Care of People with Long-Term Conditions

20 Questions for Health Economies!

(For pedants: Some questions have multiple sections.)

Terminology:

a. **Main relevant services**: GPs, district nurses, GP and nursing out of hours services, care homes, community long-term conditions services (for example, Virtual Wards, Community Matrons) and specialist services for people with diabetes, COPD, heart failure and chronic neurological conditions.

b. **Patients:** Adults with long-term conditions. Many people with long-term conditions have multiple conditions and may also be frail.

The 20 Questions

Patient and Carer Empowerment

1 Do all patients and carers have clear written information on 'early warning signs' of exacerbations or deterioration?

2 Do patients and carers have a dependable route to advice from each service with which they are in contact? If advice is not immediately available, is the maximum response time clear?

3 Do patients have a copy of their 'care plan'? (NB. This does not need to be long and complicated!)

Community LTC Service or Specialist Team Review within 24 Hours

4 Do patients and carers have a dependable route to urgent review within 24 hours if they meet appropriate criteria? Can other relevant services, including out of hours services, access urgent reviews for patients within 24 hours? Has this been communicated to the ambulance service?

5 Is urgent review available daily, seven days a week? If arrangements differ at weekends, are patients, carers and relevant services aware of the arrangements? Have you audited the appropriateness of referrals and provided feedback to patients and referring services?

6 Is urgent review by a member of the diabetic foot team available within 24 hours for patients in the community and in hospital?

7 Is patient transport available to take patients to urgent review clinics and bring them home again? How much notice needs to be given to the transport service? Will patient transport take patients to non-hospital settings? Will the patient transport help the patient from their home and ensure they are settled when they return home?

Community LTC Services

8 Can community LTC teams **quickly** either vary their input or mobilise services to respond to fluctuations in a patient's condition? Are the thresholds for this clearly defined? Do other services, such as out of hours and the ambulance service, know about these arrangements?

9 Do community LTC teams have regular input and access to advice from a consultant (probably one specialising in the care of older people)?

Condition-Specific Services

10 Is each service caring for a defined group of patients whether they are in the community or in hospital? If there are separate hospital and community teams, do they meet regularly?

11 Are acute and community services actively discharging patients to primary care when they no longer need frequent specialist care? Are there clear criteria and arrangements for patients and primary care services to re-access specialist care quickly?

Hospital Admission

12 Are all relevant services alerted when one of their patients is admitted to hospital? When alerted, are community LTC and condition-specific services pro-active in getting their patients home? Is the expected date of discharge communicated to all services?

Health Economy

13 Do you have a mechanism which brings together clinical and managerial leads of relevant services? Do they all know what services are available? Have you taken stock of these services? Have the confidence to stop and start again!

14 Have these leads agreed the key issues which need to be communicated between services?

15 Have these leads considered:

a. Multi-disciplinary meetings to discuss the care of a) people with multiple long-term conditions, b) those with more complex needs, c) those at highest risk of admission and d) frequent service users?

b. The potential for stream-lining service provision, for example, breathlessness clinics for people with COPD and / or heart failure?

c. The potential benefits of additional advice and support to staff in care homes?

16 Do all relevant services have quick and easy access to imaging and pathology results?

17 Do the leads understand the competences of staff in different services and the potential for stream-lining care? Have they considered opportunities for joint training?

18 Can overnight home care (for example, night visiting) be accessed quickly if necessary?

19 Can the leads find a way to achieve a single annual review for each patient with input from other relevant services, a single care coordinator and a single care plan?

20 Have you considered the recommendations of the Care of People with Long-Term Conditions Overview Report? (Report available at www.wmqrs.nhs.uk – choose Document Library and select Overview Reports)