Long Term Conditions

Martin McShane
Director – Domain2
Enhancing the quality of life for people with long term conditions
The challenges

<table>
<thead>
<tr>
<th>Number of Conditions(^1)</th>
<th>% self reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>30%</td>
</tr>
<tr>
<td>2</td>
<td>13%</td>
</tr>
<tr>
<td>3+</td>
<td>10%</td>
</tr>
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</table>

The 15 million people in England with long term conditions have the greatest healthcare needs of the population (50% of all GP appointments and 70% of all bed days) and their treatment and care absorbs 70% of NHS and social care budgets in England.

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\(^1\) The percentage of people aged 18 and over self-reporting experiencing long-term conditions in the GP Patient Survey
Average cost per patient by number of ETGs

<table>
<thead>
<tr>
<th>ETGs</th>
<th>Cost/patient</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>£311</td>
<td>58,490</td>
</tr>
<tr>
<td>1</td>
<td>£799</td>
<td>29,512</td>
</tr>
<tr>
<td>2</td>
<td>£1,681</td>
<td>14,050</td>
</tr>
<tr>
<td>3</td>
<td>£2,699</td>
<td>6,917</td>
</tr>
<tr>
<td>4</td>
<td>£4,473</td>
<td>3,167</td>
</tr>
<tr>
<td>5</td>
<td>£5,800</td>
<td>1,542</td>
</tr>
<tr>
<td>6</td>
<td>£7,426</td>
<td>703</td>
</tr>
<tr>
<td>7+</td>
<td>£11,092</td>
<td>495</td>
</tr>
</tbody>
</table>
Financial and population ‘gearing’

- **Primary**
  - £200
  - (6.5k)

- **Community & MH**
  - £500

- **Specialist**
  - £300

- **Acute**
  - £1000
  - (330k)

- **Social Care Public Health**
  - £500

www.england.nhs.uk
Average costs for patients with diabetes by setting and number of other ETGs

- Diabetes: N= 829
- plus 1: N=1,529
- plus 2: N=1,362
- plus 3: N= 898
- plus 4: N= 527
- plus 5: N= 279
- plus 6 or more: N= 222

www.england.nhs.uk
Geology – strata - stratification

Multiple

Single

Preventing
Intervention - stratification

- Proactive advice
- Standardised
- Individualised
Newark and Sherwood Integrated Model of Care for Long Term Conditions

CPM / PARR Tool for Systematic Risk Profiling to identify risk

Patients step up and down as risk profile changes

Level

1. 21% - 100%
Proactive Self Care Support and Management in Primary Care
Risk score recorded and reviewed annually
Active Case Finding
Disease Register
Accurate diagnosis
Information Prescriptions
Care Planning
Education relevant to patients needs
Disease prevention and Health promotion

2. 6-20%
Proactive Disease Management by General Practice supported by specialist community services and teams
Care Planning and individualised Care plan
Support to Self Manage
Education Programmes
Annual Review
Specialist Medication reviews
Anticipatory Care
Remote monitoring via tele health where appropriate

3. 0.6-5%
Intensive disease / case management by specialist teams as part of the MDT
Telehealth / Telecare
Community Specialist Services and clinics with MDT support
Care Planning and individual personalised care plan
Planned Hospital Admission for those who need it and facilitated discharge via intermediate care to reduce LOS

4. Top 0.5%
Community Matron / Virtual Ward as part of Multidisciplinary Team (Community Geriatrician, GP, Social Care, Therapists, Rehab, Domiciliary)
Care Planning and individual personalised care plan
Disease Specialist Input where required from specialist community teams (COPD, Diabetes)
Telehealth and TeleCare Psychological Support
Planned hospital admission, proactive in reach and facilitated discharge where needed

Co-ordinated Social Care

Level

1. Smoking Cessation, Health Promotion and Self Care

2. Workforce Development, Training and Education

3. Special Patient Notes / 24/7 Access to specialist support
Admissions Avoidance

4. Personal Care Navigator / Named Lead
www.england.nhs.uk
Population system approach

LTC Framework:

- Empowered patient and carers
- Professional collaboration
- Best Practice (clinical and organisational)
- Commissioning
The House of Care

Organisational and clinical supporting processes

Engaged, informed individuals and carers

Health and care professionals committed to partnership working

Person-centred coordinated care

Commissioning

www.england.nhs.uk
The House of Care - Person centred, coordinated care at three levels:

**Personal:**
How the House of Care gives professionals on the front line a framework for what they need to do for patients and ask local commissioners to secure for them.

**Local:**
How local health economies ensure that the House of Care involves a whole system approach, including ‘more than medicine’ offers.

**National:**
What can national organisations and policy makers do to enable construction of the House of Care at the next two levels.
“Yes, but what has NHS England ever done for us?”
http://www.england.nhs.uk/house-of-care/

Resources
1. Toolkit
2. Dashboard
3. Infographic
4. Improvement programme
Click on the links for more information about each component and use this to build your own house

www.england.nhs.uk
**Joined-up care**

People living with long term conditions say that they would like care planned with people who work together to understand them and their carer(s), put them in control, co-ordinate and deliver services to achieve outcomes.

Ensuring care is designed and delivered around the needs of the individual is particularly important for people with complex care needs.

**Interdisciplinary working**

Professionals from different organisations across health and social care and the voluntary sector working closely together ensuring that care feels coordinated to people living with long term conditions and their carers.

**Key Components**

- Single point of contact
- Multi disciplinary team working
- Professionals talk to each other
- Services quick and responsive people are promoted to stay independent and active
- Care developed around the individual and not the system

**Care Transition**

Ensuring a seamless transition for people with long term conditions between different care settings.

**Key Components**

- Transition following discharge from hospital
- Transition between health and social care
- Transition related to changes in long term care needs
- Transition from children's to adult services

www.england.nhs.uk
Interdisciplinary Working

Resources

Integrated care for patients and populations: Improving outcomes by working together - A report to the Department of Health and the NHS Future Forum, The Kings Fund

Integrated Care and Support Pioneers programme, NHS IQ

Integrated Care – Better Care Fund – Local Government Association

Integrated care value case toolkit

ICASE - Integrated Care Support and Exchange
http://www.icase.org.uk/pg/dashboard

Kings Fund Integrated care: making it happen
http://www.kingsfund.org.uk/projects/integrated-care-making-it-happen

Year of care, NHS Improving Quality

www.england.nhs.uk
The soft stuff…is the hard stuff

Care plan vs Care Planning

When I make a care plan:

1. I make an assessment of the patient
   - True / False
2. I pass on lots of information to the patient
   - True / False
3. I do most of the talking
   - True / False
4. I follow a template very closely
   - True / False

A care plan is primarily focused on *disease management*; whereas in care planning the focus is on *person management*
Care Planning

CARE & SUPPORT PLANNING

What is care and support planning?
Care and support planning encourages clinicians and people with long-term conditions to work together to clarify and understand what is important to that individual. They agree goals, identify support needs, develop and implement action plans, and monitor progress. This is a planned and continuous process, not a one-off event.

http://coalitionforcollaborativecare.org.uk/
Care & Support Planning

“I” statements from National Voices

I work with my team to agree a care and support plan.
I know what is in my care and support plan
I know what to do if things change or go wrong.
I have as much control of planning my care and support as I want.
I can decide the kind of support I need and how to receive it.
My care plan is clearly entered on my record.
I have regular reviews of my care and treatment, and of my care and support plan.
I have regular, comprehensive reviews of my medicines.
When something is planned, it happens.
I can plan ahead and stay in control in emergencies.
I have systems in place to get help at an early stage to avoid a crisis.

(http://www.england.nhs.uk/wp-content/uploads/2013/05/nv-narrative-cc.pdf)
Person centred coordinated care

“My care is planned with people who work together to understand me and my carer(s), put me in control, co-ordinate and deliver services to achieve my best outcomes”

Social Care

ICare

Community Care

Primary Care

General Hospital

University/Specialist Facilities