Supporting people with long-term conditions

The Government’s new model of care

The Government has published a new model of care for people with long-term conditions in advance of the National Service Framework for long-term conditions due out later this year. Supporting people with long-term conditions: an NHS and social care model to support local innovation and integration sets out ways in which the health and social care services should deliver care. The aim of the model is to improve the health and quality of life of people with long-term conditions, prevent premature death and reduce emergency admissions.

The document sets out a three-level model of care in which community matrons will play a crucial role working with patients with the most complex needs.

This Briefing explains the background to the model and details the three levels of service delivery health and social care organisations need to introduce.

Summary

Supporting people with long-term conditions: an NHS and social care model to support local innovation and integration sets out a model of care for people with long-term conditions. Health and social care organisations are expected to take immediate action to implement the model.

Central to the model are three levels of delivery of services: case management by community matrons or equivalent for those with the most complex conditions, disease-specific care management for people with complex single need or multiple conditions and supported self-care for 70 to 80 per cent of patients.

According to the Department of Health, the initial focus for health organisations will be on the high-intensive users of secondary care. One of the first steps will be to identify all long-term condition patients and group them according to their care needs.

Community matrons are central to the plans and, according to the document, there will be 3,000 community matrons in place by March 2007. The document does not, however, discuss funding and although it says there should be care plans for those people with the most complex conditions, these are not extended to all patients with long-term conditions.

Background

An estimated 17.5 million people in the UK suffer from long-term chronic diseases such as arthritis, asthma, diabetes, heart disease and depression. One in three people in...
the UK have a long-term medical condition and long-term conditions are now the most common cause of death in most industrialised nations.

The impact on the NHS and social care services is significant. For instance, care for many people with long-term conditions has traditionally been reactive, unplanned and episodic, resulting in heavy use of secondary care services. Just five per cent of inpatients, many with long-term conditions, account for 42 per cent of all acute bed days. Eight of the top eleven causes of hospital admissions are long-term conditions. It is estimated 60 per cent of GP consultations concern chronic disease management and evidence from the US suggests people with chronic disease use up to 75 per cent of healthcare resources.

Recognising these issues, the Government introduced the Public Service Agreement target to reduce inpatient emergency bed days by five per cent by March 2008, using 2003/04 as the baseline. Health organisations are expected to make progress towards this target from 2005 onwards, by offering a personalised care plan for those vulnerable people with long-term conditions who are most at risk. Subsequently, the NHS Improvement Plan published in August 2004 highlighted improving services for patients with long-term conditions through the Expert Patient programme, the new GMS contract and case management and community matrons.

Later this year the Government will publish the National Service Framework for long-term conditions. This will focus on neurological conditions, but will also cover care, treatment and support services for all people with long-term conditions.

Purpose of the model

The new model of care outlined by the DH aims to build on local and national experiences and innovations to improve the health and quality of life of those with long-term conditions. The intention is for NHS and social care organisations to treat patients sooner, nearer to home and earlier in the course of disease. Earlier detection, better control and more effective medicines management are all needed, according to the DH. The DH says the model is aimed at providing personalised but systematic on-going support and ensuring effective working between those delivering care, including secondary care, ambulance trusts, social care and voluntary and community organisations.

Delivering care

Key to the model is a three-level delivery system: case management, disease management and supported self-care. This is underpinned by a drive to promote better health. This approach builds on what is known as the Kaiser Permanente triangle.

Under the model, the first priority for health and care organisations will be to introduce a system of case management for those with the most complex needs. This focus should help deliver the emergency admissions target and have the greatest impact on the health system, the DH claims.

Level 3: Case management

Under the model, this level of care only applies to high-complexity cases. It requires the identification of the very high-intensity users of unplanned secondary care. Care for these patients will be managed by a community matron or other professional taking a case management approach, with the objective of anticipating, co-ordinating and joining up health and social care.
Level 2: Disease-specific care management
This level of care is for high-risk cases. People with a complex single need or multiple conditions will be provided with responsive, specialist services using multi-disciplinary teams and disease-specific protocols and pathways, such as the National Service Frameworks.

Level 1: Supported self-care
This level of care is for 70 to 80 per cent of people with long-term conditions. It involves collaboratively helping individuals and their carers to develop the knowledge, skills and confidence to care for themselves and their conditions effectively.

The infrastructure needed to support this three-level delivery system includes:

- community resources – such as voluntary, community and patient organisations
- decision support and clinical information systems – patient registers, recall and reminder systems and feedback to clinicians
- health and social care environment – organisations need to use the new tools available such as payments by results and the new GMS and pharmacy contracts. Pooled budgets across health and social care should be developed. Practice-based commissioning will bring front-line clinicians into the commissioning process and the choice policy will allow patients to take greater control of their condition. Community matrons and other case managers will need to have the authority to secure services for patients at the time needed and to order investigations, make referrals and arrange admissions on behalf of patients.

Case management for patients with complex long-term conditions and high-intensity needs (level 3)
The DH argues that, when patients develop multiple long-term conditions, their care becomes disproportionately complex and difficult to manage, with the risk of unplanned hospital admission or long-term institutionalisation. However, the document claims, evidence shows that intensive, continuous and personalised case management can improve the quality of life and outcomes for patients, reducing emergency admissions and shortening hospital stays.

Under the model, community matrons will have the key role in case management. The first step for health and social care organisations is to...
develop and agree ways of identifying patients with the most complex conditions who are at risk of hospital admission. Criteria are likely to take account of the number of:

- hospital admissions and the length of stay
- medical or other problems a patient has
- medicines prescribed
- GP consultations.

Once patients are identified, community matrons will be responsible for their case management, with clinical responsibility for their care and the role of co-ordinating other professionals involved. Community matrons are likely to have caseloads of around 50 to 80 patients.

Community matrons can come from any branch of nursing, according to the document, although most are likely to be district nurses. Arrangements must be in place to enhance the skills of the district nursing team so they can increase capacity and support community matrons. The model sets out the areas in which community matrons will need to be competent and there will be a self assessment tool for nurses preparing to take on the role.

The Government expects health communities to draw up a detailed local plan of how this new case management service will be introduced, how it will integrate with existing services and how rapid progress can be made in reducing admissions and length of hospital stay.

Disease specific care management for high-risk cases (level 2)

The model acknowledges proactive disease management can make a real difference to patients with a single condition or a range of problems threatening their health and well-being. Good care management involves identifying their needs early, responding promptly and providing systematic and tailored programmes.

The first step will be to identify the patients. Effective practice-based registers need to be set up to provide the cornerstone of care and the basis for call, recall, clinical care, prevention, continuous quality improvement, monitoring and clinical audit.

Primary care trusts and practices should then, with reference to national guidance, develop and extend their own local disease-based protocols as part of their wider long-term condition strategies.

In most cases, support for these patients is expected to be provided by multi-disciplinary teams based in primary or community care, with the support of specialist advice. Clinically-led and managed disease networks could provide a means of embedding such approaches locally. Experience shows the benefit of designating one member of the care team as a named contact for each person with a long-term condition, helping them navigate services and establish contact with other members of the team.

Regular clinical reviews, monitoring and audit should be conducted. Review provides an opportunity for people with long-term conditions and their lead health professional to bring together relevant information, make sense of what it means for the individual and review the care plan.

The role of a community matron

Community matrons will:

- work collaboratively with all professionals, carers and relatives to understand the patient’s physical, emotional and social situation
- develop a personalised care plan with the patient, carers, relatives and health and social care professionals
- keep in touch with the patient and monitor their condition regularly
- initiate action if required, such as ordering tests or prescribing
- update the patient’s medical records, including medicines review, and inform other professionals about changes in condition
- liaise with other local agencies such as social services
- teach carers and relatives to recognise subtle changes in the patient’s condition that could lead to an acute deterioration in health
- secure additional support as needed.
Supporting self-care (level 1)
The model requires local health and social care partners to ensure self-care and self management are priorities in local planning and commissioning and that activities to support self-care are mainstreamed. The new primary care contracting arrangements will give PCTs options for sourcing the best services to support self-care.

In order to support self-care, health and social care organisations should:

• ensure patients and carers have the skills and knowledge to understand how to handle their condition, including how to deal with flare-ups, adjust medicines, improve life-styles and access health care services
• provide accessible information people can use meaningfully
• empower patients and their carers to manage their own condition more effectively, for example, by self monitoring

• provide a trusted and consistent person to contact
• make available support from a knowledgeable patient and peer networks.

Around half of people with a long-term condition do not take their medicines as prescribed and pharmacists have a growing role as a source of advice for patients and their carers.

Health communities should do more to offer diagnostics and monitoring closer to home for patients.

PCTs and local authorities should look for opportunities to work in partnership with the voluntary and community sectors, which have expertise in supporting self-care and self management.

The DH has published Self care – a real choice, self care support – a practical option that provides information on the developing policy on support for self-care, the reasons why it is important, suggestions for practical action by those delivering health and social care and some ideas on how to support self-care.

Key actions to implement model

• identify the number of people with long-term conditions and group according to their level of need
• identify high-risk patients requiring proactive case management
• work with primary, secondary and social care to establish what services are available and where there are gaps
• find ways of involving patients and their carers in planning services
• plan and commission new and integrated services using the primary care and pharmacy contracts, practice-based commissioning as well as pooled budget arrangements between health and social care
• establish a programme of support for developing a workforce with the skills and knowledge to deliver these services.

Confederation viewpoint

The NHS Confederation welcomes the introduction of a model of care of people with long-term conditions. The model outlined is very much a development of what has already been piloted through programmes like Evercare, Kaiser and Pfizer ones. The degree of flexibility the model gives PCTs to develop locally responsive models is to be welcomed, as is the move towards models involving social care as well as primary and secondary health care elements.

The Confederation does, however, have some concerns about the framework as it has been outlined in the document – particularly how the framework will be implemented. Strategies for managing the change need to be addressed and details given on the timetable and resourcing of the framework.

We would also question the sustainability of initially dealing only with the development of case management for high-complexity cases, in particular for high-intensity users of unplanned secondary care. Although this emphasis would reduce emergency admissions in the short term, without the underpinning structure at all three levels, it would not reduce the flow of patients between the levels or the long-term impact of chronic disease on the NHS.

We welcome the strengthening of the nursing contribution to the management by the new community matron role. However, given that a maximum caseload size has been recommended, the impact on PCT services would be large. Without further funding, it might be...
difficult to find the resources necessary within already stretched community staffing budgets without increasing skill and grade mix. Moreover, the clinical quality of service offered to those people outside of the level 3 banding will need to be supported by funded educational programmes for local community and primary care nursing teams.

Several important issues are omitted including:

- the development of tariffs for long-term conditions to move money into primary care for care delivered closer to home
- systems to enable the choice agenda
- the impact of local diagnostics shortfalls on implementation
- development of an appropriate performance management framework
- specifics around children, mental health or learning disabilities. It is unclear how broad a range of individuals the framework covers. Although the framework does mention pooled budgets, no explicit reference is made to shared care packages in continuing care cases or to the issue of nursing home care budgets.

In the short term, implementation could be hindered by:

- lack of information support – the capacity to gather data across primary/secondary and social care interfaces will be essential to give demographic and care details of those individuals requiring case management
- workforce scarcity – without the necessary demographic information, it is unclear exactly how many community matrons are needed and local skills shortages could confound implementation schedules or admission criteria to the case management approach
- educational programmes – local education programmes will need to be reviewed to support district nursing teams and ensure community matrons have the necessary supplementary prescribing rights. Programmes will need to look at issues such as the availability of medical mentors.

Given the whole-system approach that will be necessary to implement the framework, there are also implications for the Quality and Outcomes Framework review if GP practices are to be fully engaged in this programme. If the care management service is seen as an enhanced service, this may also have financial implications for PCTs.

The contents of the National Service Framework on long-term conditions remain unclear and its publication is awaited with interest.

For more information about the issues covered in this *Briefing*, contact [jo.webber@nhs.confed.org](mailto:jo.webber@nhs.confed.org)

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**Further information**

*Supporting people with long-term conditions: an NHS and social care model to support local innovation and integration* on [www.dh.gov.uk](http://www.dh.gov.uk)

*National standards, local action: health and social care standards and planning framework 2005/06 to 2007/08* on [www.dh.gov.uk](http://www.dh.gov.uk)

*The NHS improvement plan: putting people at the heart of public services* on [www.dh.gov.uk](http://www.dh.gov.uk)

[www.17millionreasons.co.uk](http://www.17millionreasons.co.uk)