

# **Evolving Care Delivery Model – UK's Experience**

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# Rapid PC History - Development and Incentives

- 1948 - registered list
- 1966 - new GP contract-incentives for teams to expand the role of the practice
- 1990 - new contract-specific monetary incentives to reward good practice
- 1991 - Fundholding
- 2004 - new GP contract with extensive P4P
- New policies -
- Our Health, Our Care, Our Say, 2006
- Next Stage Review

# 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 Chronic Disease Management?

- 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.

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.

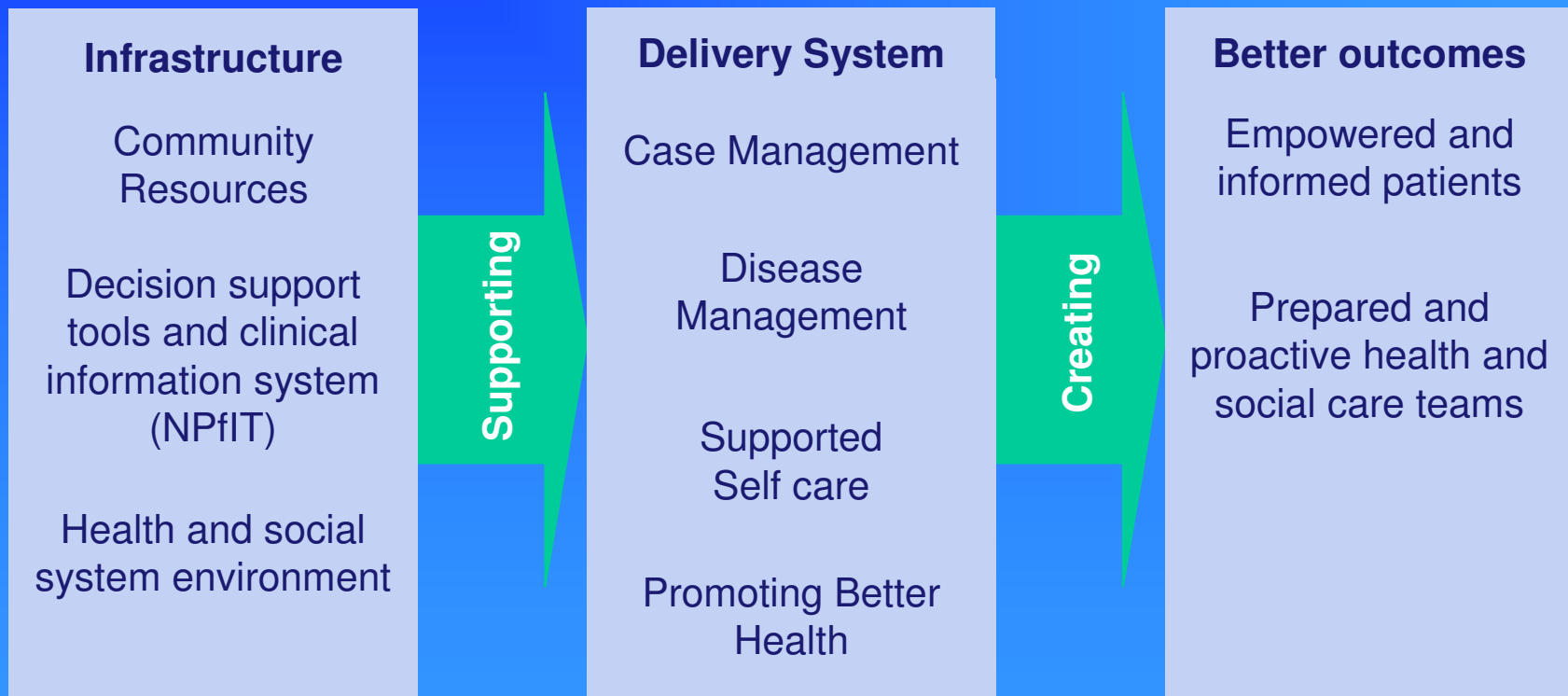
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# CDM

- In 2005 came the publication of the NHS and Social Care Chronic Disease Management 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 Chronic Disease Management Model



# CDM 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

# 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

# CDM 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](http://www.kingsfund.org.uk)

# The 2006/07 QOF

- 35 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.

## Range of White Paper CDM 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 chronic disease to be offered a care plan. We will issue good practice guidance in early 2007.*

# CDM New Developments

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

# Primary and community care strategy: overview

<b>Case for change</b>	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

<b>Our vision</b>	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

<b>Leading local change</b>	Reinvigorating PBC	Piloting integrated services	World class commissioning	Health and social care
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