# SUPPORTING PEOPLE WITH LONG-TERM CONDITIONS:

**An NHS and social care model to support local innovation and integration**
**Department of Health, January 2005**

## Strategic aims of model

- To embed into local health and social care communities an effective and systematic approach to care and management of patients with long-term conditions.
- To reduce reliance on secondary care services and increase provision of care in a primary, community or home environment.
- To provide high-quality personalised care.
- To ensure self-care support is in place – particularly for those in disadvantaged groups as set out in the public health white paper *Choosing Health*.

Key to the model is a three-level delivery system: case management, disease management and supported self-care.

***Level 3: Case management*** (for high-complexity cases)

This 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.

Community matrons can come from any branch of nursing, 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. 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.

***Level 2: Disease-specific care management*** (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.

Clinically-led and managed disease networks could provide a means of embedding such approaches locally. Experience shows the benefits 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.

***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.

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 form a knowledgeable patient and peer network.

**Conclusion**

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 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.

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.