

The King's Fund

The Future of Primary and Community Care in England

Towards Integrated Care Organisations

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Agenda

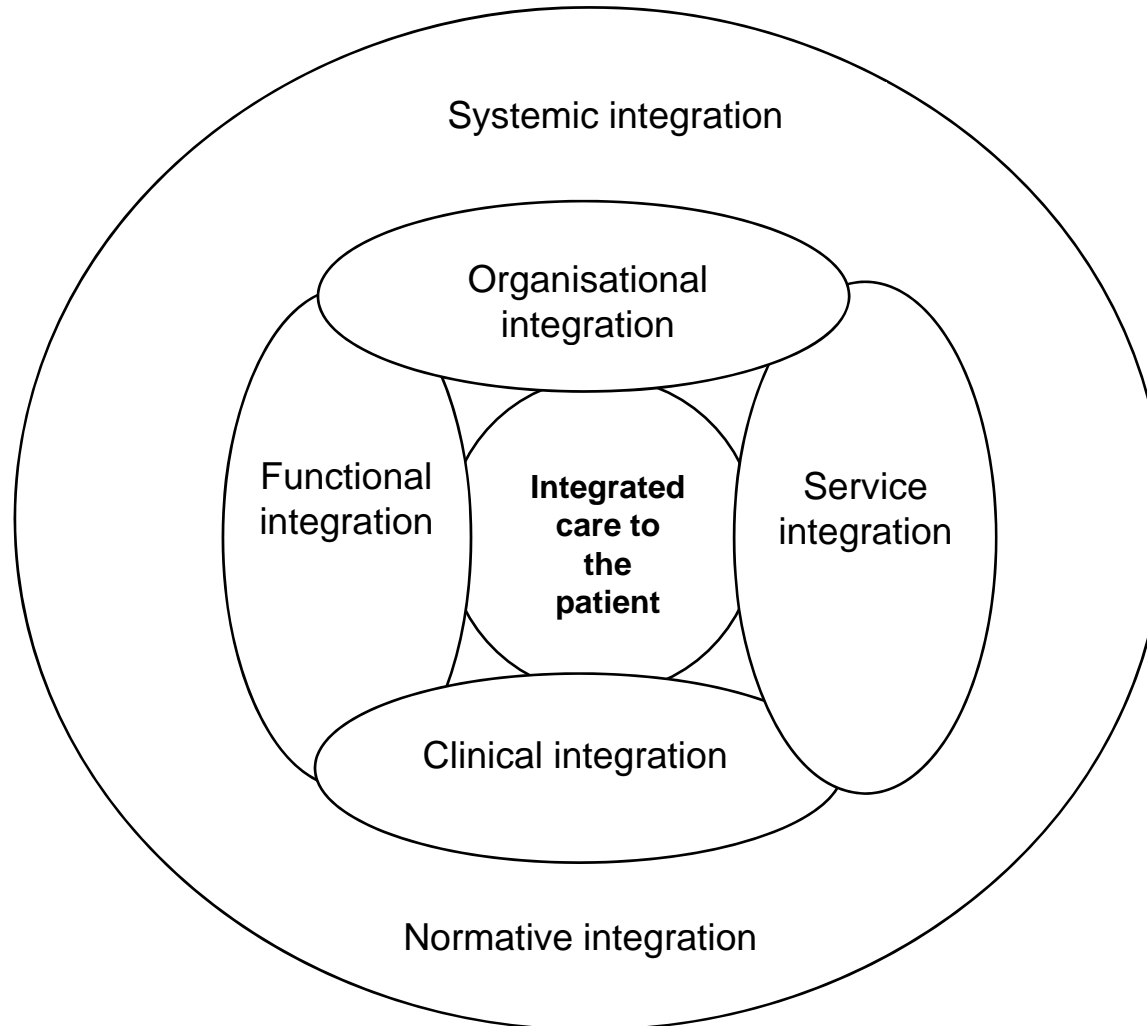
- The Integrated Care Concept
 - Recent reforms in the English NHS: a ‘battle’ for integrated care
 - Long-term conditions strategies:
 - Case management
 - Disease management
 - Health promotion
 - Integrated care organisations
 - Conclusions
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The Integrated Care Concept

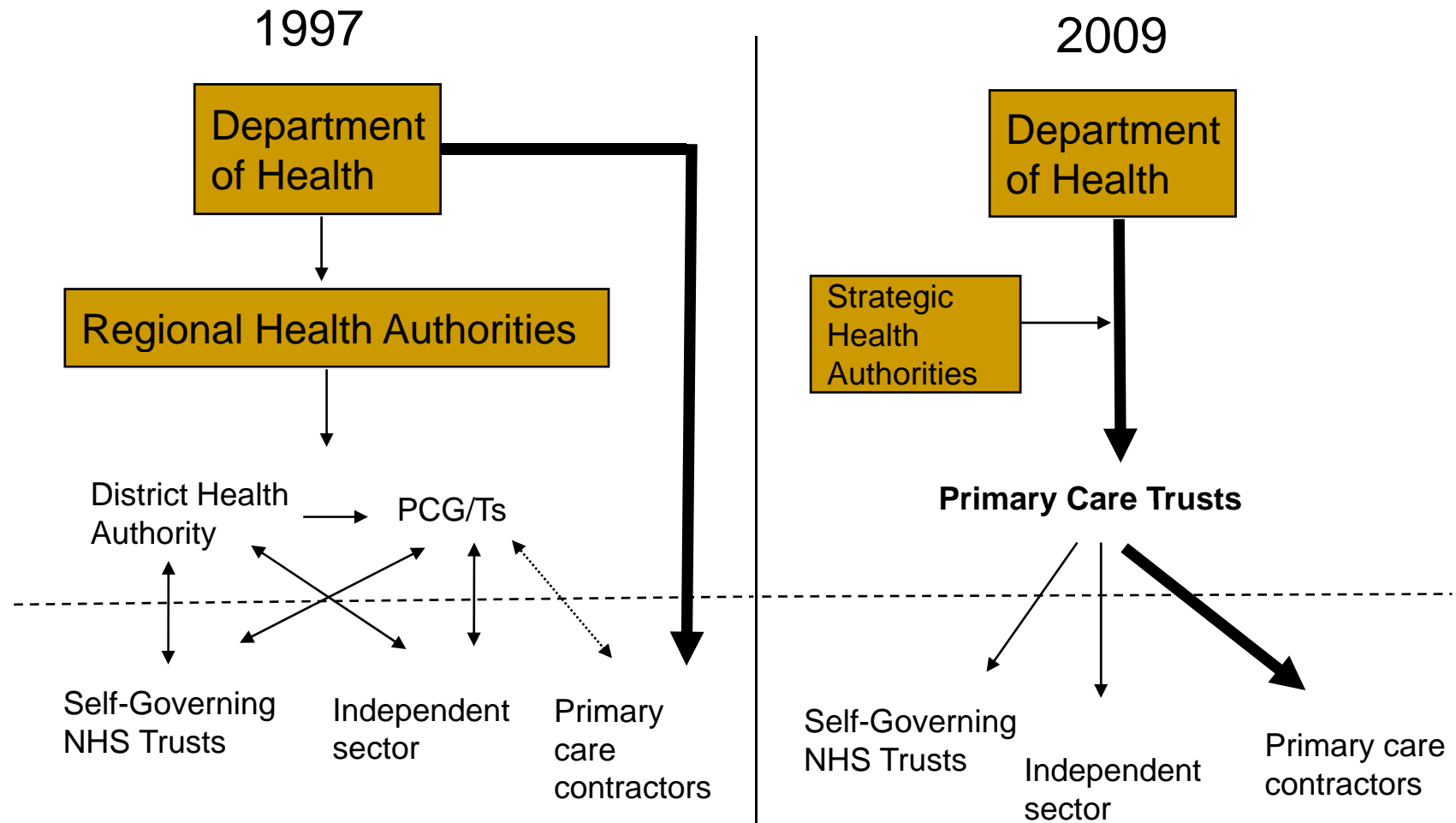


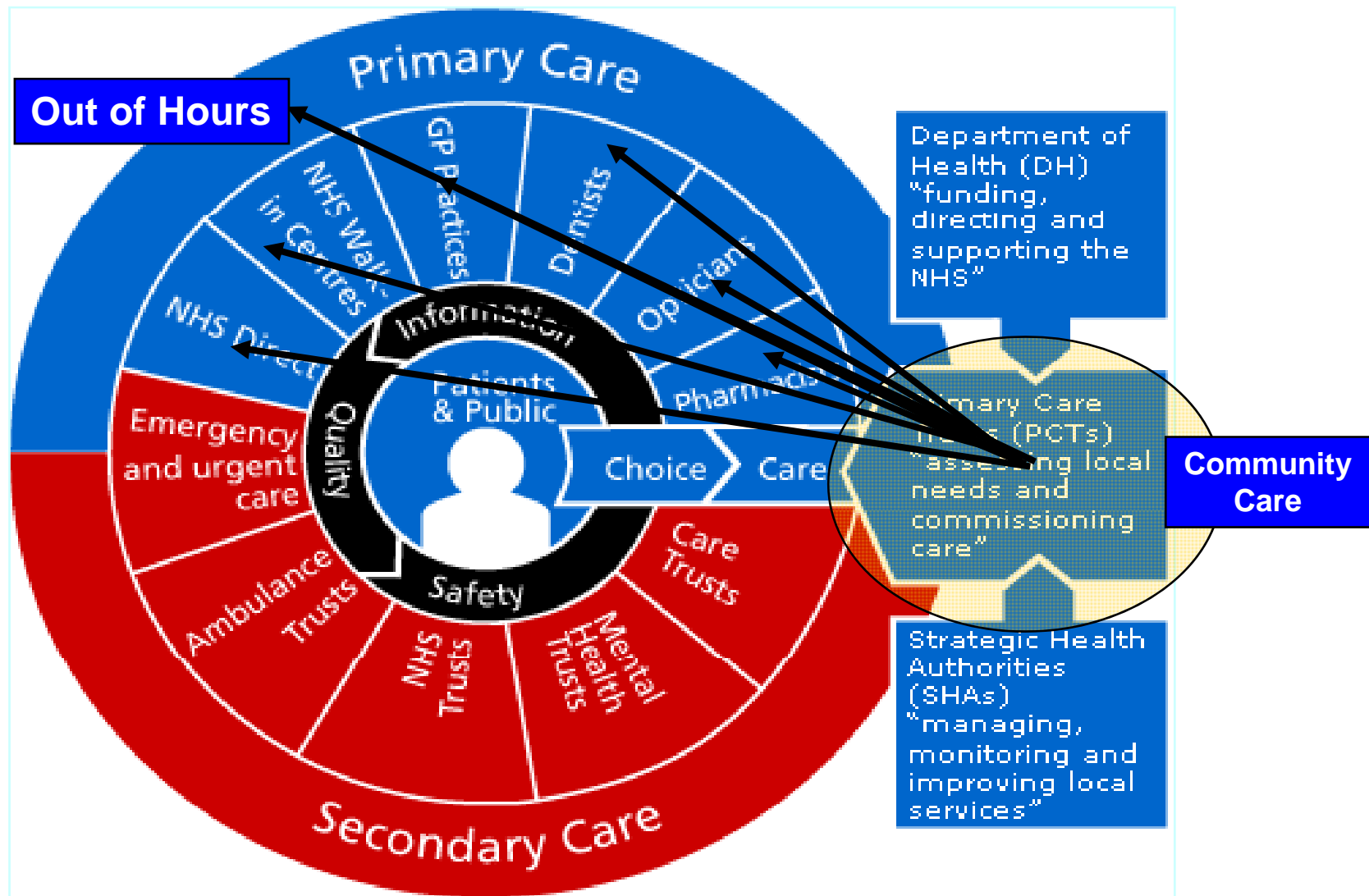
A confusion of languages

The Integrated Care Concept



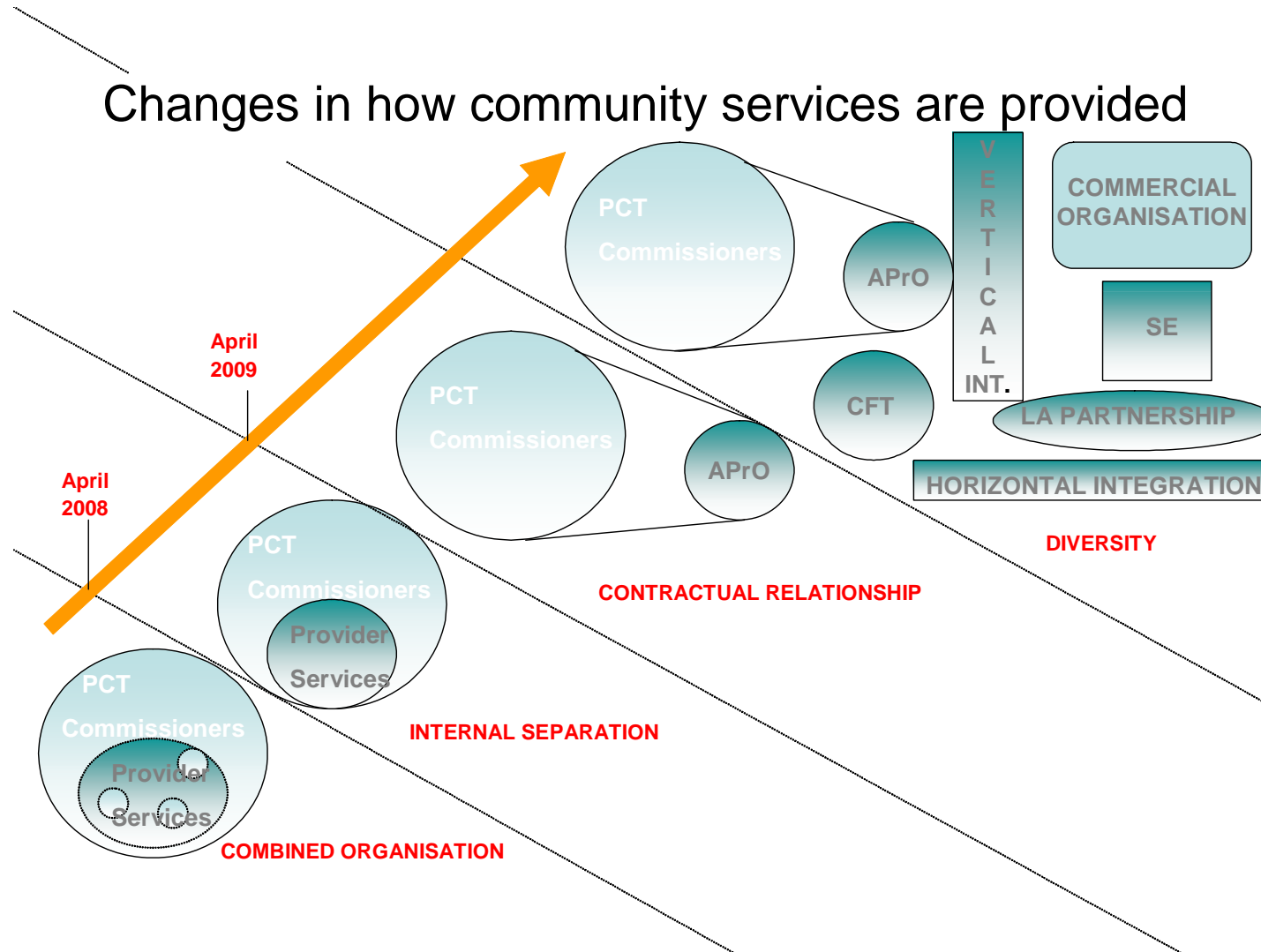
NHS, 1997-2009: A Commissioner-Provider Model





'Independent' Community Providers

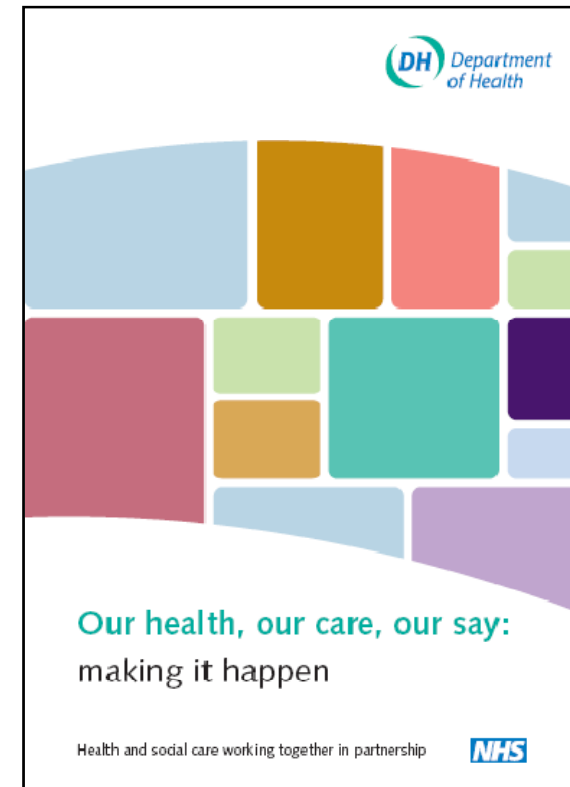
Changes in how community services are provided



UK Department of Health's Position

Four main goals:

1. *Better preventative services, earlier intervention and self-care strategies*
2. *More support to people with chronic conditions and long-term care needs of the elderly*
3. *Improve access to community services, reduce inequalities of access and improve joint working between health and social care*
4. *Give people a louder voice and more choice – social justice and self-determination agenda*



DARZI

NHS Next Stage Review



“ An NHS that gives patients and the public more information and choice, works in partnership and has quality of care at its heart ”



“ This is a once-in-a-generation opportunity to ensure that a properly resourced NHS is clinically led, patient-centred and locally accountable ”



DARZI :‘The Headlines’

- NHS Constitution
 - ‘enshrines’ choice of treatment and provider
 - NHS Constitution shows we are a single-insurance payer system
 - ‘End’ of postcode lottery to drug treatments through guaranteed access to NICE-approved drugs
 - **Managing health on an ‘industrial’ scale**
 - Comprehensive health and wellbeing services
 - Coalition for better health
 - Individualised care plans
 - ‘Reduce your risk’ campaign
 - Stay health at work
 - Personal healthcare budgets
 - Quality at the heart of the NHS:
 - Care Quality Commission
 - National Quality Board
 - **Attention on community services**
 - **World Class Commissioning and PBC ‘reinvigorated’**
 - Making the NHS locally accountable
 - Clinical leadership
 - PROMs
 - Investment
 - **Tackling long-term conditions - individualised care plans**
 - **Integrated care organisations**
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The 'Battle' for Integrated Care

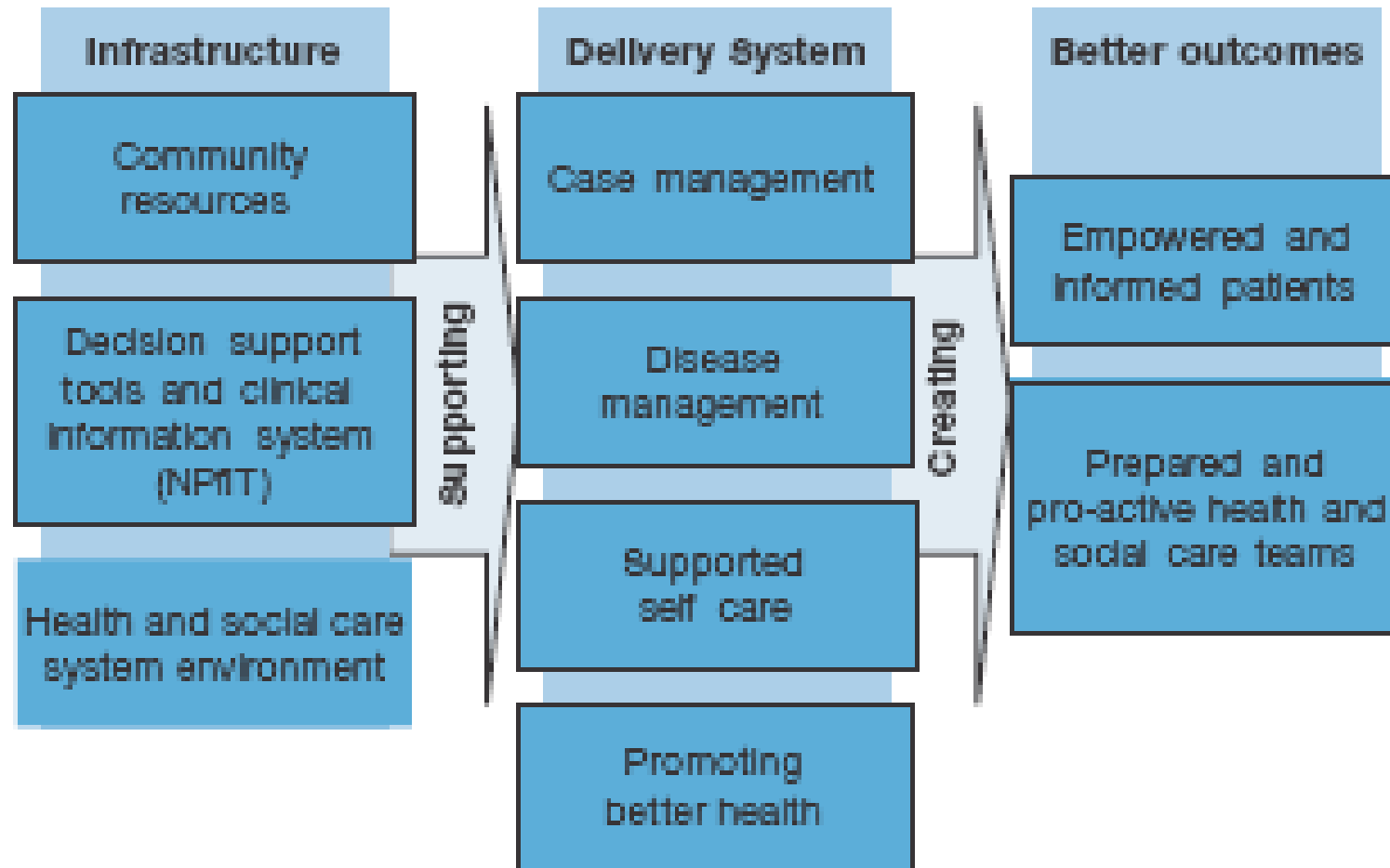
Non-integrating forces

- 'Isolated' providers: GPs; community trusts; hospital care; social care
- Payment reforms: payment by results
- Competition rules – contract culture
- Choice
- Foundation trusts
- Professional tribalism

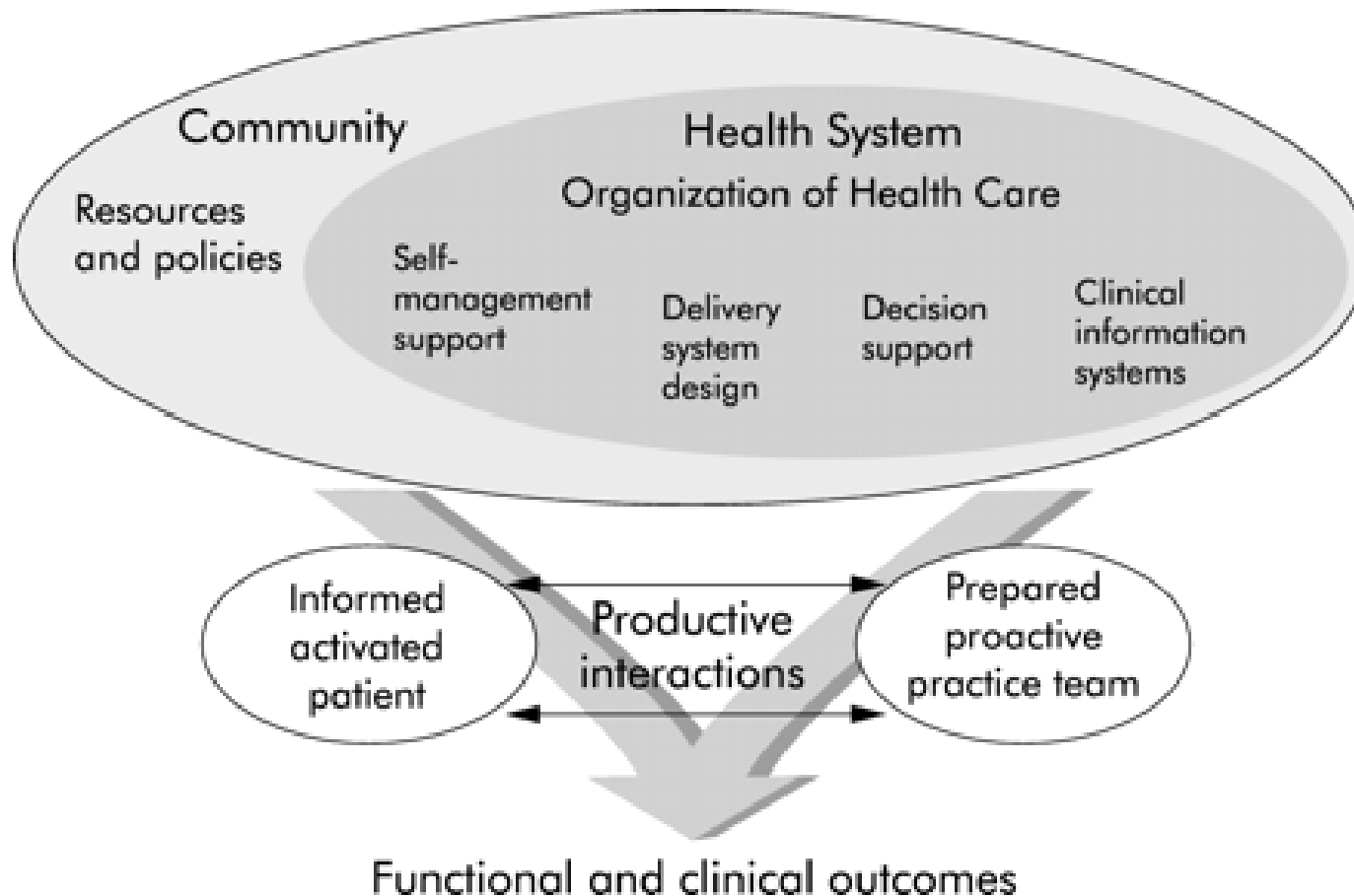
Integrating forces

- Best practice - e.g. NICE guidance
 - Regulation/CQC
 - Policy-focus
 - Quality agenda, including payment for quality
 - Integrated care organisations
 - *World Class Commissioning*
 - Health and wellbeing
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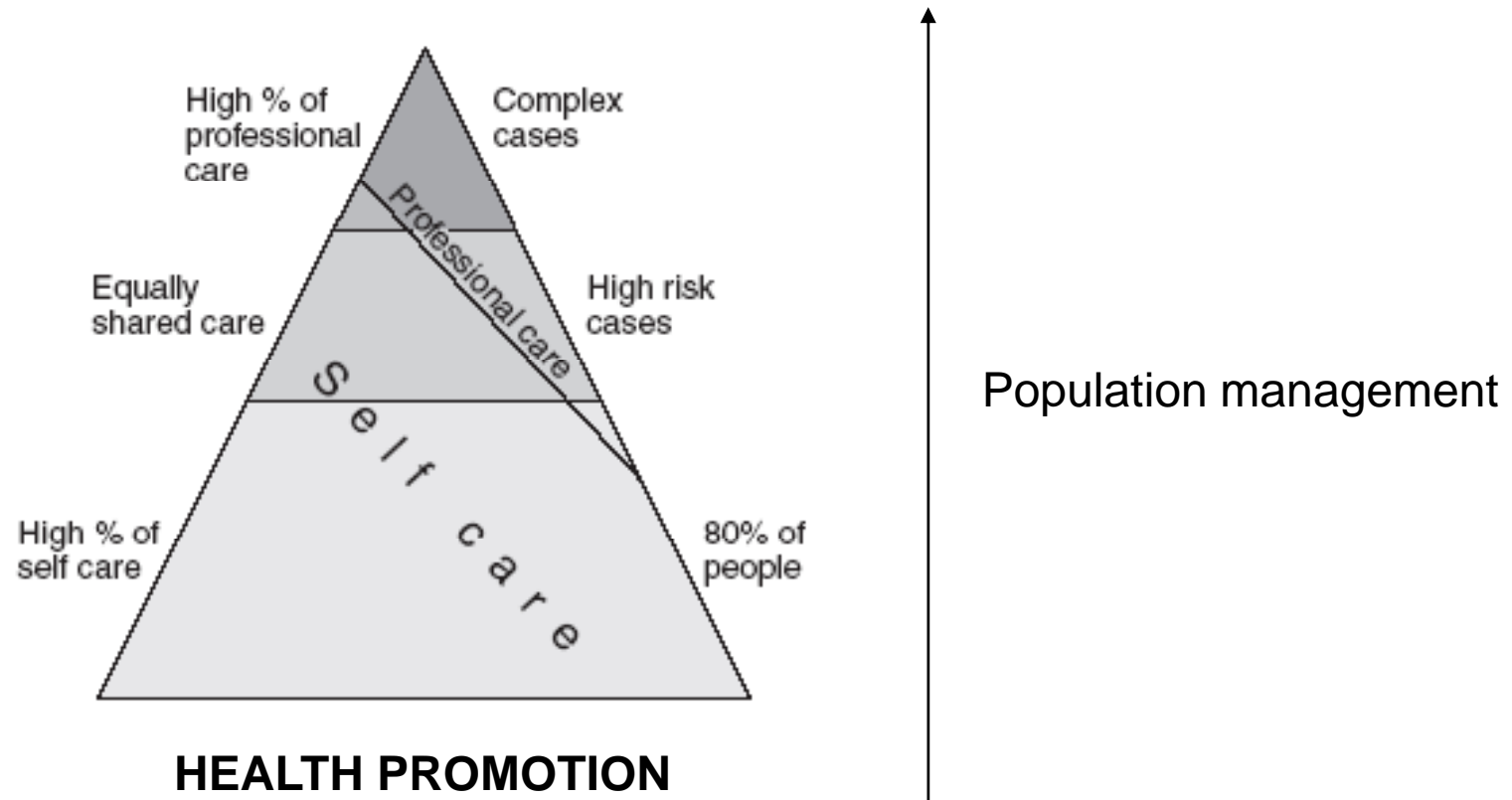
DH Long Term Conditions 'Model'



Inspiration from the Chronic Care Model



The Long Term Conditions Policy: Case Management, Disease Management, and Self Care



Case Management

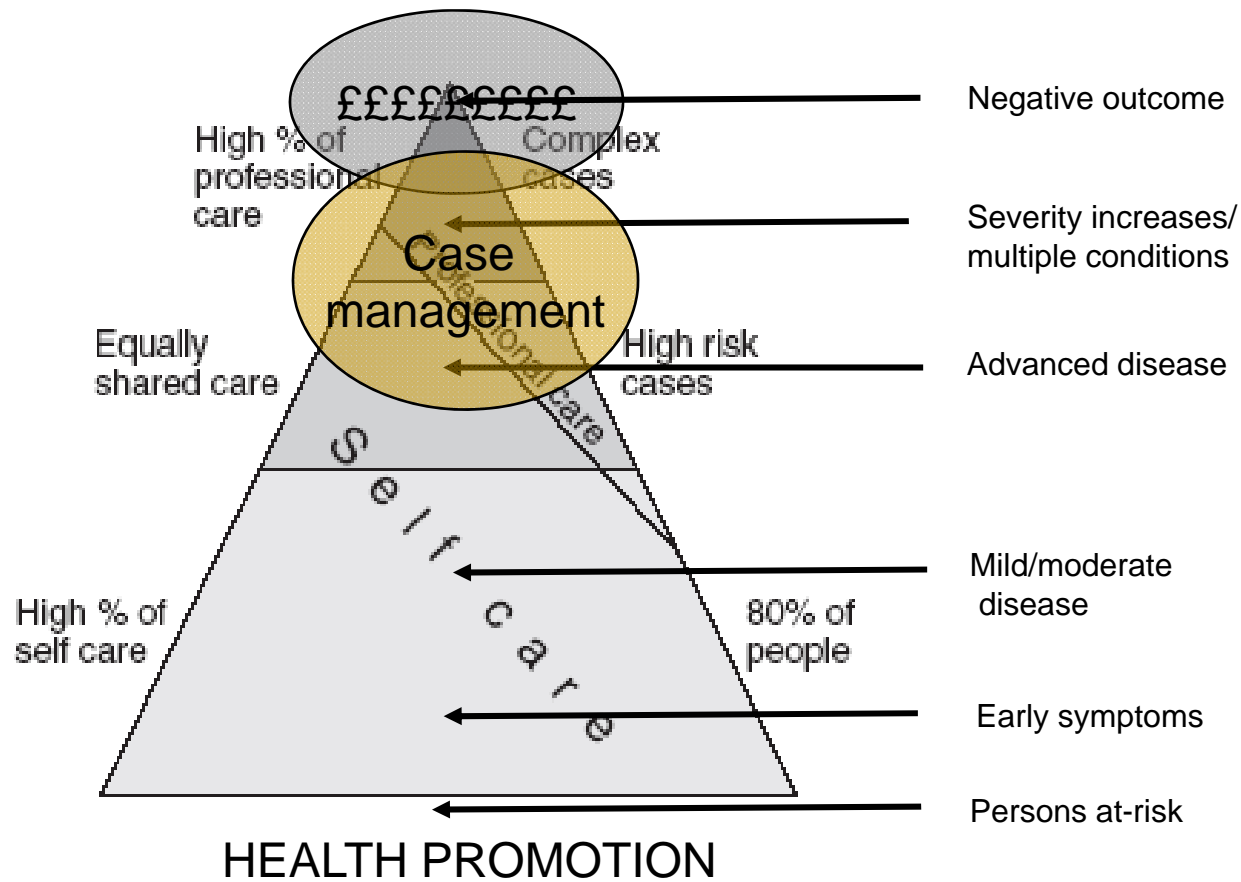
Key Actions

1. Identify patients with complex conditions who are most at high risk of unplanned admissions or long term institutionalisation.
2. Develop the role of community matron in your locality.
3. Use this information to draw up a plan of how this new service will be introduced and integrated with existing services. This should project the impact case management will have on hospital admissions and lengths of stay.

Why developed?

- Patients stay at home for longer – so reduces numbers of unplanned emergency admissions to hospitals and so reduces costs
 - Attempt to shift care out of hospitals into the community – promoting supported self-care in the home
 - Enables choice and independence for patients
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Preventing negative outcomes

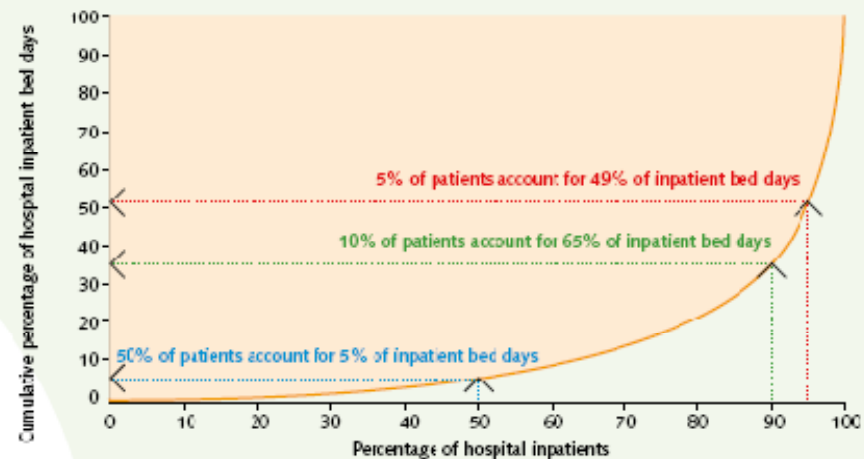


Predicting risk and community matron services: information is power!

- In England, 5% of patients account for 49% of inpatient bed days in hospitals (and associated costs)
- Just 2% of patients with long-term conditions account for 30% of unplanned admissions & 80% of visits to a general practitioner

Only 5% of inpatients account for 49% of all inpatient bed day usage.

Percentage of those admitted as inpatients by cumulative days spent as inpatients



Source: Hospital Episode Statistics 2005/06 for England.

Rationale

- Recognition that many hospital admissions (especially for long-term care LTC) can be prevented
- Targeted interventions required to tackle ‘at-risk’ individuals ‘upstream’ from traditional care
- Government policy of caring for people outside hospital and closer to home
 - Community Matrons to ‘case manage’ high risk patients
 - Expert patient and carer programmes
 - £120 million investment in telecare and telehealth
 - ‘*Your Health, Your Way*’ - five ‘pillars’

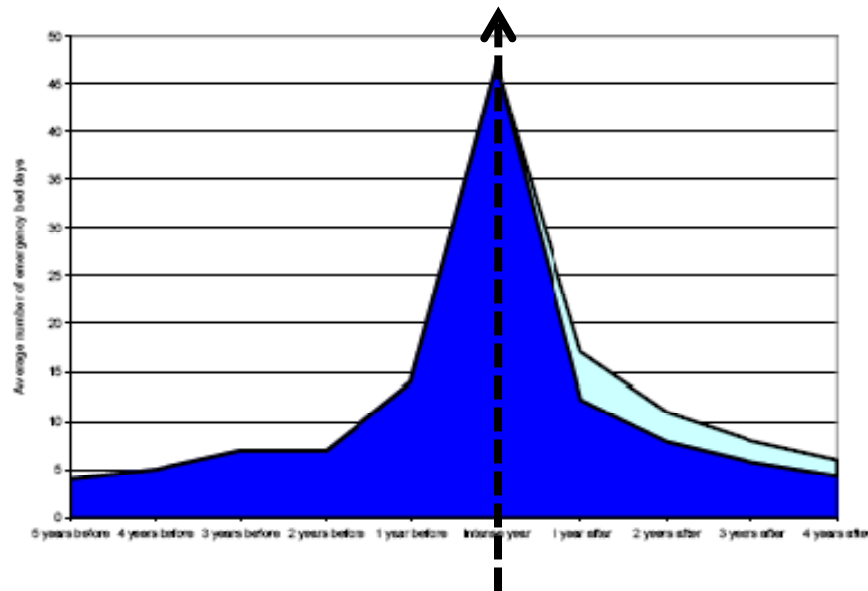
Community Matrons

- New clinical role for nurses
 - Case-management of 'high-intensity' users of health services in the home
 - 3000 community matrons established.
 - Role is to:
 - Use data to actively seek out patients who will benefit
 - Combine physical, mental and social care needs
 - Medications management, some prescribing
 - Provide clinical care and promote health
 - Teach and educate patients (and carers) to self-care
 - Co-ordinate inputs from other agencies
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Community Matrons

- Community matron role inspired by case management success in US – e.g. by Evercare
 - Community matron service as yet not ‘cost-effective’ in most parts of the country – issue of ‘impactability’ on ‘high intensity’ patients
 - Community matrons not integrated with the rest of the system, especially GPs – co-ordination role without power
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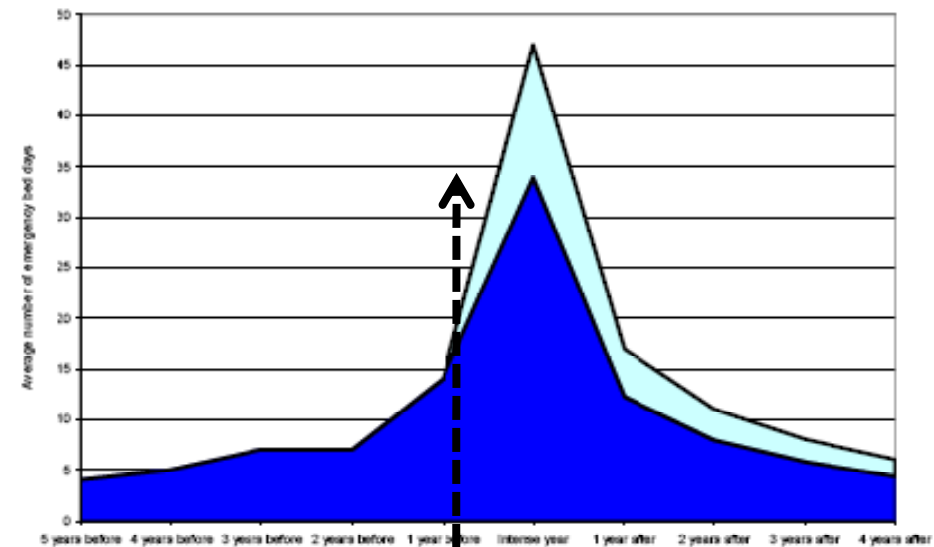
Potential benefits from predictive tools



If patients are identified during the year they are most intensive users [Threshold models & clinical knowledge], case management could save 9% resource use over these ten years

However, if patients are identified in the year prior to which they are most intensive users [predictive models], case management could save 20% resource use over the ten years

Saving (in light blue) that could be achieved assuming case management can prevent 10% admissions and reduce length of stay by 20% on average



PARR:

Patient's at Risk of Rehospitalisation

- Predictive case-finding tool developed by King's Fund and Health Dialog
 - Developed algorithms using prior hospital discharge data to identify patients at high risk of hospitalisation
 - Flags patients with a high probability of subsequent emergency admission enabling health and social services to 'case manage' patients and reduce hospitalisations
 - Algorithms produce a 'risk score' (0-100) for every individual across an entire population
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PARR variables

- Prior utilisation
- Diagnostic information
- Demographic information
- Re-hospitalisation rates at hospital of current admission for certain conditions
- Contextual information about area of residence

PARR approach

- Trigger: emergency admission
- Use information in hospital records to predict patients at high risk for re-hospitalisation in the next 12 months
- An algorithm produces a “Risk Score” of 0.1-100 for individual patients
 - PARR 1: trigger based on a reference condition where improved management can help prevent future admissions
 - PARR 2: not limited to a reference condition, focuses on a larger number of patients

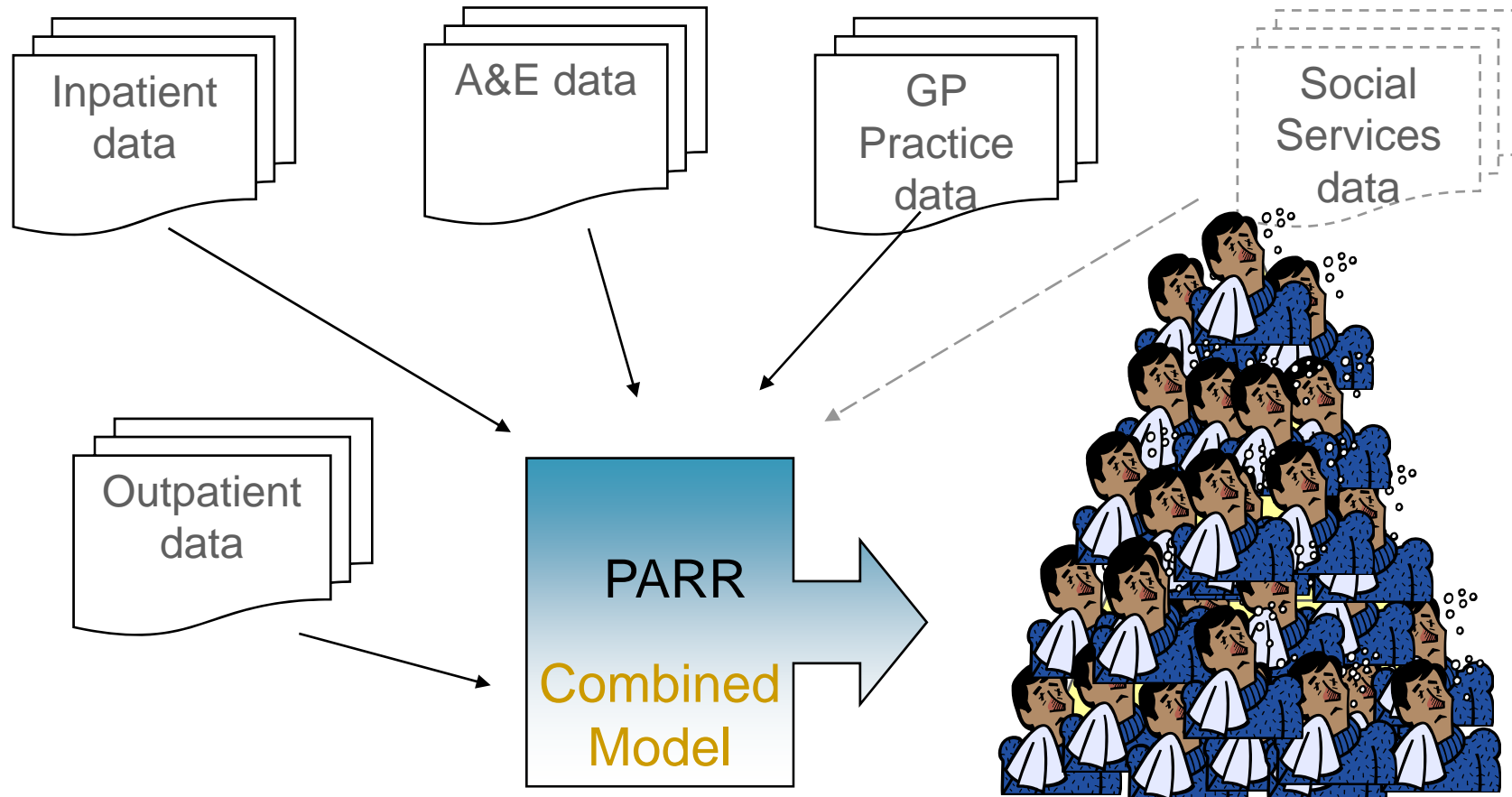
PARR population

- 80% had multiple long term conditions compared with 35% of all admissions
- Most common conditions of highest risk: Heart disease, hypertension, COPD
- Mental illness was also higher in the PARR population than all admissions

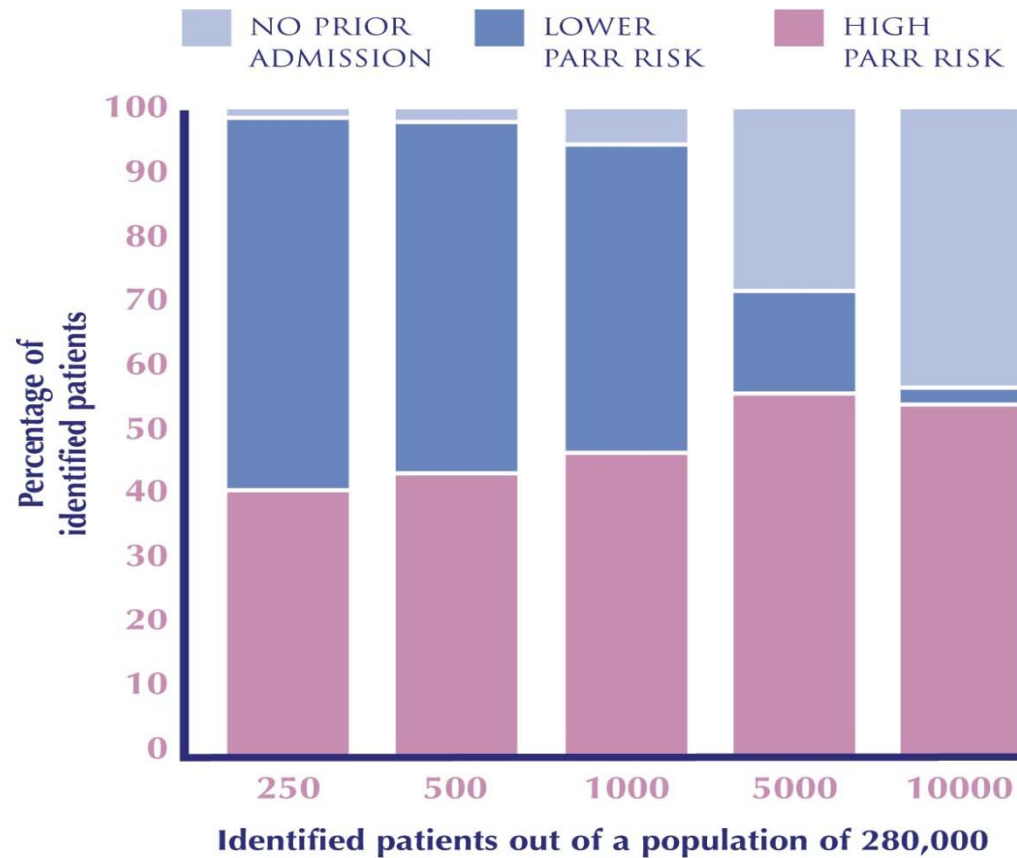
The Combined Predictive Model

- Aim: to develop a model that uses a number of routine datasets to stratify an entire Primary Care Trust (PCT) population according to risk of admission in the next 12 months
- Developed and piloted in Croydon PCT (280,000 people)
- Used as a method to develop community-based case management services

Multiple Data Sources Enrich the Predictive Opportunity



Combined Model Population



Combined model identifies a different population to PARR

Some patients in top 1000 'highest risk' with no PARR score

Model is slightly more accurate than PARR (73% instead of 65%)

Case study:

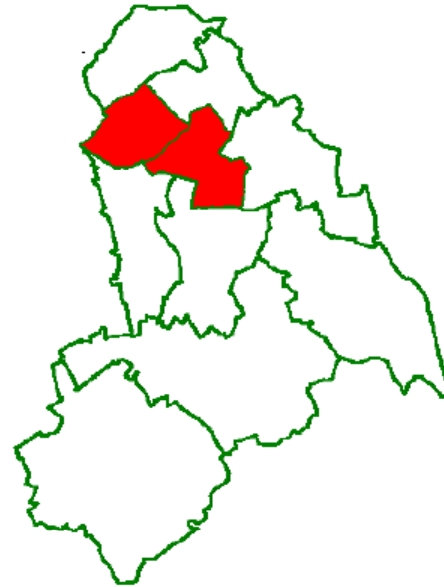
Virtual Wards in Croydon PCT

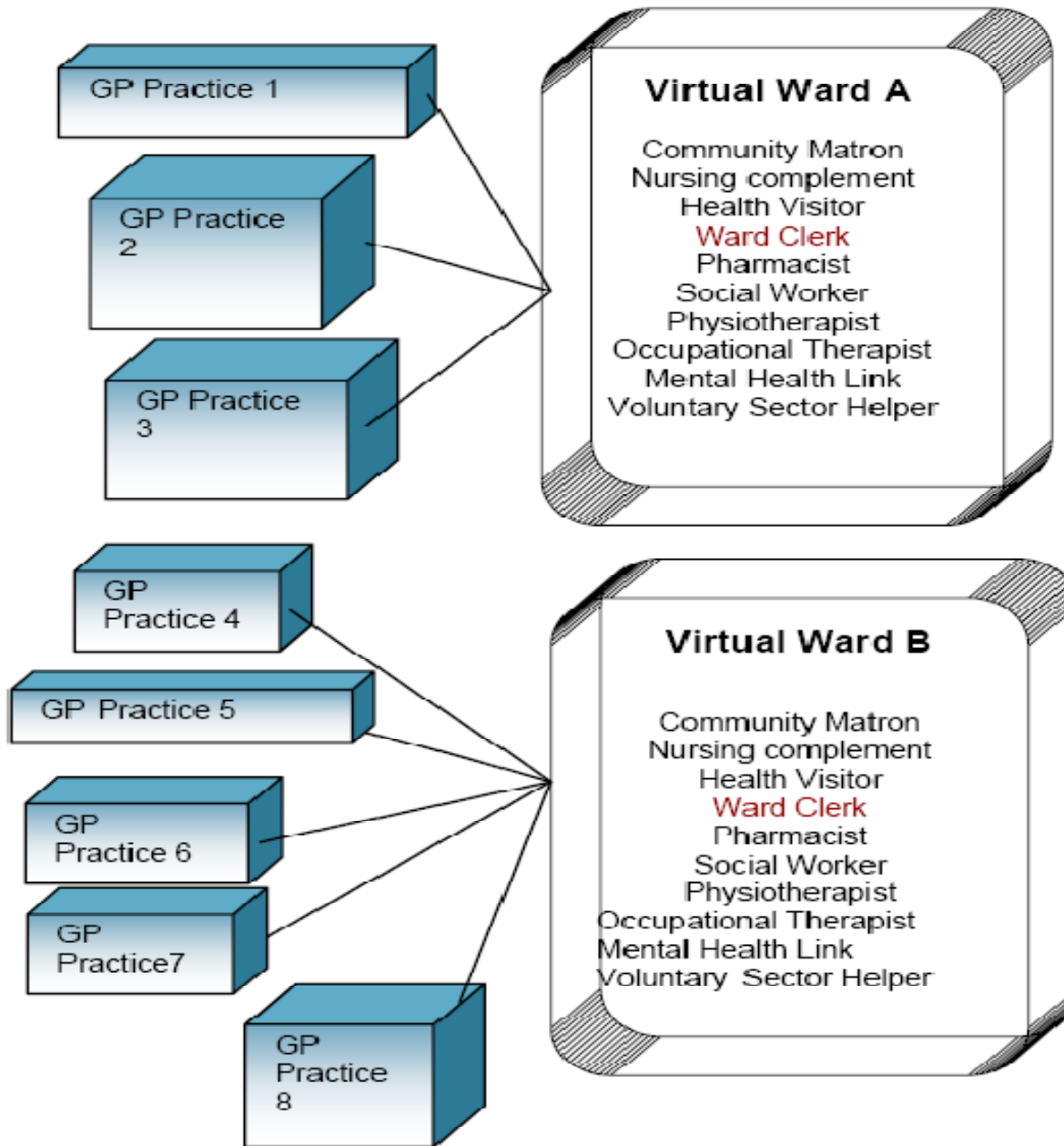
- Piloted the practical use of the Combined Model on behalf of the King's Fund and Health Dialog since May 2006.
- Package of care called *virtual wards* - solely to people at highest predicted risk.
- Virtual wards now being introduced in other parts of the UK.

Case study:

Virtual Wards in Croydon PCT

- In essence, virtual wards use the systems, staffing and daily routine of a hospital ward to provide case management in the community.





Specialist staff

Specialist nurses

- Asthma

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- Continence

- Heart Failure

Palliative care team

Alcohol service

Dietician

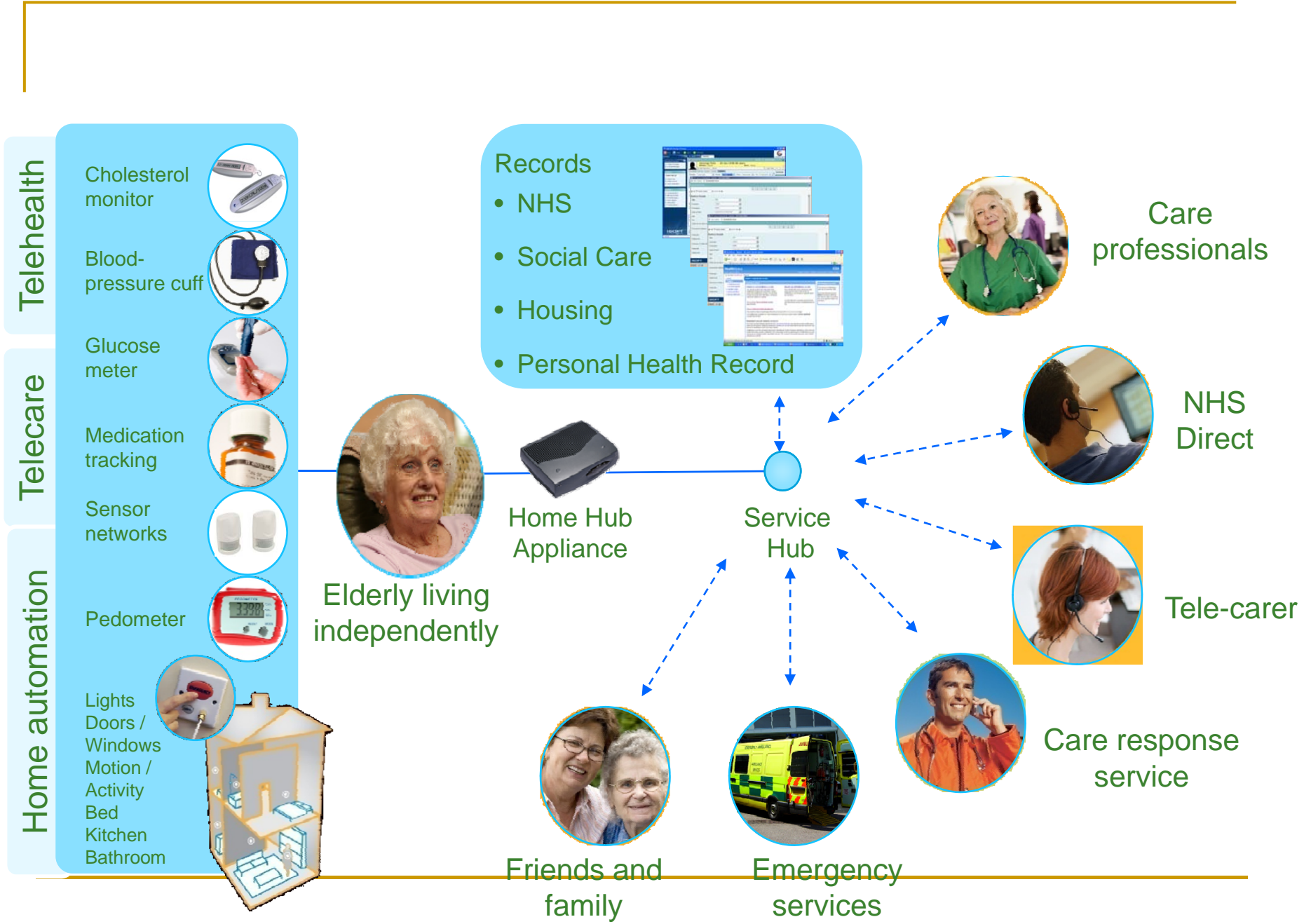
Impact on health system in Croydon

- Since the introduction of the Virtual Community Wards the PCT has saved £1 million in Emergency Admissions and over the last 18 months the local hospital has closed 100 beds.
 - The Virtual Community Wards project won four prizes at the Health Service Journal Awards in November 2006: Primary Care Innovation, Clinical Service Redesign, Patient-Centred Care, and Information-Based Decision Making.
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Telecare and Telehealth

Telecare: the remote delivery of care to people in their own home by means of telecommunications and computer-based systems – e.g. a falls sensor

Telehealth: the remote exchange of physiological data between a patient at home and medical staff to assist in diagnosis and monitoring – e.g. blood pressure monitor



‘Whole System Demonstrator’ Pilots

- £31m randomised control trial of 6000 patients in three ‘localities’ of England
 - Proof of concept approach - the level of benefit associated with telehealth and telecare in an integrated health and social care environment.
 - To what extent does the WSD model of care:
 - ❑ promote long term well-being and independence
 - ❑ improve individuals and their carer’s quality of life
 - ❑ is more cost effective
 - ❑ is more clinically effective
 - ❑ provides an evidence base for future care and technology models.
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- Action network
 - Events, research and development
 - To assess and evaluate the progress and impact of telecare and telehealth in enabling long-term conditions management
 - An integrated point of access for published materials on the evidence
 - All the latest news on telehealth and telecare in the management of long-term conditions
 - Regular updates from the WSD pilot sites
 - Regular features on the latest policies and evidence
 - Archive of WSDAN events, presentations and papers
 - A new 'one-touch' searchable directory of the evidence-base
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Disease Management

- Policy that every individual with a LTC (15.4m people) should have an *individualised care plan* and *care co-ordinator*
 - *Personal health budgets* – just being piloted
 - Payment to primary and community care providers incentivises disease management: e.g. QOF payments
 - Clinical guidelines – e.g. for diabetes - influential
 - BUT: no direct imposition of ‘disease management’ programmes and approach fragmented
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Health Promotion and Disease Prevention

- Immunization and screening programmes in primary care extended: e.g. the 'Life Check'
 - *Your Health, Your Way:*
 - Information prescriptions
 - Peer-support groups
 - Expert patients and expert carers
 - Healthy lifestyle advice: e.g. 5-a-day, smoking cessation
 - Tools and self-monitoring devices
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Practice-based commissioning (PBC)

- ‘Budget-holding’ GP practices since 2004
 - Design ‘integrated’ services for local patients with incentives to keep them ‘out’ of hospital
 - Some developments towards ‘referral management’ systems, but a *failing policy*
 - DH calls for ‘reinvigoration’ and creates the idea of the ‘integrated care organisation’
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Integrated Care Organisations

- Darzi Review indicated DH will set up integrated care pilots in primary care
 - ‘The principle of better care integration between primary, community and social care implies a welcome move to better continuity of care, a more personalised service, and more efficient care co-ordination to patients’.
 - Tension between integrating care across community, primary and secondary care on the one hand, whilst on the other promising patients in the draft constitution the right of greater choice not only over treatment but over providers.
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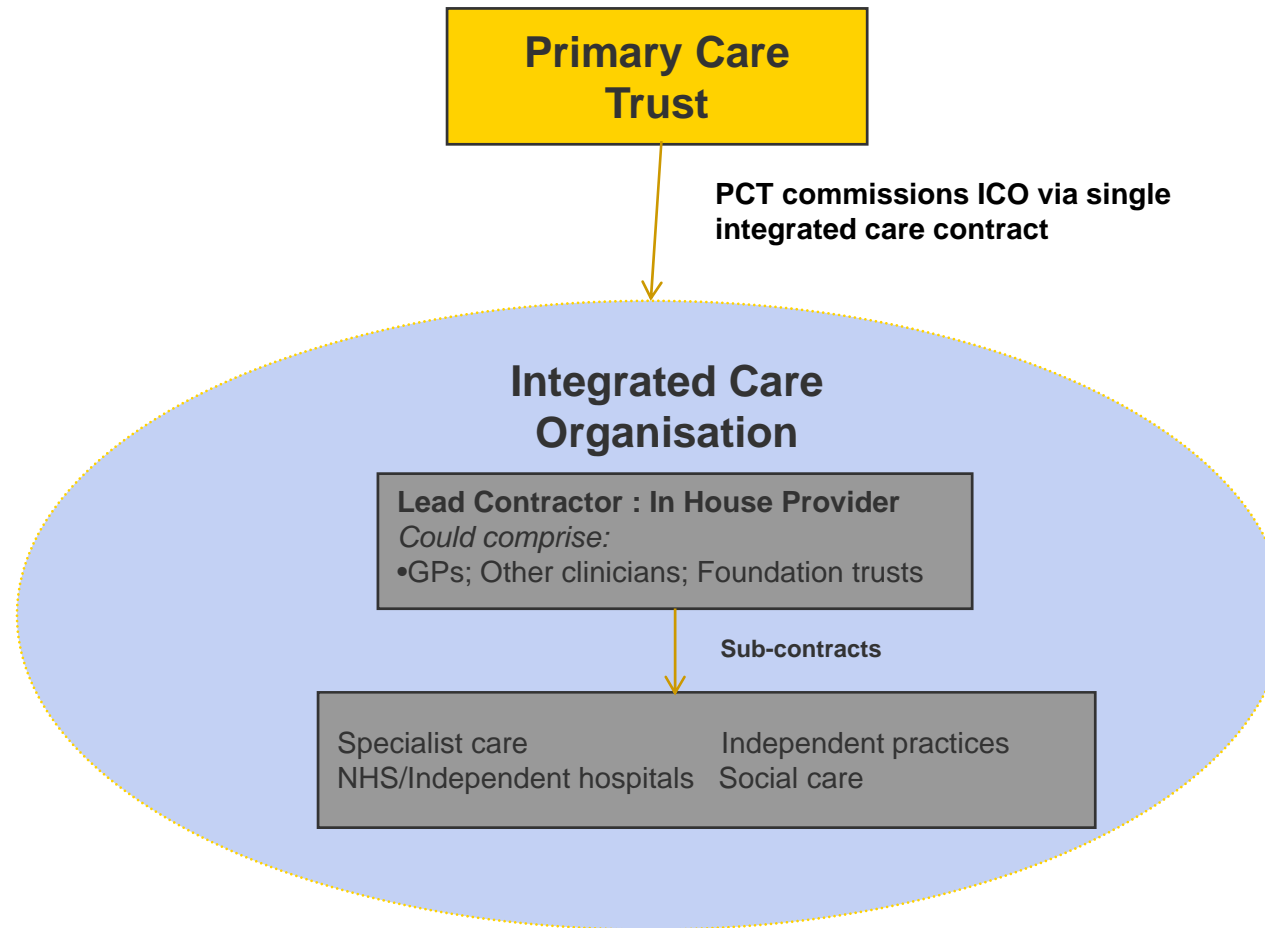
Integrated Care Organisations

- A first wave of 16 ICO pilots went live on 2 July 2009, to 'initially run for two years'
 - Evaluation being undertaken by RAND Europe and Cambridge University
 - Vary significantly in their scale and scope of their operation
 - size of the population served,
 - degree of organisational 'linkage'
 - the range of services involved: closer alignment of provider services for selected conditions (e.g. diabetes) or care groups (e.g. older people)
 - vertically *and* horizontally integrated
 - system-wide integration of payer and provider functions across a whole health economy.
 - 'aspirational' pilots – roles and functions developing over time
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The 16 ICO Pilots

BOURNEMOUTH & POOLE PCT	Dementia care
CAMBRIDGE ASSURA LLP	End of life care
CHURCH VIEW MEDICAL PRACTICE	Personalised LTC management
NEWQUAY	Dementia care
NHS CUMBRIA	Case management of people with severe LTCs
DURHAM DALES	Integrated care to a rural population
NENE COMMISSIONING CIC	New models of LTC management
NHS NORFOLK & NORFOLK CC	Personalised care planning to the elderly
NORTH TYNESIDE	Prevention of falls
NORTHUMBRIA HEALTHCARE FT	COPD self-management and care co-ordination
PORT ISAAC	Integrated mental health care teams
PRINCIPIA (Nottinghamshire)	COPD care – community wards
NHS TAMESIDE & GLOSSOP	CVD care – pro-active case management
TORBAY CARE TRUST	Personalised care for the elderly
TOWER HAMLETS PCT	New models of LTC management
WAKEFIELD	Substance misuse service

An ICO Example



Conclusions

- Primary and community care remains poorly integrated in England
 - Many GP practices remain isolated, and community trusts now creating a further organisational 'tier' in the system
 - Some moves to larger 'federations' of practices with greater integration with community nurses, hospital specialists and social care staff
 - Integrated care strategies remain 'haphazard' – lack of investment and commitment nationally
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Gracias!

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