Making integrated Out of Hospital Care work

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Health Reform Bill 2012
Underpinning drivers

- Local determination and accountability
- Clinical not management leadership
- Public health responsibility moves to local government
- Primary care reform
- Transformational change from below in times of austerity
- Use of the market when appropriate?
- Changing role patient and public
Accountability

Pre 1\textsuperscript{st} April 2013

- Strategic Health Authority
  - PCT

Post 1\textsuperscript{st} April 2013

- NCB (old SHA)
  - Member practices
  - H&WB
  - CCG
Long Term Conditions

• 15.4m people in England have one or more long term conditions (LTCs)

• Utilisation of health services is high amongst the LTC group – they account for 30% of the population, but 70% of NHS spending (c. £70bn)

• The number of people with multiple conditions is projected to increase and this will put pressure on NHS budgets

• LTCs are strongly linked to health and economic inequalities

• While the majority are elderly by no means all
The rise in numbers and complexity
The Impact

Annual admission rate per 1000 patients vs. No of conditions

- Potentially preventable admission
- Other emergency admissions
And the money

- Arctic’ scenario: real funding cuts (-2 per cent for first three years, -1 per cent for second three years)
- ‘Cold’ scenario: 0 per cent real growth in six years
- ‘Tepid’ scenario: real increase (+2 per cent for first 3 years, then +3 per cent for the next three years).

Long Term Conditions
The Personalisation agenda

• Risk profiling and stratification of risk in primary care
• Integrated community teams with single point of contact supported by Care Planning
• Transferring knowledge and control back to the patient

Enabled by
• Change in tariff moving to “A year of Care”

Aimed at
• Proactive, personalised care for those “at risk”

Moving away from
• Single disease specific pathways
What is stopping us

• Uphill all the way. Lack of Change Management skills
• Fragmented systems and teams (Organisation before system) “who is the district nurse?”
• Perverse contractual incentives and immature contracting
• Social services operating on a shoe string
• Primary care overwhelmed and needs reform
• Self management an unknown quantity
• Insufficient operational calibre management
• IT systems and support disjointed and controlled by powerful suppliers
Complex system change requires interconnected solutions and a structured program

Aim
Reduce hospital admissions and bed days by proactive care in the community and intensive community support

Primary driver’s
- Risk profiling (5%)
- Pt self-management programme
- Integrated community teams working with primary care
- Agreed patient pathways with monitoring
- Shared Objectives with Local Authority Objectives
- End of Life Care

Secondary drivers
- Reliable accepted tool used by primary care
- Clinical review of high risk patients with care planning
- Integrated around clusters to support practices in managing high risk pts
- Proactive manage high risk pts by practices & community
- A&E and MIU pathways
- SCAS pathways
- Local Authority involvement in care planning and care in the community
- End of Life care part of virtual wards

Enabling projects
- Roll out and action re-calibration of ACG tool
- Clinical dashboard and care planning part of OD programme for practices “The Productive Practice”
- OD programme for community prior to writing spec in partnership with practices and service
- Contracting strategy for providers with shared risk/incentives
- Single 111 number and SPA linked by enabling IT (PCT & Solent)
- Shared objective for use of reablement funding

Centre for Commissioning
Design hub for the House of Care

- Coalition “of the determined” hosted by the RCGP
- Support delivery
- Learning by doing in real time
- Aimed at “Communities of Practice”
My own experience

• Part of the local governance system
• Putting into practice in my surgery (Asian Elders)
• Using risk stratification tools (applying the DES)

But

• Care planning not the same as a care plan
• Culture continually pushing towards the reactive medical dependency model
• Professional anxieties and time pressures
Critical Success Factors

• Whole system clinical support for the model of care
• A proper implementation programme with high calibre operational change management in place
• Separate (for now) the “reactive” day job from “proactive” process of care planning
• Reinvent the primary care team including bringing together disparate teams
• Good working relationship with the voluntary sector and patient groups
• Getting the right contractual incentives in place
• Address cultural tribal difference
Summary

• Collaborative pro-active care planning is key
• Making this a reality is hard work
• Culture and process change must be aligned – too many elephants in the room
• Driven from the bottom as well as the top
• Public and community involvement a critical success factor

But

Does anyone have an alternative?