NHS RightCare

# NHS RightCare scenario:
# **The variation between standard and optimal pathways**

## Clara's story: Multimorbidity

Appendix 2: Short summary slide pack

January 2018

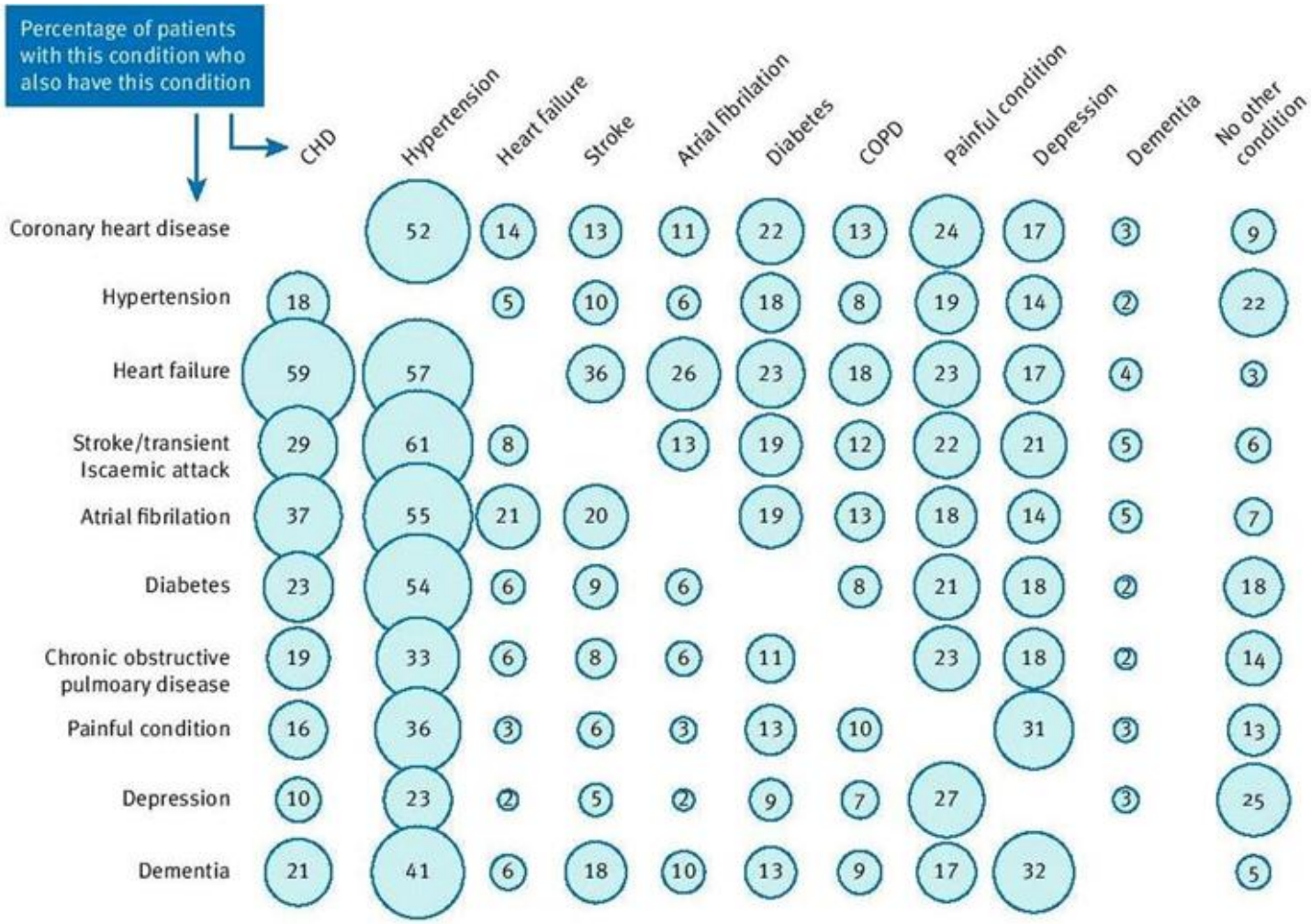
# Clara and the sub-optimal pathway

- Clara, born in Jamaica, is 78 years old; she is widowed and has no relatives within a hundred mile radius - but **her dog Bella is a great companion**. She tries to attend church and enjoys going to pensioners' clubs, although a struggle due to her worsening health
- Clara has **multiple long term conditions**, including ischaemic heart disease, type 2 diabetes, osteoarthritis, hypertension and depression. She also has obesity and feels lonely and isolated. She is living with increasing frailty
- She is prescribed around **10 medications** and has to take around 20 tablets a day. However, her memory is getting worse and she sometimes forgets some of them. She also has to **attend around 30 medical appointments a year**, if she is able
- Clara's journey started aged 75 when she started experiencing chest pain. The pain quickly became severe and she was taken to A&E by ambulance. The diagnosis was angina (due to ischaemic heart disease) – her medication increased
- The following night, she felt light-headed (blood pressure drop). She collapsed, banging her head on the wall; another ambulance & CT scan & overnight stay in hospital. Following this, **Clara was more reluctant to get out and about**
- **Bella died** the following January and this was a **significant event for Clara**. Her GP prescribed anti-depressants

# Clara and the sub-optimal pathway

- Over a few months, Clara lost a lot of weight, going from 83kg to 62kg, due to her low mood, advancing frailty and a lack of appetite caused by all of the medication she was taking. This **weight loss led to diabetes medication problems**
- In June 2015, aged 76, Clara had another fall at home, hurting her hip, and was taken to A&E by ambulance and given **less than ideal painkiller prescriptions and advice**
- She then had a further fall and was taken to A&E and was found to have a fractured wrist. Over the three weeks she was in hospital, **Clara's mental state deteriorated** and she was noted as having ongoing cognitive impairment
- **Clara then required 24 hour care** to meet the needs associated with her frailty and cognitive impairment. Although she found the carers very helpful, she still **felt very lonely**
- In August 2016, Clara deteriorated quickly with an acute chest infection and associated acute kidney failure, and was admitted to hospital. She remained there for the next 10 days, declining and **sadly passing away on the ward**

# People living with multimorbidity




Source: BMJ 2016;354:i4843

# Clara and the optimal pathway

- The story of Clara's optimal pathway starts **two years earlier** when her GP surgery **identified moderate frailty** using the electronic Frailty Index (eFI) and multimorbidity. She was identified as needing the tailored approach. (NICE guidance NG56 refers to multimorbidity: clinical assessment and management)
- Clara's practice allocated her a **dedicated care co-ordinator**, Sarah. Clara felt at ease with her and Sarah understood that Clara had a number of different problems and arranged for **regular check-ups**
- Sarah also offered **support such as signposting** to financial entitlements, advice on arranging Lasting Powers of Attorney and for personal welfare, even talking through the care Clara would like if she developed a serious illness
- Re concerns over Bella, the practice **referred her to a local charity**, which gave support including organising a local voluntary organisation to take Bella out for walks most days
- Clara explained to Sarah that she was struggling with her medication; Sarah arranged for an **automatic pill dispenser** and she was also set up with a **telehealth system**
- Her GP **referred her to a memory clinic** for an assessment which showed only mild cognitive impairment. This presented a valuable opportunity to alert Clara and her family to the higher risk of delirium in acute illness and to plan for this eventuality

# Clara and the optimal pathway

- Clara was also referred to a **falls risk assessment**. As a result, the council put in place a movement sensor and a care call. She was also referred to a **strength and balance class**
- During Clara's chest pain and angina episode the A&E team had access to Clara's **electronic shared record**, which showed which medicines were issued when and that she was living with frailty, and so initiated a **comprehensive geriatric assessment**
- Clara was kept in hospital overnight and given a **medication review**
- When Bella died her GP referred her for psychological support through the local '**Talking Mental Health**' service
- Clara began to lose weight quickly due to her increasing frailty. She was given a further holistic review, referred for assessment and was given a **care package** that included twice-daily support at home to carry out basic tasks
- Clara fell and hurt her hip at church. She was taken to A&E and the x-ray showed nothing serious. Her up-to-date shared record showed that she was already on analgesics for her osteoarthritis, so she was referred her to an **intermediate care team** to support her at home after discharge; she returned home the next day
- As Clara's health declined, her GP made sure they understood her **end of life wishes** and her care package was increased. Rather than being rushed to hospital she was kept at home in line with her wishes, where she **died peacefully** surrounded by her family

# Financial information

| Analysis by provider | Sub-optimal | Optimal | Optimal % |
|---|---|---|---|
| Third sector | £0 | £510 | N/A |
| Acute | £14,570 | £1,028 | 7% |
| Ambulance service | £932 | £466 | 50% |
| Community teams | £75 | £1,717 | 2276% |
| Mental health provider | £0 | £1,655 | N/A |
| Primary care | £657 | £1,140 | 174% |
| Social services | £10,227 | £9,024 | 88% |
| Dentist / Optician | £0 | £40 | N/A |
| **Grand total** | **£26,462** | **£15,581** | **58.9%** |

As can be seen from the table, secondary care expenditure in the two scenarios is radically different. Acute costs in the optimal case represent only 7% of the original sub-optimal case (94% reduction in bed days from 35 days in the suboptimal case to two days in the optimal case) equating to a reduction of £13.2k.

# Financial information

| Analysis by cost category | Sub-optimal | Optimal | Optimal % |
|---|---|---|---|
| Primary care management | £627 | £1,090 | 174% |
| Urgent and emergency care | £1,160 | £694 | 60% |
| Secondary care management | £14,342 | £2,455 | 17% |
| Prevention and public health | £30 | £885 | 2,941% |
| Community care | £75 | £8,740 | 11,584% |
| Nursing home care | £10,277 | £0 | 0% |
| Intermediate care | £0 | £1,717 | N/A |
| **Grand total** | **£26,462** | **£15,581** | **58.9%** |

In the sub-optimal pathway Clara's care was over-reliant on secondary care and was not sufficiently managed in primary care or at home. Improved management had a dramatic impact on her and her family. Such costs are difficult to quantify, but are very real. The secondary point is that a saving of 41% is material to any health economy.

# NHS RightCare Approach

# Further information

For more information about Clara's journey, NHS RightCare or long term conditions you can:

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Visit

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