Integrating care for people with long-term conditions

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Department of Health (2001) *Diabetes National Service Framework (NSF) Diabetes: Standards* DH, London

Department of Health (2005) *Supporting People with Long Term Conditions: An NHS and Social Care Model to Support Local Innovation and Integration.* DH, London

Department of Health (2006a) *Our Health, Our Care, Our Say: A New Direction for Community Services.* DH, London

Department of Health (2006b) *Caring for People with Long Term Conditions: An Education Framework for Community Matrons and Case Managers.* DH, London

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A total of 17.5 million people report living with a long-term condition (LTC) in this country, many of them with diabetes as well as at least one other LTC such as asthma or chronic obstructive pulmonary disease (Department of Health [DH], 2005). LTCs are expensive: 5% of inpatients, many with an LTC, account for 42% of acute bed days. People with an LTC are typically prescribed a large number of medications, but only about 50% of medicines are taken as prescribed (DH, 2005).

Managing diabetes by itself can be a complex affair, with self-monitoring, clinic visits, and the polypharmacy required for the various aspects of diabetes – dealing with the side-effects, interactions and mode of delivery of the medications. However, many people live with other LTCs as well as diabetes. Their diabetes management is complicated by the different symptoms, disability, and multiple medications needed for these other conditions. Interactions with a variety of different healthcare professionals will be required, usually at different locations and on different days. People with such complex needs often need considerable integrated support.

The National Service Framework for diabetes (DH, 2001) states that "all people with diabetes requiring multi-agency support will receive integrated health and social care".

Chapter 5 in the White Paper, *Our Health, Our Care, Our Say: A New Direction for Community Services* (DH, 2006a), recommends that services support people to take greater control over their own lives and should allow everyone to enjoy a good quality of life. They should be seamless, proactive and tailored to individual needs. There needs to be a greater focus on prevention and the early use of low-level support services. People need to be treated sooner, nearer to home and before their condition causes more serious problems. The document recognises that there is a need to move from fragmented to integrated service provision, from "an episodic focus to one of continuous relationships – relationships that are flexible enough to respond to changing needs". The needs of people with LTCs may fluctuate markedly and health and social care must be able to respond accordingly.

Community matrons support vulnerable people living with several LTCs and meet the recommendations of "Our Health, Our Care, Our Say". They can offer a personalised care plan, signpost people to available appropriate services, act as advocate in negotiating the complicated health system, liaise between various healthcare professionals and services, and will have a holistic perspective to their management.

Many people have social problems that impact on their health and vice versa (for example, LTCs can make it difficult to keep a job, leading to financial problems, which can lead to depression) and so experience in negotiating social care may be as important as clinical care when supporting these people. Community matrons are skilled and experienced nurses, with good links to social services as part of their competencies (DH, 2006b).

As independent prescribers, community matrons can manage medications for a variety of conditions, allowing early intervention (for example, use of antibiotics and steroids in asthma) and predicting effects on other conditions (for example, hyperglycaemia in diabetes in response to steroid treatment), enabling proactive adjustment of other treatment to prevent crises. Their caseload should allow them to maintain long-term relationships with people with LTCs, but with the flexibility to vary contact time depending on the individual's current health and needs.

People with diabetes and other LTCs usually have many health problems and complex needs. The conditions and medications required by them can interact and cause other complications. A holistic approach, working with all health and social professionals involved in their care, as well as the patient and their family, can improve quality of life and reduce medical emergencies and hospital admissions. The role of the community matron is invaluable to the vulnerable person with complex needs. ■