NHS
Camden
Clinical Commissioning Group

Improving Quality of Life of Long-Term Patient - From the Community Perspective

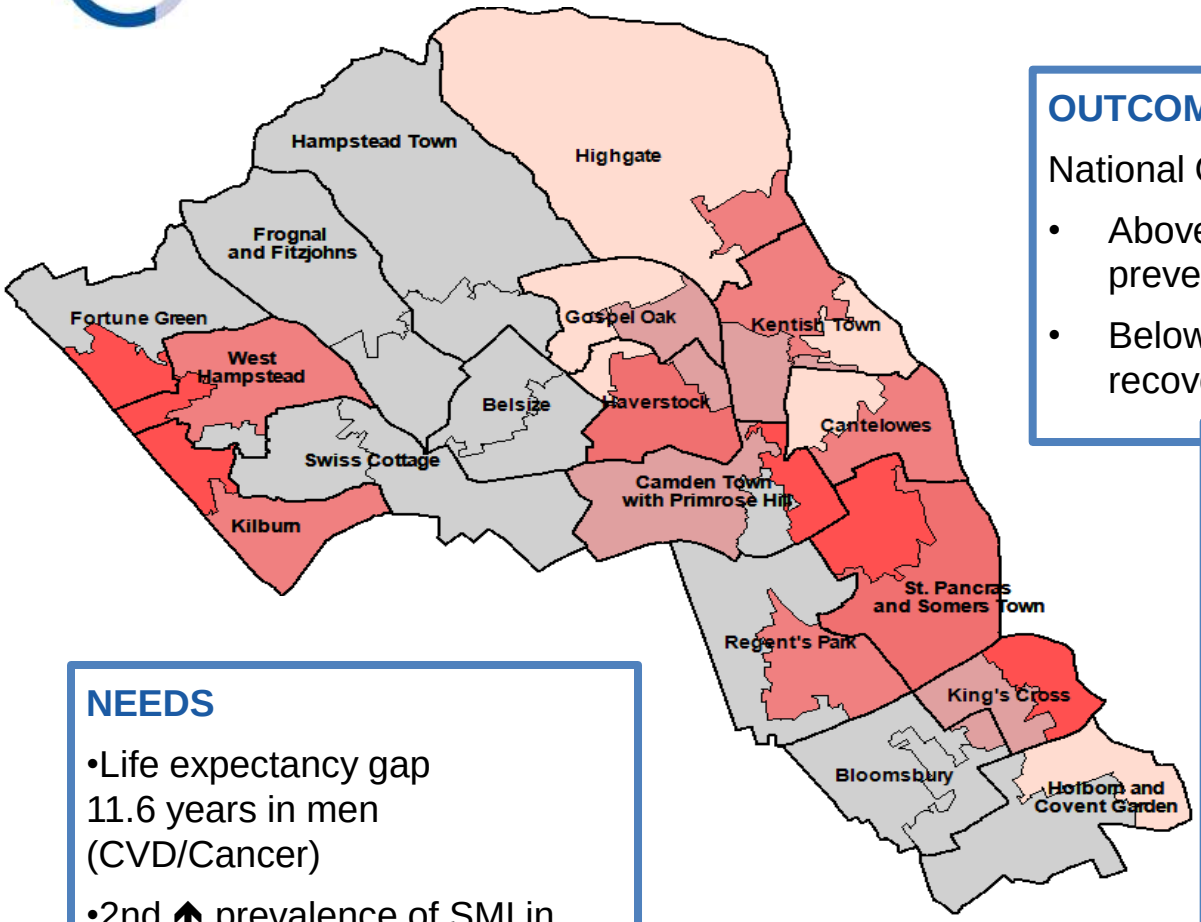
Dr Caz Sayer, Camden CCG Chair

Context

- The Health and Social Care Act 2012 created new statutory organisations - Clinical Commissioning Groups (CCGs). These are:
  1. Led by clinicians
  2. Responsible for commissioning community and most hospital services

- Camden CCG:
  - Inner-city London borough
  - Population of around 250,000
  - Health inequalities linked to deprivation

Camden story – why action is needed



OUTCOMES

National Outcomes Framework:

- Above-average results related to preventing people dying prematurely
- Below-average for helping people recover and live with illness

VALUE

- 2nd highest spend per weighted population of London CCGs with variable outcomes
- Spend on acute highest in London
- Primary care spend among lowest in London but good outcomes
- Mental health spend highest in London
- Community care spend average

NEEDS

•Life expectancy gap 11.6 years in men (CVD/Cancer)

•2nd ↑ prevalence of SMI in England

•High proportion 19-40's ↑ access to urgent care

•Poor outcomes in under 5's

•By 2017 over 85s ↑ 35%

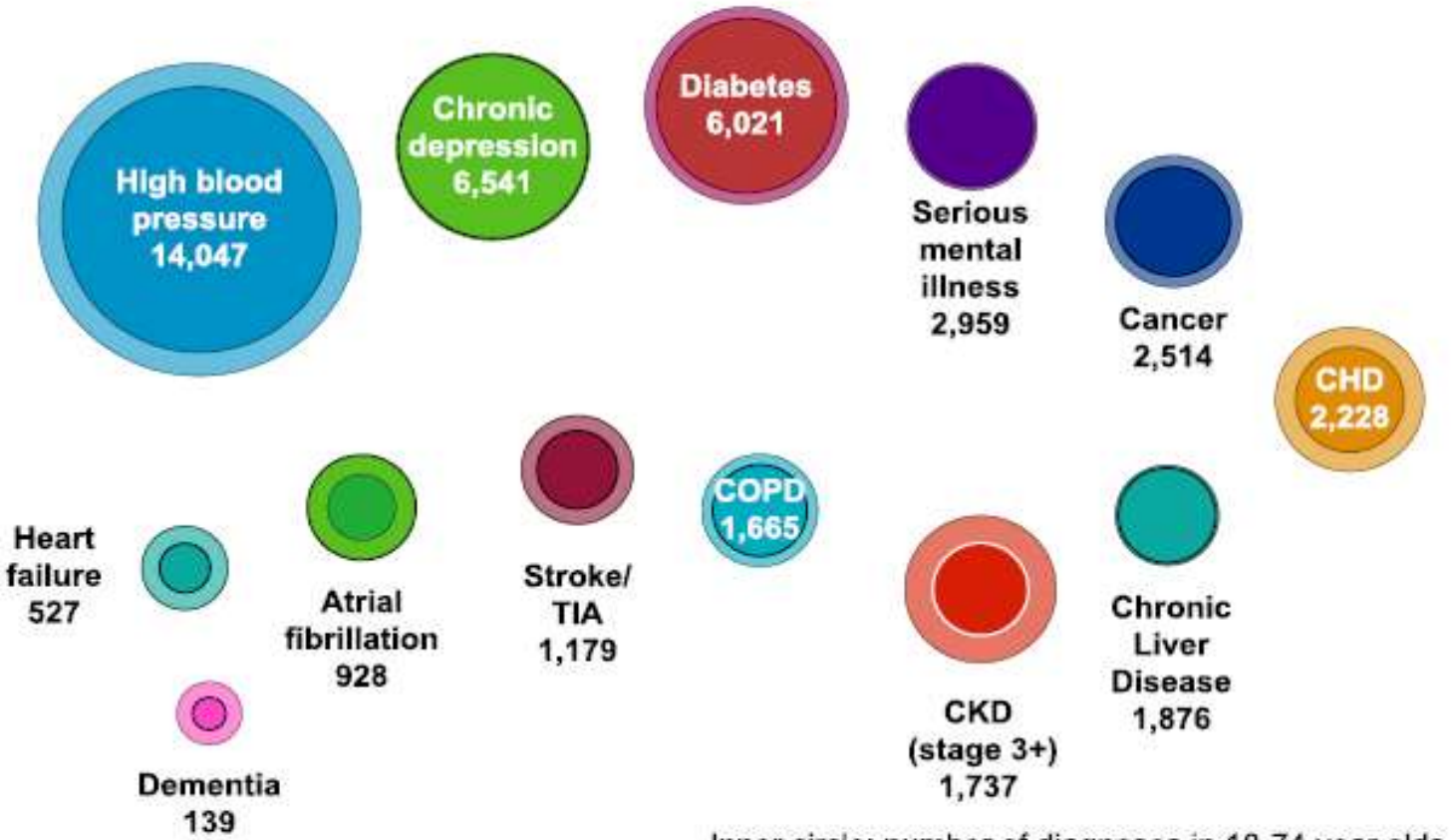
UTILISATION

- Demand increasing greater than population growth
- e.g. in excess of 87,000 A+E attendances per year for Camden Registered patients

Why are Long Term Conditions a Priority in Camden?

1 in 7 people living in Camden have a Long Term Condition

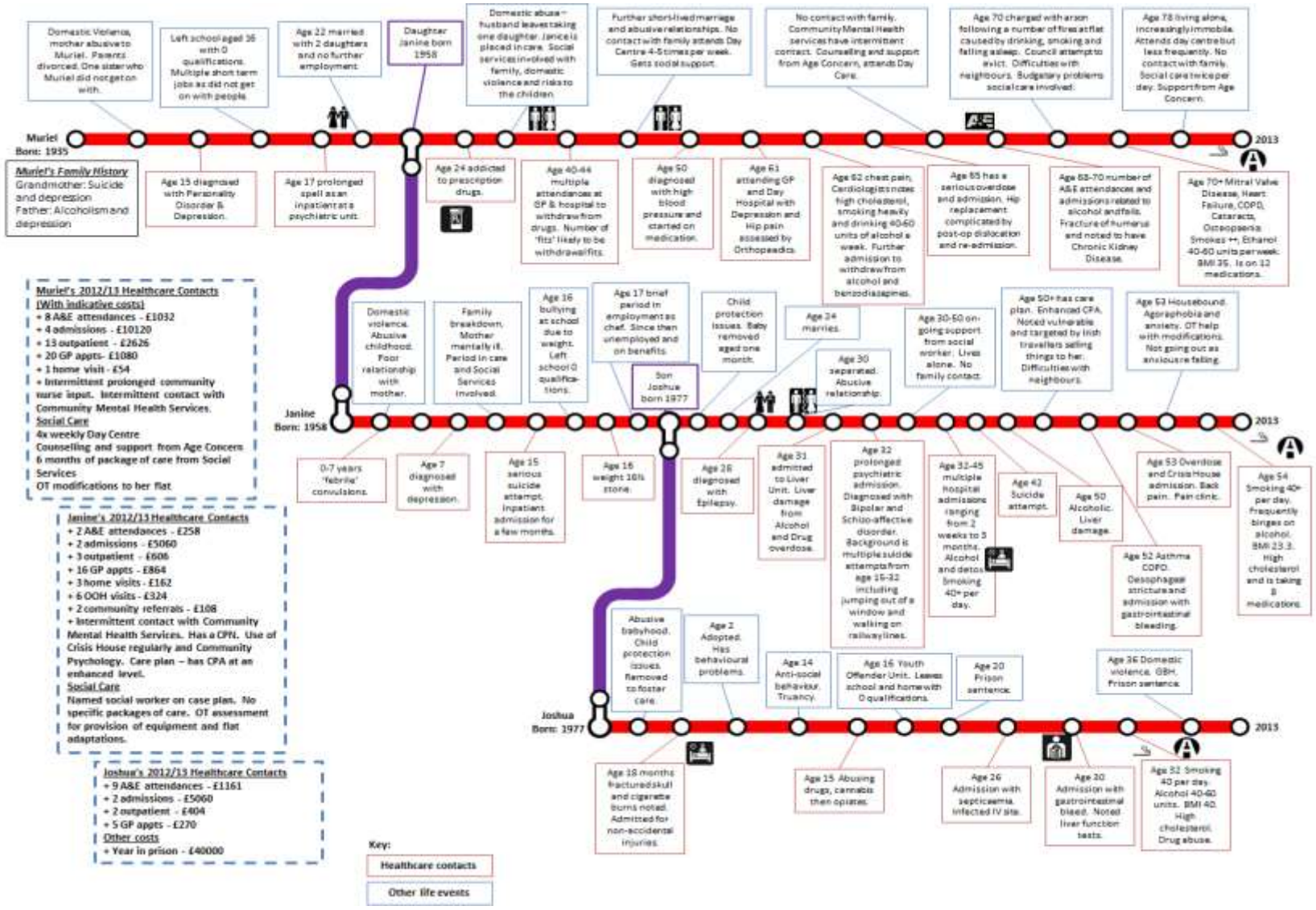
- such as heart disease, lung cancer, high blood pressure or diabetes



Inner circle: number of diagnoses in 18–74 year olds
Outer circle: number of diagnoses in all ages
Note: It was not possible to extract data for chronic depression for six practices
Source: Camden's GP PH dataset, 2012

Camden CCG's Strategic Vision

- Case study of three generations of long-term conditions



Camden CCG's Strategic Vision

The challenges

1. Population level:

- Predictably poor health outcomes
- Lack of focus on prevention
- Lack of personal responsibility for health
- Too little supported self-management

2. Systems level:

- Reactive, poorly co-ordinated services little integration
- Focused on organisations' needs not patients'
- Fragmented, duplicative and inefficient
- Reliance on unplanned care
- Payments and incentives that do not support integration

3. Individual:

- Complex patients mirror complex system
- Primary care needs support to manage
- Health and social care not integrated
- IT systems need developing

Who are the major stakeholders?

How do you get them invested?

1. **Clinical Leadership**
   - case for change
   - pace of change
   - culture/relationships/behaviours

2. **Partnerships** - patients, Local Authority, Providers, Voluntary sector.

3. **IT, Data, Information, Knowledge, Insights**
   - Camden Integrated Digital Record, data-sharing agreements, measurement including what does not happen (wellness not illness)

4. **Structures** - new pathways, settings of care, extended primary/community provision

5. **Contracts/Incentives/Lead provider**, **Personal Budgets**

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Key Strands

Identification

…of people at high risk of illness or complications

- Adequately resourced services responsible for identifying people at high risk
- Training
- Maximum use of IT capability

High quality services

Good care in the right place at the right time

- Clearly defined pathways
- Sufficient capacity and skills
- Quality of care information measures & feedback

Integrated Care

Health and social care built around people's needs

- Creating an environment that promotes collaboration between existing services
- Investing in services/roles that promote integrated care
- Contractually incentivising an integrated care approach

Improved Outcomes

Prevention where possible - Early diagnosis - Consistent quality - Patient consultation - Review and reconfigure if necessary

Every Camden Child

- School nursing-health checks, life-style advice, immunisations, emotional support
- Activity parks and weight management (reduction in Year 6 obesity 37%-34% in 3 years)
- Integrated care for children with developmental concerns and disabilities
- Support for parents with mental health needs (98% improvement in relationships with child)
- Domestic Violence workers and training (343 new referrals in 14 months-previous 3/year)
- Improving the health of looked after children (5% increase in annual assessments 89-94%)
- Complex needs integrated working (75% achievement of goals, 63% reduction in out of borough placements
- ‘Mind the Gap’ project

CAMHS

Outcomes

Methodology

•Triangulated outcomes measurement tools, combining a range of tools (e.g. clinical rated, patient rated and 'significant other' such as parent or teacher rated) to ensure inter-subjective testability

•Goal based measures (GBM) used across all services:

- Ensures consistency of approach
- Enables commissioners to benchmark services against one another

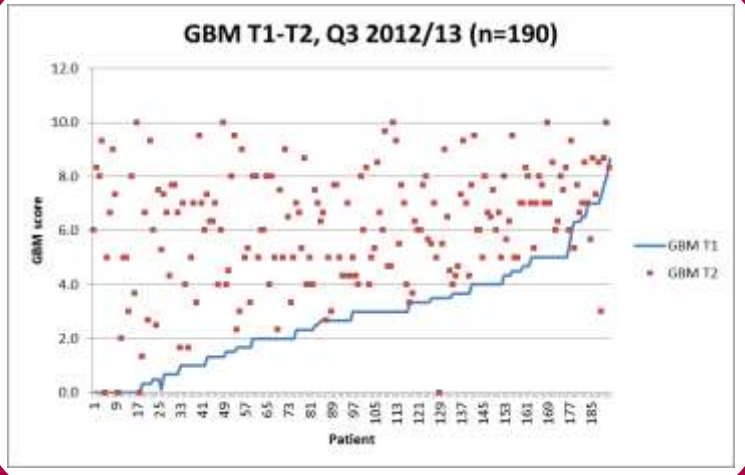
Clinical effectiveness measures

• The number of children in the treatment cohort who have improved mental health as measured against GBM

• The percentage of cases falling within clinically significant ranges at the start of the intervention and at case review / case closure, as measured against the Child Global Assessment Scale (CGAS – clinician rated measure)

CQUIN

• 75% of patients to achieve an improvement in their score on the GBM, from Time 1 to Time 2, on at least 2 targets (goal)



Impact on acute activity (CAMHS Tier 4)

• **32% reduction in Tier 4 admissions from 2010/11 to 2012/13** (from 31 admissions in 10/11 to 21 admissions in 12/13)

• **72.8% reduction in expenditure on out of area admissions from 2010/11 to 2012/13** (from £924k in 10/11 to £251k in 12/13)

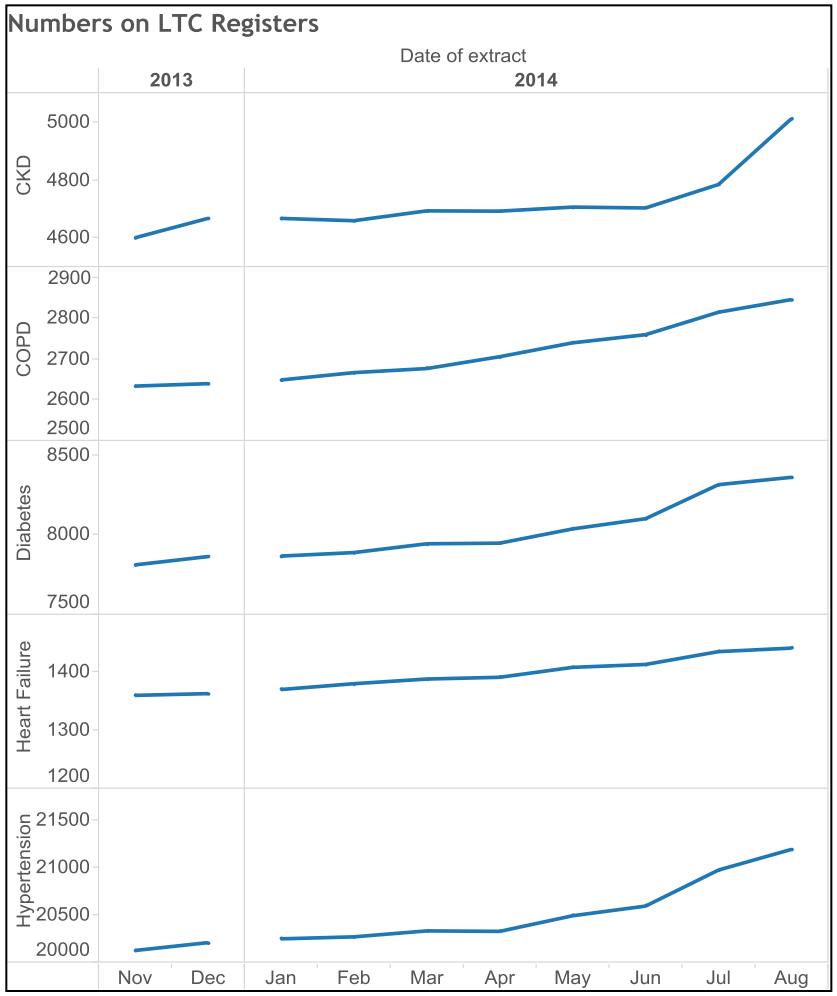
Long Term Conditions – what are we doing?

Strategic Objective	Project	Activity
IDENTIFICATION *People at high risk of illness or complications*	Long Term Conditions local commissioned service (LTC LCS)	Systematic **review** of practice lists and invitation of high risk for testing linked to practice and locality **prevalence** targets
	Community Heart Failure (HF) and COPD Services	Specialist diagnosis in **community** settings of **high risk cases** identified and referred by GP
	Cardiovascular disease root cause analysis	Of all new MI and CVA, understand where interventions to **prevent** these could be improved
	Early diagnosis of cancer programme	A systematic programme for promoting **best practice assessment** in practices and raising **awareness** of symptoms and signs in the community
	Mind the Gap	**Transition service** for 19-25yr old with mental health illness

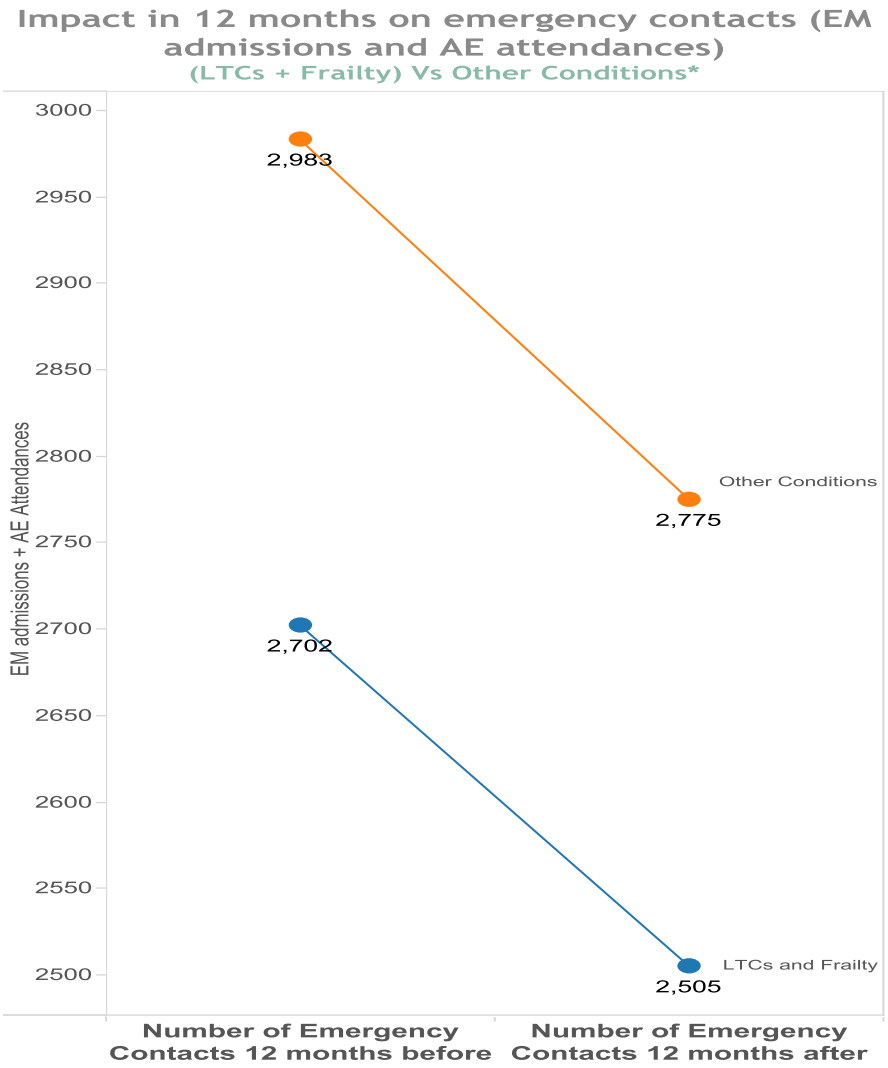
Long Term Conditions – what are we doing?

HIGH QUALITY SERVICES ***Good care, right place, right time***	LTC LCS	In-depth **clinical reviews** and **care planning** for patients with high risk diabetes, HF and COPD
	LTC Education programme	Education events, training courses, practice visits and peer review to **improve skills in managing LTCs** in primary and community care
	Hypertension strategy	**Identification and effective management** of people with HPT
	Atrial Fibrillation (AF) project	Increase % people with AF on **anticoagulation**
INTEGRATED CARE *Co-ordinated and responsive, patient centred, across health and social care*	Integrated diabetes service	**Integrated** Camden diabetes service as partnership b/t RFH, UCH, CNWL, C&I, Haverstock Health
	Camden Integrated Care Services for HF, COPD and CKD	**Community services** for promoting integration between primary, community and secondary care services for specific long term conditions

Identifying People at Risk



Did it work?



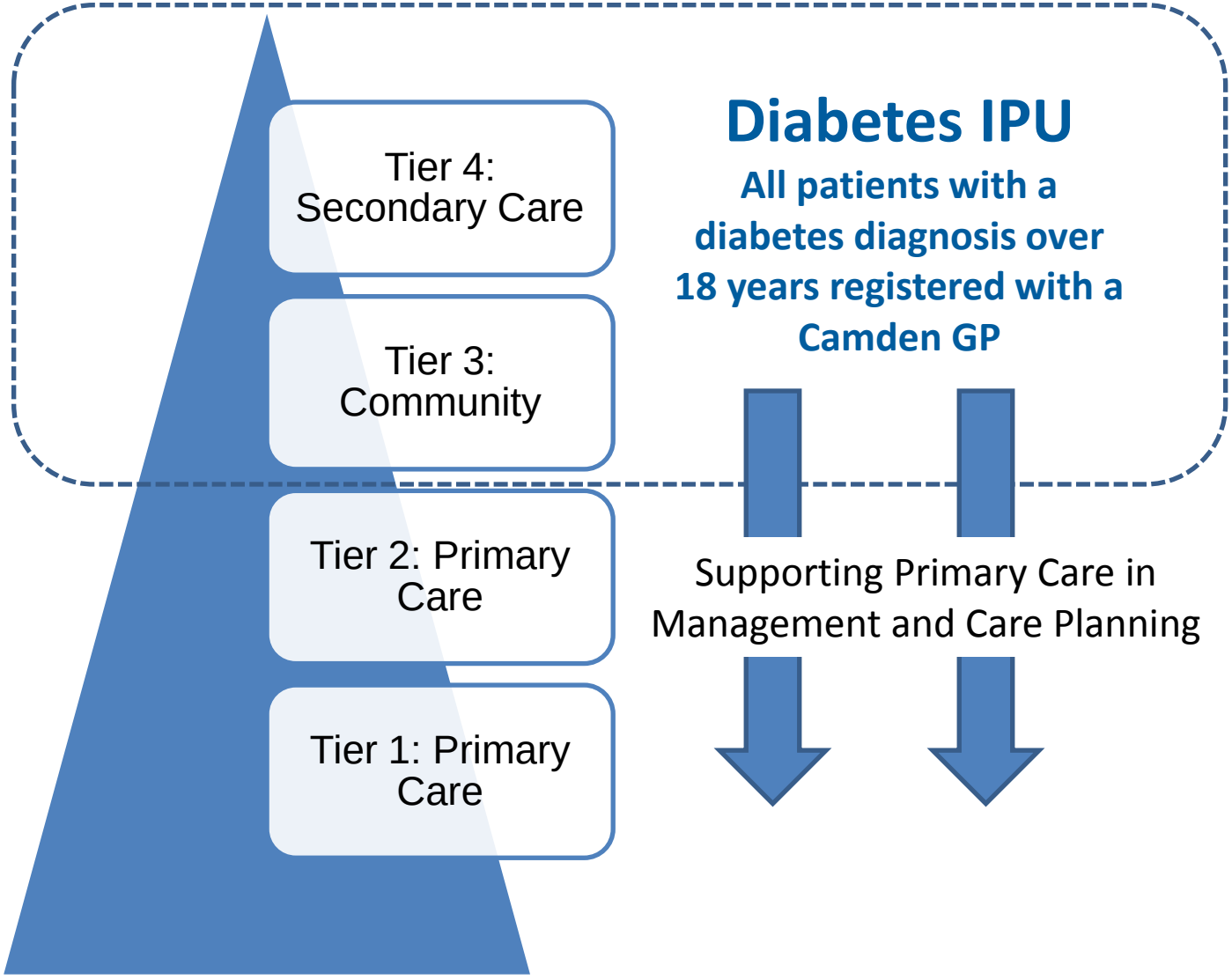
* 'LTC & Frailty' include Patients with one or more of Diabetic medicine, CKD, COPD, CHD, Heart Failure and Frailty but do not have any other conditions.

* Other conditions include patients with one or more of conditions Asthma, Peripheral Arterial Disease, Stroke and TIA, Atrial Fibrillation', Palliative Care, Rheumatoid Arthritis, Hypothyroidism & Hypertension but do not have the five LTCs or Frailty

Outcomes Achieved in Long Term Conditions

- **5.5** strokes prevented
- **9% increase** in people with Atrial Fibrillation started on anticoagulation medication since October 2013 (5.5 strokes prevented)
- Increased number of people with Heart Failure on evidence based medication
- **1000** more people identified with hypertension (November 13 – July 14)
- Increased proportion of people with a BP of less than 140/90
- **6.9%** improvement in the number of Diabetic patients with an HbA1C of <75mmol/mol in one year (proxy measure for improved outcomes)
- **7.4%** reduction in Diabetes admissions from April 2013-April 2014
- **16%** increase in dementia diagnosis rate in 2 years now **67%** in 13/14 with increased referrals and investment in Memory service
- **19.9%** successfully completed drug addiction treatment 13/14 (49% increase on previous year, 5%>national)
- **6%** increase access to ETOH treatment-42% increase in successful completion

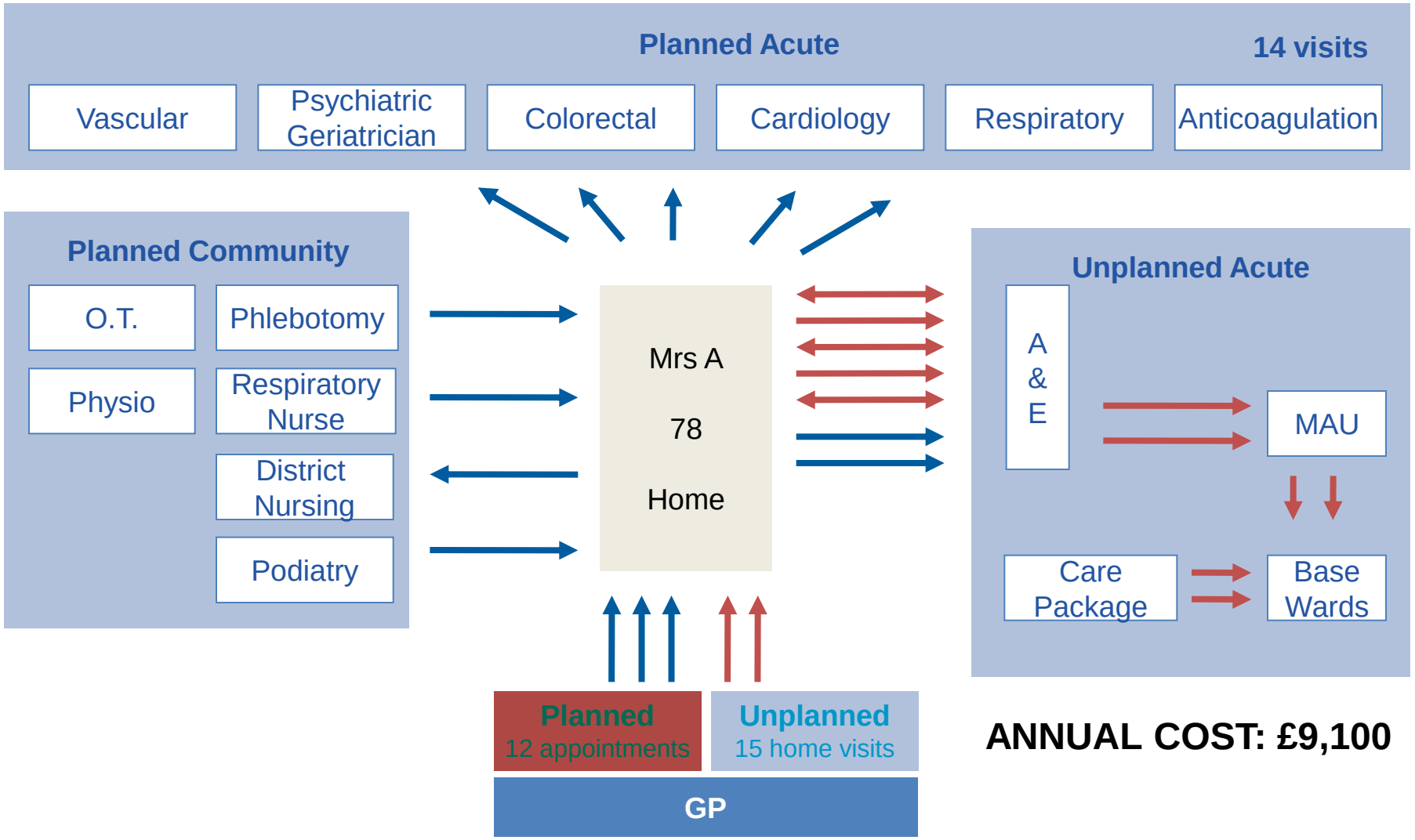
Service Model



Diabetes IPU Clinical Establishment

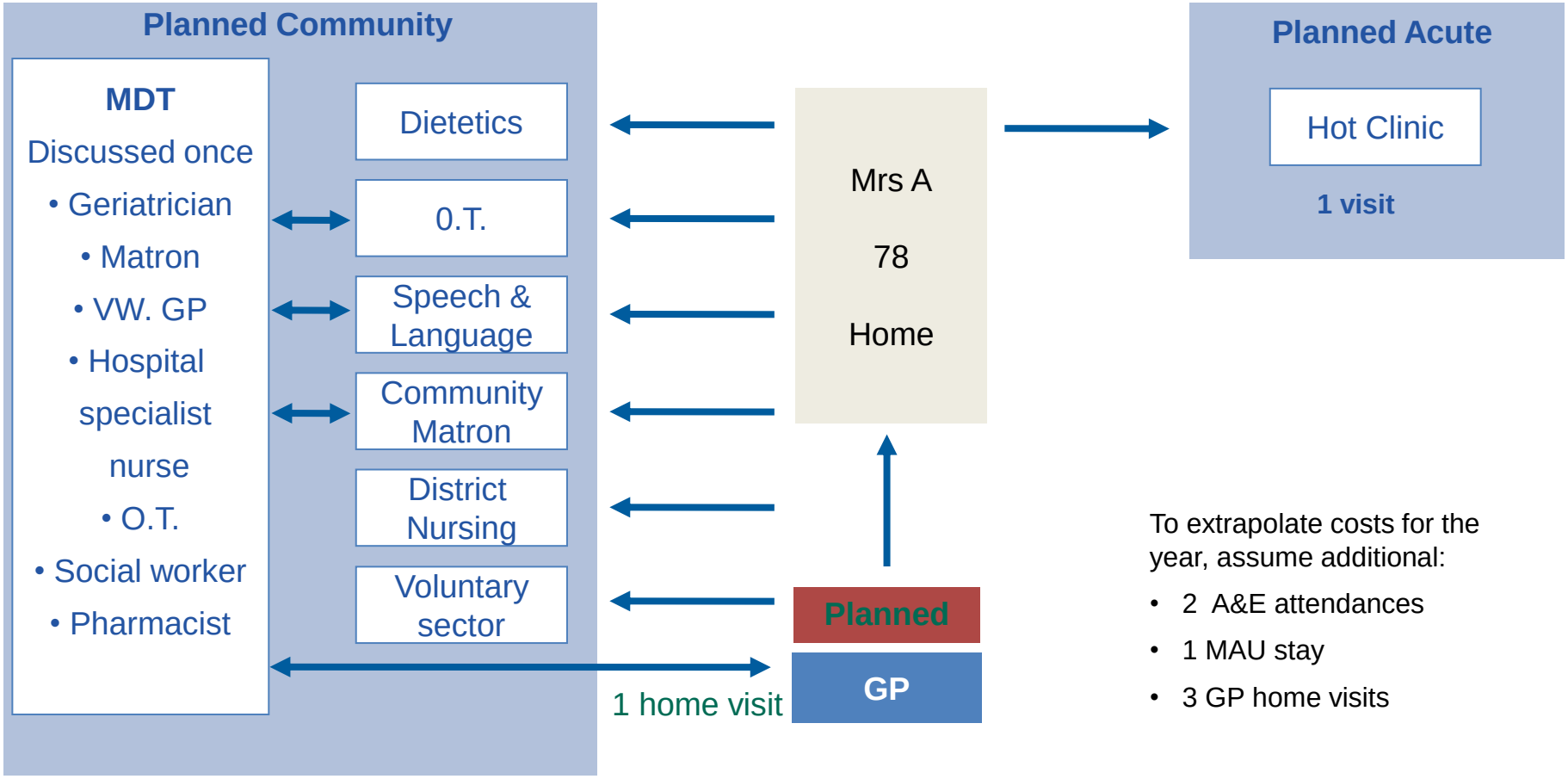
- DSNs
- Podiatry
- Dietetics
- Psychology
- Consultant Sessions

A Patient Journey - Before care planning



ANNUAL COST: £9,100

A Patient Journey – in the 6 months following care planning



To extrapolate costs for the year, assume additional:

- 2 A&E attendances
- 1 MAU stay
- 3 GP home visits

ANNUAL COST: £3,600

Evaluation Outcomes

Underlying Assumption: Population clearly defined using Edmonton Frailty score or similar

Outcome Hierarchy for Frail Elderly:

Tier 1

Survival

- Mortality Measure: Six months might not be a good measure, but 1, 3 and/or 5 years could be a better measure for this population. Longer time periods may be less valuable. Not necessarily a single measure
- Appropriate duration for mortality measure should include durations around the current mean survival for this patient population

Health Status Achieved or Retained

Degree of recovery / health

- Measure extent the person feels able to live independently and do the things that matter to them e.g. doing their shopping, driving, getting out.
- Measure how much control the person feels he/she has over his/her life and care package
- Measures of depression, isolation- depression score, isolation score
- Metrics of satisfaction in (or understanding of) care given
- Carer metric/stress measure (eg. Strain index)

Tier 2

Time to recovery, maintenance of/return to normal activities

- Number of days spent at home / not spent in hospital (e.g. Proportion in (6) month period)
- Measure extent still able to see friends / family at the same frequency
- Short-term 'chaos' avoidance measure (reflecting speed of implementation of care package)
- Length of time patient remains in own home from identification

Process of Recovery

Disutility of care or treatment process (e.g. treatment-related discomfort, complications, adverse effects, diagnostic errors, treatment errors)

- Measure extent pts feel care is co-ordinated
- Measure extent pts have to 'repeat their story' when receiving care
- Measures of poly-pharmacy (eg. 'bags of wasted medication measure', reported adverse drug rtn)
- Length/number of unscheduled hospital stays/A&E attendances per (year)
- (Appropriate) Residential care referral rates (eg. post admission)

Tier 3

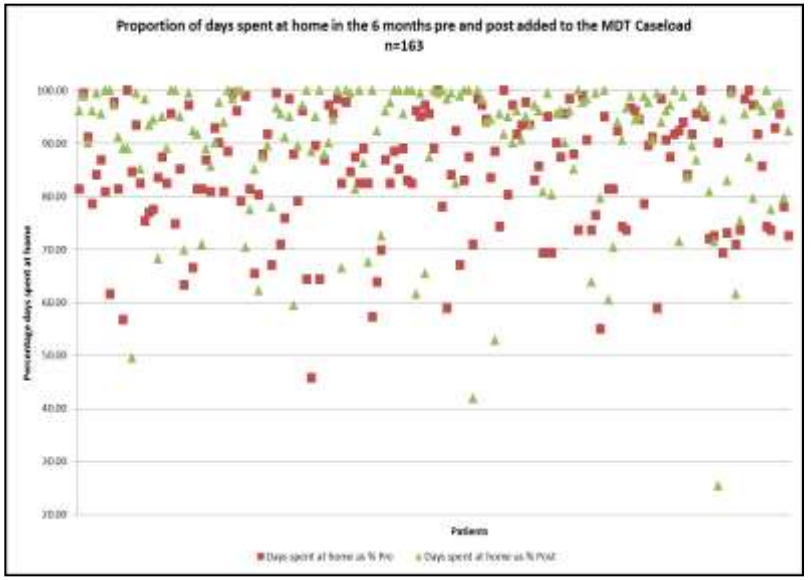
Sustainability of recovery or health over time

- Measure sustainability/rate of decline in general health
- Multi-morbidity measures (eg. CVA, MI rates over time)
- Change in EFS score over time
- Measure extent patients feel they are reliant on carers or relatives over time
- Measure extent to which they drive the treatment they are willing to receive if there are multiple long term conditions
- Number of carers/carer hours required per (week), over time
- Number of outpatient appointments per (month/annum) over time

Sustainability of Health

Long-term consequences of therapy/lack of (e.g. care-induced illnesses)

- Falls rates (or fracture NOF) per (year)
- Independent living measures over time (subjective – extent patient believes they are living independently over time)
- BMI/nutrition measures over time
- Confusion scores over time



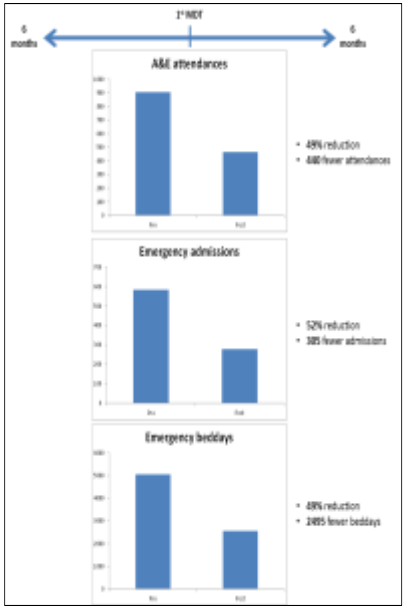
Caseload Specific

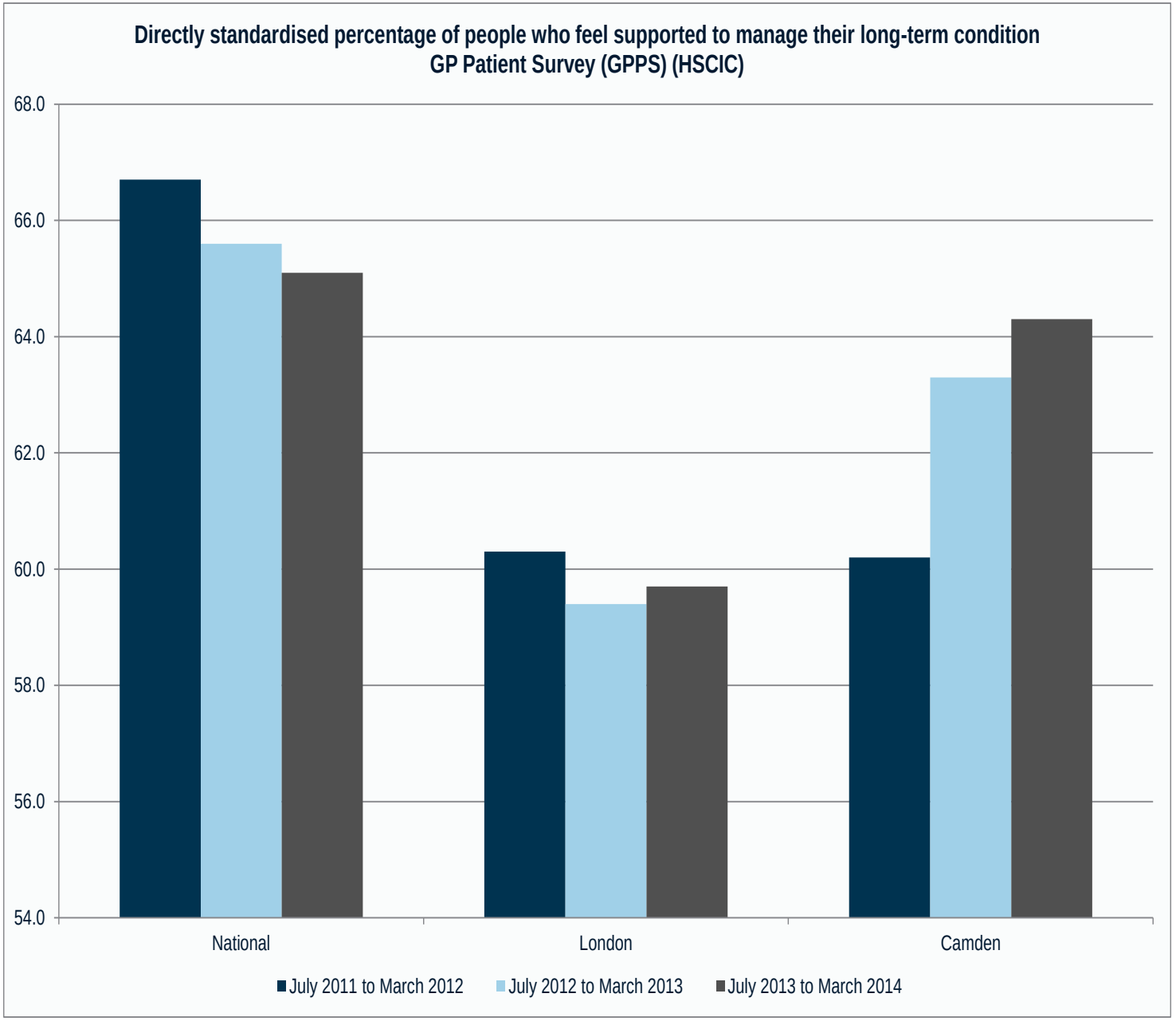
The chart above shows the days spent at home 6 months prior to case management and the days spent at home 6 months post case management, a T-test analysis shows that these results are statistically significant.

The reduction in acute activity following case management and review by the frailty multi-disciplinary team – is shown above right.

All patients over 60

These charts present A&E attendance and admissions trends for the CCG over 60 population.




Directly standardised percentage of people who feel supported to manage their long-term condition
GP Patient Survey (GPPS) (HSCIC)
68.0
66.0
64.0
62.0
60.0
58.0
56.0
54.0
National
London
Camden
July 2011 to March 2012
July 2012 to March 2013
July 2013 to March 2014

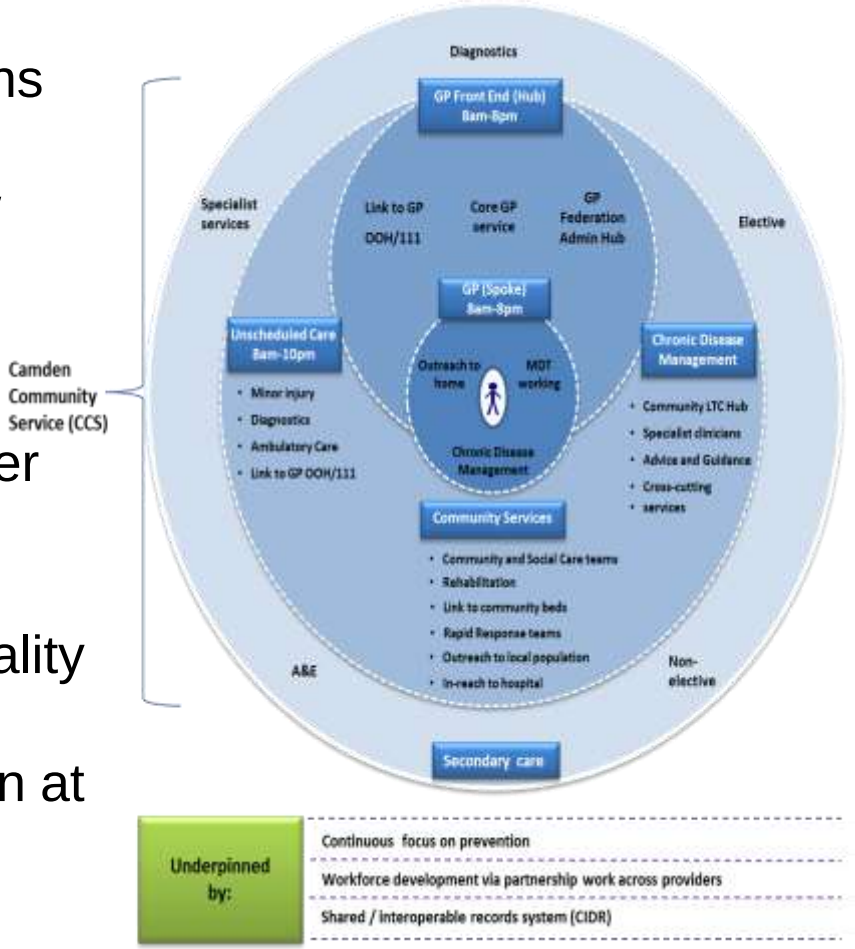
Future State

Upscale:

1.Extend approach to all chronic conditions
2.Wider geographical coverage
3.New structures/contracts to deliver new models

Key messages:

1.Integration of the whole system to deliver improved outcomes to populations and individuals
2.Measurement and evaluation drives quality and adoption
3.The clinical case for change can happen at pace



Camden CCG's Strategic Vision

Joshua

" I will be able to access, in ways that work for me, help and advice on employment, housing and healthy life-style choices and opportunities and that enable me to take more responsibility for my future family and health"

Janine

" I will be able to access services conveniently and quickly that will identify my illness early, treat me within services that see me as a whole person and consider all my health and well-being needs and support me to stay well and plan for my future"

Muriel

" I will be able to stay at home where possible and feel secure, cared-for and valued with someone I know and trust who I can rely on to organise and plan my care"