Building the House of Care for Long-Term conditions in Berkshire West CCGs

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Berkshire West has come a long way since 2012...

- Identified as 3\textsuperscript{rd} worst performing PCT in England for attainment of HbA1c

- This was our ‘burning platform’ to do better
We found our burning platform...

...we needed to do things differently!
What happened then

- Redesign of services began in July 2012 and launched at TIPS (PLT) in May 2013 at scale and pace

- The current service now attracts national attention for all the right reasons!
Question 1

What proportion of the population have one or more long term conditions?

a) 20%
b) 30%
c) 40%
d) 50%
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b) 30%
c) 40%
d) 50%
Proportion of people with LTCs by age, England 2009

Source: General Lifestyle Survey 2009
Question 2

People with LTCs account for what proportion of GP appointments?

a) 35%
b) 45%
c) 55%
d) 65%
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d) 65%
People with limiting LTCs continue to be the most intensive users of the most expensive services.

Source: 2009 General Lifestyle Survey.
Question 3

What proportion of the spend in health and social care is on people with LTCs?

a) 40%
b) 50%
c) 60%
d) 70%
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a) 40%
b) 50%
c) 60%
d) 70%
Question 4

What proportion of their time do most people with LTCs spend with healthcare professionals?

a) 0.1%
b) 1%
c) 5%
d) 10%
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Long term conditions are different

- Hours with healthcare professional = 4 hours in a year
- Self-management = 8756 hours in a year
had at least one check up in the last 12 months

agreed a plan to manage their diabetes over next 12 months

discussed ideas about best way to manage their diabetes

discussed their goals in caring for their diabetes

Poor quality of care and ineffective use of resources

Year of Care: addressing the problem (diabetes)

The Year of Care

Pilot sites:

NHS Calderdale and NHS Kirklees PCT
NHS Tower Hamlets PCT
NHS North of Tyne
Care Planning in Year of Care

‘The key to good outcomes’ is

Engaged empowered patient

Organised proactive system

Productive interactions

Based on the: National Service Framework for Diabetes (UK) Wagner Chronic Care Model (USA)
The individual's perspective

More meaningful conversations

Support for self-management
Engaged, informed patient

Organisational processes

Collaborative care planning consultation

Commissioning - The foundation

HCP committed to partnership working
Quick revision: what’s care planning?
Here’s what it’s not:

• It’s a verb not a noun: a process, not a list
• It’s not the same as a care plan, but the process of care planning leads to a care plan
• It’s nothing to do with Care Plans for admission avoidance for high-risk patients.
Sent to patient > 1 week before consultation; with agenda setting prompts

Prepared HCP and patient

Resultant care plan shared with patient, immediately or by post

Information sharing

Consultation and joint decision making

Agreed and shared goals and actions (care plan)

1st visit

Between visits

2nd visit

HCA performs annual review tests

Sent to patient > 1 week before consultation; with agenda setting prompts

Prepared HCP and patient

Resultant care plan shared with patient, immediately or by post

...and this is what care planning is (in a nutshell)
The House of Care is central to the vision. It gives a cohesive, rational, overarching model of care centred on the patient.
Building the House of Care for diabetes in Berkshire West

Commissioning of all services led by stakeholder network

- Stakeholder network
- Metrics & monitoring - Eclipse
- Eye screening
- Dietetics
- Podiatry
- Monthly newsletter
- HCP Education
- Community specialist
- Link to secondary care
- Diabetes Specialist Nurses
- Website
- Virtual clinics
- Meds management
- Community pharmacy

Engaged, informed individuals and carers

Person-centred coordinated care

Health and care professionals committed to partnership working

Organisational and supporting processes

3rd sector support - DUK
Care planning
DAFNE
X-PERT
CarbAware
Talking health
Website

Commissioning
Progress is being made

- Proportion achieving HbA1c ≤59mmol/mol increased from **46.5%** (06/12) to **59.5%** (12/14)
XPERT

• HbA1c down by 18% among X-PERT attendees:
  • 67.5mmols before course,
  • 55.5mmols 6 months after X-PERT
Carb Awareness

- HbA1c reduction 6 months after CarbAware course of 13mmol/mol among Type 1 patients
Virtual Clinics

• HbA1c reduction 6 months after virtual clinic MDT consultation of 10 mmol/mol
Cholesterol

- Proportion achieving total cholesterol ≤5 increased from 46.3% (06/12) to 79.3% (12/14)
• Care planning is now established in nearly 95% of practices in Berkshire West as the standard process of annual review in diabetes

• Work has now begun to extend this into other LTC’s such as COPD, CVD, Heart failure, NHS health checks.
Building the House of Care for respiratory conditions

- Stakeholder Network
- Metrics & monitoring - Eclipse
- Spirometry training for HCAs
- Spirometry training for PNs/GPs
- Additional capacity in community resp team
- Website
- Monthly newsletter
- Strong links to 2° care
- Care pathway development → DXS

Organisational and supporting processes

- Engaged, informed individuals and carers
- Person-centred coordinated care
- Health and care professionals committed to partnership working

Commissioning

Care planning
Website
3rd sector British Lung Foundation
Pulmonary rehabilitation
Stop smoking services

Coherent commissioning by network supported by CSU
LTC Programme supporting-Pt Centred Co-ordinated Care.

Care Planning Training
Thames Valley Strategic Clinical Networks 2015
Thames Valley

• Thames Valley SCN have now developed a implementation programme for all CCG’s in Thames Valley area.

• Created an expert Hub to support the process

• Including ALL long term conditions and training is generic not disease specific.

• Programme includes primary care and integrated care teams.
• www.breatheberkshirewest.org.uk
• www.berkshirewestdiabetes.org.uk