and went on a self management course after seeing a poster in the local library. She found the course run by Arthritis Care and the camaraderie enormously helpful. Pam thinks self management courses should be routinely available and health professionals should promote them.

She also suggests that transport to these courses and other third sector resources should be available. She uses a walking aid and is reliant on her car. Loss of her Blue Badge meant eight months without her car and huge practical problems as well as stress and depression.

**"Self management is important to me as it liberates mind and body from fear of the now and the future. 'I can and I will' is my daily mantra."**

**"Peer support from those who feel this way can lift others out of the despair that can follow diagnosis of any long term condition - you are not alone, we are here for you."**

Pam is now a self management trainer herself for Arthritis Care. She is also an independent advocate, volunteers for Action on Hearing Loss, runs Tai Chi classes for disabled people and leads gardening workshops.

#### What we will do more of

- Ensure all GP practices and integrated primary care and community teams use risk prediction tools and professional judgement to identify people who need anticipatory care, support for self management and proactive and flexible clinical support from a lead professional as their conditions change.
- Use technology to enable clusters of GP practices to function as a 'community ward' linking primary and secondary care to improve communication and coordination of care for people with intensive and frequently changing needs.



# Many conditions, One life

An Action Plan to improve care and support for

## Making it Happen

The actions in this plan will be taken forward in every Health Board and integration authority in Scotland. The Integrated Care Fund of £100 million for 2015/16 provides additional funding to test and refine the approaches to fit local circumstances.

To support partnerships to make this happen, the Scottish Government and the national organisations that lead on workforce development and education, information, and support for improvement will work together and with people who live with multiple conditions to:

- Provide education about self management and multiple conditions for people training to become health and social care staff.
- Build the knowledge and skills of the existing

workforce to adopt the principles in this Action Plan and to improve local support and services.

- Provide better ways of identifying people with complex care and support needs, tailoring interventions to their support needs, sharing information across teams and agencies and linking data across health and social care.
- Make sure service pathways and guidelines help the workforce to understand that the person may be living with other conditions and to respond appropriately.
- Strengthen the level of collaboration in Scotland on support for improvement, action research, evaluation of outcomes and understanding what works in integrated care for people with multiple conditions.

### There's no ward like home



## Living Well with Multiple Conditions

people living with multiple conditions in Scotland

## Measuring Impact

Use of data to measure system performance and capture the outcomes and experience of those who use services is at the heart of improvement. Improving outcomes for people with multiple conditions is at the heart of

integration. We expect partnerships to use the core suite of indicators for the health and wellbeing outcomes from integration to track improvements in care for people with multiple conditions.

### National Health and Wellbeing Outcomes

1. **People are able to look after and improve their own health and wellbeing and live in good health for longer.**
2. **People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.**
3. **People who use health and social care services have positive experiences of those services, and have their dignity respected.**
4. **Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.**
5. **Health and social care services contribute to reducing health inequalities.**
6. **People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.**
7. **People who use health and social care services are safe from harm.**
8. **People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.**
9. **Resources are used effectively and efficiently in the provision of health and social care services.**

# Many conditions, One life

## An Action Plan to improve care and support for

Measurement for improvement uses local and 'just enough' data to help staff reflect on the quality of care and support and to continually improve care through small cycle tests of change. Local improvement measures for multiple conditions could draw on the following framework to track progress on these person centred outcomes that would be expected at practice, community team or at the interface between home and hospital.

Preventative and Anticipatory Care	Proactive Care and Support at Home	Care at Times of Transition	Unscheduled Care
I am given information, and advice on opportunities to stay well and be physically active	I agree my own care plan for flexible and personalised support for What Matters to Me	I have a single agreed point of contact for my community health and care team	If I phone NHS 24 or attend A&E the staff take note of my wishes from my Key Information Summary
I am offered emotional and psychological support from my peers, local community or professionals	My care plan identifies any help I may need to remain in work	I receive the help I need to understand and to manage my medicines	The specialists I see talk with each other and agree who will coordinate my care while I am in hospital
I develop my own 'Thinking Ahead' Anticipatory Care Plan	I can access the equipment or support I need by one call	If I do not wish to attend more than one hospital clinic I can be seen in a 'one stop shop'	My care manager and the team who usually oversee my conditions know that I am in hospital and why
My GP shares my Key Information Summary with other services so they can do what I would want in the event of an emergency	I am able to stay safe and can monitor my conditions at home using everyday technology	I know how to be seen urgently by my GP or specialist team if any of my conditions suddenly flares up	I return home with the support I need without delay, or am transferred for care closer to home
My GP practice offers me longer consultation times with my nurse or GP	I have a named Care Manager to coordinate my care and support if it is complex	If I start to become more dependent I am offered review and rehabilitation	Staff review my medicines with me and check my understanding of any changes
My home and housing support help me stay well	Staff know if I have a carer and my carer feels supported	When any of my conditions requires it I receive excellent palliative care	My GP, local pharmacist and I receive a summary within 48 hours of my discharge

# Living Well with Multiple Conditions

## people living with multiple conditions in Scotland

# Useful Resources

### Anticipatory Care Planning

<http://www.qihub.scot.nhs.uk/quality-and-efficiency/outpatient-primary-and-community-care/primary-and-community-care.aspx>

### Care Planning in General Practice for people with Long Term Conditions

[http://www.rcgp.org.uk/clinical-and-research/clinicalresources/~/\\_media/Files/CIRC/Cancer/Improving%20the%20Lives%20of%20people%20with%20LTC%20-%202012%2005%2009.ashx](http://www.rcgp.org.uk/clinical-and-research/clinicalresources/~/_media/Files/CIRC/Cancer/Improving%20the%20Lives%20of%20people%20with%20LTC%20-%202012%2005%2009.ashx)

### Emotional Support Matters and Living Better Report

[http://www.alliance-scotland.org.uk/resources/library/grid/1/type/2/topic/all/tag/7/condition/all/download/library/lib\\_4e3ab46435632/](http://www.alliance-scotland.org.uk/resources/library/grid/1/type/2/topic/all/tag/7/condition/all/download/library/lib_4e3ab46435632/)

### Health Literacy Action Plan for Scotland

– [Making it Easy](#).

### House of Care

in [www.yearofcare.co.uk](http://www.yearofcare.co.uk) and in Kings Fund <http://www.kingsfund.org.uk/blog/2013/10/supporting-people-long-term-conditions-what-house-care>

### Integrated Community Ward / Virtual Ward case studies and stories are at

[Intermediate Care Community of Practice](#)

### Key Information Summary

[www.keyinformationsummary.org.uk](http://www.keyinformationsummary.org.uk)

### Improving Links in Primary Care and Links Worker Programme

[www.improvinglinks.scot.nhs.uk](http://www.improvinglinks.scot.nhs.uk) and <http://www.alliance-scotland.org.uk/what-we-do/projects/linksworkerprogramme/>

### 'Living Well with Long Term Conditions' report

[Long Term Conditions Action Plan – 2009](#)

### Living with Multiple Conditions: Issues, Challenges and Solutions

[http://www.alliancescotland.org.uk/download/library/lib\\_4e858df323e51](http://www.alliancescotland.org.uk/download/library/lib_4e858df323e51)

### Polypharmacy reviews

- guidance within [CEL36](#)

### Self Management: The Health Foundation, Self Management Works 2013

<http://personcentredcare.health.org.uk/resources/self-management-works>

### 'Gau'n Yersel' The Self Management Strategy for Scotland

### Self-Directed Support

<http://www.selfdirectedsupportscotland.org.uk/professionals/document-library/>

### Self Management campaign: My Condition, My Terms, My Life

[My Condition, My Terms, My Life](#)

### SPARRA risk prediction tool

<http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/SPARRA/>

### SPIRE (Scottish Primary Care Information Resource) <http://www.spire.scot.nhs.uk/>

### Technology enabled care and support – case studies and resources

[www.sctt.scot.nhs.uk](http://www.sctt.scot.nhs.uk)  
[www.livingitup.org](http://www.livingitup.org);  
[www.aliss.org](http://www.aliss.org)  
[www.jitscotland.org.uk/action-areas/telecare-in-scotland/](http://www.jitscotland.org.uk/action-areas/telecare-in-scotland/)  
[www.knowledge.scot.nhs.uk/telehealthcare.aspx](http://www.knowledge.scot.nhs.uk/telehealthcare.aspx)

## Health and Social Care Academy

The Health and Social Care Academy has been developed to help drive fundamental change in health and social care in Scotland. It has a unique role in doing this through the lens of lived experience, with a focus on relational, rather than organisational aspects of change. The Academy offers a safe place for people to come together, to connect and share learning, with all partners working together on an equal basis.



## The Joint Improvement Team

The Joint Improvement Team (JIT) is a uniquely positioned strategic improvement partnership between the Scottish Government, NHS Scotland, COSLA (Convention of Scottish Local Authorities) and the Third, Independent and Housing Sectors. They provide a range of practical improvement support and challenge including knowledge exchange, developmental innovation and improvement capacity and direct practical support to local health, housing and social

care partnerships across Scotland. JIT champions the identification, development, evaluation, spread and adoption of good practice to accelerate the pace of improvement towards the Scottish Government's vision for 2020; a vision that includes the aims that each of us is able to lead a longer, healthier life at home or in our own choice of setting in an integrated health and social care environment – which includes an increasing focus on prevention, anticipation and supported self management.



## People Powered Health and Wellbeing

The 'People Powered Health and Wellbeing; Shifting the Balance of Power' programme is funded by the Scottish Government to embed co-production in person centred health and care. Drawing on third sector partners and the ALLIANCE experience of self management, it aims to ensure that people are able to influence their services and supports for their own health and wellbeing, and contribute to the design, delivery and improvement of support and services (including through peer support).



**ALLIANCE**  
HEALTH AND SOCIAL CARE  
ALLIANCE SCOTLAND  
people at the centre

## The Health and Social Care Alliance Scotland (the ALLIANCE)

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[www.alliance-scotland.org.uk](http://www.alliance-scotland.org.uk)

The ALLIANCE is supported by a grant from the Scottish Government. The ALLIANCE is a company registered by guarantee. Registered in Scotland No.307731 Charity number SC037475

