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Long term conditions

- 70% health and social care cost
- 70% unscheduled admissions
- 55% GP consultations
- Etc!
Unscheduled admissions

- NHS since 2000 36% rise
- Sweden since 2000 1.6% rise
Primary drivers

• Risk profiling
• Integrated care teams at locality level
• Systematic empowerment of patients to self care
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Risk stratification

• Better targeted services improves outcomes

• Enhanced targeted assessment was associated with improved mortality and physical function after one year\(^1\)

• Targeted activities to activate patients have the greatest impact when targeted a specific high risk groups\(^2\)

• When integrated stroke care was targeted at highest risk, this increase survival and reduced need for institutional care\(^3\)

Integrated teams

- Improved health status, reduced weight and improved diet.\(^1,^4\)
- People were most likely to be alive, living independently at home.\(^6\)
- Improved symptoms and behaviours.\(^5\)
- Improved health status & mental well-being. Outcomes for lower cost.\(^3,^7\)

- Source: (1) Kasper “A Randomized Trial of the Efficacy of Multidisciplinary Care in Heart Failure Outpatients at High Risk of Hospital Readmission”. Journal of the American College of Cardiology Vol. 39, No. 3, 2002
- Source: (6) Stroke Unit Trialists’ collaboration “Organised inpatient care for stroke” Cochrane Library, issue 2, 2004
Supported self care

- reduce number of GP visits
- help to prevent unnecessary admissions to hospital
- reduce length of stay of necessary hospital admissions
- improve health status and self efficacy
- enable patients to remain in their homes and communities
- improve feeling of control in their condition
- increase choice for patients
- improve end of life care
- integrate all elements of care
- deliver better glycaemic control for diabetic patients
- lead to reduced stress for people with mental health conditions

1. [http://www.crd.york.ac.uk/CRDWeb/ShowRecord.asp?View=Full&ID=32006001556](http://www.crd.york.ac.uk/CRDWeb/ShowRecord.asp?View=Full&ID=32006001556)
But.....

You need to do them all

.. And status quo is not an option
Long Term Needs patients’ eye

- “I want you to deal with the whole of me and for you to work as one team”

- Commissioner
  - Disease specific pathways
  - Neighbourhood care teams
    - Single point of contact
    - Joint delivery teams, community services, social services, ahp practices, mental health
    - Specialist skills
    - Continuity of personnel for individual patient
    - Care plan
    - Broader skill mix

- E-Learning
  - Self-management is default
  - Remote monitoring
  - Personalisation

- Risk Profiling
Goals

• 20% reduction in unscheduled admissions
• 25% reduction in length of stay
Milestones for risk profiling

• Choosing, populating and testing a tool
• Engaging clinicians and plan for action in each locality
• Systematically using list of patients for proactive care in each locality
Measuring progress

- Baseline measures: for people with LTC
  - Emergency admissions
  - Length of stay
  - LTC6

- Details in your ‘Members’ Guide’
- Baseline for quantitative & qualitative data by 23rd December 2011
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