NHS RightCare

NHS RightCare scenario:
The variation between standard and optimal pathways

Sarah's story: Parkinson's

Appendix 2: Short summary slide pack

January 2018

Sarah and the sub-optimal pathway

- **Sarah**, a 70-year-old retired librarian, lives with her husband Ian. She is an **active volunteer** in the community
- Sarah first visited her GP in March of year one – she had noticed ‘slowing down’. At the third visit in July, her GP **started to suspect Parkinson’s** and organised investigations and treatment
- The **diagnosis of Parkinson’s** was confirmed by the neurologist almost a year later and her medication changed
- Sarah and Ian tried to come to terms with her diagnosis but her **social life was diminished** because of symptoms causing her embarrassment
- In year six, Sarah was admitted for surgery on her troublesome bunion. The **Parkinson’s medication was omitted pre-op** and not reinstated quickly enough post-op, causing significant physical regression and led to **prolonged hospital stay**
- In year seven, the caring situation at home was reaching **crisis point** and Sarah was admitted to a Community Intermediate Care bed for respite – where she started on an antidepressant
- There was a catalogue of primary and secondary care events which were distressing for both Sarah and Ian and **affected quality of life** for both of them
- By May of year nine, Sarah’s condition was **deteriorating relentlessly**. Her care package was increased but they still struggled to cope
- When she deteriorated acutely, she was **transferred to the acute medical unit** but died there 18 hours later; staff hadn’t had time to get to know or support her or Ian
- Ian was very distressed and became **depressed and mentally unwell** for over a year after Sarah’s death

An integrated Parkinson's pathway. Care needs can be made explicit and coordinated between team members

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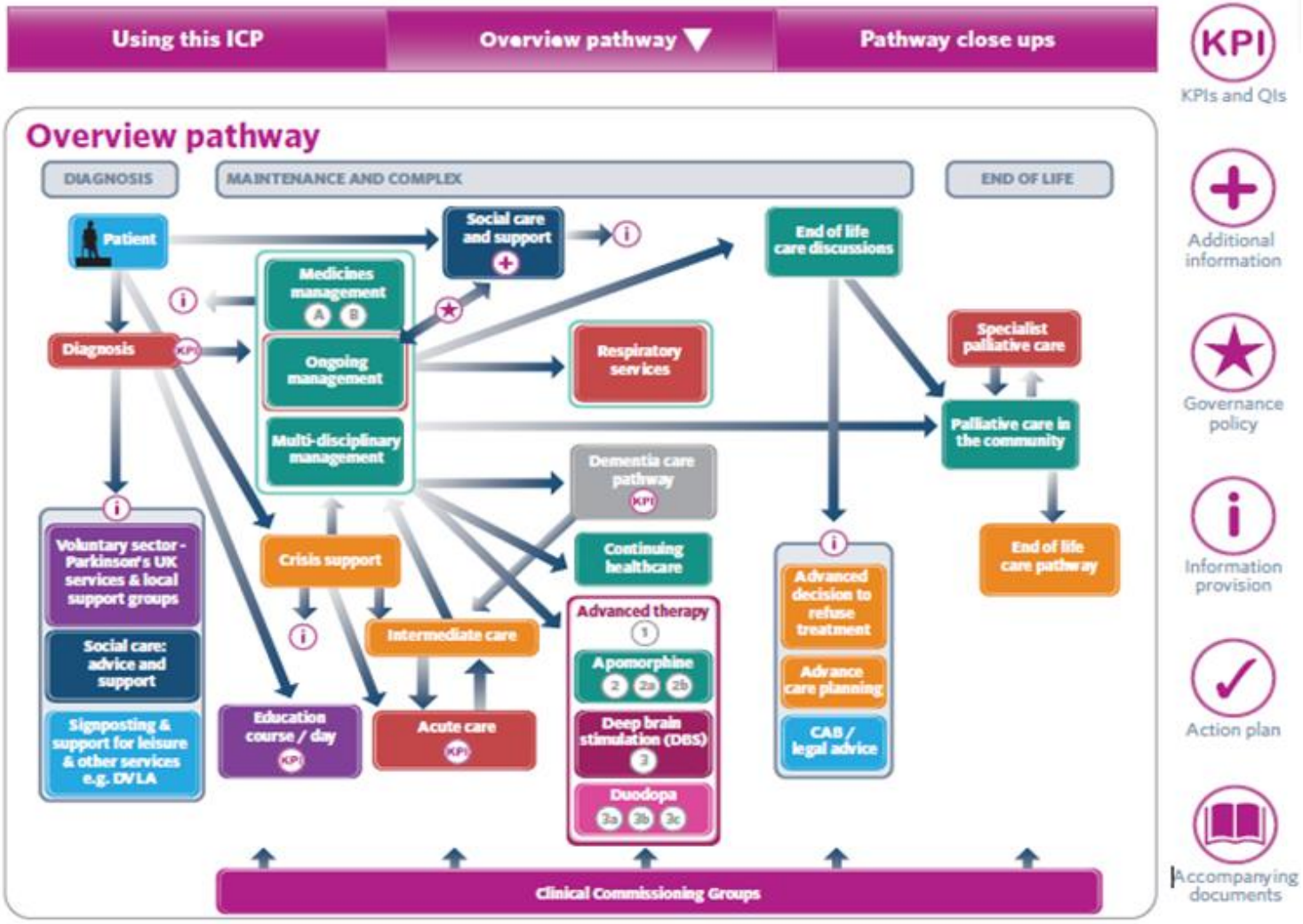

Source: Peel et al (2013) BJNN, 9(6): 292-300

Sarah and the optimal pathway

- In April, Sarah saw her GP who suspected Parkinson's and **immediately referred her**, untreated, to the local neurology clinic. Treatment was initiated quickly using shared decision making
- The **Parkinson's nurse specialist** provided excellent support around medication, links to therapists, signposting to the Parkinson's UK website and introduced the idea of advance care planning
- Sarah had **structured reviews with her practice nurse** and GP in between annual reviews at the neurology clinic, with the Parkinson's nurse specialist available directly by phone at any time
- Sarah undertook exercise classes in the community and Ian joined a **carer support group** run by the local Parkinson's UK branch for social activities and mutual support, attending regularly over that year. This support was very valuable and continued for four years
- Sarah's hospital stay for her bunion surgery was minimal (four days) and uneventful because her **medication regime was tightly managed**
- There were a series of primary and secondary care interventions to support both Sarah and Ian as her condition began to deteriorate. The **specialist palliative care team**, primary care team and other specialists worked together to support her and Ian
- Sarah was regularly discussed at MDT meetings, her records updated on the Electronic Palliative Care Coordinating System and her **care package increased** to meet her needs
- In year 10 Sarah died peacefully at home **with Ian at her side**
- Three months after Sarah's death the Parkinson's nurse specialist visited Ian, who expressed his gratitude for **all the care they both received**

Financial information

Analysis by provider	Sub-optimal	Optimal	Optimal %
Third Sector	£2,880	£1,219	42%
Acute	£50,757	£3,542	7%
Ambulance service	£2,330	£0	0%
Community hospital	£3,843	£2,404	63%
Community teams	£3,025	£7,351	243%
Primary care	£702	£1,552	221%
Social services	£4,466	£8,214	184%
Grand total	**£68,004**	**£24,282**	**36%**

Secondary care expenditure in the scenarios is radically different. The optimal case represents only 7% of the original sub-optimal case – a reduction of £47k.

Primary care and social care expenditure are necessarily higher in the optimal scenario as the optimal case invests in early intervention, community teams, practice-level support and social services (which raises the importance of improved strategic budgeting across the wider health economy). This is more than offset by the secondary care savings. However, please note the financial costs are calculated on a cost per patient basis and local decisions would need to take a population view of costs and improvement.

Financial information

Analysis by cost category	Sub-optimal	Optimal	Optimal %
Community care	£8,732	£10,718	123%
Elective admissions	£800	£1,600	200%
Intermediate care	£3,607	£2,404	67%
Non-elective admissions	£13,600	£0	0%
Palliative and end of life care	£480	£2,958	617%
Prescribing and meds optimisation	£313	£2,015	644%
Prevention and public health	£0	£457	n/a
Primary care management	£360	£879	245%
Rehabilitation	£5,768	£1,362	24%
Secondary care management	£32,692	£1,609	5%
Self care	£0	£155	n/a
Urgent and emergency care	£1,654	£125	8%
Grand total	**£68,004**	**£24,282**	**36%**

This is a scenario that clearly highlights that proactive planning and correct signposting to well trained (and equipped) teams is important - there is a significant impact on patient outcomes, quality and finance. Care can be improved by investigating the root cause of sub-optimal care and working with clinicians to design an improved evidence-based pathway.

Not only is Sarah's health and quality of life much better in the optimal scenario, the cost savings are significant.

NHS RightCare Approach

Further information

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

Email

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- england.longtermconditions@nhs.net

Visit

- www.england.nhs.uk/rightcare

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You can watch the supporting video on the NHS RightCare YouTube page