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Optimising care for people with multiple chronic conditions including heart failure: A comparative case study of organisational delivery systems in general practice.

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Research Questions

- A recognised strategy for improving the quality of care for people with chronic conditions is the coordination of care across different care settings. Given the organisational context of contemporary healthcare, how do professionals in general practice conceptualise and organise care for people with multiple chronic conditions?

- The aim of the research is to understand how and to what extent the quality of existing, emerging and future services are constrained by the way organisations are traditionally structured within the NHS.

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Background

- Global challenge of aging population with associated rising incidence and prevalence of chronic conditions.
- UK 17.5 million chronic conditions, many people more than one
- The enduring divide primary/secondary care and increasing specialisation and sub-specialisation

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Current provision

- Emphasis on biomedical determinants of disease. Disease specific provision
- Reactive services, fragmented across different professionals and disciplines
- Patient centric care, supported self management, improved continuity and coordination = key principles for improvement
- Largely failed to materialise

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Increasing focus on coordination

- Coordination and integration of care a recognised strategy for improving quality
- Increase of nurse specialists in primary care (diabetes, heart failure, COPD)
- Introduction of case managers and community matrons
- Increasing evidence to suggest GPs and general practice key role in facilitating coordination

(DH, 2010, King's Fund, 2010)

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Overall Design

Comparative case study of a number of English NHS general practices

Data gathering

- Data collected over 6 months
- Up to 4 weeks spent in individual general practices
- Semi-structured interviews with various practice staff, patient and carers
- Documentary analysis
- Non-participant observations will be undertaken.

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Analysis

- Data coded using Nvivo or MaxQDA
- Use recognised qualitative analytical process such as Miles and Huberman (1994) – data reduction, data display, conclusions and verification

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Fragmentation

- Fragmentation continues
- QoF – disease specific organisation of care
- Downwards role substitution perpetuates fragmentation
- Authority to coordinate not conferred to non-medical staff

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Path Dependency

- Entrenched physical and professional divide between primary/secondary care
- Power differential between GPs/hospital consultants, health and social care
- Marginalised role of generalists = reduction in holism and patient centred care
- Evidence of new forms of fragmentation

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Context of general practice

- Structure of primary care undermines collaborative practices and collective agency
- Lack of ownership particularly at interface with secondary care
- Heterogeneity of general practice and independent status, difficult to influence as a whole

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Sense-making in general practice

- Organisations socially constructed and perpetuated ‘enactment of negotiated order’
- Inherent hierarchies of decision making
- ? Staff aware coordination problems, but few mechanisms available to influence wider systems of care
- Individual and collective sense making may provide a plausible explanation for current services

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Key text

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- John Gabbay and Andree Le May (2011). Practice based evidence for healthcare: Clinical Mindlines. Oxon:Routledge.

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Suggestions/Advice

- How to persuade busy practice staff to particpate
- Data management and analysis
- Nvivo or MaxQDA

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3 Questions

- 1. Does this perspective of chronic disease management and primary care resonate in other countries?
- 2. Are there other influential perspectives that I have missed?
- 3. How to encourage closer integration between professionals, practices, other disciplines and services?