The New Clinical Paradigm

"While the global disease burden has been shifting towards chronic conditions, health systems have not evolved to meet this changing demand. Care is fragmented, focused on acute and emergent symptoms, and often provided without the benefit of complete medical information".

WHO (2002)

Why focus on long term conditions?

- Prioritising care for those who have a long term condition was announced by the English Department of Health in The NHS Improvement Plan published in 2004, although elements of the policy set out there predated the Plan.
- These elements include the Expert Patient Programme, inspired by the chronic disease self management programme developed by Kate Lorig at Stanford.
- and the new contract for general medical practitioners that provides financial incentives to GPs and their teams to improve the quality of chronic care.
- The NHS Improvement Plan was significant in bringing together these and other initiatives. Prioritising was an explicit recognition of the changing burden of disease in the population arising from an ageing population.

Why focus on long term conditions?

- Data from the General Household Survey indicate that over 30% of people report that they have a chronic condition accounting for 52% of all appointments with GPs, 65% of all hospital outpatient appointments, and 72% of hospital bed days.

- The Department of Health's best estimate is that the treatment and care of those with chronic diseases account for 69% of the total health and social care spend in England, or almost £7 in every £10 spent.

Why focus on long term conditions?

In England 15.4 m people have a long term condition:

- 1.9m - Diabetes
- 3.1m - Asthma
- 1.9m - Coronary Heart Disease
- 766k - Chronic Obstructive Pulmonary Disease
- 863k - Stroke and transient ischaemic attack

Long Term Conditions

- 50% of people with LTCs have not been told about treatment options
- 25% do not have a care plan
- 50% do not have a self care plan
- 50% medicines are not taken as intended.

Personal health services have a relatively greater impact on severity (including death) than on incidence. As inequities in severity of health problems (including disability, death, and co-morbidity) are even greater than are inequities in incidence of health problems, appropriate health services have a major role to play in reducing inequities in health.

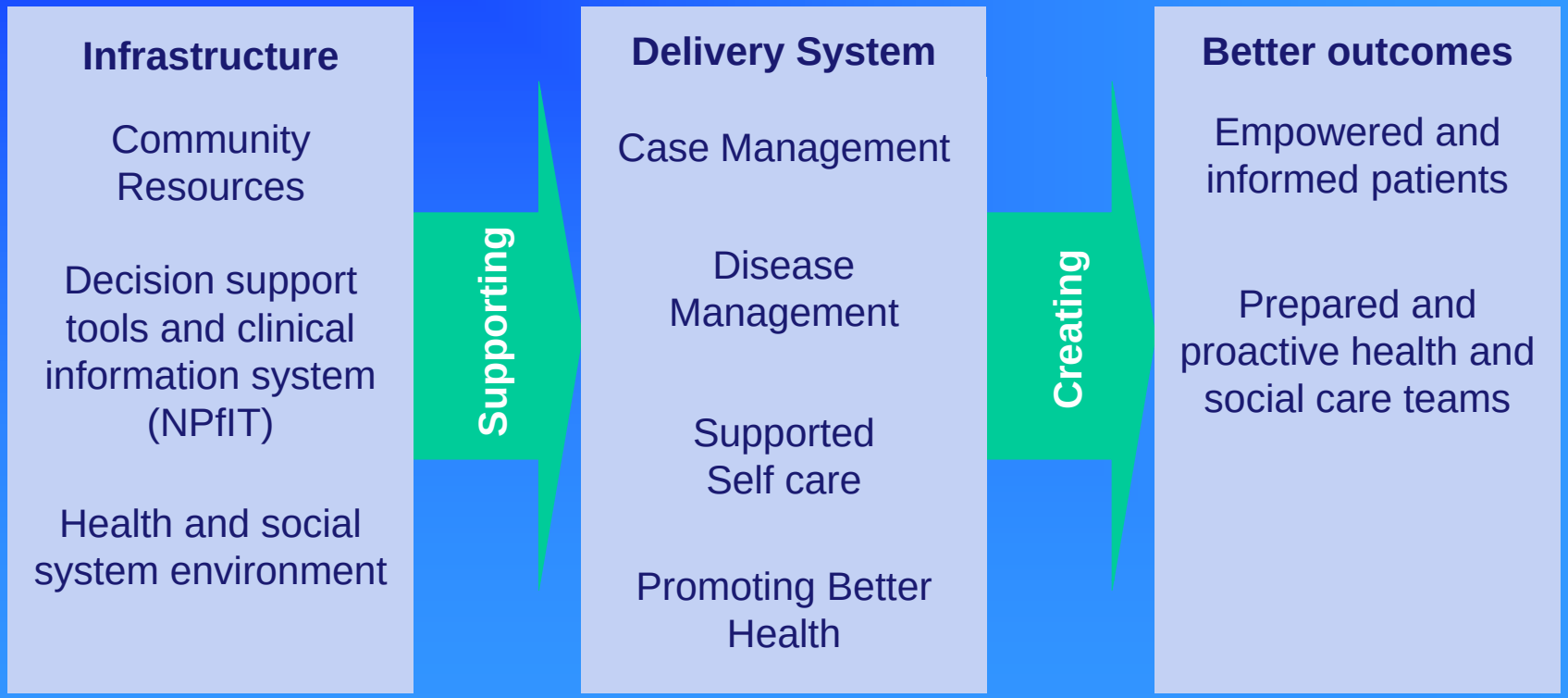
Starfield 12/03

03-385

LTC

- In 2005 came the publication of the NHS and Social Care Long Term Conditions Model .
- The Model drew explicitly on the Chronic Care Model developed by Ed Wagner and colleagues and also the risk stratification pyramid used in Kaiser Permanente to analyse the different levels of need experienced by the chronic care population.
- The inclusion of social care in the Model signified that people with chronic conditions required a range of support that extended beyond the limits of the NHS.

The NHS and Social Care Long Term Conditions Model



LTC Care matched to need

- **Case Management**
  - 5% of people who account for 42% of bed days
- **Disease Management**
  - National Service Frameworks
  - Promoted in GP contract
- **Self Care**
  - Expert Patient Programme
- **Promoting Better Health**
  - Choosing Health

Social and Health Model

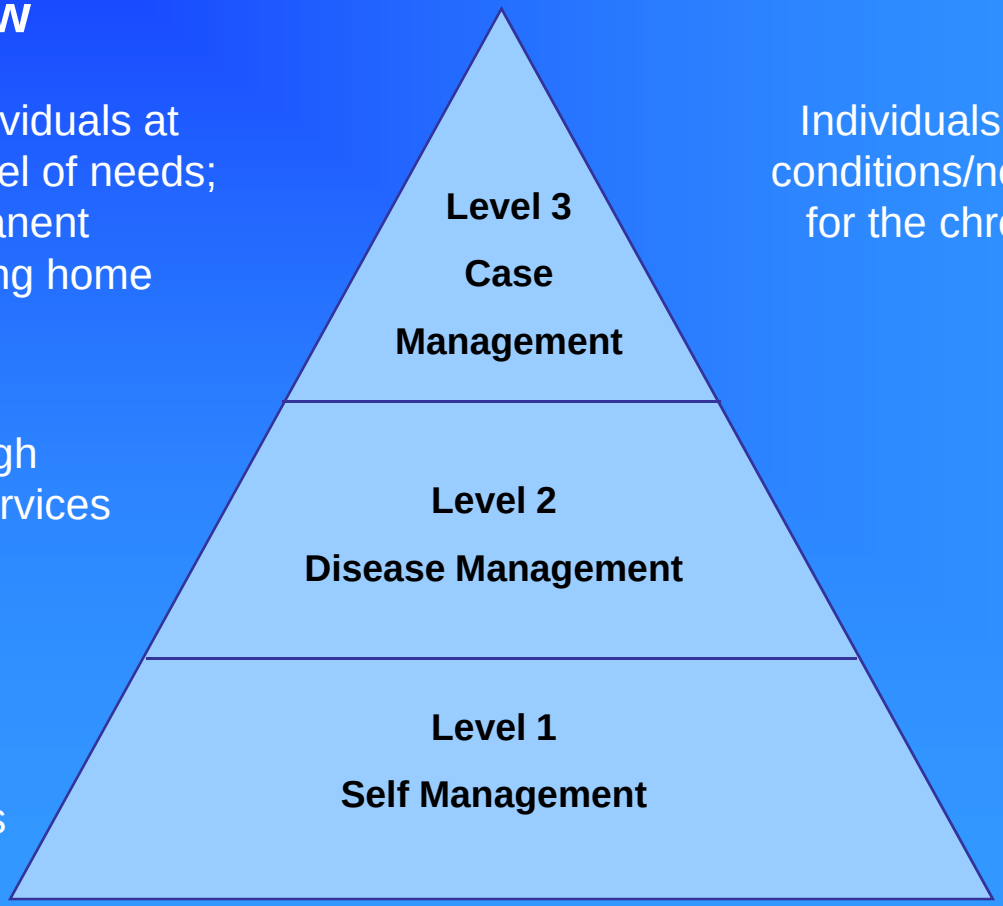
The Right Service for Individuals

Social Care View

Supporting more individuals at home with higher level of needs; diversion from permanent residential and nursing home care

Support to carers; high quality home care services

Valuing People; investment in voluntary sector; preventative services



Health View

Individuals with highly complex conditions/needs improving care for the chronically ill; Diversion from acute care.

Higher risk patients. Disease specific interventions; early diagnosis.

70-80% of individuals Health promotion; diet; exercise

What difference can case management make?

Kings Fund study (2004) found:

- Mixed evidence for case management reducing hospital admissions (in 10 of 19 studies)
- Evidence that case management leads to falls in length of stay
- No consistent effect between case management and use of A&E
- Some evidence that case management improves functional status (4 of 19 studies)
- Many models of case management and some are more effective than others

LTC Updates

- Hospital Episodes Statistics (HES) 2005/06 data on emergency bed days on December 06 is showing a 5.4%reduction in emergency bed days in PSA 2003/04 target baseline (some 1.7million bed days) despite a 5% increase in emergency admissions in 05-06

- Official launch of the Combined Predictive Model, the final tool delivered by the King's Fund. This tool combines both hospital and GP data to not only increase positive power of prediction but predict people who have never had a hospital admission.

www.kingsfund.org.uk

The 2006/07 QOF

- comprises 135 indicators and 1000 points (see http://www.nhsemployers.org/primary/index.cfm to view the full QOF). It is split into four areas or domains: clinical, organisational, patient experience and additional services. There is also a bonus payment: for holistic care, which is a payment based on the achievement in the clinical domain.

- The clinical domain is the largest section of the QOF, forming just over half of the QOF's content (80 indicators, 655 points).

The 2006/07 QOF

- nineteen indicator groups: coronary heart disease, heart failure (formerly left ventricular dysfunction), stroke (including transient ischaemic attacks), hypertension, diabetes, chronic obstructive pulmonary disease, epilepsy, hypothyroidism, cancer, palliative care, mental health, asthma, dementia, depression, chronic kidney disease, atrial fibrillation, obesity, learning disabilities and smoking.

QOF and Health Inequalities

- Although there are limitations to the data, QOF scores for practices serving the most disadvantaged populations are catching up with those of practices serving the least disadvantaged populations.

- Between 2004/5 and 2005/6, the average QOF score for 20% of practices with the highest Standardised Mortality Rates for the under 65s grew 8%. This compares to 3% for the 20% of practices with the lowest Standardised Mortality Rates for the under 65s.

- In 2005/6, the average QOF score for the most disadvantaged group was 96% of that for the least disadvantaged group. This compares to 92% in 2004/5.

Our health, our care, our say – a new direction for community services

- Ambition
- Enabling health, independence and well being
- Better access to GP
- Better access to community services
- Support for people with longer term needs
- Care close to home
- Ensuring reforms put people in control
- Making sure change happens

Range of White Paper LTC commitments

- Bigger emphasis on self care and integration
- Universal case management for VHIUs
- Requirement for multidisciplinary teams/networks
- Personal Health and Care Plans
- Assistive Technology

Care Plans

White Paper *Our Health Our Care Our Say* makes a commitment:

- **By 2008 we would expect everyone with both long term health and social care needs to have an integrated care plan if they want one. By 2010 we would expect everyone with a long term condition to be offered a care plan. We will issue good practice guidance in early 2007.**

Keeping it Personal

- Build on the best of traditional General Practice
- Primary Health Care more than general practice
- …but registered population and 80% of all NHS clinical consultations
- 90% of care solely undertaken in primary care
- Support for self care
- Long term conditions management
- Care Closer to home
- The practice can link the wider public's health and bio-clinical care
- The practice as the local micro yet strategic health organisation

Vision
‘Adding years to life and life to years’

- **Better health and well being for all**
  - People live healthier and longer lives
  - Health inequalities are dramatically reduced
  - NHS and health gain
- **Better care for all**
  - Services are of the best quality which is evidence based
  - People have choice and control over the services that they use so they become more personalised
- **Better value for all**
  - Informed investment decisions
  - PCTs work with others to optimise effective care
  - Wildavsky

Our NHS, Our Future
Next Stage Review

- **Fair -** Mal-distribution, Often lower performance for patients from socially deprived communities-
- **Personalised -** White paper ambition, a want is a need, segmentation, PROMs
- **Effective** - VFM, skill mix, variation in performance even when similar demography, reflective practice, use of evidence base, inappropriate/ineffective interventions
- **Safe** - Accreditation and regulation, NPSA advice
- **Locally accountable** - 'transparent accountability leads to transparent autonomy', PPI, different forms of ownership
- And focused relentlessly on improving the quality of care

NSR interim report

- New GP practices for deprived areas
- GP-led health centres for all PC
- Extending opening hours for at least 50% of GP practices
- Linking greater proportion of pay to patient satisfaction
- Publication of key information about all GP practices

NHS Choices via www.nhs.uk

Overview of findings of clinical pathway groups

Staying healthy

- Support people to take responsibility for their own health, through reaching out to disadvantaged groups

Maternity & new born

- Women want greater choice over place of birth and a more personal experience, with care provided by a named midwife

Children's

- Services needed to be more effectively designed around the needs of children and families, delivered in schools and children's centres too

Acute care

- Saving lives by creating specialised centres for major trauma, heart attack and stroke care, supported by skilled ambulance services

Overview of findings of clinical pathway group

Planned care

- More care should be provided closer to people's homes, with greater use of technology and outpatient care not always meaning a trip to hospital

Mental health

- Extending services in the community, benefits to general wellbeing and to physical health arising from stronger mental health promotion

Long-term conditions

- Need for true partnerships between people with long-term conditions and the professionals and volunteers caring for them

End of life

- Necessity for greater dignity and respect and desire to have round the clock access to palliative services

Primary and community care strategy: overview

Case for change	Strengths	Highly valued services	Ties to local communities	A decade of improvements
	Challenges	Services that don't join up	Unwarranted variability in quality	Changing demands
Our vision	Services shaped around individuals	Responsive and integrated care	Choice in primary & community care	Empowered patients & public
	Promoting healthy lives	Promoting health throughout life	Access to healthy living services	Tackling health inequalities
	Continuously improving quality	Transforming community services	Driving continuous improvement	Assuring essential standards

Leading local change	Reinvigorating PBC	Piloting integrated services	World class commissioning	Health and social care

Personalised to individual need

Improving the lives of people with LTCs

- Supported self care
- Personalisation and choice
- Easy access to accredited information
- Empowerment and personalisation key themes in NHS Next Stage Review and Primary and Community Care Strategy

Setting the context: What have we achieved so far?

- Long term conditions model being implemented across the country – many examples of excellence
- 10.1% reduction in emergency bed days (2003/04 – 2006/07) – driven by mental health and circulatory bed days – National Service Frameworks having impact.
- But we need to sustain this and there is still much more to do.

Setting the context: The future direction – a growing priority

- LTC growing priority – included in *Our NHS Our Future* Interim Report and is one of 8 clinical pathways

- Prime Minister announced “Patient Prospectus” for people with long term conditions – may set out what self care services people can expect to be offered under 4 key pillars:
  - **Information**
  - **Skills**
  - **Equipment, tools and devices**
  - **Support networks**

LTC new developments

- Year of Care pilot
- Patient Prospectus-incorporating Information Prescriptions
- Individual Budgets

What is personalised and integrated Care Planning?

STATEMENT OF VALUES AND PRINCIPLES OF PERSON CENTRED CARE PLANNING

- Person centred care planning is a continuous process, however it will result in a product – the overarching care plan
- It is a dynamic process of discussion, negotiation, shared decision making and review that takes place between the individual and the professional - who have an equal partnership
- The process should be led by the individual with them at the centre, based upon their strengths, goals, aspirations and lifestyle wishes

How will this support integration?

- Effective care planning requires integration of health and social care at both strategic and individual level
- Make use of Joint needs assessment, joint commissioning, integrated care pathways, improved information sharing, Joint Strategic Partnerships, Local Area Agreements
- Needs to be supported by a multidisciplinary team approach – all members of the MDT have a shared understanding of the person's needs and desired outcomes