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

<table>
<thead>
<tr>
<th>HRG</th>
<th>HRG label</th>
<th>% Adm</th>
<th>% B Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>D20</td>
<td>Chron Obstruct Pulmonary Dis/Bronch</td>
<td>37.22</td>
<td>39.16</td>
</tr>
<tr>
<td>S16</td>
<td>Poison Toxic Effects /Overdose</td>
<td>18.26</td>
<td>17.82</td>
</tr>
<tr>
<td>P06</td>
<td>Minor Infections (incl Immune Deficit)</td>
<td>5.41</td>
<td>7.29</td>
</tr>
<tr>
<td>E36</td>
<td>Chest Pain &lt;70 w/o cc</td>
<td>7.57</td>
<td>7.81</td>
</tr>
<tr>
<td>D21</td>
<td>Asthma &lt;69 or w cc</td>
<td>1.44</td>
<td>1.41</td>
</tr>
<tr>
<td>F47</td>
<td>Gen Abdom Disord &lt;70 w/c cc</td>
<td>4.84</td>
<td>7.65</td>
</tr>
<tr>
<td>E33</td>
<td>Angina &lt;69 or w cc</td>
<td>18.11</td>
<td>18.73</td>
</tr>
<tr>
<td>T42</td>
<td>Sprains Strains /Mini Open Wounds &lt;70 w/o cc</td>
<td>1.43</td>
<td>1.11</td>
</tr>
<tr>
<td>L49</td>
<td>Kidney/Amin Tact Infections &lt;69 or wcc</td>
<td>3.77</td>
<td>2.92</td>
</tr>
<tr>
<td>D49</td>
<td>Comp Eiol w a Respiratory Sys PDx</td>
<td>6.54</td>
<td>5.51</td>
</tr>
<tr>
<td>E18</td>
<td>Heart Fail/ Shock &lt;69 or wcc</td>
<td>6.87</td>
<td>5.36</td>
</tr>
<tr>
<td>E39</td>
<td>Arrhythmia/Conduction Disord &lt;69 or wcc</td>
<td>4.88</td>
<td>5.97</td>
</tr>
<tr>
<td>P10</td>
<td>Other Gastro/Metabol Disord</td>
<td>9.16</td>
<td>15.00</td>
</tr>
<tr>
<td>E31</td>
<td>Syncope/Collapse &lt;69 or wcc</td>
<td>2.87</td>
<td>3.31</td>
</tr>
<tr>
<td>D46</td>
<td>Gen Abdom Disord &lt;69 or wcc</td>
<td>5.78</td>
<td>4.44</td>
</tr>
<tr>
<td>E12</td>
<td>Acute Myocardial Infaction w/o cc</td>
<td>0.86</td>
<td>0.97</td>
</tr>
<tr>
<td>P03</td>
<td>Upper Respiratory Tract Disord</td>
<td>5.73</td>
<td>9.07</td>
</tr>
<tr>
<td>E35</td>
<td>Chest Pain &lt;69 or w cc</td>
<td>7.26</td>
<td>6.99</td>
</tr>
<tr>
<td>P15</td>
<td>Accidental Injury</td>
<td>1.68</td>
<td>1.36</td>
</tr>
<tr>
<td>P04</td>
<td>Lower Respiratory Tract Disord</td>
<td>11.37</td>
<td>21.33</td>
</tr>
<tr>
<td>E34</td>
<td>Angina &lt;70 w/o cc</td>
<td>13.85</td>
<td>17.11</td>
</tr>
<tr>
<td>P17</td>
<td>Stom/Duod Disord &lt;69 or wcc</td>
<td>2.23</td>
<td>2.17</td>
</tr>
<tr>
<td>A22</td>
<td>Non-Transient Stroke/CHA &lt;69 or wcc</td>
<td>0.50</td>
<td>0.72</td>
</tr>
<tr>
<td>D13</td>
<td>Lobar Apix/Viral Pneumon &lt;69 or wcc</td>
<td>2.13</td>
<td>2.33</td>
</tr>
</tbody>
</table>
Variation in Chronic Disease Management between GP Practices
Percentages of hospital patient admissions for COPD & Angina by GP practice

Scatter graph of Percentage of Excess Repeated Episodes COPD & Asthma > 49 w.cc by Angina > 69 w.cc & Angina < 70 w/o cc

Total number of respiratory bed days that could have been saved by GP practice (2003-2004)
### Readmissions to any HRG

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

*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

<table>
<thead>
<tr>
<th>Acute (4)</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>MC</td>
<td>103</td>
</tr>
<tr>
<td>MM</td>
<td>24</td>
</tr>
<tr>
<td>GM</td>
<td>63</td>
</tr>
<tr>
<td>NM</td>
<td>69</td>
</tr>
<tr>
<td>NC</td>
<td>81</td>
</tr>
<tr>
<td>AHM</td>
<td>51</td>
</tr>
<tr>
<td>AHC</td>
<td>63</td>
</tr>
<tr>
<td>Achieved</td>
<td>454</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PCT (10)</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead</td>
<td>32</td>
</tr>
<tr>
<td>GM</td>
<td>87</td>
</tr>
<tr>
<td>NM</td>
<td>39</td>
</tr>
<tr>
<td>NC</td>
<td>111</td>
</tr>
<tr>
<td>GP</td>
<td>138</td>
</tr>
<tr>
<td>PN</td>
<td>65</td>
</tr>
<tr>
<td>PM</td>
<td>61</td>
</tr>
<tr>
<td>Achieved</td>
<td>533</td>
</tr>
</tbody>
</table>
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

<table>
<thead>
<tr>
<th>Acute</th>
<th>MC</th>
<th>MM</th>
<th>GM</th>
<th>NM</th>
<th>NC</th>
<th>AHM</th>
<th>AHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognise interconnections</td>
<td>-</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+/-</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>Balance accountability and accountability</td>
<td>-</td>
<td>+/-</td>
<td>+</td>
<td>+</td>
<td>+/-</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>Systematisation of clinical work</td>
<td>-</td>
<td>-</td>
<td>+/-</td>
<td>+/-</td>
<td>+/-</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>Multidisciplinary teams</td>
<td>-</td>
<td>-</td>
<td>+/-</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>-</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PCT</th>
<th>Lead</th>
<th>GM</th>
<th>NM</th>
<th>NC</th>
<th>GP</th>
<th>PN</th>
<th>PM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognise interconnections</td>
<td>+/-</td>
<td>+</td>
<td>+</td>
<td>+/-</td>
<td>-</td>
<td>+/-</td>
<td>-</td>
</tr>
<tr>
<td>Balance accountability and accountability</td>
<td>+/-</td>
<td>+</td>
<td>+</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>+/-</td>
</tr>
<tr>
<td>Systematisation of clinical work</td>
<td>+/-</td>
<td>+</td>
<td>+</td>
<td>-</td>
<td>-</td>
<td>+/-</td>
<td>+/-</td>
</tr>
<tr>
<td>Multidisciplinary teams</td>
<td>+/-</td>
<td>+/-</td>
<td>+</td>
<td>+</td>
<td>-</td>
<td>-</td>
<td>+/-</td>
</tr>
</tbody>
</table>
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

Emphasis on financial realism and transparent accountability

Emphasis on clinical purism and opaque accountability

Systematised concepts of clinical work

Individualistic concepts of clinical work

Ranking of Organisational Goals across the Health Economy

<table>
<thead>
<tr>
<th>Acute Care Trusts</th>
<th>PCTs</th>
<th>General Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Financial viability</td>
<td>Financial viability</td>
</tr>
<tr>
<td>2</td>
<td>Quality</td>
<td>Equal access</td>
</tr>
<tr>
<td>3</td>
<td>Organisational stability</td>
<td>Organisational stability</td>
</tr>
<tr>
<td>4</td>
<td>Productivity</td>
<td>Quality</td>
</tr>
<tr>
<td>5</td>
<td>Equal access</td>
<td>Staff welfare</td>
</tr>
<tr>
<td>6</td>
<td>Service innovation</td>
<td>Service innovation</td>
</tr>
<tr>
<td>7</td>
<td>Staff welfare</td>
<td>Productivity</td>
</tr>
<tr>
<td>8</td>
<td>Teaching and research</td>
<td>Teaching and research</td>
</tr>
</tbody>
</table>
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

![Graph showing stages of wellness over time.
Stage 1: Wellness is high.
Stage 2: Wellness starts to decline.
Stage 3: Wellness continues to decline.]
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

Prospectively Costed

Quality indicators

Clinical Pathway

Routine Review of Variance

Outcome Indicators
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

- TRUST
- Clinical Governance Committee
  - Risk management
  - Clinical Audit
  - Clinical Effectiveness
  - Quality Assurance
  - Staff
  - Research Development
What changes were produced?

Intermediate Products

Final Products

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

TRUST/MANAGEMENT BOARD

CLINICAL GOVERNANCE COUNCIL (PEC GROUP)

Year of care for Diabetes  Year of care for COPD  Year of care for CHD  Year of care for Self harm patients  Year of care for Asthma

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

Your gateway to effective clinical management systems

Further information:
Pick up a brochure
Visit: www.durham.ac.uk/ccmd
Instead of silos...

Pathways as mediums for integrating the policy agenda
Some emerging implementation issues

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