Recent developments in chronic illness policy in the UK

Chris Ham
The King’s Fund
1 July 2011

The Big Picture

› 1900-50  Infectious diseases
› 1950-2000 Acute diseases
› 2000-    Chronic diseases
Figure 1  The Chronic Care Model (CCM).

Infrastructure
- Health and social system environment
- Decision support tools and clinical information system (NPfIT)

Health System
- Organization of Health Care
  - Self-management support
  - Delivery system design
  - Decision support
  - Clinical information systems

Community
- Resources and policies

Functional and clinical outcomes
- Informed activated patient
- Productive interactions
- Prepared proactive practice team

Better outcomes
- Empowered and informed patients
- Prepared and proactive health and social care teams

Supporting
- Case Management
- Disease Management
- Supported Self care
- Promoting Better Health

Creating


TheKingsFund
The English Story

- A major programme of health care reform since 2000, with a focus on improving access to care
- Significant investment in areas of clinical priority, especially cancer and cardiac care
- Chronic care was explicitly recognised as a priority in 2004 in The NHS Improvement Plan
- What has been tried and what has been achieved?

The Right Service for Individuals

- Social Care view: Supporting more individuals at home with higher level of needs; diversion from permanent residential and nursing home care
- Health view: Individuals with highly complex conditions/needs; improving care for the chronically ill; diversion from acute care
- Valuing People: involvement in voluntary sector; preventative services
- Level 1: Self Management
- Level 2: Disease Management
- Level 3: Case Management

7/4/2011
Self Management

- Expert Patient Programme (EPP) has been implemented for c.100,000 people
- EPP draws on Kate Lorig’s work and provides generic skills training
- The programme is delivered by trained lay people with experience of chronic care
- Evaluation has shown some positive results, though no reduction in service use

Health care professionals may only interact with people with a chronic disease for a few hours a year…

the rest of the time patients care for themselves…
Disease Management

- Much routine chronic disease management is delivered by the primary care team, especially nurses
- The three Rs - registration, recall and review - are fundamental building blocks
- Primary care is well developed in England, although standards vary
- A new pay for performance contract has been in place since 2004

Pay for performance

- Primary care teams earn extra income for achieving the government’s targets for quality care
- The targets are mainly focused on processes of care and intermediate outcomes e.g. having disease registers and doing regular checks of patients on these registers
- Teams have achieved a high level of performance against targets, but at a high cost
Case Management

- An early priority was to strengthen case management for people with complex needs.
- The rationale was that these people are intensive users of services, and they incur a high proportion of costs.
- The NHS was asked to appoint 3,000 ‘community matrons’ to work with primary care teams.
- A key aim was to reduce hospital use.

A small proportion of patients account for a high proportion of use.

![Graph showing cumulative percentage of inpatients by cumulative days spent as inpatients.](https://via.placeholder.com/150)

- 5% of patients account for 42% of bed use.
- 10% of patients account for 55% of bed use.
UK Evercare programme of case management: evaluation

- No significant effect on rates of hospital admission and lengths of stay
- Qualitative evidence of admission avoidance but not length of stay reduction
- Nurses and others were positive about the Evercare model
- Patients were positive and carers even more positive

What patients liked

- Psychological support of nurses
- Ability to respond rapidly in crises
- Ability to monitor medications etc
- Ability to explain about diseases
- Advocacy of patients’ needs
- Ability to obtain appliances
Lessons from Evercare

- The methods used to identify high risk patients are important
- Evercare used ‘two or more unplanned hospital admissions’ for this purpose
- We know there is ‘regression to the mean’ in this group
- More sophisticated risk assessment methods have been developed e.g. PARR by The King’s Fund

Other initiatives

- National service frameworks e.g. for diabetes and mental health
- NICE and the appraisal of new drugs
- Assistive technology to support home care
- Care plans for everyone with a chronic condition who wants a plan
- Local innovations like ‘virtual wards’ for high risk patients in the community
- Investment in IT
NHS Kaiser pilots and integration

- Three areas of England have been adapting elements of the Kaiser model
- They have focused on chronic diseases and service integration
- One of these areas (Torbay) is able to demonstrate impressive reductions in hospital use
- There is increasing interest in service integration at a national level

What has been achieved?

- Self management has gained a foothold
- Disease management has led to some acceleration of long term improvements in chronic care
- Case management is valued by patients and carers but has not reduced hospital use
- Many other initiatives have been taken
Lessons from England

› There is no single intervention that works best
› Chronic care programmes have to work on several components simultaneously
› Wagner’s model and its adaptations provide an overarching framework
› The *means* of reform have to be linked to the *ends* of reform
› England did not do this well

The 10 characteristics of the high performing chronic care system (1)

› Universal coverage
› Care that is free at the point of use
› A delivery system focused on prevention
› Support for patients, carers and families to self-manage their conditions
› Priority for primary care
The 10 characteristics of the high performing chronic care system (2)

- Population management is emphasised
- Care should be integrated
- IT should underpin the provision of chronic care
- Care should be effectively coordinated
- These ten characteristics should be linked into a coherent whole

Four implementation strategies

- Physician leadership
- Measurement of outcomes
- Aligned incentives
- Community engagement
References


c.ham@kingsfund.org.uk