A Year of Care in Tower Hamlets PCT

10th December 2008

The story so far…..

Things Going OK (so far)

- 8 practices (1 locality) “signed up”
- Steering group (board) meeting every 2/52
- Patient engagement, rolling programme of events with excellent attendances
- Charismatic GP champion retained
- Intensive support team recruited & active
- Social marketing materials printed in use
- Commissioning intentions budget available

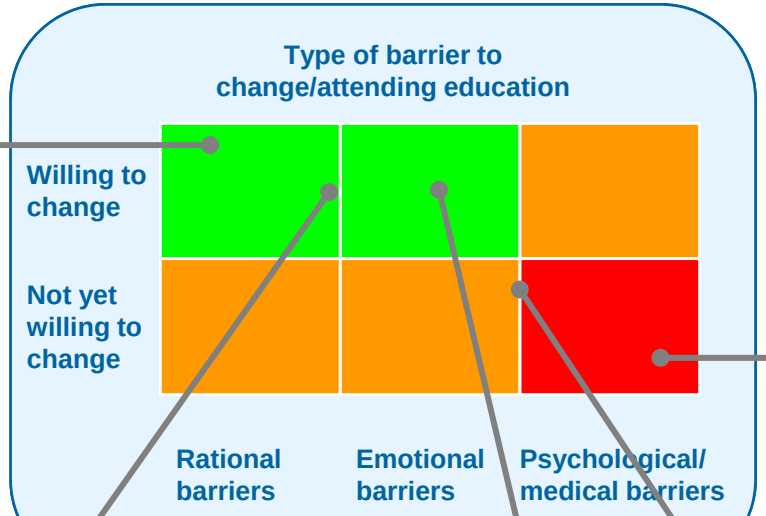
Engagement with Commissioners

- Leadership
  - Charismatic GP champion
  - Medical director SRO and YoC board chair
- CEO engaged (HfL SRO)
- Members diabetes LIT fully involved
- Substantial investment in diabetes in CIs
- Cross membership diabetes commissioning group
- Feedback presentation to PEC
- Refresh of diabetes strategy (building on Humana work)
- McKinsey work on retinopathy screening & segmentation
- Informing diabetes strategy and whole commissioning approach

We have segmented diabetic patients by attitude to self-management and education to identify appropriate interventions

1 Proactive learners

- **'I like getting education and managing my diabetes is very important to me'**
- Patient tends to have good control and good understanding of condition
- Proactively seeks out information
- Practical issues are main barrier to attendance at HAMLET



5 Resigned

- **'I've had diabetes for a while, I'm not going to change my lifestyle any more'**
- Patient may have very poor knowledge about diabetes and control
- Reticent attitude means often ignore advice, don't seek out information
- Greatest challenge is to get patients interested and motivated to learn by tackling psychological barriers first

2 Confident with unknown knowledge gaps

- **'I know enough, I'm not really interested in learning more'**
- Patient feels sufficiently informed although may lack clarity/information on issues
- Consequently often moderate to low proactivity
- Diabetes self-management competes with other demands in their lives

3 Confused and anxious

- **'I don't know what I can eat sometimes or what my test scores mean . . .'**
- Patients recognise that they lack knowledge
- However may not be very proactive in seeking out help/information
- Making access to education easier and clinician encouragement needed

4 Unconcerned

- **'Diabetes is not so bad really, lots of people suffer from worse so I think I'm doing ok'**
- Low level of knowledge, patient doesn't realise could be better
- Low proactivity
- Challenge is getting patient to appreciate seriousness of diabetes and self-management

Source: Team analysis from patient and clinician interviews

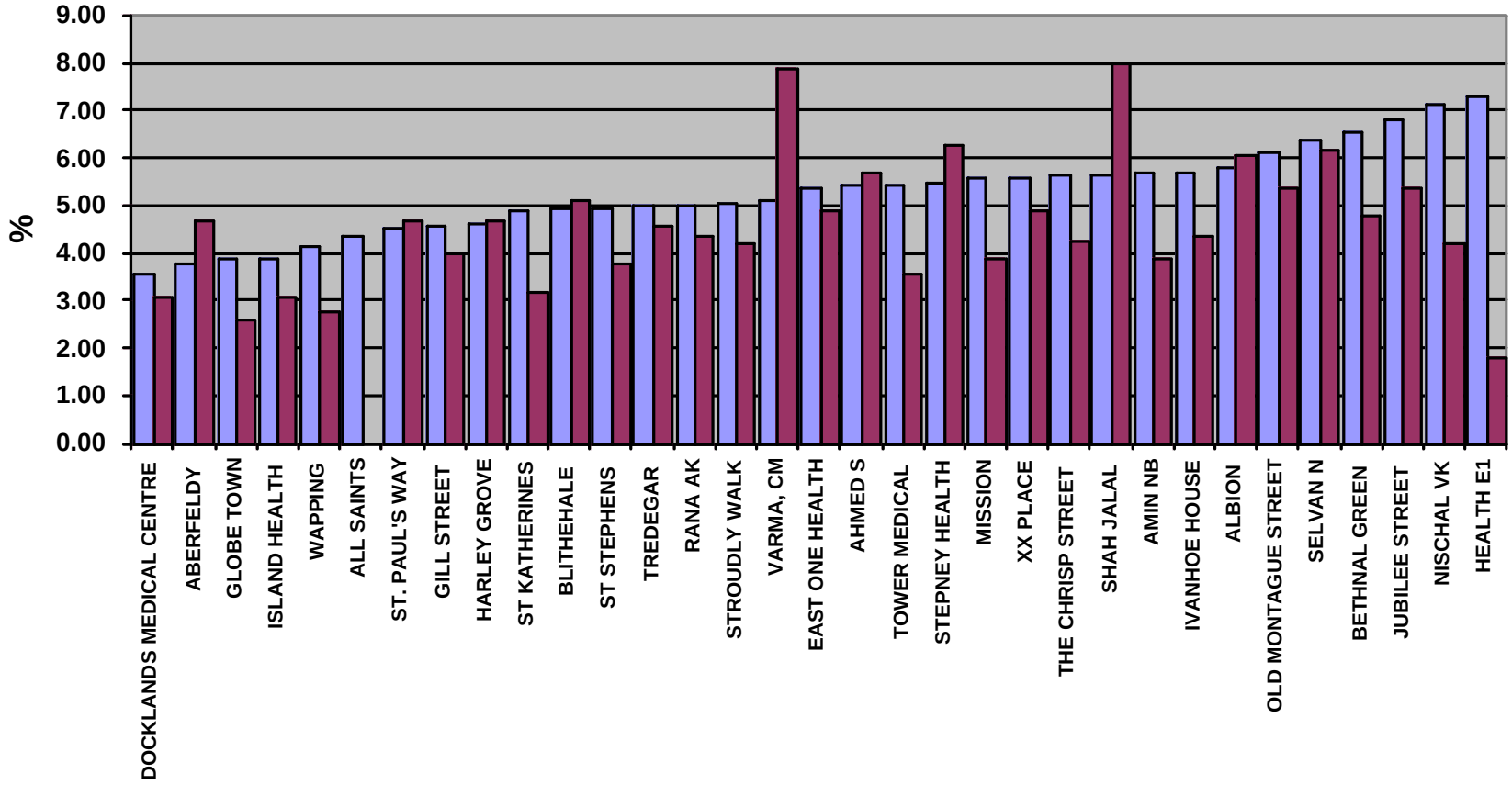
Commissioning mechanisms

- GPs Local Enhanced Service (LES)
  - Insulin starts
  - Care planning approach (needs more money £25 + £10 pppa)
  - N of Tyne package £46 pppa
- Practice target setting (dashboard)
- Outreach intensive support team
- Provider arm to re-bid to provide education
- Aim to have much more clarity in service spec for providers
- Refresh of diabetes strategy with consultancy help involving LIT and commissioners
- GP champion has met with Practice Based Commissioners

Unmet Need

- Estimated to be total of 12,000 diabetics in the borough

Observed vs estimated Diabetes prevalence by practice



Practice performance on key QOF diabetes domains

Colouring shows England Z scores		HbA1c<7.5	HbA1c>10	BP<145/85	Chol<5mmol/l	Record of neuropathy testing	Record of micro-albuminuria	Record of retinopathy testing	Flu immunisation
Practice	Register size	DM10	DM17	DM12	DM17	DM10	DM13	DM21	DM8
ABERFELDY PRACTICE	203	64.5	91.6	84.7	86.7	90.1	90.6	79.3	89.2
AHMED S	239	53.1	79.5	83.3	70.7	96.2	82.0	72.0	89.5
ALBION HEALTH CENTRE	451	46.1	83.6	69.8	75.4	81.8	1.8	64.7	67.0
ALL SAINTS PRACTICE	240	40.8	67.1	69.2	62.5	70.4	39.2	50.0	68.3
AMIN NB	107	68.2	94.4	87.9	83.2	92.5	90.7	46.7	90.7
BARKANTINE PRACTICE	144	47.2	80.6	86.8	72.9	83.3	68.1	72.2	68.1
BETHNAL GREEN HEALTH CENTRE	304	55.3	82.9	73.0	72.7	78.6	76.6	68.1	75.7
BLITHEHALE MEDICAL CENTRE	317	52.1	85.5	82.3	80.8	84.5	14.5	65.3	81.1
CHRISP STREET HEALTH CENTRE	473	50.7	79.9	63.4	73.2	78.6	1.5	48.8	74.6
DOCKLANDS MEDICAL CENTRE	85	58.8	87.1	87.1	81.2	69.4	75.3	61.2	68.2
EAST ONE HEALTH	337	49.3	82.5	70.3	72.7	84.3	70.9	76.0	79.8
GLOBE TOWN SURGERY	242	46.3	76.4	68.2	70.2	81.4	20.2	78.9	74.4
HARLEY GROVE MEDICAL CENTRE	226	60.2	92.0	83.2	81.4	96.5	77.4	85.4	86.7
Health E.1	25	44.0	64.0	60.0	64.0	64.0	44.0	40.0	64.0
ISLAND HEALTH	323	59.4	83.9	79.3	75.5	80.8	78.3	66.9	75.5
ISLAND MEDICAL CENTRE	84	60.7	84.5	79.8	85.7	86.9	92.9	61.9	85.7
JUBILEE STREET PRACTICE	475	53.9	83.4	76.8	76.4	82.1	0.6	60.6	69.7
LIMEHOUSE PRACTICE	385	57.1	87.0	74.5	76.9	83.9	39.0	56.9	75.8
MISSION PRACTICE	360	52.5	81.4	79.7	68.1	84.4	0.8	58.6	73.1
NISCHAL VK	109	49.5	79.8	67.0	72.5	76.1	26.6	67.0	80.7
POLLARD ROW PRACTICE	65	41.5	64.6	60.0	56.9	67.7	41.5	43.1	72.3
RANA AK	173	57.2	86.7	82.1	82.7	90.8	76.9	62.4	86.1
SELVAN N	176	48.3	79.0	79.5	72.7	89.2	60.2	63.6	76.7
SHAH JALAL MEDICAL CENTRE	569	44.5	80.5	64.1	76.1	76.1	1.8	56.9	84.0
SHAH KP	143	62.2	88.8	71.3	80.4	94.4	80.4	58.7	89.5
SPITALFIELDS PRACTICE	628	49.0	83.4	80.4	79.9	78.3	3.8	57.8	69.9
ST KATHARINE'S DOCK PRACTICE	74	79.7	94.6	91.9	89.2	98.6	90.5	83.8	94.6
ST PAULS WAY PRACTICE	464	48.5	84.1	57.1	74.6	68.5	43.5	61.6	70.0
ST STEPHEN'S HEALTH CENTRE	377	58.1	88.1	74.0	83.8	88.1	33.2	68.4	79.0
STEPNEY GREEN	551	53.0	82.4	72.8	77.1	74.0	53.0	51.7	78.9
STROUDLEY WALK PRACTICE	161	47.8	80.1	67.1	70.8	84.5	0.0	64.6	80.1
TOWER MEDICAL CENTRE	182	52.2	78.6	65.4	76.9	85.2	65.9	72.0	85.2
TREDEGAR PRACTICE	139	56.1	86.3	75.5	70.5	87.1	6.5	60.4	69.8
VARMA, CM	224	50.9	82.6	96.9	79.5	96.0	73.7	72.3	85.7
WAPPING GROUP PRACTICE	239	66.1	88.3	74.1	83.7	92.9	2.5	82.4	83.7
XX PLACE	581	53.9	84.2	75.7	80.2	88.6	4.6	87.6	78.0
TH AVERAGE (%)	274.3	53.9	82.8	75.4	76.0	83.5	45.3	64.7	78.4
ENGLAND AVERAGE (%)	234.5	59.1	86.5	72.8	74.3	84.2	74.6	80.9	77.6
TH STANDARD DEVIATION	164.8	8.0	6.9	9.3	6.9	8.8	33.5	11.7	7.9
ENGLAND STANDARD DEVIATION	151.8	9.7	6.5	9.5	7.9	11.3	18.2	12.4	7.9

Year of Care (as a Lever)

- For THPCT more stimulus than lever –investment plan and recognition of delivery gap
- World Class Commissioning “exam” preparation
- External interest +++
- Magnified need to address patient experience Picker
- Care planning skills clinicians (more training needed probably on going)
- Consultation skills clinicians (in addition to above)
- Care co-ordinators at grass roots level
- Patient comprehension “gap”
- Does it work??

Links to other activity

- Care planning approach applies to all Long Term Conditions
- Diabetes link with vascular – new vascular check programme
- Obesity
- Health inequalities
- Screening / prevention
- Healthcare for London (Darzi)
- Social marketing
- Corporate strategic priorities 1 of 6
- Developing self care strategy
- Distinct Commissioner & Provider PPE sectors

Sustainability (?)

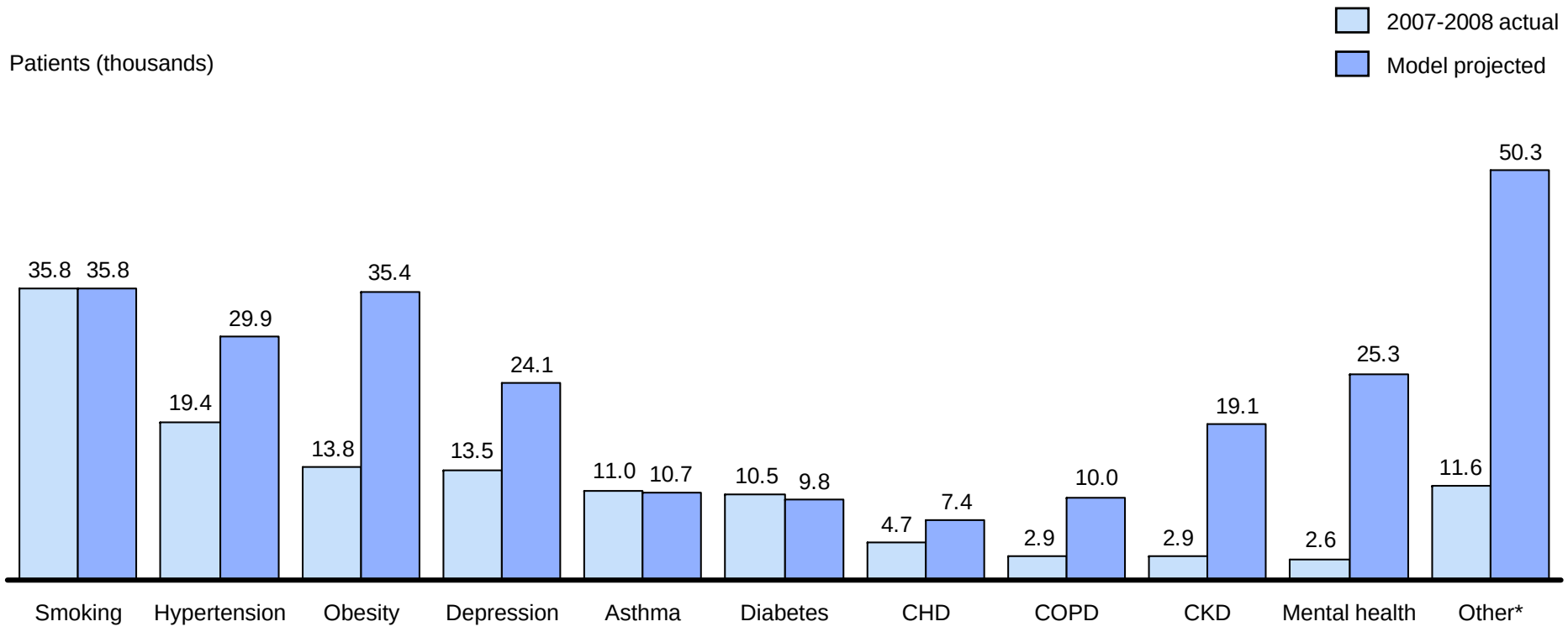
- Resource intensive
- Patient “but what does it all mean?” – additional “rapid access education” required
- In practice 2 X care planning appointments
- LES 2 requires +£10 pp pa (on top of £25 now)
  - Total for LES 2 £237,000 pa + £9k retainer (£250/practice)
- Colour printers @ practice
- Additional costs patient engagement events
- Picker repeat survey, focus groups,
- Opportunity costs significant

Sustainability? Practice Fatigue

- Constant change and pressure GPs “under the cosh”
- Communication overload
- Access, access, access (oh, and more access)
- Extended hours
- Polyclinics and GP led health centres
- “Privatisation” – BMA / GPC / LMC
- Lord Darzi next steps and HfL
- GMS “freeze” – eroding profits
- Rising patient public and politician expectation

MODEL PREDICTS TWICE AS MANY PATIENTS AS CURRENTLY REGISTERED

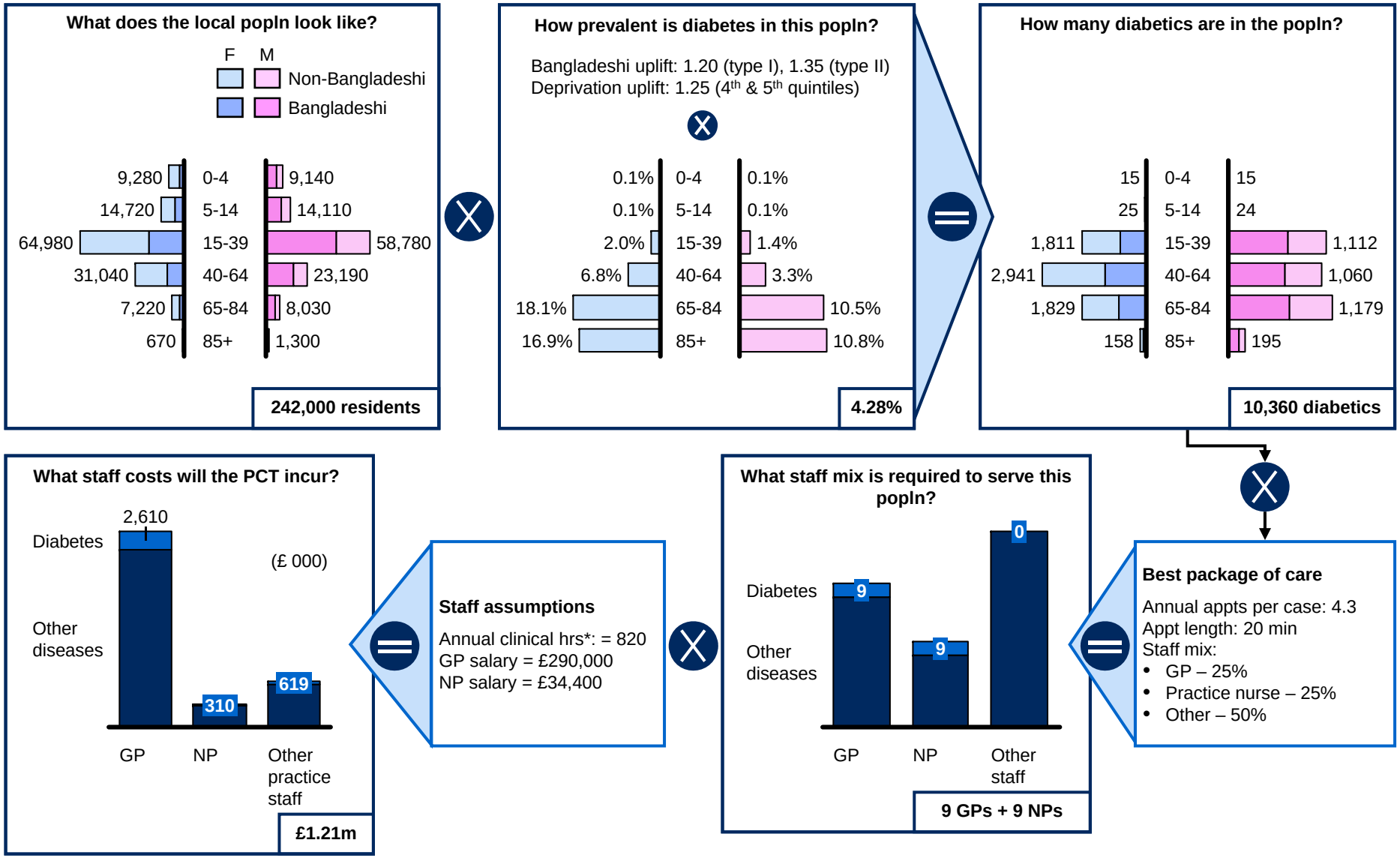
- The PCT currently treats **128,700** patients on QOF disease registers
- Model predicts **257,800** patients for these diseases



* "Other" includes epilepsy, palliative care, cancer, dementia, learning difficulties, heart failure, atrial fibrillation, hypothyroidism and stroke; palliative care and learning difficulties account for majority of difference between QOF and model's predictions

Source: QMAS disease register 2007/08

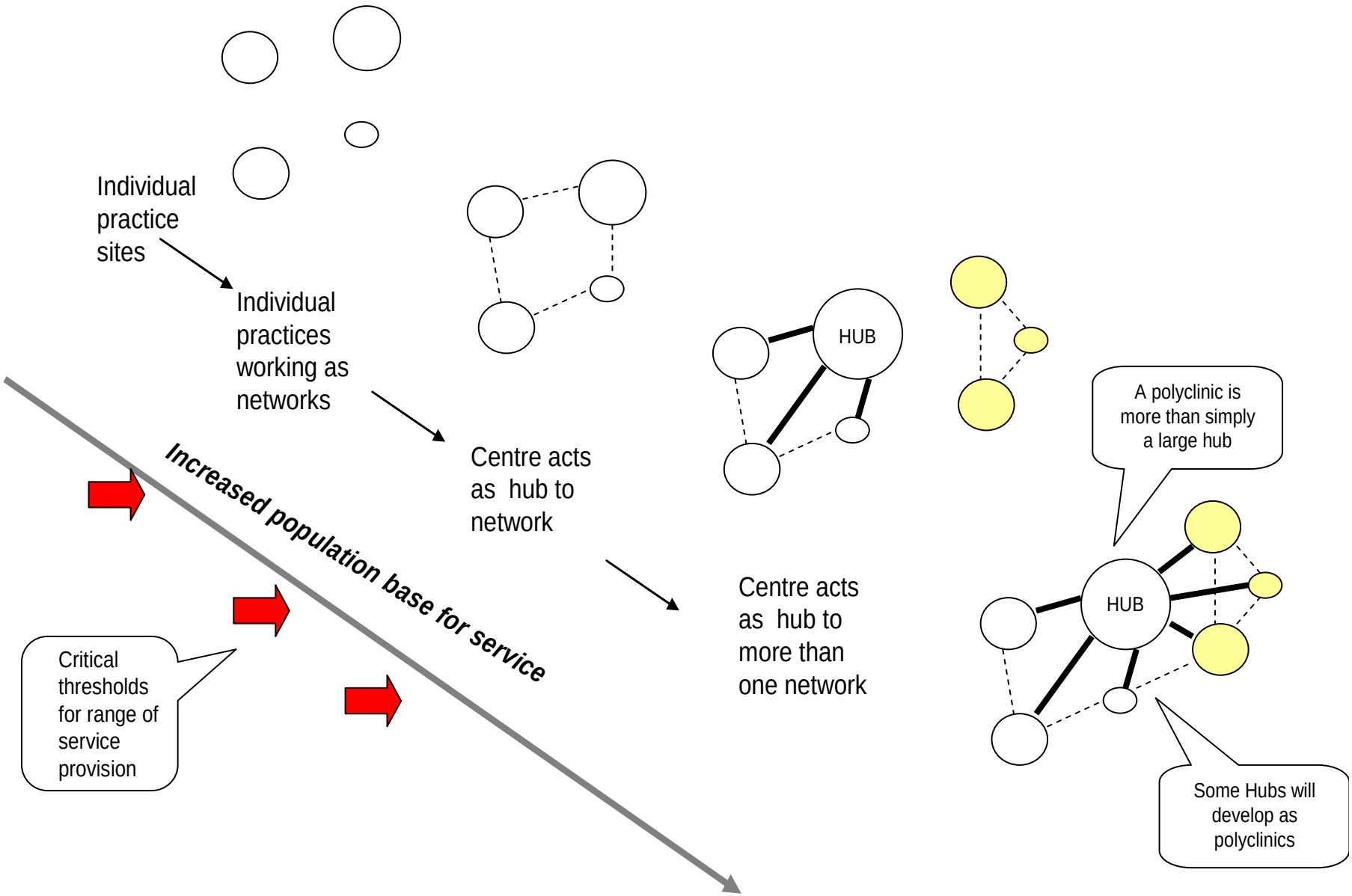
MODEL PREDICTS STAFF AND COSTS REQUIRED TO SERVE TH POPULATION, BASED ON DEMOGRAPHICS, DISEASE PREVALENCE & BEST CARE ASSUMPTIONS

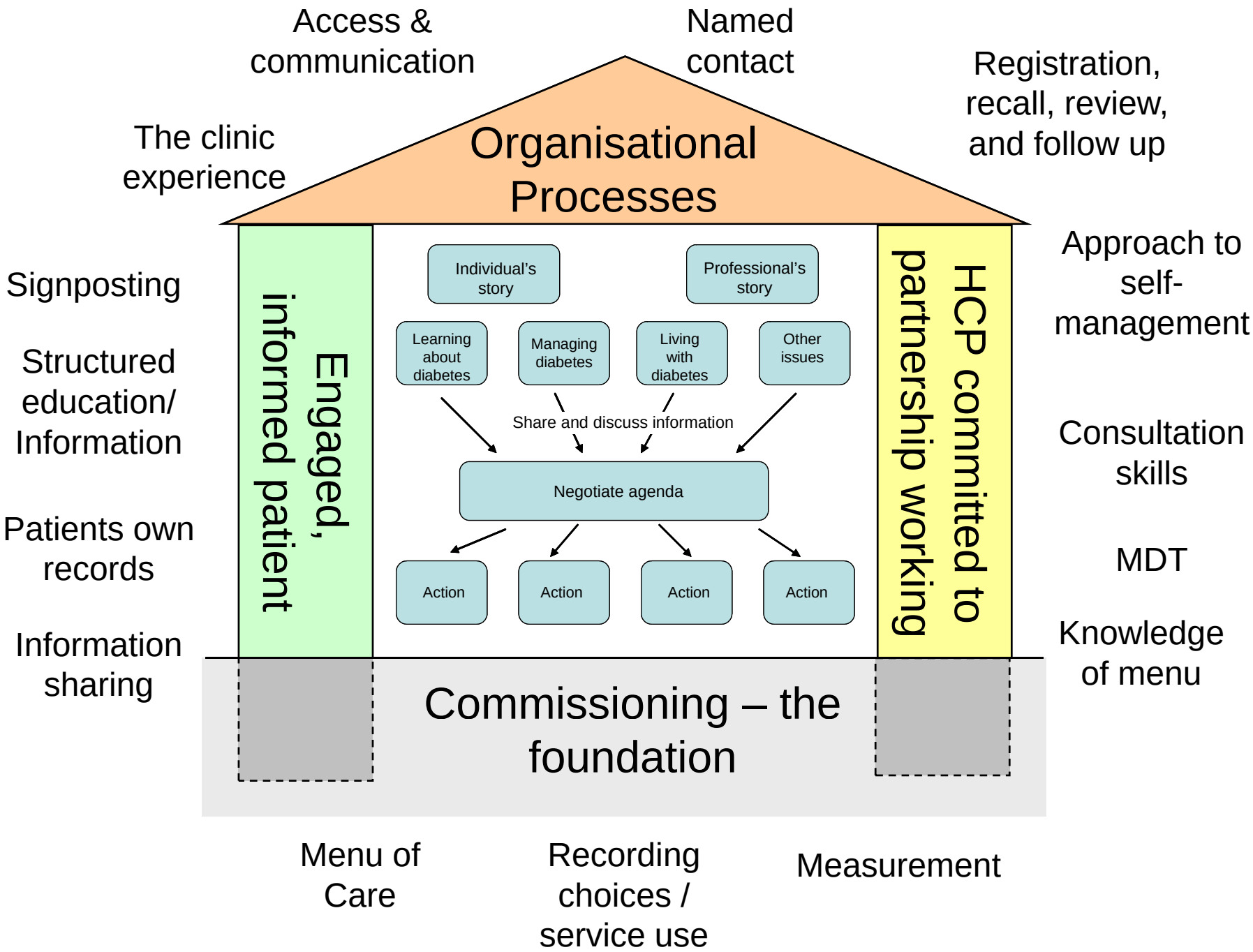


* Assumes: 7 clinical sessions/week, 3 hours/session, 40 weeks per year

Source: Annual appts per case: 2003 UK doctor consultations by selected ICD10 groups, Compendium of Health Statistics (2007); appt length: Penny Dash; GP salary, Laing & Buisson NHS Financial Report 2007 (FY05/06)

Evolution towards Polyclinics




Access & communication
Named contact
Registration, recall, review, and follow up
The clinic experience
Organisational Processes
Signposting
Structured education/ Information
Patients own records
Information sharing
Engaged, informed patient
Individual's story
Professional's story
Learning about diabetes
Managing diabetes
Living with diabetes
Other issues
Share and discuss information
Negotiate agenda
Action
Action
Action
Action
HCP committed to partnership working
Approach to self-management
Consultation skills
MDT
Knowledge of menu
Commissioning – the foundation
Menu of Care
Recording choices / service use
Measurement

Systematic long-term condition management that enhances the patient experience within a polyclinic setting

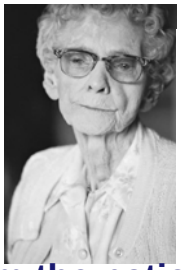
Long-term condition self care comprises

- **An entitlement to a care plan and navigator to aid in better self management**
- **More choice over nature of care and where it is delivered**
- **Services feel more integrated, personalised & responsive**

Greater choice of service provider

Entitlement to a care plan

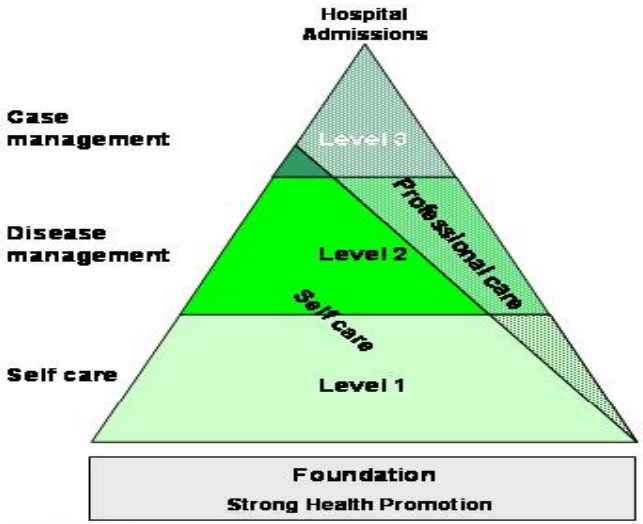
Navigator to help choose services



From the patients perspective…

More information on managing condition

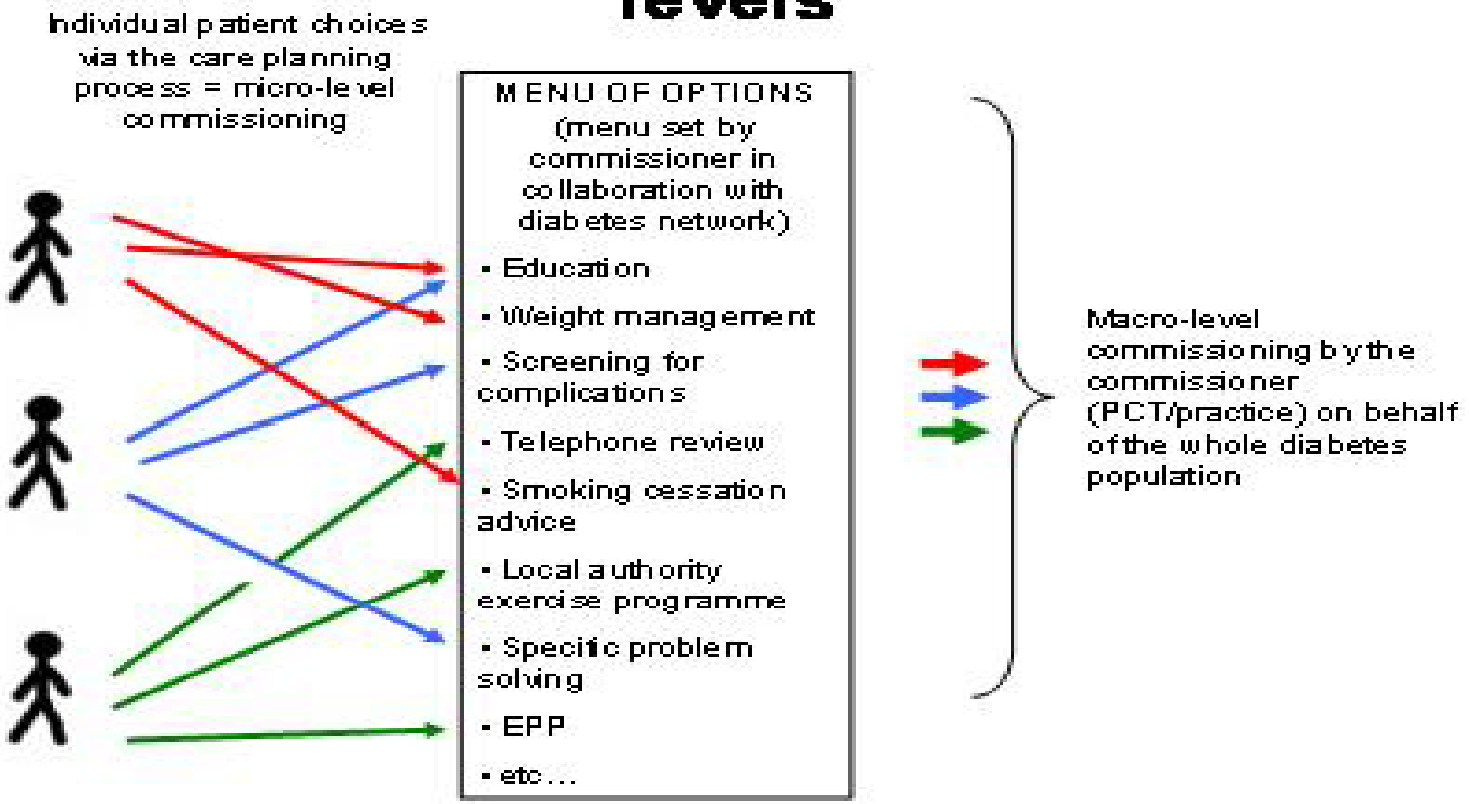
More use of assistive technology

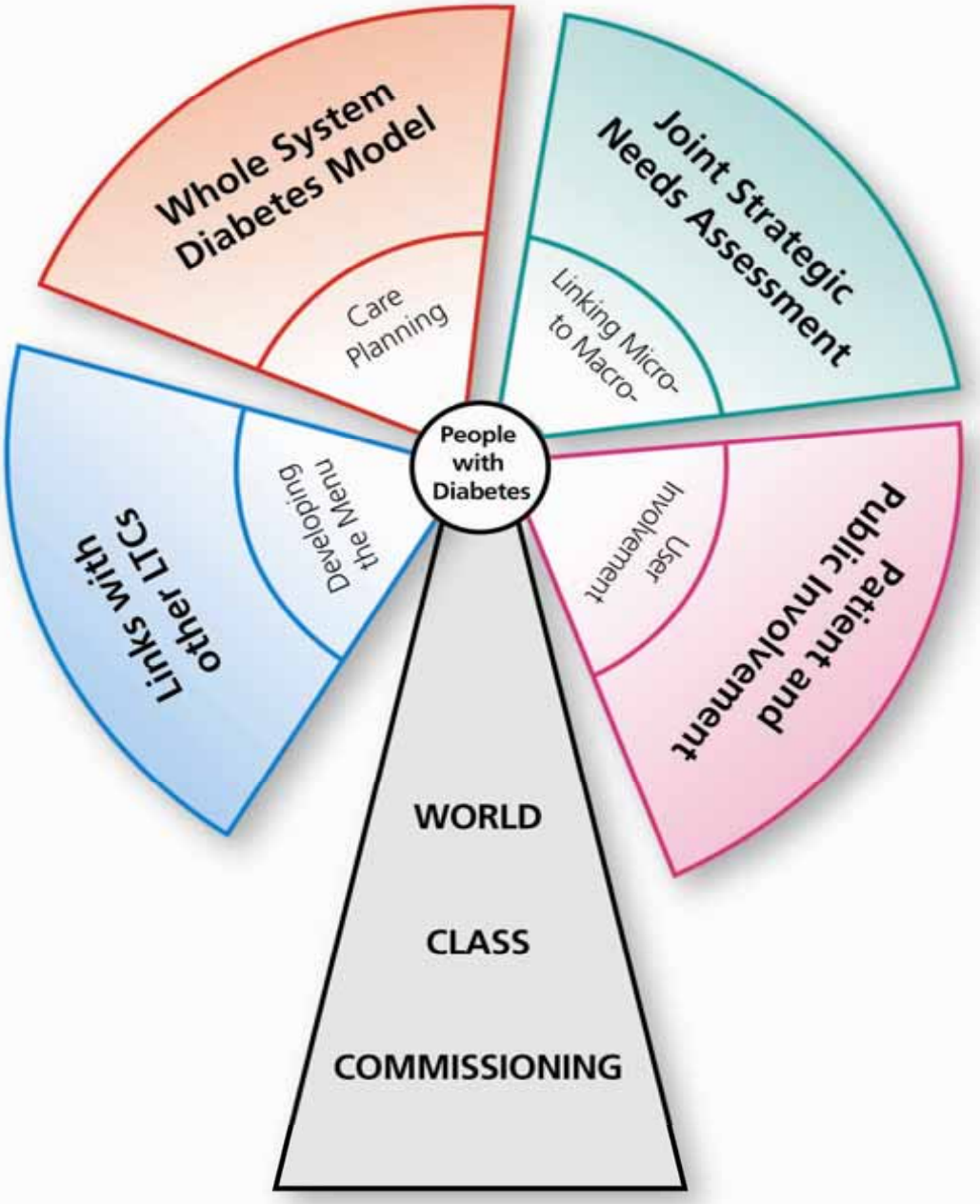


The model of long-term condition care

- **Empowered and informed patients** - fully engaged and informed ("Expert") patients, with continuous support and resources offered to patients where necessary
- **Team based care** - a team comprising of a diverse workforce, covering GPs, specialist nurses and specialists, as well as those with expertise in areas like nutrition, psychology, and behavior modification; the team works in collaboration to improve the health of the patient
- **Comprehensive clinical guidelines** - treatment decisions based on explicit, proven guidelines integrated into the day-to-day practice of the primary care providers. Follow up as part of standard procedure
- **Real time patient data** - all clinicians have centralized, up-to-date information about the patient's status. Information system tracks individual patients , as well as populations of patients and profile risk
- **Effective risk modeling and patient selection** - intensity of support matched to an assessment of need

Commissioning at micro and macro levels




Whole System Diabetes Model
Care Planning
Joint Strategic Needs Assessment
Linking Micro- to Macro-
Patient and Public Involvement
User involvement
Links with other LTCs
Developing the Menu
People with Diabetes
WORLD
CLASS
COMMISSIONING

YEAR OF CARE

A partnership programme being delivered by the Department of Health, Diabetes UK, The Health Foundation and the National Diabetes Support Team

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