

Unique care - integrated care for people with complex needs

The Unique Care approach is aimed at helping patients with complex long-term conditions within a primary care setting. It involves setting up a coordinated approach between health, social care and other services, and is particularly aimed at patients over 65. A personal care plan is agreed in advance of any crisis so the patient is able to remain at home, and not be admitted to hospital. The key benefits are:

Better quality of life and improved health outcomes for patients
Greater choice and control for individuals over how their needs should be met
Reduction in emergency admissions and emergency bed days in hospital
More appropriate use of resources and a reduction in duplication of services across the system as care is better organised.

It is based upon the socio-medical model of case management developed at the Castlefields Health Centre in Runcorn and was developed through working with PCTs, acute trusts, practices and local authorities. It is a system of coordinating health and social care to respond to referrals more efficiently and more effectively, to involve community staff in developing discharge plans for inpatients and to identify high risk individuals for preventative interventions. The model brings together primary and community services, secondary care, social services, housing, the voluntary sector, allied health professionals and others. With the focus on patient-centred care, intermediate care and the promotion of healthy living and self-care, the model is adaptable and transferable to many different client groups. The national policy and guidance on helping patients with long-term conditions is set out in the long-term conditions section of the [Department of Health's website](#).

Integrated Care Pilots: Unique Care Approach In 2008 the Department of Health published a prospectus inviting applications from prospective integrated care pilot sites. The Improvement Foundation will be helping a number of pilot sites in developing their approach based on our experience with the Unique Care model. [Click here](#) to read more. If you are interested in working with the Improvement Foundation please go to [How we can help](#) or [click here to contact us](#). Who is involved The Unique Care the approach is now up and running in 181 general practices across England, covering an estimated population of 1.1 million people. The sites are all at different stages of implementation. Sites range from a whole PCT and local authority working together, to GP consortia with their local social services team, through to single practices working with one social worker. What we are doing Key principles The approach is underpinned by five key principles, however it is not a one-size fits all universal solution to anticipatory care and how the principles are addressed is down to local circumstances. The five key principles of Unique Care are:

Ensure local health and social services work side-by-side to effectively coordinate care
Establish excellent communications between GPs, community nurses and social workers
Establish proactive, practice-based systems to identify people at risk of falling into crisis
Establish 'in-reach' systems in hospitals to ensure patients return home as soon as they possibly can
Constantly adapt and respond to the individual needs of patients and support people to live at home.

These principles differentiate it from other case management approaches and, in order to establish effective implementation, all five key principles need to be addressed. Other important elements of the approach include:

Social care requirements are central to the process
Patients can discharge their team once they are confident in managing their own care
Patients come out of hospital quickly and easily through close working with the hospital discharge team from the point of admission
Patients are able to take responsibility for their own health and social care, with support as and when required.

Support The Improvement Foundation offers a tailored support framework to Unique Care teams, which usually involve senior managers, frontline staff and service users, to help them to develop local solutions to local problems. Local activities include:

Workshops
Conflict resolution
Site visits and problem-solving
Facilitation of joint meetings
On-line and telephone support
Creating networks and sharing good practice
Advice on health and social care policy and the key levers for change
Delivering quality improvement skills training
Mentoring
Involving elected members and non-executives
Developing a shared strategy
Creating opportunities

for more face-to-face contacts between organisations Bringing together the statutory and third sectors to identify local solutions.

Key results CHANGE PRINCIPLES MEASURES RESULTS POPULATION COVERAGE PARTICIPANTS Create a Unique Care team between health and social services Create and maintain a practice based register of patients with complex needs Case find patients at risk of admission Establish hospital in-reach Create a bespoke plan with each patient Number of people per practice identified as requiring proactive case management / care co-ordination (cumulative measure) Number of people receiving case management / care co-ordination, including the inactive cohort who have discharged themselves (cumulative measure) Number of acute medical admissions and bed occupancy for the over 65 population within the last 12 months per practice (rolling 12 month figure) Outcomes include a reduction of 13 - 25% in total admissions for the over 65 population, not just a small cohort of case managed individuals In addition bed days in entire over 65 practice populations have been reduced by 20 - 40% In one practice: 53% reduction in emergency admissions (12% in comparator practice) and 70% bed days reduction (10% in comparator practice) Increases in user and carer satisfaction and quality of life Reductions in GP attendance, GP home visits and A&E attendance More efficient use of social care 2,560,160 35 Unique Care sites Majority of sites are PCT led, others are Local Authority led, GP practice led and GP consortia led Mix of staff involved in the improvement work ranges from senior executives (health and social care) to frontline staff and service users