Building the House of Care

Martin McShane
Director: Enhancing the quality of life for people with long term conditions
Overview

- Context
- Follow the money
- New approach?
A man being treated for heart failure in UK primary care rejected the offer to attend a specialist heart failure clinic to optimise management of his condition. He stated that in the previous two years he had made 54 visits to specialist clinics for consultant appointments, diagnostic tests, and treatment. The equivalent of one full day every two weeks was devoted to this work.
Contact with services

Source: produced by a person with ltcs for the Health Foundation
It is not enough to think Patient/Clinician

- Given as much control as they want
- Mobilisation of assets
- Engaged, involved & supported
- Coaching, coordinating, collaborating

Person

Carers

Community

Professionals

NHS England
The soft stuff…is the hard stuff

Changing the nature of the conversation
....the biggest challenge?

Doctor, I want to choose how I’m treated

Hmm. You’re not just ill – you’re deluded
What is the Patient Activation Measure?

Patient activation measure (PAM) – is a measurement scale for the knowledge, skill and confidence a patient has in managing their health and care.

The PAM score is based on patients’ responses to 13 questions which include measures of individuals’:

• knowledge
• beliefs
• confidence in interacting with healthcare professionals
• self-efficacy
Activation is developmental

**Level 1**
Starting to take a role
Patients do not yet grasp that they must play an active role in their own health. They are disposed to being passive recipients of care.

**Level 2**
Building knowledge and confidence
Patients lack the basic health-related facts or have not connected these facts into larger understanding of their health or recommended health regimen.

**Level 3**
Taking action
Patients have the key facts and are beginning to take action but may lack confidence and the skill to support their behaviors.

**Level 4**
Maintaining behaviors
Patients have adopted new behaviors but may not be able to maintain them in the face of stress or health crises.

Source: J. Hibbard, University of Oregon
Follow the money…….
Year of Care Costs

Average costs by age group

<table>
<thead>
<tr>
<th>Age bands in years</th>
<th>Average cost per patient (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-24</td>
<td>569</td>
</tr>
<tr>
<td>25-29</td>
<td>632</td>
</tr>
<tr>
<td>30-34</td>
<td>615</td>
</tr>
<tr>
<td>35-39</td>
<td>581</td>
</tr>
<tr>
<td>40-44</td>
<td>647</td>
</tr>
<tr>
<td>45-49</td>
<td>592</td>
</tr>
<tr>
<td>50-54</td>
<td>638</td>
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<tr>
<td>55-59</td>
<td>739</td>
</tr>
<tr>
<td>60-64</td>
<td>953</td>
</tr>
<tr>
<td>65-69</td>
<td>1038</td>
</tr>
<tr>
<td>70-74</td>
<td>1587</td>
</tr>
<tr>
<td>75-79</td>
<td>1930</td>
</tr>
<tr>
<td>80-84</td>
<td>2697</td>
</tr>
<tr>
<td>85+</td>
<td>4465</td>
</tr>
</tbody>
</table>

NHS
England
Risk stratification versus no. of LTCs – do they select the same patients?

LTC Year of Care Programme
Do Integrated Care teams change service delivery?

LTC Year of Care Programme
Gearing of investment across the system

- **Primary Care**: £200
- **Comm/MH**: £500
- **Specialised**: £300
- **Acute**: £1000

£2000/head of population

NHS England

CCGs

Public Health Social Care (H&WB Board)
Gearing in activity into acute care

Cluster Level

Proportion of Total Activity and Cost by Activity Type - Cluster

- Planned Same Day
- Elective Inpatient
- Non-Elective
- First Outpatient
- Follow-up Outpatient
- A&E Attendances

Activity vs. Cost graph showing the distribution of activity and cost across different types of activities.
New system approach to care?
CARE GAP

Complexity

Activity

GP

Specialist  Specialist

1990

2014

NHS England
### Newark and Sherwood Integrated Model of Care for Long Term Conditions

<table>
<thead>
<tr>
<th>Level</th>
<th>21% - 100%</th>
<th>6-20%</th>
<th>0.6-5%</th>
<th>Top 0.5%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Proactive Self Care Support and Management in Primary Care</td>
<td>Proactive Disease Management by General Practice supported by specialist community services and teams</td>
<td>Intensive disease / case management by specialist teams as part of the MDT</td>
<td>Community Matron / Virtual Ward as part of Multidisciplinary Team (Community Geriatrician, GP, Social Care, Therapists, Rehab, Domiciliary)</td>
</tr>
<tr>
<td></td>
<td>Risk score recorded and reviewed annually</td>
<td>Care Planning and individualised Care plan</td>
<td>Telehealth / Telecare</td>
<td>Care Planning and individual personalised care plan</td>
</tr>
<tr>
<td></td>
<td>Active Case Finding</td>
<td>Support to Self Manage</td>
<td>Community Specialist Services and clinics with MDT support</td>
<td>Planned Hospital Admission for those who need it and facilitated discharge via intermediate care to reduce LOS</td>
</tr>
<tr>
<td></td>
<td>Disease Register</td>
<td>Education Programmes</td>
<td>Care Planning and individual personalised care plan</td>
<td>Disease Specialist Input where required from specialist community teams (COPD, Diabetes)</td>
</tr>
<tr>
<td></td>
<td>Accurate diagnosis</td>
<td>Annual Review</td>
<td>Planned Hospital Admission for those who need it and facilitated discharge via intermediate care to reduce LOS</td>
<td>Telehealth and Tele Care Psychological Support</td>
</tr>
<tr>
<td></td>
<td>Information Prescriptions</td>
<td>Specialist Medication reviews</td>
<td>Anticipatory Care</td>
<td>Planned hospital admission, proactive in reach and facilitated discharge where needed</td>
</tr>
<tr>
<td></td>
<td>Care Planning</td>
<td>Remote monitoring via tele health where appropriate</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Education relevant to patients needs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Disease prevention and Health promotion</td>
<td></td>
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</tbody>
</table>

### Workforce Development, Training and Education

- Smoking Cessation, Health Promotion and Self Care
- Co-ordinated Social Care
- Admissions Avoidance
- Personal Care Navigator / Named Lead
- Special Patient Notes / 24/7 Access to specialist support

### High Risk / Complexity

- Smoking Cessation, Health Promotion and Self Care
- Co-ordinated Social Care
- Admissions Avoidance
- Personal Care Navigator / Named Lead
- Special Patient Notes / 24/7 Access to specialist support
Bridging the gap

INTEGRATED CARE

Self-management
Risk profiling
Long Term Condition Management incl Cancer
Locality teams
Third sector provision
Primary Care

SHIFT LEFT

COMPLEX CARE PRACTICE

ACUTE CARE

Specialty Clinic
Planned procedures
ICU

Cost of Care per Day
What people with LTCs want

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”
Person Centred Coordinated Care

1. Engaged, informed, empowered individuals and carers
2. Organisational and clinical processes
3. Health and care professionals working in partnership
4. Commissioning
The House of Care

Engaged, informed individuals & carers

Organisational & clinical processes

Person-centred, coordinated care

Health & care professionals committed to partnership working

Plan → Do → Study

Act

Commissioning
The House supports:

– Informational continuity
– Management continuity
– Relational continuity
The House of Care in value to people/patients:

The House supports National Voices ‘I’ statements

My goals/outcomes e.g.
- All my needs as a person were assessed and taken into account.

Emergencies e.g.
- I had systems in place so that I could get help at an early stage to avoid a crisis.

Transitions e.g.
- When I went to a new service, they knew who I was, and about my own views, preferences and circumstances.

Communication e.g.
- I always knew who was the main person in charge of my care.

Information e.g.
- I could see my health and care records at any time to check what was going on

Decision-making e.g.
- I was as involved in discussions and decisions about my care and treatment as I wanted to be.

Care planning e.g.
- I had regular reviews of my care and treatment, and of my care plan.
The House of Care in value to NHS:

£1.2bn: Avoid ambulatory care sensitive admissions though e.g. following NICE guidelines (1)

£0.8bn: Reduction of hospital admissions for common LTCs through integrated care esp frailty, comorbid (2)

£0.8-1.2bn: Reduce use of low value drugs, devices and elective procedures using commissioning analytics and clinician education (3)

£0.4-0.6bn: Avoidance of drug errors e.g. through electronic records/e-prescribing (7)

£0.2-0.4bn: Empower people in supportive self-management (4)

£1-1.6bn: Shift activity to cost effective settings e.g. pharmacy minor ailments (5)

£0.2-0.4bn: Incentivised wellness programmes in healthy pop & early stage LTCs inc. smoking cessation, salt ↓, exercise ↑(6)

£5.5bn: Incentivised wellness programmes in healthy pop & early stage LTCs inc. smoking cessation, salt ↓, exercise ↑(6)

£0.4-0.6bn: Avoidance of drug errors e.g. through electronic records/e-prescribing (7)
The House of Care - Person centred, coordinated care at three levels:

**National:**
What can national organisations and policy makers do to enable construction of the House of Care at the next two levels.

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

**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
6 key characteristics

- Empowered patients
- Primary Care at Scale
- Modern, integrated care
- Urgent Care
- Elective care
- Specialised Services
Problems for integration

• Lack of common definitions and boundaries.

  integrated, coordinated or collaborative care, case management, continuity of care etc. The Kings Fund (2010) found 165 definitions of integration.

• Vertical and/or horizontal integration

• Patchy evidence and lack of focus on patients

  No national picture on integration but lots of case studies

• Clinicians and commissioners convinced? When asked whether integration had the potential to produce desirable outcomes, respondents to a BMA survey (2011) answered as follows:
  - Nearly half said ‘yes’ (47%)
  - Nearly half said ‘don’t know’ (45%)
  - The remainder said ‘no’ (8%)
Does the NHS measure what matters to patients?

<table>
<thead>
<tr>
<th>Classic NHS measure</th>
<th>Outcomes that matter to patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finance</td>
<td>Quality of life</td>
</tr>
<tr>
<td>Process measures/waiting times</td>
<td>Being supported to stay well</td>
</tr>
<tr>
<td>Clinical information</td>
<td>Being treated with dignity and respect</td>
</tr>
<tr>
<td>Patient safety data</td>
<td>Seamless and coordinated care</td>
</tr>
<tr>
<td></td>
<td>Being supported to make decisions</td>
</tr>
<tr>
<td></td>
<td>Services that listen to feedback and improve</td>
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</tbody>
</table>
Long Term Conditions Dashboard - Purpose

• Support intelligent commissioning for long term conditions (LTCs) across health and social care
• Review the impact of implementing the house of care and to set local priorities
• Provide a population level snapshot of indicators related to long term conditions relevant to a Health and Wellbeing Board (HWB) at a local level
• Provide a number of indicators for LTCs from which to benchmark against national averages and comparable authorities.
• A move away from disease specific indicators towards a view of multi-morbidity and LTCs overall
Dashboard Sections

1. **Risk Factors** – “What are the risk factors that might reduce our population’s ability to manage long term conditions and increase the risk of developing further long term conditions?”

2. **Prevalence** - “How many people do we have with long term conditions in our locality?”

3. **Quality of Care** “How well are we supporting people with long term conditions?”

4. **Quality of Life** - “How are people living with long term conditions in our area doing?”

5. **Economic and activity impact**- “What is the economic impact of people living with long term conditions in our locality that is potentially modifiable?”
## Long Term Conditions Dashboard - Proposed Metrics

<table>
<thead>
<tr>
<th>1. Risk Factors</th>
<th>2. Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking prevalence (aged &gt;18 years)</td>
<td>Overall number of people with 1 LTC*</td>
</tr>
<tr>
<td>Obesity prevalence (aged &gt;16 years)</td>
<td>Overall number of people with 2 LTCs*</td>
</tr>
<tr>
<td>Income deprivation Affecting Older People</td>
<td>Overall number of people with 3 or more LTCs*</td>
</tr>
<tr>
<td>Prevalence of adults (age 16+) who binge drink</td>
<td>Dementia Prevalence</td>
</tr>
<tr>
<td>Long Term Unemployment</td>
<td>People with LTC reporting MH problems</td>
</tr>
<tr>
<td>% of people with caring responsibilities</td>
<td>% people with LTC who smoke*</td>
</tr>
<tr>
<td>% reporting learning difficulty</td>
<td>Expected vs. actual prevalence for LTC (Diagnoses ratio)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Quality of Care</th>
<th>4. Quality of Life</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of people living with a LTC who report having a care plan</td>
<td>Health related quality of life people with LTC</td>
</tr>
<tr>
<td>Smoking cessation support and treatment offered</td>
<td>People with LTC reported to feel supported</td>
</tr>
<tr>
<td>Influenza Vaccination</td>
<td>% point gap in the employment rate between those with a LTC condition and the overall employment rate</td>
</tr>
<tr>
<td>Diagnosing depression in people living with long term conditions</td>
<td>% point gap in the employment rate between those with MH condition and the overall employment rate</td>
</tr>
<tr>
<td>Mental health record of BMI in last 15 months</td>
<td>Health Related Quality of Life for Carers</td>
</tr>
<tr>
<td>Medicine usage reviews following discharge from hospital</td>
<td>Loneliness and isolation in adult carers</td>
</tr>
<tr>
<td>Loneliness and isolation is social care service users</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Economic/ Activity Impact of LTCs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency hospital admissions for people aged over 85 years</td>
</tr>
<tr>
<td>LOS for emergency hospital admissions for people aged over 85 years</td>
</tr>
<tr>
<td>Emergency readmissions</td>
</tr>
<tr>
<td>Permanent admissions to residential and nursing care homes</td>
</tr>
</tbody>
</table>

ICare
Community Care
Primary Care
Social Care
General Hospital
University/Specialist Facilities
Final thought

The good physician treats the disease; the great physician treats the patient who has the disease.

*William Osler*
Thank you