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

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

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.
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

**Phase 1**
**Where to Look**
Highlighting the top priorities and best opportunities to increase value by identifying unwarranted variation.

**Phase 2**
**What to Change**
Designing optimal care pathways to improve patient experience and outcomes.

**Phase 3**
**How to Change**
Delivering sustainable change by using systematic improvement processes.

**Key Ingredients**
- Indicative & Evidential Data
- Engagement & Clinical Leadership
- Effective Improvement Processes
For more information about Clara’s journey, NHS RightCare or long term conditions you can:

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Visit
- www.england.nhs.uk/rightcare

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