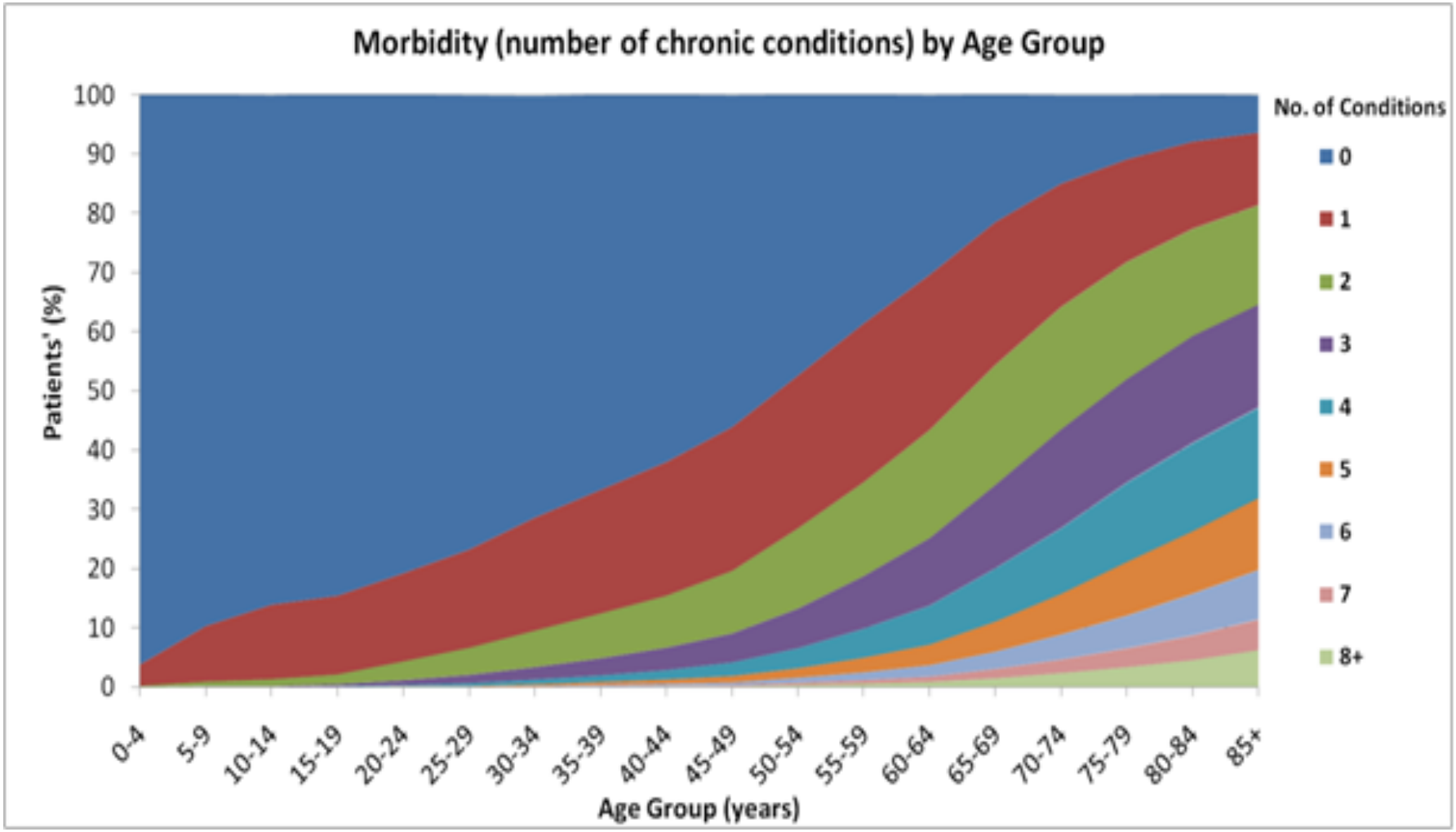
One Person One Team One System

Sir John Oldham OBE MBA

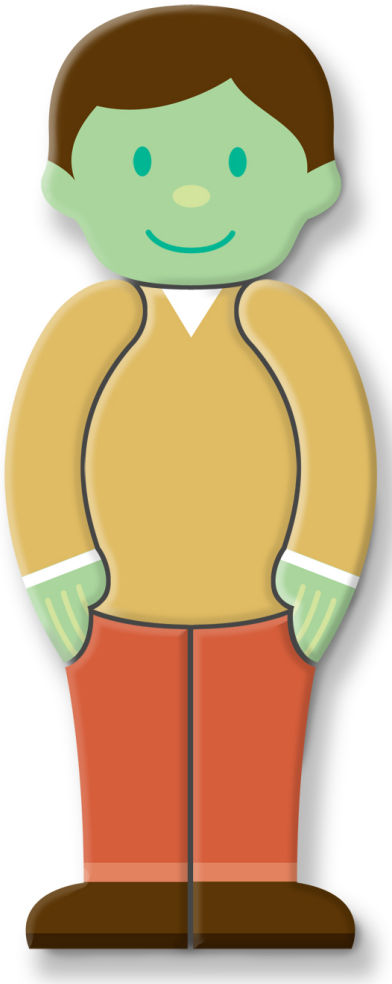
@sirjohnoldham

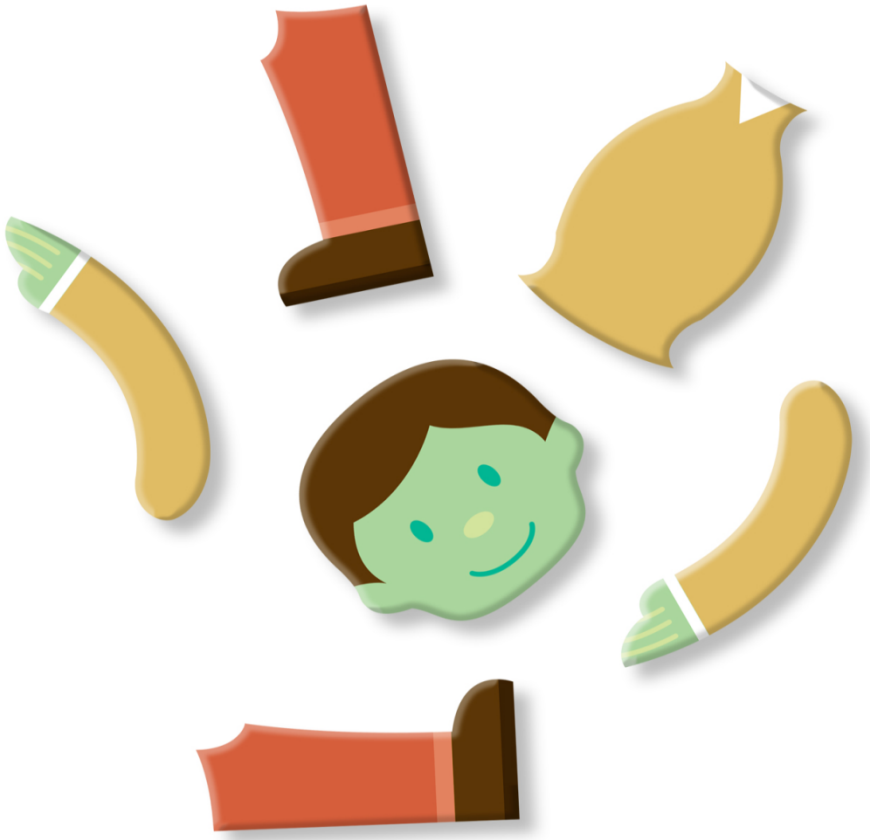
John.oldham@quest4quality.co.uk

Multimorbidity is common in Scotland



- The majority of over-65s have 2 or more conditions, and the majority of over-75s have 3 or more conditions
- More people have 2 or more conditions than only have 1



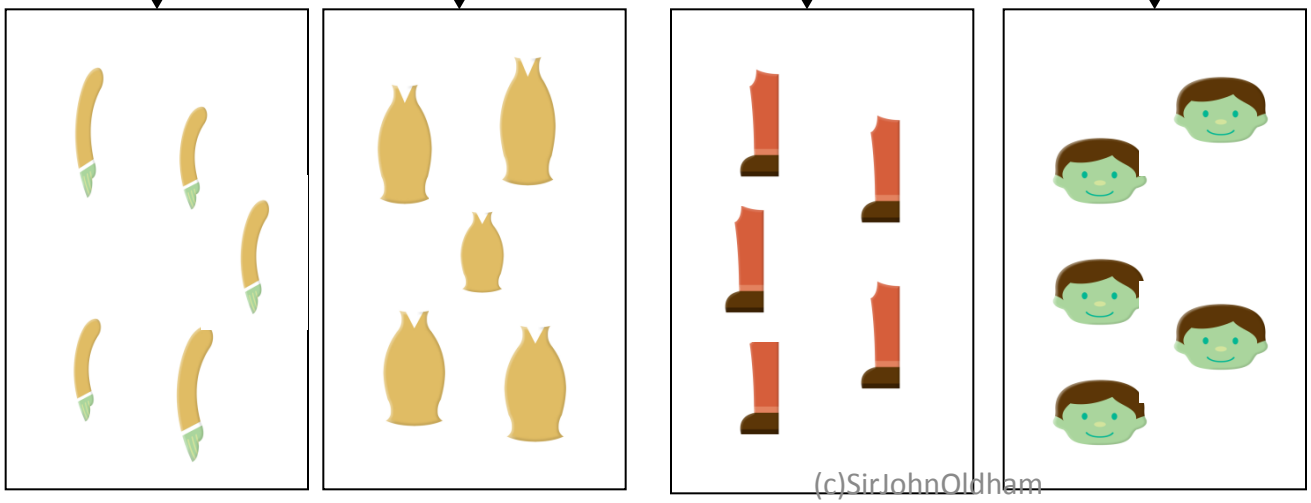


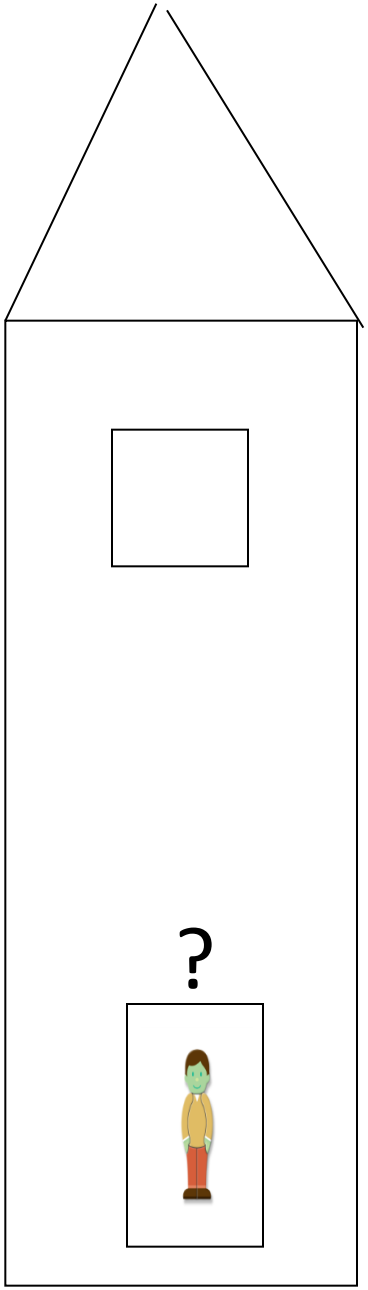
Team A

Team B

Team C

Team D





How are we doing?

How should we meet this challenge?

One Person

supported by people acting as

One Team

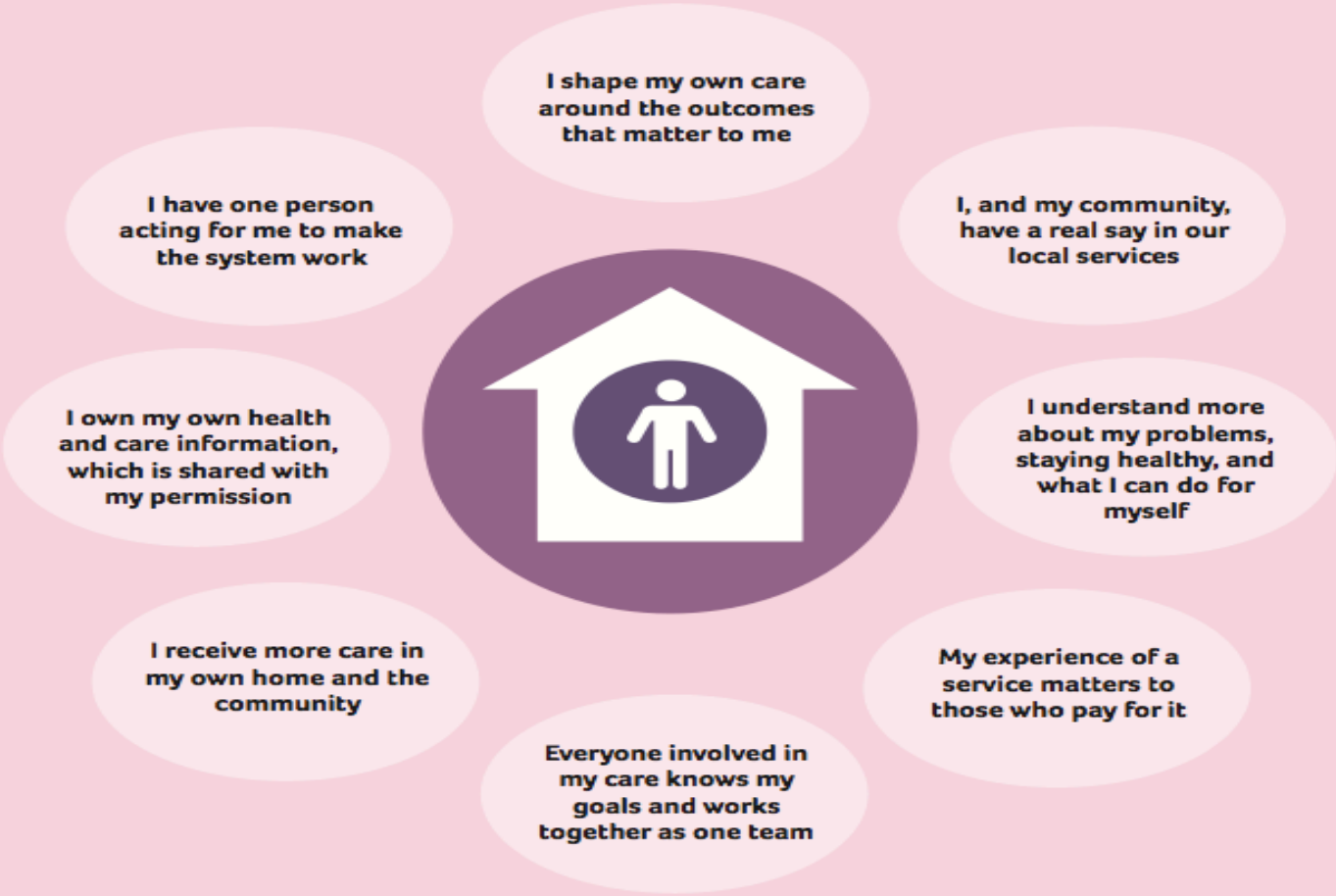
from organisations behaving as

One System

Evidence based policy:
296 references from literature search

293 Humphries R et al, 2012. Health and wellbeing boards: system leaders or talking shops? London: King's Fund.
294 Charles Alessi discussion paper – personal communication.
295 For example, see the following case studies on the Alzira model in Valencia: NHS Confederation, 2011. The search for low-cost integrated healthcare: The Alzira model – from the region of Valencia. Available at: http://www.nhsconfed.org/Publications/Documents/Integrated_healthcare_141211.pdf AND European Observatory on Health Systems and Policies, 2009, Capital Investment for Health: Case Studies from Europe. Available at: http://www.sfes.info/IMG/pdf/capital-investment-for-health.pdf#page=27 AND see the following summaries of the Veteran's Health Administration model in the US: Klein S, 2011. The Veterans Health Administration: Implementing Patient-Centered Medical Homes in the Nation's Largest Integrated Delivery System. The Commonwealth Fund. AND Curry N and C Ham, 2010. Clinical and service Integration: The route to improved outcomes. London: King's Fund.
296 National Voices, 2011. Integrated care: what do patients, service users and carers want? Available at: http://www.nationalvoices.

What would whole person care mean for you?



One Person, One Team, One System

Provision of care

Getting the right people working in the right way

Making the money work

Information solutions

Prevention/ Staying as independent as you can

Primary drivers

- Systematic risk profiling of population
- Integrated care teams including social care, community services, allied health professionals and general practice
- Maximising number of patients who can self manage through systematic transfer of knowledge, and care planning

Risk of admission register

Reports: All patients at risk | Registered: Registered

Practice: --SELECT ONE-- | Status: -SELECT- | Source: --SELECT--

NHS number | Risk More than | Risk Less than

Practice	NHSNumber	Name	Activity	Status	Risk	Change	Caseloads eol/copd hf/comm	Comment	Last updated	
C84087			25 95 ✓	No further action	**95.87** 98.35 98.35	↓	✗✗ ✗✗	deducted from practice as patient has moved 05.11.2012	08/11/2012 13:16:58	
C84087			12 16 ✗	Action taken	**93.67** 95.44 95.44	↓	✗✗ ✗✗	under care of Community Matron, records reviewed today by Dr Bolsher, to consider reducing Bisoprolol to 2.5mgs bd post myocardial perfusion scan	08/11/2012 13:36:20	
C84087			7 10 ✓	Not reviewed	**92.78** 97.09 97.09	↓	✗✗ ✗✗			
C84087			5 5 ✗	Not reviewed	**91.76** 62.2 91.76	↑ ↑	✗✗ ✗✗			
C84656			7 10 ✓	Action taken	**86.79** 90.21 90.2	↓	✗✗ ✗✗	Referred to CM team	22/11/2012 13:50:48	
C84087			9 5 ✓	Not reviewed	**84.1** 64.46 84.1	↑ ↑	✗✗ ✗✗			

Last

Right people, right way

- Undergraduate curricula
- Postgraduate training
- Teamworking the norm
- Increase patient knowledge as core purpose

One Person, One Team, One System

Provision of care

Getting the right people working in the right way

Making the money work

Information solutions

Prevention/ Staying as independent as you can

How are we doing?

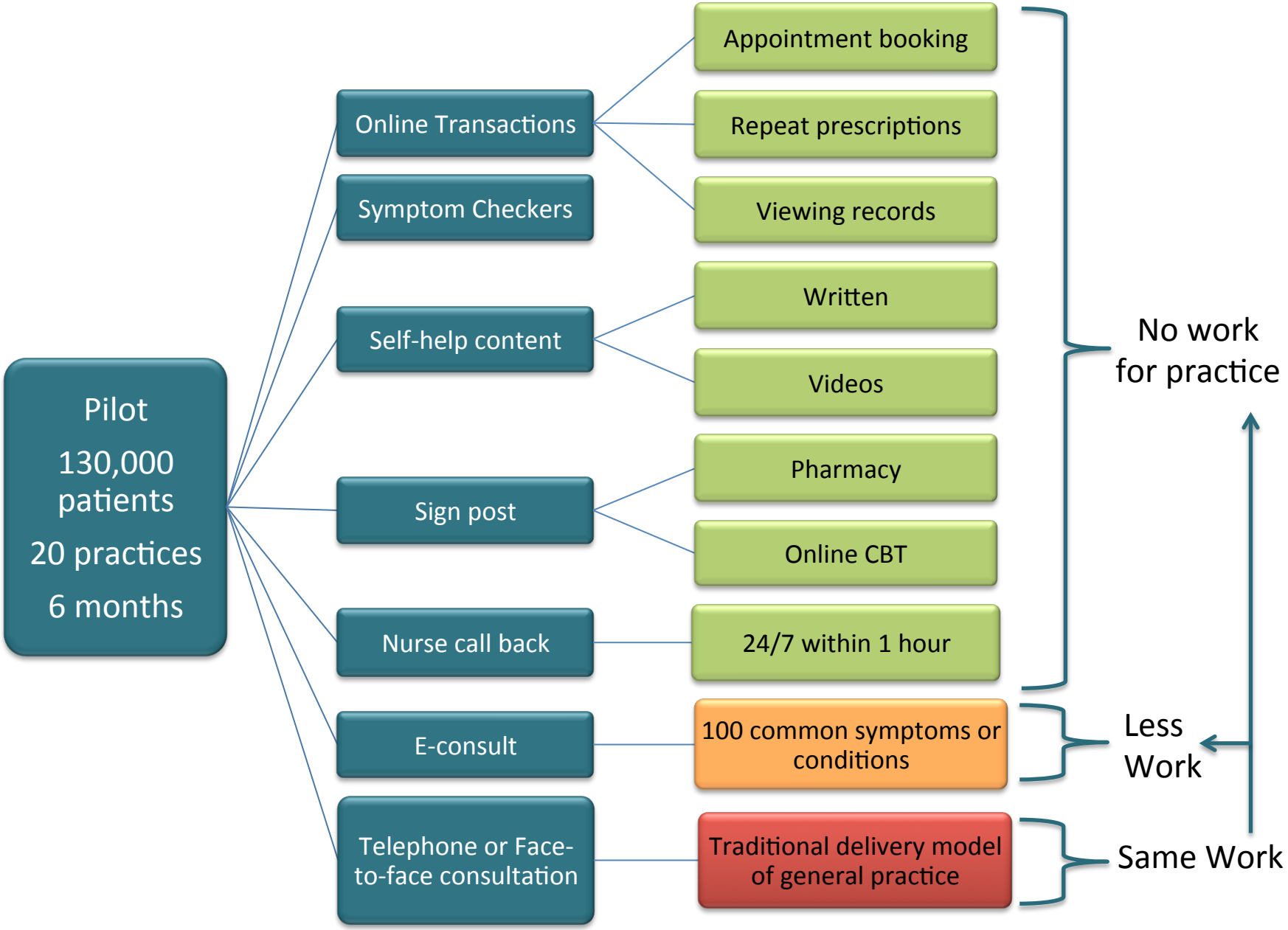
Airedale

Initially focussed on care homes but has expanded

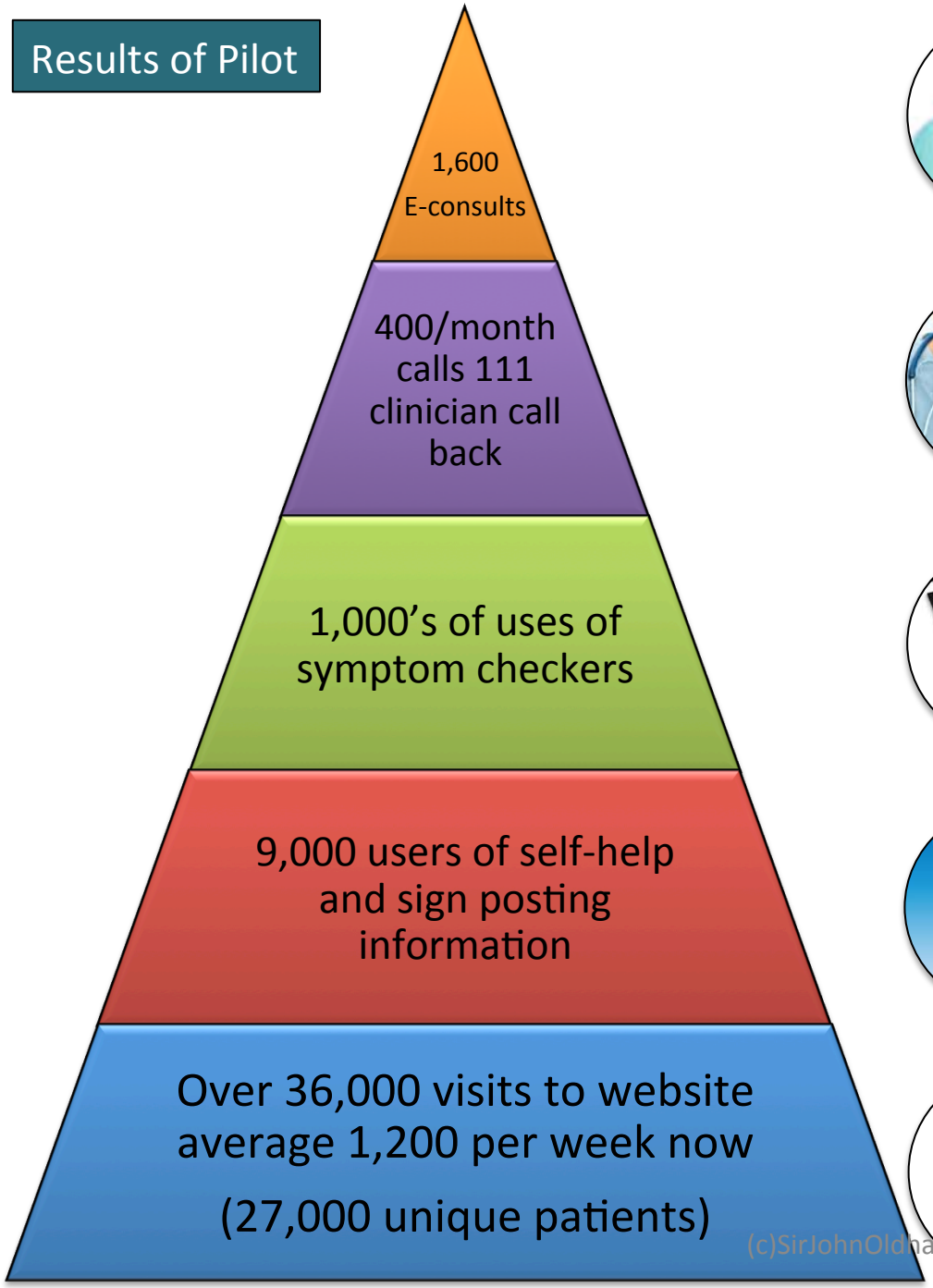
- Telemonitoring; allows people to be monitored remotely
- Telecoaching; uses 1:1 audio/visual technology for coaching, access to health education materials
- Telemedicine; remote specialist consultations in patients own home, care homes or with other professionals

RCT evaluation Airedale

- 37% reduction in emergency admissions
- 45% reduction in A&E attendances



Results of Pilot



60% E-Consults
closed remotely

80% Nurse calls
closed remotely

Ensures right
service first time

18% of users planned
to book an appointment
and then didn't

Popular with Patients

When asked in polls…….

- 85% of clinicians believe they share decisions about treatment with patients

- 50% of patients believe this is the case

Blakeman T BJGP 2004

PatientsLikeMe : Patients ...

http://www.patientslikeme.com/

Notepad | Quick Edit | Post to Scuttle | Magnolia | Simpy | del.icio.us | [Blink] | More | National Examiner | Yahoo! | Other bookmarks

patientslikeme™ Patients helping patients live better every day.

Patients | Treatments | Symptoms | Research

Search this site | Search | Help | Crisis

Share Your Experience »

See how easy it is...

Find Patients Like You »

Try it out...

Learn From Others »

Discover the power of many...

Join Now (It's free!)

Already a member? **Log in**

Click on member photos for more details

Our Current Communities

Neurological Conditions

MS (Multiple Sclerosis)

Parkinson's Disease

Mood Conditions

Depression

Anxiety

Highlights

Lithium & ALS Study

See how ALS patients taking lithium are doing in real-time. **Learn more...**

Responses to disruptive innovation

“The people wont use them”

Trains

“They won’t replace our products”

IBM about Personal Computers and Microsoft

“They won’t replace our products”

Microsoft about I pads

“???”

Responses to co-management

- Patients can't do this
- It will never happen where I work
- Thats my job as doctor –its what they pay me for.
- No evidence about co-management making a difference
- Quality will fall

Self management of warfarin and INR.

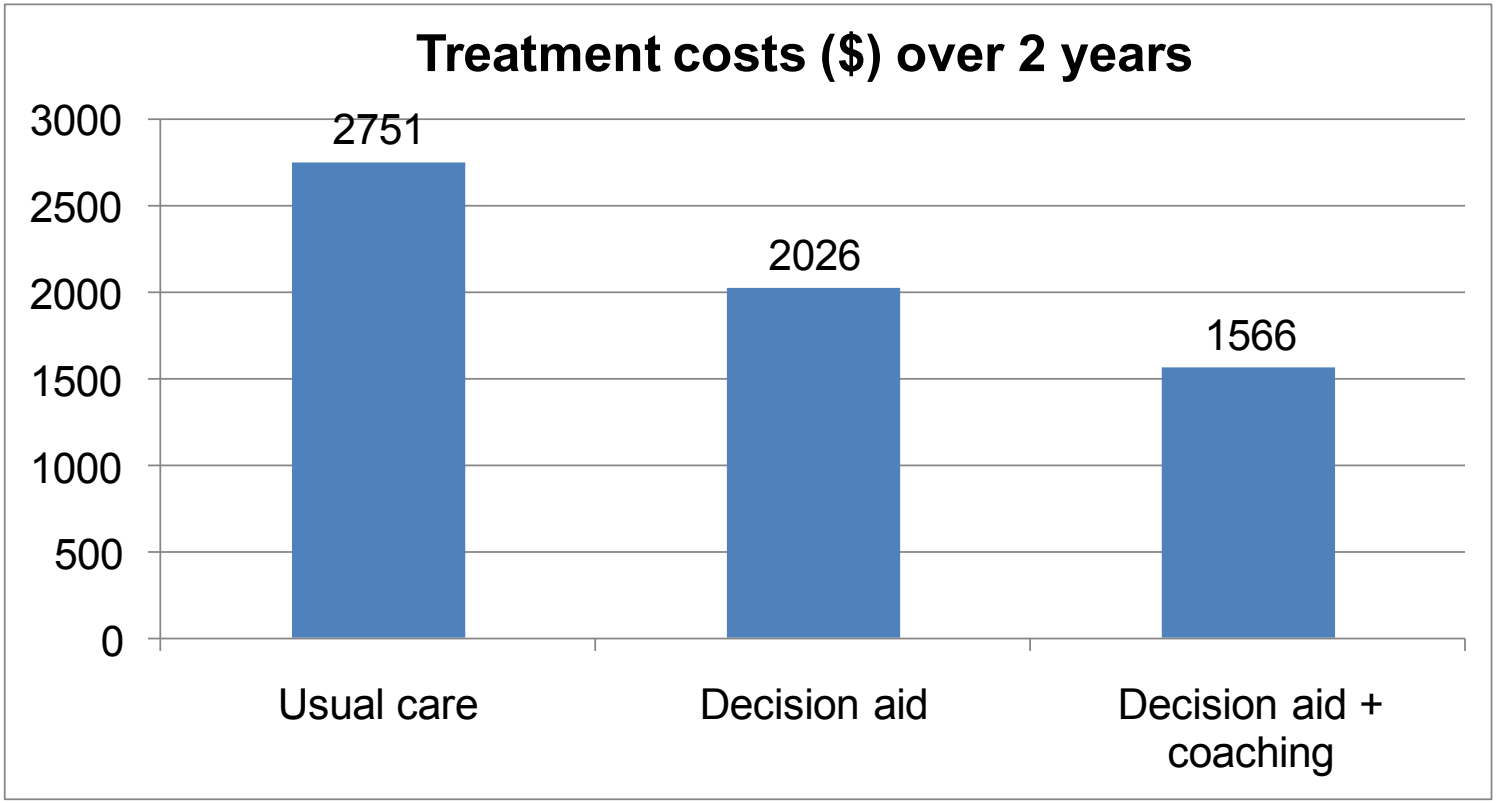
Cochrane review Heneghan et al April 2010

1. Clinician management of warfarin and INR
2. Self monitoring of INR and clinician advice re: warfarin dose
3. Self management of INR and warfarin

Compared to groups 1 and 2, group 3 have

- **same risk of bleeding**
- **50% fewer thrombotic episodes**
- **36% lower mortality**

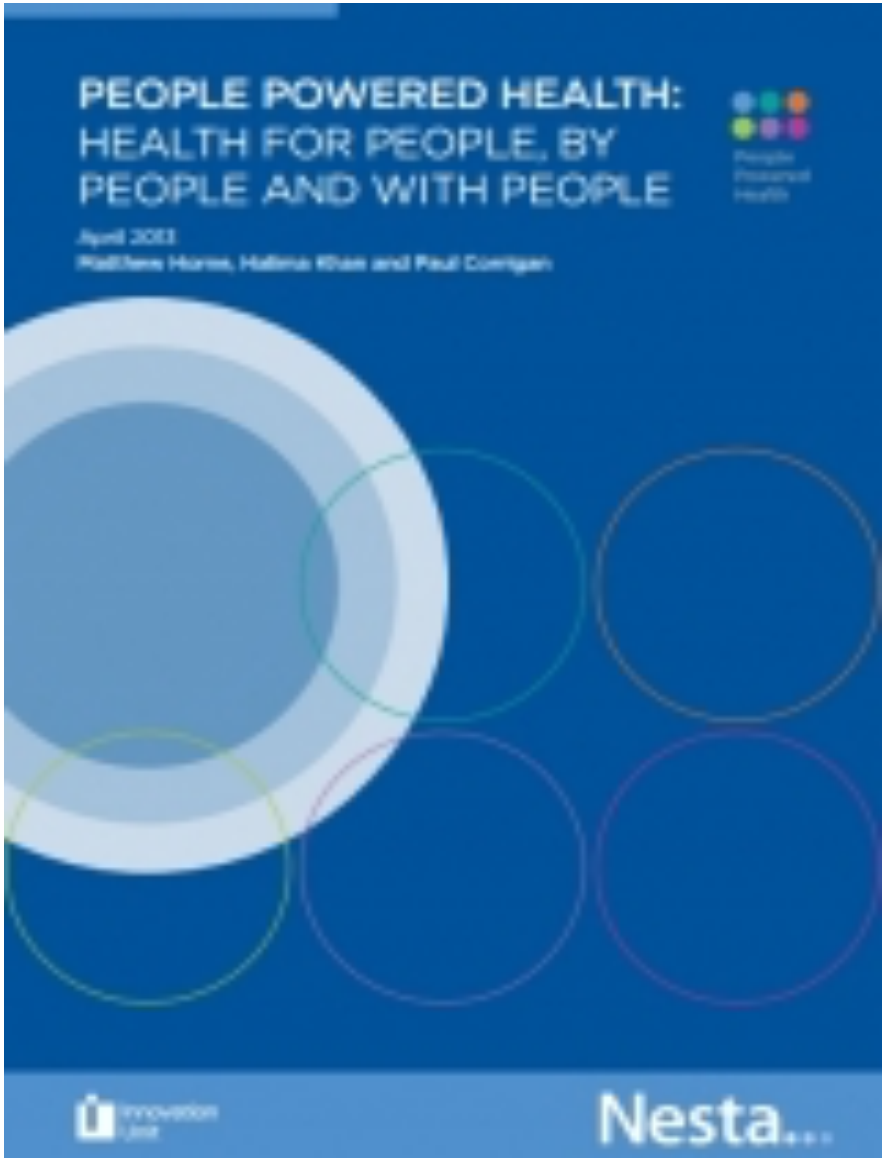
Decision aid and coaching in gynaecology



RightCare

Data from reablement

- Tordis had 9,3 hours a week of community nurse before reablement started
- Intensive reablementprogram was initiated
- She ended up with 0,5 hours a week from community nurse



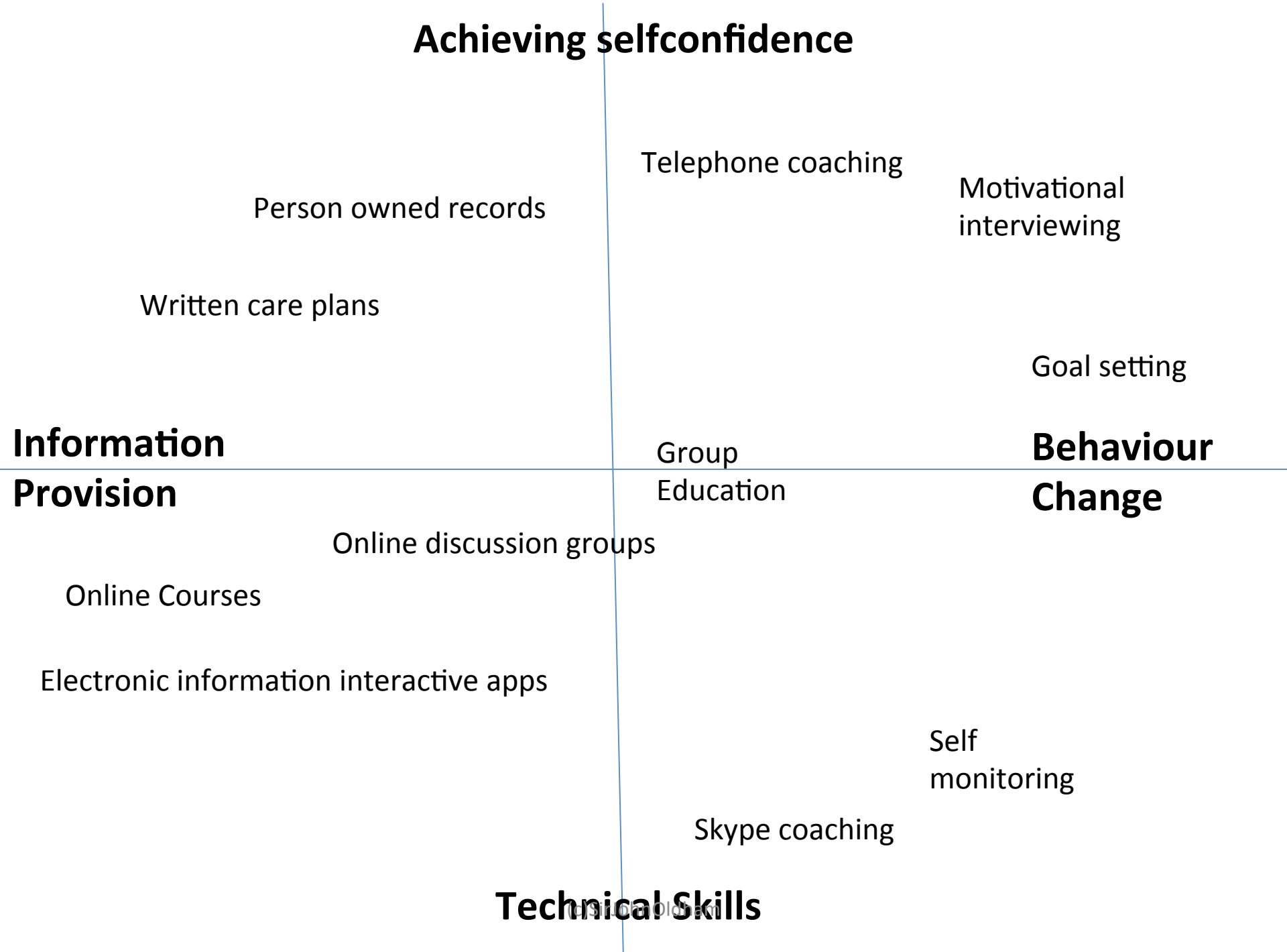
Business case for People Powered Health (Nesta 2013)

- Reduction in cost of managing people with long term conditions by up to 20%
- 7% reduction in ED attendances
- 7% reduction in emergency admissions
- 60% primary care interventions can be dealt with remotely

Key things for co- management

(Ref: www.health.org.uk)

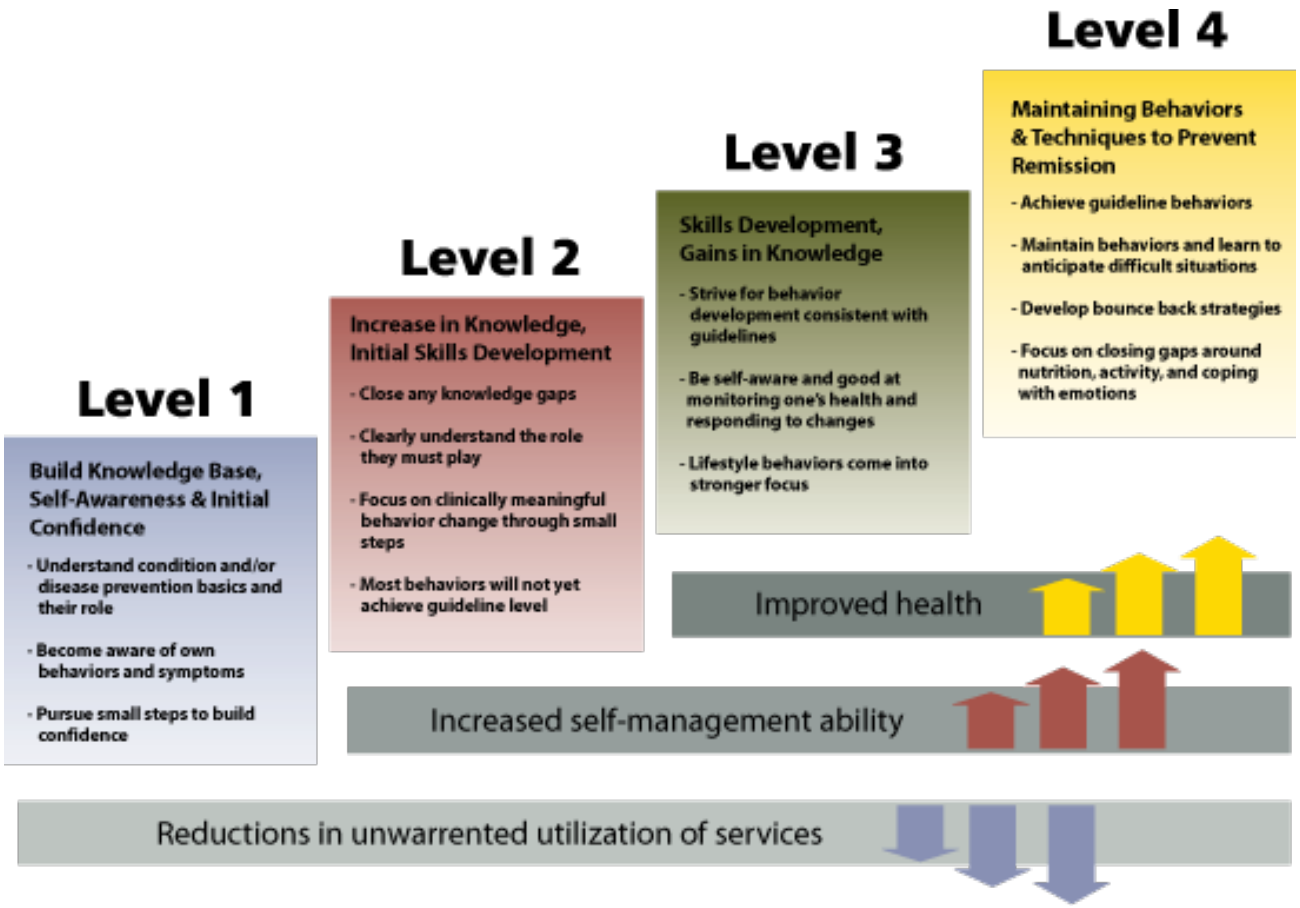
- **Getting good information**
- **Achieving self confidence**
- **Altering behaviour**
- **Technical skills**


Achieving selfconfidence
Telephone coaching
Motivational interviewing
Person owned records
Written care plans
Goal setting
Information Provision
Group Education
Behaviour Change
Online discussion groups
Online Courses
Electronic information interactive apps
Self monitoring
Skype coaching
Technical Skills

Levels of activation

(Ref:Health Foundation)

ACTIVATION PREDICTS OUTCOMES



What matters to you?

4th of June 2014

House of Care

(variation on the original by Dr Sue Roberts)

So...

- Recognise the biggest issue is multiple morbidity and frailty needing whole person care – pool don't silo specialist knowledge
- Embrace the digital revolution to *transform* how we deliver healthcare – before it is done to you
- Involve patients meaningfully as part of the care team – the most underused capacity in the health care system

One Person

supported by people acting as

One Team

from organisations behaving as

One System