Keeping Healthy will help you improve services and increase efficiency.

Whatever you are doing for people with Long Term Conditions we can assist you to:

- Review your current Long Term Conditions systems
- Restructure all elements of the clinical workforce to focus more pro-actively on this client group
- Set up clinics
- Work with Commissioners and hospitals to right-size your bed base
- Regularly review progress
- Support hospitals to restructure their current Out-Patient and Specialist Nurse services
- Use apps to support people to stay well

Improving Services Reducing Costs

Keeping Healthy has been developed by a former Director of Nursing, Luke O'Byrne, with input from expert clinicians & commissioner to assist people to manage their Long Term

Conditions more effectively, improve their quality of life and reduce admissions.

The approach is client focused, evidence based and relies on safe practice and effective systems including clear information sharing policies.

Keeping Healthy is part of Dynamic Delivery. We work with Health and Social Care systems to address large scale challenges and reduce costs.

Areas of expertise include:
Care outside hospital
Workforce development
Business planning

We deliver sustainable change rapidly and effectively.

To find out more please contact:
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KEEPING HEALTHY

Improving Services - Reducing Costs

Improving Services - Reducing Costs

Evidence shows that by managing Long Term Conditions (LTCs) more systematically and proactively the need for unplanned admissions reduces significantly

Keeping Healthy is a straightforward system to achieve **significant reductions in urgent hospital admissions**.

At any one time **40% of medical beds** are occupied by people with four long term conditions: **Asthma, Diabetes, Heart Disease and Lung Disease**.

Using the Keeping Healthy system people at significant risk are given a **simple Green Amber Red care plan** and an improvement plan to help them stay healthy by managing their symptoms more effectively. The plans are reviewed every three months and will **significantly reduce the likelihood** of them being admitted to hospital.

This will improve **quality of life** for participants and ensure the **effective and efficient use of resources**.

Economic Evidence

National and international research demonstrates that there is clear evidence that interventions in the community can reduce unplanned admission rates and length of stay, leading to improved care for LTCs including COPD and Heart Failure.

Lord Darzi suggests that people should receive regular and proactive support from GPs and specialist Nurses to reduce unplanned admissions.

A recent kings fund report shows that only 4 - 8% of people with Long Term Conditions report having a care plan and that only 3% of newly diagnosed diabetic patients attended a structured education course.

The Keeping Healthy Clinic Model

Patients will attend a clinic 4 times a year. At the clinic each person will:

Receive a Green/Amber/Red care plan that is regularly reviewed and updated

Have their condition monitored and if necessary their care plan adjusted

Have a medication review

Develop a healthy living plan that is agreed and evaluated

Attend a health education session

To find out more about how you can improve services for people with Long Term Conditions please contact Luke O'Byrne on 07880 588326 or luke.obyrne@dynamicdelivery.co.uk

Identifying Patients

Many areas will have systems in place for identifying patients who are vulnerable to admission to hospital.

Many patients who are being discharged from hospital are at risk of readmission or would benefit from a structured programme.

GP practices have QOF Registers which can be also used to identify relevant patients.

Information Sharing

At each appointment an updated copy of the 'Keeping Health' care plan will be given to the patient.

A copy of the updated care plan will be shared with the GP with a noth asking for it to be shared with other members of the team.

If the patient is receiving active secondary care treatment a copy of the care plan will be share with the revevant clinician.