Reducing Variation in Management of Long-Term Conditions in Primary Care

29th October 2015 – London Clinical Senate Forum

Guy Gross - ICHP, Innovation Delivery Lead
Arindam Kar - ICHP, Consultant Stroke Physician, Imperial
Sotiris Antoniou - UCLP, Consultant Pharmacist, NEL & NCL
Helen Williams - HIN, Consultant Pharmacist, SL
Introduction

1. Sources of variation
2. Size of “best practice” prize
3. Example: Atrial Fibrillation (ISPAF)
4. Barriers to scale
5. Framework
6. Next steps
CCG self-assessed current and future delivery of best practice in COPD vs the NICE quality standards
To **achieve consistent delivery of best practice** in the management of long-term conditions throughout primary and community care across London in order to **raise minimum levels of care and improve outcomes**.
What is the key challenge?

“70% of all major change efforts in organisations fail. Why do they fail? Because organisations often do not take the holistic approach required to see the change through.”

Why is this important?
Demonstrating the value of best practice

1. Porter ME; Lee TH NEJM 2010;363:2477-2481; 2481-2483

Quality of care for patients
Better outcomes by doing the right things for patients at the right time

Economic gain
Realisation of funds currently spent on management of failure of control

Health Outcomes
- Patient defined bundle of care

Value
- Outcomes

Cost
- Cost of delivery
Quality of care for patients
Right care. Right place. Right time.

1. Adapted from London Respiratory Team work

Glossary
QALY – Quality adjusted life years
LAMA – Long acting Muscarinic antagonist
LABA – Long acting Beta agonist

Can we optimise value from our pathways?

Where value lies in COPD

Flu vaccination? £1000/QALY in “at risk” population

Stop Smoking Support with pharmacotherapy £2000/QALY

Pulmonary Rehabilitation £2000-8000/QALY

Tiotropium/LAMA £7000/QALY

LABA £5-8000/QALY

Long term Oxygen Therapy £11-16000/QALY

Triple Therapy £7000-£18700/QALY

£92000/QALY

Where we currently focus

LAMA + LABA +ICS – TRIPLE THERAPY

LABA

LAMA

PR

Stop Smoking

Flu Vaccine
Quality of care for patients
Impact on outcomes

Emergency Bed days 2012/13 by age band across England

Emergency Bed Days calculated by:
Number of admissions
x Length of stay

Total bed day absolute numbers are from Martin McShane, NHSE. The proportions of avoidable, unavoidable and LTC to other ratios are for illustration purposes.
Economic gain
What impact does delivery of best practice have?

### COPD

<table>
<thead>
<tr>
<th>Best Practice module</th>
<th>Est. cost saving per patient per year</th>
<th>Est. cost saving per patient per 5 years</th>
<th>Current performance in NW London</th>
<th>London relevant patient pop. size</th>
<th>Estimated savings over 5 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Appropriate diagnosis</td>
<td>£166</td>
<td>£830</td>
<td></td>
<td>80,000 x 7%/35% = 16,000</td>
<td>£13.28m</td>
</tr>
<tr>
<td>2 Individual management planning</td>
<td>£141</td>
<td>£705</td>
<td></td>
<td>80,000 x 5% = 4,000</td>
<td>£2.82m</td>
</tr>
<tr>
<td>3 Inhaled oral therapy offered as per NICE guidance</td>
<td>£249 - £394</td>
<td>£1,245 - £1,970</td>
<td></td>
<td>80,000 x 32% = 26,000</td>
<td>£32 - £51.2m</td>
</tr>
<tr>
<td>13 Palliative care</td>
<td>£450 - £600</td>
<td>£450 - £600</td>
<td></td>
<td></td>
<td>£20.8m - £27.8m</td>
</tr>
</tbody>
</table>

**Total savings COPD**: £100m - £120m

### 5yr savings COPD

1. Diabetes                                  £500m - £900m
2. COPD                                      £100m - £120m
3. Arthritis                                 £300m - £600m
4. Chronic Heart Disease                     £400m - £1bn
5. ...                                       £...m - £...m

**TOTAL London-wide savings over 5 years**: £1.5bn – 2.5bn

This exemplar of what we would like to get to was created using incomplete data for COPD and requires health economists input for a true reflection of the potential savings across London.
1. How can we get 1500 practices across London to deliver current best practice to every relevant patient?

2. What common barriers to implementation could be addressed once, well, to facilitate delivery of LTC initiatives at scale?

3. Can we make it simpler to implement best practice pathways than it is to iterate existing ones that underperform?
Why are we here?

- Mandate to expand our work on the framework
- Mandate for the AF work
Where are we with Atrial Fibrillation?

AF at high risk of stroke (QOF 2013/14)

- No Treatment: 17,019 (33%)
- Anticoagulation: 34,090 (67%)

London stroke admissions in patients with known AF (2014/15)

- No Treatment: 426 (31%)
- Anticoagulation: 585 (43%)
- Aspirin: 348 (26%)

Preventing >600 AF-related strokes/year in London is achievable saving £7.5 million/year repeatedly.
To prevent AF-related stroke and associated mortality through better identification and management of people with atrial fibrillation

1. Increase anticoagulation use

2. Improve anticoagulation control

3. Identify more AF
Current best isn’t good enough

% Rates of anticoagulation in high risk AF patients (CHADS\textsubscript{2} \geq 2) and number of untreated high risk patients by CCG (QOF 2014)

QOF data 2014 shows that more than 17,000 people across London with AF and CHADS\textsubscript{2} \geq 2 are not anticoagulated
Current provision varies significantly

South London geography: Improving Uptake of Anticoagulation in AF

**Strategy 1**
Educational events for primary care

**Strategy 2**
Prescribing incentive schemes / audits

**Strategy 3**
Specialist support to general practice through virtual clinics

**Outcomes**
- Reduced events?
- Savings £££?
- Sustainability?
Current best isn’t good enough

% Rates of anticoagulation in high risk AF patients (CHADS$_2 \geq 2$) and number of untreated high risk patients by CCG (QOF 2014)

QOF data 2014 shows that more than 17,000 people across London with AF and CHADS$_2 \geq 2$ are not anticoagulated
There are projects that have been successful

City & Hackney, Newham and Tower Hamlets Anticoagulation in people with AF (CHADS\textsubscript{VASC} $\geq 1$ net of exceptions)

- Improvement programme
- Anticoagulant
- Aspirin
- Neither

<table>
<thead>
<tr>
<th>Year</th>
<th>% on treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-08</td>
<td>40%</td>
</tr>
<tr>
<td>Apr-09</td>
<td>35%</td>
</tr>
<tr>
<td>Apr-10</td>
<td>30%</td>
</tr>
<tr>
<td>Apr-11</td>
<td>25%</td>
</tr>
<tr>
<td>Apr-12</td>
<td>20%</td>
</tr>
<tr>
<td>Apr-13</td>
<td>15%</td>
</tr>
<tr>
<td>Apr-14</td>
<td>10%</td>
</tr>
<tr>
<td>Apr-15</td>
<td>5%</td>
</tr>
</tbody>
</table>

- ISPAF Target 80%
- Aspirin 18.6%
- Neither 11.7%

Anticoagulant 69.7%
These programmes struggle to scale at worst or realise benefits of scale at best

Doing it once

Planning
• Project Management
• Clinical Leadership
• KPIs

Implementation
• Agree guideline
• Rollout audit tool
• Education strategy
• Set up IT Tools

Scaling

Planning
• Project Management
• Clinical Leadership
• KPIs

Implementation
• Agree guideline
• Rollout audit tool
• Education strategy
• Set up IT Tools
Framework applied to AF

1. Development
   - Clinical buy in and awareness
     1. Define best practice and its benefits
     2. Raise awareness of best practice

2. Delivery
   - Development of levers and services that drive delivery of best practice
     3. Improve data quality & measurement
     4. Assess competencies and fill gaps
     5. Co-create service specs & contracts

3. Support
   - Support for clinicians and patients to optimise use of resources
     6. Empower patient self-management
     7. 1º and community care peer support
     8. 1º - specialist care support

4. Robustness & Sustainability
   - Embed innovation & research across the pathway
   - Development of a culture of continuing improvement, openness and responsibility to adoption of technology, data sharing, templates, trials etc.
Why are we here?

- Mandate to expand our work on the framework
- Mandate for the AF work
For further information:

Dr. Guy Gross (on behalf of ICHP, UCLP & HIN)
Innovation Delivery Lead,
Imperial College Health Partners
Guy.gross@imperialcollegehealthpartners.com
07961 040 804

Or

Peter Kohn
Director,
London Office of CCGs
Peterkohn@nhs.net
Framework next steps

1. Assess the value of best practice

Health Outcomes

Value

Outcomes

Cost

Cost of delivery

Patient defined bundle of care

© Slide by Framework next steps

Emergency Bed days 2012/13 by age band across England

Number of admissions x Length of stay

Emergency Bed Days =
Framework next steps
2. Feasibility and Options for curricular best practice CPD

Online platform for best practice awareness and education across primary care in London.

- Compulsory modules adapted for each CCG
- CPD bundle aligned with initiative delivery
- Best practice awareness and training

Accrue a database of service design matrices that feed into initiative design processes

Pan London

- North-West SPGs
  - 8 CCGs
  - 18 Feds
  - CEPNs

- North-East & Central SPGs
  - 12 CCGs
  - 19 Feds
  - CEPNs

- South SPGs
  - 12 CCGs
  - 19 Feds
  - CEPNs

~400 practices
Community providers, support staff, pharmacy etc.

~560 practices

~470 practices

Confirmation of completion of modules
Online competency assessment
Performance data to demonstrate learning

Office of London Clinical Commissioning Groups
### Components of spec

<table>
<thead>
<tr>
<th>Level</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PR</td>
<td>HOSAR</td>
<td>COPD home visits</td>
<td>COPD clinics</td>
<td>Early supported discharge</td>
<td>NIV</td>
<td>Psychology</td>
</tr>
<tr>
<td>1</td>
<td>0.5 WTE</td>
<td>0.2 WTE</td>
<td>0.2 WTE</td>
<td>0.2 WTE</td>
<td>0.6 WTE</td>
<td>0.2 WTE</td>
<td>0.2 WTE</td>
</tr>
<tr>
<td></td>
<td>Description KPIs (1° &amp; 2°)</td>
<td>Description KPIs (1° &amp; 2°)</td>
<td>Description KPIs (1° &amp; 2°)</td>
<td>Description KPIs (1° &amp; 2°)</td>
<td>Description KPIs (1° &amp; 2°)</td>
<td>Description KPIs (1° &amp; 2°)</td>
<td>Description KPIs (1° &amp; 2°)</td>
</tr>
<tr>
<td>2</td>
<td>1 WTE</td>
<td>0.4 WTE</td>
<td>1 WTE</td>
<td>0.5 WTE</td>
<td>1 WTE</td>
<td>1 WTE</td>
<td>0.5 WTE</td>
</tr>
<tr>
<td></td>
<td>Description KPIs (1° &amp; 2°)</td>
<td>Description KPIs (1° &amp; 2°)</td>
<td>Description KPIs (1° &amp; 2°)</td>
<td>Description KPIs (1° &amp; 2°)</td>
<td>Description KPIs (1° &amp; 2°)</td>
<td>Description KPIs (1° &amp; 2°)</td>
<td>Description KPIs (1° &amp; 2°)</td>
</tr>
<tr>
<td>3</td>
<td>2 WTE</td>
<td>1 WTE</td>
<td>3 WTE</td>
<td>1 WTE</td>
<td>1.6 WTE</td>
<td>3 WTE</td>
<td>1 WTE</td>
</tr>
<tr>
<td></td>
<td>Description KPIs (1° &amp; 2°)</td>
<td>Description KPIs (1° &amp; 2°)</td>
<td>Description KPIs (1° &amp; 2°)</td>
<td>Description KPIs (1° &amp; 2°)</td>
<td>Description KPIs (1° &amp; 2°)</td>
<td>Description KPIs (1° &amp; 2°)</td>
<td>Description KPIs (1° &amp; 2°)</td>
</tr>
<tr>
<td>4</td>
<td>3 WTE</td>
<td>3 WTE</td>
<td></td>
<td></td>
<td></td>
<td>3 WTE</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Description KPIs (1° &amp; 2°)</td>
<td>Description KPIs (1° &amp; 2°)</td>
<td></td>
<td></td>
<td></td>
<td>Description KPIs (1° &amp; 2°)</td>
<td></td>
</tr>
</tbody>
</table>

This mock up is for illustrative purposes and is not based on any evidence or research.
## Framework next steps

4. Develop pan-London EMIS/ TPP / VISION data templates with understanding of sustainable outcome-based incentives

### Diabetes Level 1 – Performance related pay

<table>
<thead>
<tr>
<th>Title</th>
<th>Metric</th>
<th>Target</th>
<th>% of payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP Network average for % key care processes in last 12 months</td>
<td>% receiving 9 key care processes</td>
<td>35 - 80%</td>
<td>2%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>40 - 70%</td>
<td>5%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&gt;70%</td>
<td>10%</td>
</tr>
<tr>
<td>GP Network average for HbA1c</td>
<td>% of diabetes patients with latest HbA1c &lt; 58</td>
<td>55-60%</td>
<td>1%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&gt;60%</td>
<td>2%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&gt;65%</td>
<td>5%</td>
</tr>
<tr>
<td>GP Network average for BP controlled</td>
<td>% of diabetes patients with latest BP &lt; 140/90</td>
<td>60-62%</td>
<td>1%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&gt;63%</td>
<td>2%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&gt;67%</td>
<td>5%</td>
</tr>
<tr>
<td>GP Network average for cholesterol controlled</td>
<td>% of diabetes patients with latest cholesterol &lt; 4.0</td>
<td>35-40%</td>
<td>1%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&gt;40%</td>
<td>2%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&gt;45%</td>
<td>5%</td>
</tr>
<tr>
<td>GP Network average for diabetes patients with a care plan</td>
<td>% of patients on the diabetes register who have documented diabetes care planning</td>
<td>60-70%</td>
<td>5%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&gt;70%</td>
<td>10%</td>
</tr>
<tr>
<td>GP Network average for recording of hypoglycaemia</td>
<td>% of patients on metformin and/or insulin with record of hypoglycaemia frequency</td>
<td>20-50%</td>
<td>1%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&gt;50%</td>
<td>2%</td>
</tr>
<tr>
<td>Follow up of hypoglycaemia</td>
<td>Clear protocol in place for follow-up within 1 week of patients requiring third party intervention for hypoglycaemia</td>
<td>crseda</td>
<td>5%</td>
</tr>
<tr>
<td>GP Network average for blood-glucose test result for patients with type 2 diabetes</td>
<td>% of prescriptions for BGLS of the CCG framework/ inpatient prescriptions for all DG 10</td>
<td>50-60%</td>
<td>1%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&gt;60%</td>
<td>2%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&gt;70%</td>
<td>5%</td>
</tr>
</tbody>
</table>

### Diabetes Level 2 – Performance related pay

<table>
<thead>
<tr>
<th>Title</th>
<th>Metric</th>
<th>Target</th>
<th>% of payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injectable education and diabetes advice</td>
<td>% patients receiving appropriate education and diabetic advice at injectable initiation</td>
<td>100%</td>
<td>23%</td>
</tr>
<tr>
<td>Individualized HbA1c targets</td>
<td>% patients seen by level 2 service with record of individualized HbA1c target</td>
<td>70-80%</td>
<td>9%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>80-90%</td>
<td>13%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&gt;90%</td>
<td>20%</td>
</tr>
<tr>
<td>Improvement in HbA1c following injectable initiation</td>
<td>Average improvement in HbA1c measured 3-6 months after initiating injectable therapy</td>
<td>5 - 8 mmol/L</td>
<td>16%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&gt;8 mmol/L</td>
<td>22%</td>
</tr>
<tr>
<td>Percentage prescribing of human insulin vs analogue in patients initiated on insulin</td>
<td>% human insulin as initial insulin prescribed in patients starting insulin</td>
<td>50-60%</td>
<td>2%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&gt;60%</td>
<td>5%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&gt;70%</td>
<td>10%</td>
</tr>
</tbody>
</table>
A consistent approach is possible across LTCs


2. Create a guiding coalition

3. Develop a clear shared vision

4. Communicate the vision

5. Empower people to act on the vision

6. Create short-term wins

7. Consolidate & build on the gains

8. Institutionalise the change

London-wide rollout of LTC 1º care Best Practice

Tools to support London-wide rollout of LTC 1º care Best Practice

* Adopted from J. Kotter’s “Eight Steps to Successful Change”
A consistent approach is possible across LTCs

**1. Expose current performance vs best practice**
Systematically define LTC best practice, its benefits (care quality vs financial) and demonstrate CCG current performance vs best practice

**2. Develop clinical leadership**
Build a strong pan-London reference group made of key stakeholders and influencers across the care pathway (SCN?)

**3. Prioritise local gaps in a common vision**
London-wide vision with customisation locally that addresses gaps, impact that implementation will have on daily practice, support offered, and the benefits etc.

**4. Communicate the vision**
Develop a platform to raise awareness and set expectation by delivering the vision to all clinical staff in LTC 1° care accompanied by training and competency assessment as necessary

**5. Empower people to act on the vision**
Drive outcome based datasets with appropriate incentives (co-commissioning, PMS, out-of-hospitals, Local incentive schemes, CQUINs etc.)

**6. Create short-term wins**
e.g. Systematically reduce clinical admin via templates (e.g. London-wide common referral docs, co-created service specs)

**7. Performance comparison**
Make peer-to-peer stats openly available

**8. Institutionalise the change**
Ensure competency is maintained after initial training to prevent skills decay and embed peer support within ways of working

**London-wide rollout of LTC 1° care Best Practice**

**Tools to support London-wide rollout of LTC 1° care Best Practice**
- Set up peer, specialist and patient networks; competency maintenance
- Make datasets available to see improvement in performance
- Reduce duplication across CCGs and reduce clinical form filling
- Develop KPIs/ incentives; curricular LTC education; contract templates
- Centralised virtual platform for clinical learning in primary care

---

*Adopted from J. Kotter’s “Eight Steps to Successful Change”