A primary care led NHS ?

Pieter Degeling

Conceptions of policy

- Policy as intention
- Policy as the committed structure of important resources i.e. policy as structured practice

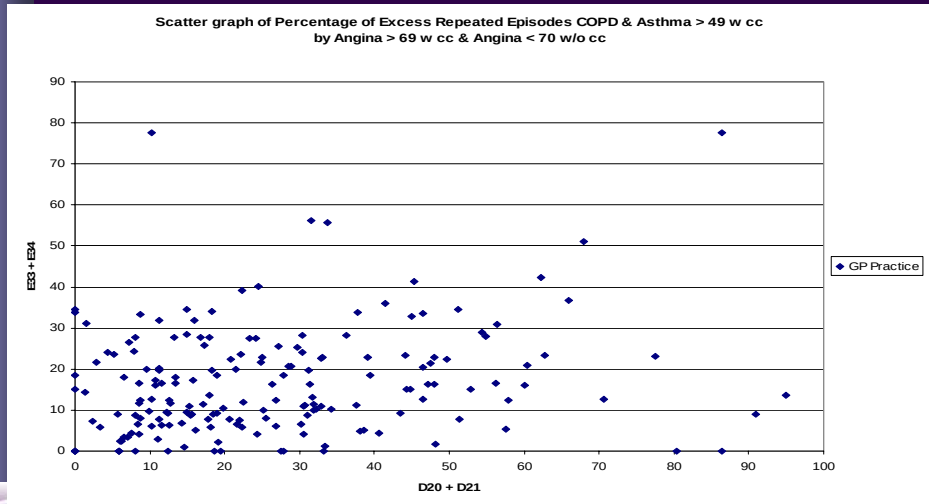
Some indications of structured practice in primary care

High Volume Emergency Admissions – Repeated Adm

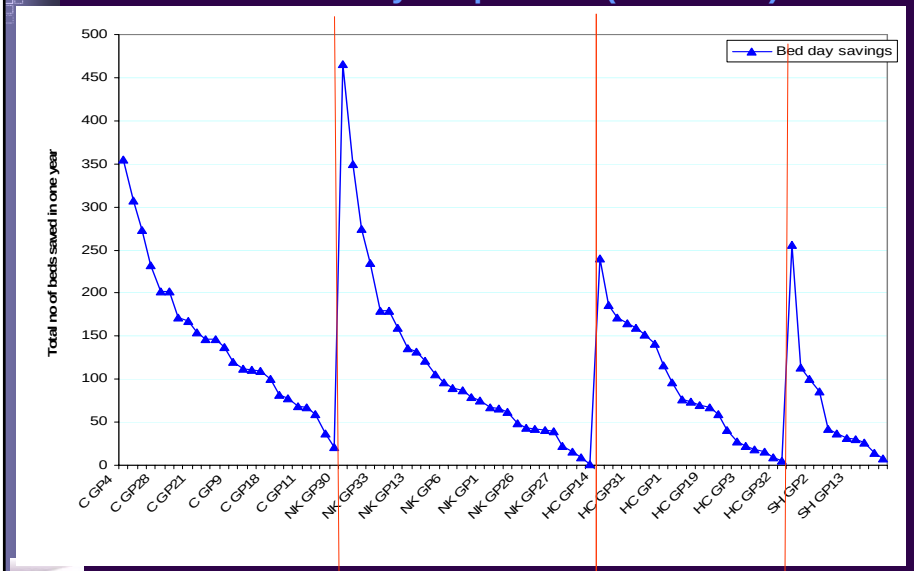
HRG	HRG label	% Adm	% B Days
D20	Chron Obstruct Pulmonary Dis/Bronch	37.22	39.16
S16	Poison Toxic Effects /Overdoses	18.25	17.62
P06	Minor Infections (incl Immune Disord)	5.41	7.73
E36	Chest Pain <70 w/o cc	7.47	7.81
D21	Asthma >49 or w cc	1.44	1.41
F47	Gen Abdom Disord <70 w/o cc	4.84	7.85
E33	Angina >69 or w cc	18.11	18.73
H42	Sprains Strains /Minr Open Wounds <70 w/o cc	1.43	1.11
L09	Kidney/Urin Tract Infections >69 or wcc	3.77	2.92
D99	Comp Eld w a Respiratory Sys PDx	6.54	5.81
E18	Heart Fail/Shock >69 or wcc	6.67	5.38
E29	Arrhythmia/Conduction Disord >69 or wcc	4.68	3.37
P13	Other Gastro/Metabol Disord	9.16	15.09
E31	Syncope/Collapse >69 or wcc	2.87	3.31
F46	Gen Abdom Disord >69 or wcc	5.78	4.44
E12	Acute Myocardial Infarction w/o cc	0.66	0.37
P03	Upper Respiratory Tract Disord	5.73	9.07
E35	Chest Pain >69 or w cc	7.26	6.99
P15	Accidental Injury	1.68	1.38
P04	Lower Respiratory Tract Disord	11.37	21.33
E34	Angina <70 w/o cc	13.65	17.11
F17	Stom/Duod Disord >69 or wcc	2.22	2.17
A22	Non-Transient Stroke/CVA >69 or wcc	0.10	0.12
D13	Lobar Atyp/Viral Pneumon >69 or wcc	2.13	2.33

Variation in Chronic Disease Management between GP Practices

Percentages of hospital patient admissions for COPD & Angina by GP practice



Total number of respiratory bed days that could have been saved by GP practice (2003-2004)



Calderdale PCT | North Kirklees PCT | Huddersfield Central PCT | South Huddersfield PCT

Readmissions to any HRG

		% of emergency admissions that have higher than expected readmission rate	Potential bed day savings for all emergency admissions	Bed-day savings per day	Savings as a percentage of total trusts' beds per day
SHA 1	Trust A - C&H	20%	49,956	137	12%*
	Trust B	25%	134,789	369	12%
SHA 2	Trust1	17%	34,957	95	11%
	Trust2	19%	27,560	75	10%
	Trust3	20%	18,787	51	11%
	Trust4	21%	45,972	125	10%
	Trust5	23%	67,807	185	14%

*based on C&H having 1,127 beds

High volume case types- DGH (4)

- Emergency admissions account for 53% of all care episodes and 82.9% of all bed days consumed within the Trusts
- 30 HRGs (out of 547) account for 46% of all emergency episodes and these HRGs account for 39% of all emergency generated bed days within the Trusts.
- 18 of these 30 HRGs reference conditions (usually chronic) with a high risk of repeated emergency admission. These patients tend to account for 32.8% of all emergency patient episodes and 17.6% of all bed days.

Some indications of what may be causing the indifferent impact of reform in primary care

Study Sample

Acute (4)	N
MC	103
MM	24
GM	63
NM	69
NC	81
AHM	51
AHC	63
Achieved	454

PCT (10)	N
Lead	32
GM	87
NM	39
NC	111
GP	138
PN	65
PM	61
Achieved	533

Focus of survey

Views on :

- Health care issues
- Strategies for addressing hospital resource issues
- Autonomy and accountability
- Clinical governance
- Clinical and resource interconnections
- Causes of clinical practice variation
- Basis for setting clinical standards

Focus of survey cont…

Views on:

- Management models appropriate for improving the overall performance of clinical units
- The management style of trusts
- Trusts' organisational goals
- Staff affiliation with their trust

Culture Change: 'From What to What?'

- Recognise interconnections between the clinical and financial dimensions of care
- Accept the need to balance autonomy with transparent accountability
- Recognise need to systematise clinical work
- Accept the power sharing implications of the team based nature of clinical work

Summary of Professional Cultures

Acute	MC	MM	GM	NM	NC	AHM	AHC
Recognise interconnections	-	+	+	+	+/-	+	-
Balance accountability and accountability	-	+/-	+	+	+/-	+	-
Systematisation of clinical work	-	-	+/-	+/-	+/-	+/-	-
Multidisciplinary teams	-	-	+/-	+	+	+	-

PCT	Lead	GM	NM	NC	GP	PN	PM
Recognise interconnections	+/-	+	+	+/-	-	+/-	-
Balance accountability and accountability	+/-	+	+	+	-	-	+/-
Systematisation of clinical work	+/-	+	+	+	-	+/-	+/-
Multidisciplinary teams	+/-	+/-	+	+	-	-	+/-

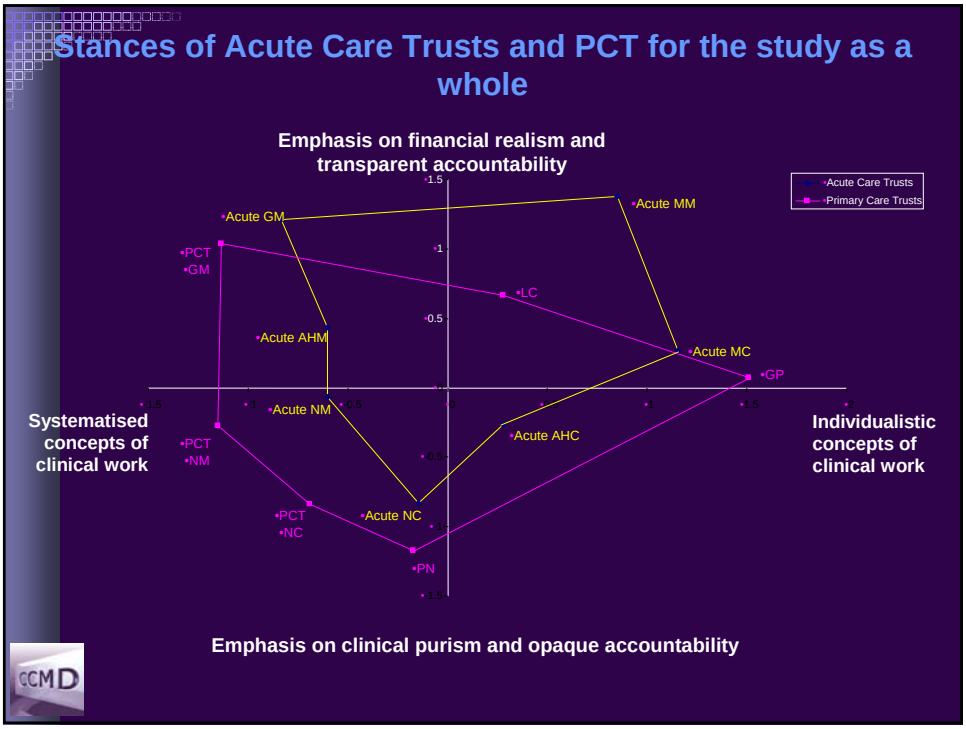
Study Findings

- Differences between respondents best explained by their occupational background
- These differences occur on six dimensions, two of which explain 84% of the variances between all respondents across the Acute Trust, PCT and General Practice

The two dimensions were

- Individualistic vs systematised concepts of clinical work performance (50%)
- financial realism and transparent accountability vs clinical purism and opaque accountability (34%)

Stances of Acute Care Trusts and PCT for the study as a whole



Ranking of Organisational Goals across the Health Economy

	Acute Care Trusts	PCTs	General Practice
1	Financial viability	Financial viability	Quality
2	Quality	Equal access	Equal access
3	Organisational stability	Organisational stability	Organisational stability
4	Productivity	Quality	Staff welfare
5	Equal access	Staff welfare	Financial viability
6	Service innovation	Service innovation	Productivity
7	Staff welfare	Productivity	Service innovation
8	Teaching and research	Teaching and research	Teaching and research

Evidence from acute hospitals suggests that we can change culture by changing practice

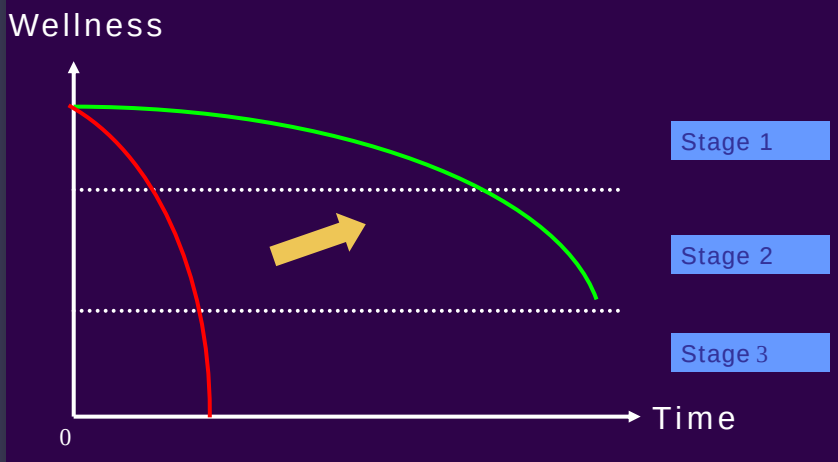
- **Requires new**
  - **Methods - year of care**
  - **Structures - product focussed model of clinical governance**

Further thoughts on the application of a 'year of care' concept to long-term conditions

Why focus on chronic conditions

- They represent a significant proportion of clinical work in both acute and primary care
- The evidence suggests:
  - That one half of the top 40 HRGs (that explain about 50% of A&E generated bed days) reference chronic conditions with a high rate of re-admission
  - considerable variation in the way that these are managed in primary care to the detriment of:
    - clinical effectiveness and
    - efficient resource usage

Characteristics of Long-term Conditions



Issues

- Can we affect the rate of disease progression? Yes
- Who is best placed to do this? Primary care working in conjunction with acute care and social care
- What do we require to bring it off? 'Year of care pathway'

Requires …

Year of care pathways that, for each stage of disease progression (stage 1,2, 3 …),

- describe the cycles (weekly/monthly) of 'care activities'
- that will be undertaken by 'patients' and service providers
- in the period of a year

Year of Care Pathways for LTC

- A comprehensive systematically developed written statement
- that for each stage of disease progression,
- specifies the cycles of events in self care, primary, and community settings
- whose occurrence or non occurrence will significantly affect, quality, outcomes and cost.

Defining features of a year of care pathway

- Emphasis on supporting patients to self-manage their care
- Specified time based cycles within a year
- Events and activities within each cycle tailored to the stage of disease progression and stated resource constraints

Components of a 'Year of Care'

- Clinical management
  - Diagnostic/Monitoring
  - Drugs
  - Therapy
- Self-management
  - Emphasis on empowerment (not a patient but a person with a long term condition) who is a:
    - co-producer and
    - choice maker
- Support Component

Co-production …

Co-producing people with long term conditions are people who take responsibility for managing their condition with respect to:

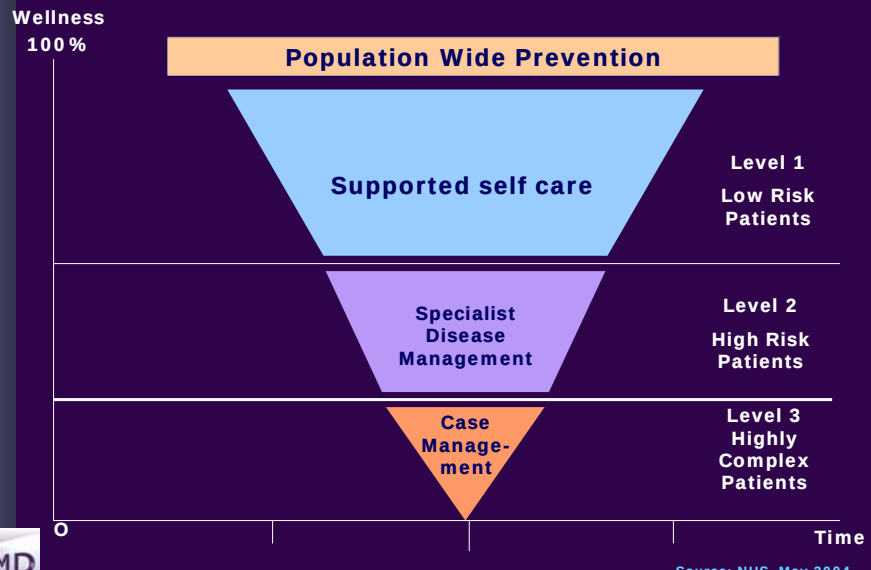
- Knowledge of their disease
- Self monitoring
- Therapeutic interventions
- Diet
- Exercise
- Smoking

Paradoxically: this requires structured support from service providers (often working from within different settings)

Co-production and disease progression …

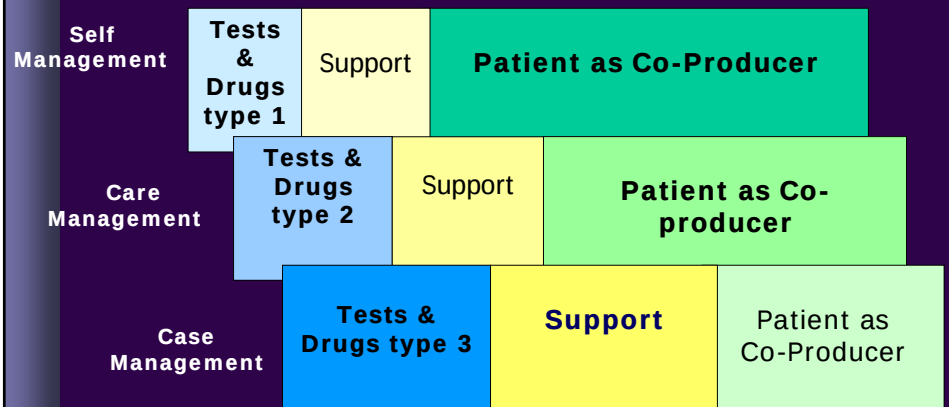
- The extent and nature of an individual's co-producing role will vary depending on the stage to which their disease has progressed
- Hence need to identify the key indicators (clinical, social, psychological) that characterise each stage of a disease progression
- These indicators can then be used to the benefit of:
  - early identification and registration of target populations
  - clarifying an individual's location on the disease trajectory
  - developing and implementing of year of care pathways that are tailored to maximise
    - clinical effectiveness (as measured by a reduced rate of disease progression),
    - quality of life
    - resource efficiency

Disease Progression & Management Sub-Groups

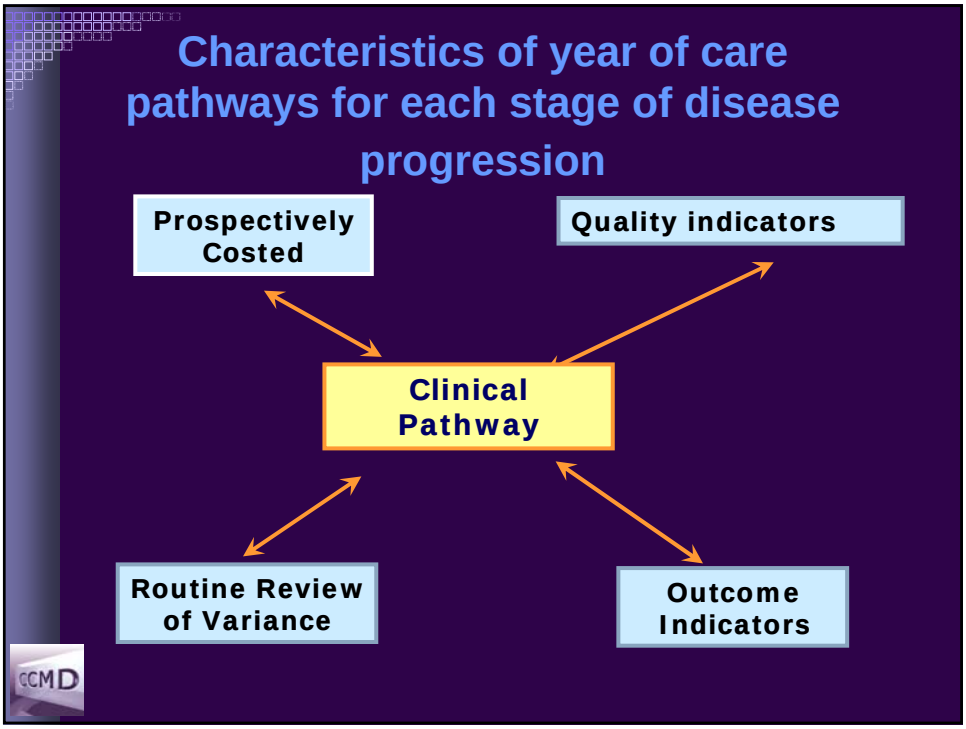


Source: NHS, May 2004

Possible 'Year of Care' Models for CHD



Characteristics of year of care pathways for each stage of disease progression



A number of important provisos

- ICPs are not immutable documents setting out inviolable treatment regimens.
- The existence of a pathway does not obviate clinicians' responsibility to make clinical judgements and to tailor care according to their assessment of the clinical needs of individual patients.
- Thus clinical variation remains a 'to be expected' (in the sense of an often required) feature of clinical practice.
- The matter at issue is what a clinical team can learn from these variations and how they can systematize this learning.
- Accordingly, when the care process varies from that described in the pathway, the reasons for the variance are recorded and become the focus of structured across-profession conversations described above.

Advantages of year of care model

The model provides a basis for:

- **stratifying individuals on specified clinical, personal and social criteria**
- **describing and hence materialising the contributions of co-producers and service providers within a nominated time frame (i.e who will do what, where and when)**
- **specifying the contract between co-producers and service providers**
- **integrating care provision between acute and primary care and**
  specifying the support services required for realising co-production
- **specifying how these services will be funded (vouchers?)**

Advantages cont:

- Prospectively costing the pathway in question
- Specifying quality and outcome indicators
- Monitoring performance with respect to the occurrence and non occurrence of specified events
- Identifying (via variance analysis) where improvements can and need to be made
- Benchmarking across health economies

Issues to be answered on implementing 'year of care'

- Development of criteria for stratifying patients on disease progression
- Specification of characteristics of each element of the 'year of care' for each stage of disease progression
- Authorisation of 'year of care' model across primary and acute care – (dis)incentives of profession, contract, regulatory, organisational mechanisms
- Identification of factors (social, psychological, cultural, organisational and funding) that may facilitate or impede realisation of co-producer and development of strategies to address these
- IT issues - social aspects, data ownership
- System issues ie how do we avoid creating new silos

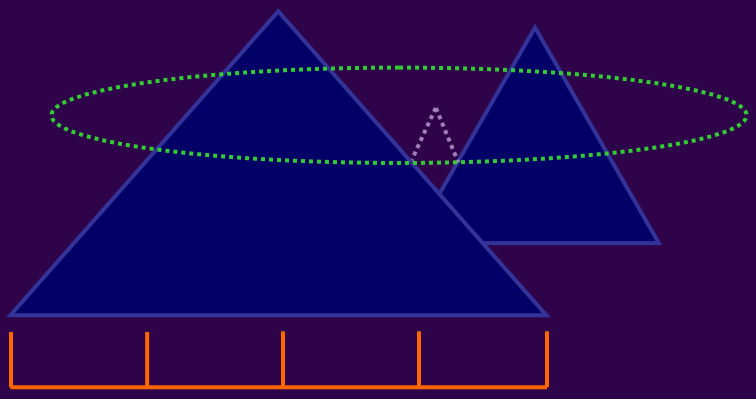
More questions to be answered on implementing 'year of care'

- What structures and processes need to be put in place across PCTs and Acute trusts to authorise use of year of care pathways and to monitor performance?
- What are the workforce development implications?
- How do we move from where we are to where we want to be?

But what about Structure?

Some lessons from acute care

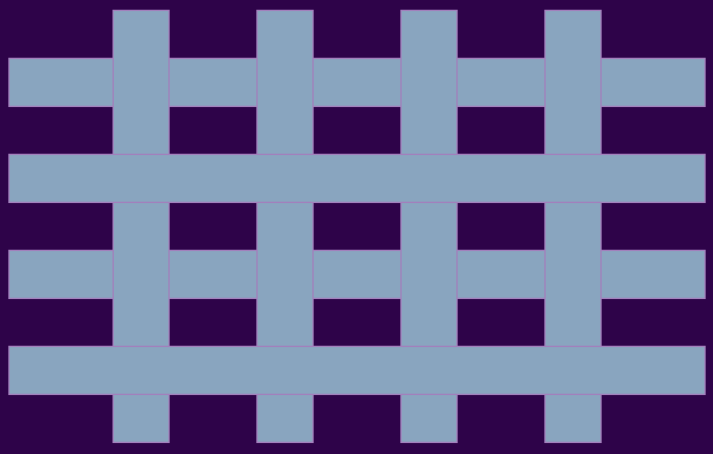
Traditional Service Delivery Model



"Clinical Product Line" Model

Intermediate Products

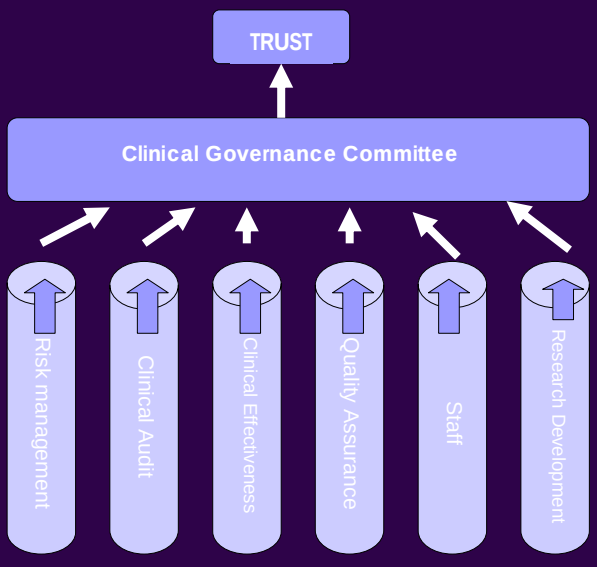
Final Products



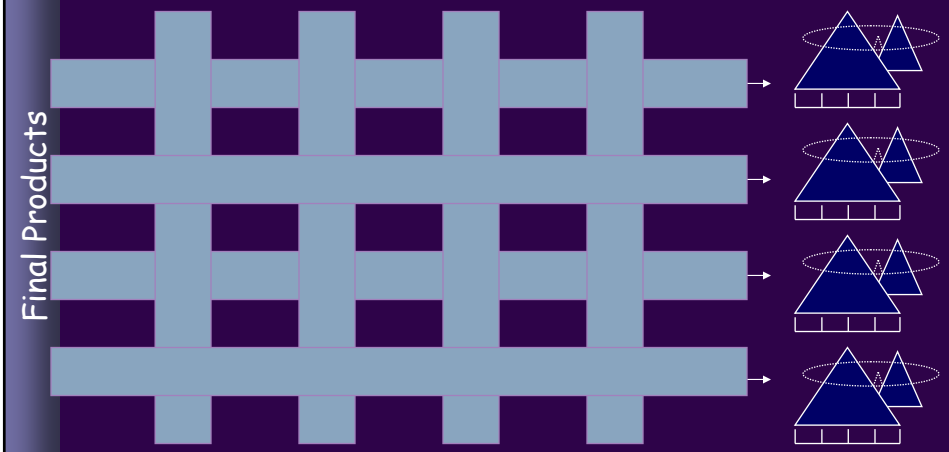
This was a start but because of the absence of a method the wrong focus

- **Still focused on issues rather than the substantive management of clinical work**
- **Issue focused management**
  - **Budgets – technical efficiency**
  - **Waiting lists**
  - **Political noise**
  - **Safety and risk reduction**
  - **Quality**

Conventional issues focussed model of clinical governance



What changes were produced?



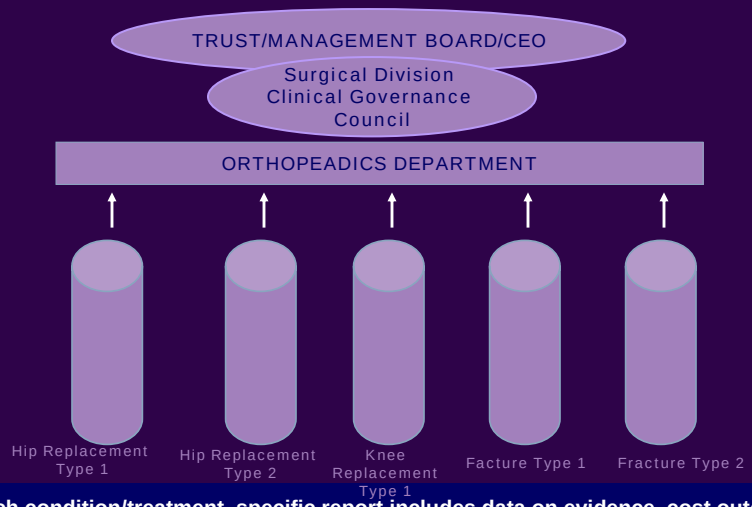
Ways Forward

An Alternative Approach

Put clinical production at the centre of clinical governance, for example within acute care settings:

- Establish a clinical governance council as the peak clinical production management body of a Division.
- Task of this body to monitor and improve condition and/or treatment specific clinical 'production' processes, i.e how we do hips or a year of care for a patient with Chronic heart disease.
- Signifies a shift in emphasis from a concern for 'issues management' and meeting performance targets to a concern for the detailed composition of clinical work for particular patient categories.

Clinical Production Focused Clinical Governance – Acute settings

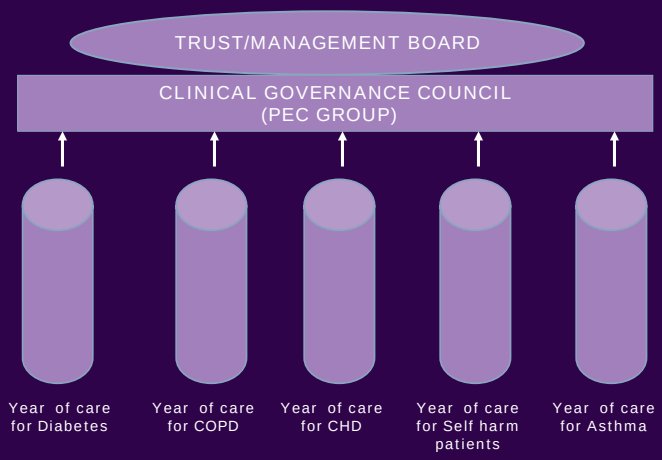


Each condition/treatment specific report includes data on evidence, cost outcomes, clinical effectiveness, quality, safety, adverse events, variance, complaints/claims

Possible primary care application

- **Create linkages between:**
  - **GP contracts**
  - **Year of care pathways**
  - **Clinical governance**

Clinical Production Focused Structure PCT settings



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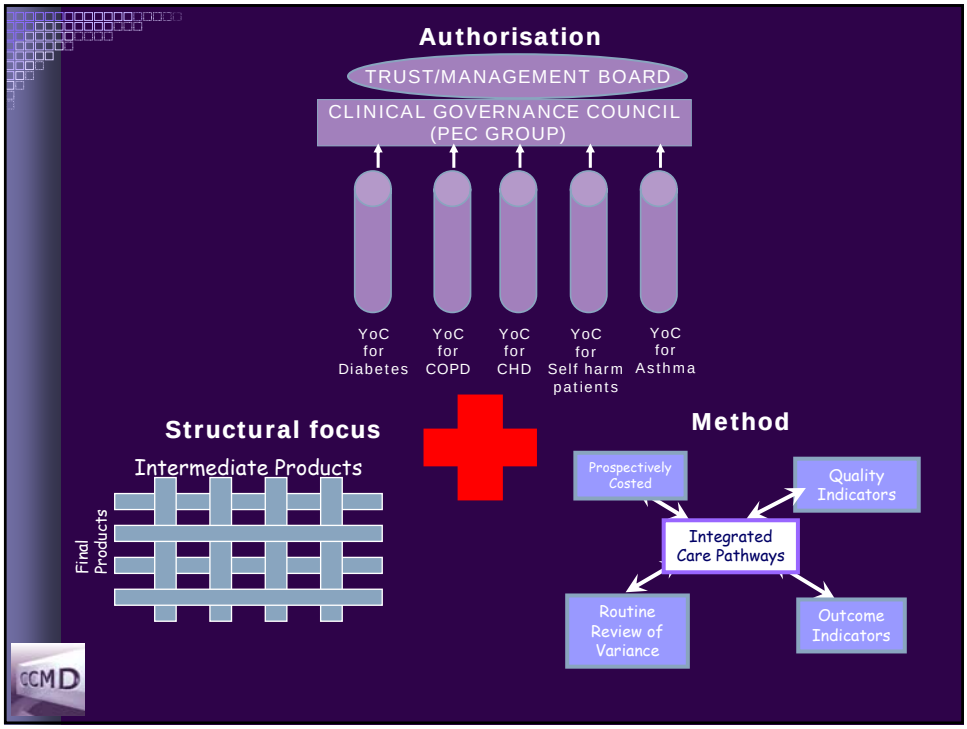
Authorisation
TRUST/MANAGEMENT BOARD
CLINICAL GOVERNANCE COUNCIL (PEC GROUP)
YoC for Diabetes
YoC for COPD
YoC for CHD
YoC for Self harm patients
YoC for Asthma
Structural focus
Intermediate Products
Final Products
Method
Prospectively Costed
Quality Indicators
Integrated Care Pathways
Routine Review of Variance
Outcome Indicators
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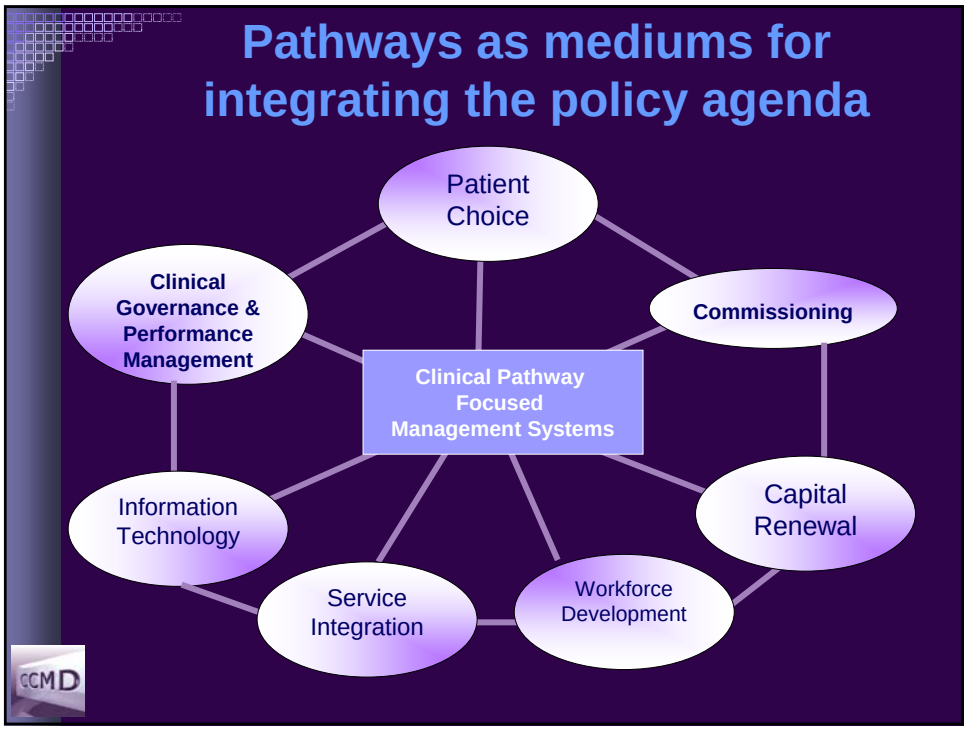
Pathways as mediums for integrating the policy agenda
Patient Choice
Clinical Governance & Performance Management
Commissioning
Clinical Pathway Focused Management Systems
Information Technology
Capital Renewal
Service Integration
Workforce Development
CCMD

Some emerging implementation issues

- Foundation Trusts
- Payment by results
- PCT based commissioning
- GP commissioning