## Long Term Conditions QIPP
### Commissioning Pack: Evidence and Examples

## Reductions in Unscheduled Admissions

### Greenwich
#### Virtual Admission Avoidance

| Summary | The GCHS Virtual Admission Avoidance Team was established in December 2009 in response to a growing and urgent need for community services to step up the effort required to relieve congestion at the Queen Elizabeth Hospital. |
| Results | The data collected since January 2010 demonstrates that as a team, we **avoided 476 admissions for quarter 4 of 09/10 and 223 admissions in April 10**. We expect this to improve throughout the rest of the year as the team is now more focused on systematically evidencing their admissions avoidance activity by capturing each occurrence. Using an average tariff of £2500 per medical admission and using this as the basis for a trajectory for 2010/11, the expected **savings will be a total of £4,760,000.00 for the year**. |
| Further information | Giselle Brooms [Giselle.Brooms@greenwichPCT.nhs.uk](mailto:Giselle.Brooms@greenwichPCT.nhs.uk) |

### Nene
#### Risk stratification, care planning and integrated care teams

| Summary | Commissioning model around frail elderly with LTC- 76 practices 1 consortia 660.000 population 351 GPs. "Pro Active care" is a case management support service for patients. The population is stratified and support has been targeted initially at the patients with the highest risk of admission. GPs, Advanced Nurse Practitioners, District Nurses, Age Concern all work in partnership to support patients and links are being strengthened between social services and secondary care etc. PAC provides intervention and support for those patients at highest risk of hospital admission. GP Practices hold weekly meetings to review the case management of each patient supported by district nurse/community matron and a “tracker”. This team provides support for patients and carers by accessing services from the other agencies involved in the scheme. Newly appointed Carer Assessment Support Workers will now provide systematic support to carers who are looking after patients in PAC, thus providing a safety net for those most vulnerable carers. |
| Results | Targeted population top 1% so 6000 via clinically owned, clinically led, integrated care - **45% reduction in emergency admissions for those patients being supported** |
| Further information | Email: [ben.gowland@nenecommissioning.com](mailto:ben.gowland@nenecommissioning.com) Contact phone number:01604 641162 |

### Kirklees
#### Care planning

| Summary | Partnership working within Kirklees has led to the development and implementation of an individualised patient ‘emergency care plan’ identifying early warning signs of deterioration in their LTC and follow up with appropriate actions. The partnership working has enhanced effective communication between the ambulance service, community matron team and secondary care. The emergency care plan provides essential information for ambulance staff to help them to appropriately manage patients with LTCs including avoiding unnecessary hospital admissions. |
| Results | **60% reduction in acute admissions and 20% reduction in bed days** |
| Further information | Angela Harris, Community Matron, Kirklees Community Healthcare Services, email: [angela.harris@kirkleeschs.nhs.uk](mailto:angela.harris@kirkleeschs.nhs.uk) telephone: 01924 351582 or 07507 640 240 |
### Carmarthenshire
**Integrated care teams**

**Summary:** Community based teams for the management of chronic obstructive pulmonary disease (COPD) have been developed in Carmarthenshire. This team use guideline based systematic management to reduce unwarranted variation in care as well as improving clinical effectiveness and patient experience.

**Results:** Emergency admissions for COPD were reduced by 36% in Carmarthenshire.


### Sandwell
**Risk profiling: cardiovascular disease screening and treatment**

**Summary:** Mapping of patients on Cardiovascular Disease risk register against estimated prevalence for the area; finding 'missing' patients and assessing risks; and undertaking preventative work to improve outcomes and quality. Patients who might benefit from Cardiovascular Disease (CVD) screening were identified by comparing those on a CVD risk register with estimated prevalence. Screening and evidence based treatments were then offered to those at risk.

**Results:**
- As of April 2009:
  - 5018 new patients have been invited for CVD screening;
  - 2603 people have been screened (52%);
  - 1200 people have been medicated (69 New Diabetic) (46%);
  - 651 lifestyle referrals have been processed (282 Smoking & 369 Activity and Diet) (25%);
  - Nine referrals have been made to the Rapid Access Chest Pain Clinic;
  - **120 Heart attacks and strokes have been prevented**;
  - 40 Lives have been saved.

An estimated **£1-2 million will be saved in one Primary Care Trust (PCT)**. It is predicted that a £1-2m saving will be made, mainly from preventing CVD incidents. Lifestyle changes such as smoking cessation will also contribute savings to the wider health economy but are not yet quantified.


### Yorkshire and the Humber
**Patient record sharing in diabetes management**

**Summary:** Two trusts used electronic record sharing between primary care and diabetologists. A patient record shared between primary and secondary care enables rapid e-consultation between general practitioner (GP) seeking specialist advice on a patient and the diabetologist (usually secondary care based). Quality was improved by increased and improved management of diabetes in primary care.

**Results:** Productivity was improved by reduction in the number of hospital visits, admissions and unnecessary or inappropriate consultations. If diabetes prevalence increases as predicted in Yorkshire and the Humber, by 2014/15 we would expect the savings from implementing the e-consultation approach to be between £20m and £25m across our Primary Care Trust (PCT). Savings are driven by the differing unit cost between first outpatient appointments and the e-consultation tariff, and the reduction in volume of follow up appointments (first to follow up appointment ratios are very high for diabetes). There are further benefits to be accrued from the diabetes pathway from reduced ambulance journeys and the possibility of fewer emergency admissions.

REDUCTIONS IN LOS

**Salford Integrated care teams**

| Summary: | Integrated care team across primary and secondary care delivered in community settings. |
| Results: | LOS reduced by 18% emergency admissions by 10% cost savings £38,480 per patient total cost saving on admissions £227,998 |
| Further information: | Margaret.o’dwyer@salford.nhs.uk |

**Berkshire West Early discharge and intensive community rehabilitation**

| Summary: | The trust identified patients suitable for early discharge and intensive community rehabilitation, thereby releasing an average of 8 bed days for 200 patients per annum with effective results and good patient support for the programme. Increased dependency can be avoided over time. |
| Results: | ESD services have been shown to reduce hospital length of stay by an average of 8 eight days for each stroke patient on their caseload. Based on 2006/07 data on stroke acute admissions, it is estimated that 201 patients per year in Berkshire West would be medically eligible for care in an ESD service and therefore 1,608 bed days would be saved and there would be eight fewer adverse outcomes (death or dependency) at follow-up. |

**Glasgow, Liverpool, Edinburgh, Southend Hospital at Home**

| Summary: | Hospital at Home schemes allow patients with acute exacerbations of chronic obstructive pulmonary disease (COPD) to be treated at home instead of being admitted to hospital. Patient satisfaction with these schemes is high. |
| Results: | Average length of stay decreased from 4.2 to 1.7 days. |

**Leeds Community COPD service**

| Summary: | The Respiratory Service provides comprehensive, responsive care to patients with COPD across Leeds, key service components are:  
* Pulmonary Rehabilitation – an exercise and education programme which increases exercise tolerance, quality of life, self-care skills and confidence.  
* Providing a Supported Early Discharge Scheme. This enables people to be discharged earlier from hospital if they so wish and be managed in their own homes during exacerbations of COPD. The service was developed in partnership with the acute hospital trust and demonstrates effective unity of purpose and collaboration in developing services.  
* Delivery of a Telemedicine pilot in one area of the city, and now extending across the city, to support patients at home when they are less well. This provides access to assessment via the telephone so that reassurance and advice can be provided by the team as required by patients and carers.  
* Development of a ‘rolling’ COPD education programme to staff across the city.  
* Self-management and self-treatment guidelines will soon be ratified and made available to all health professionals to support more holistic education and |
management of their patients with COPD

Results:
Supported early Discharge has contributed to a 17% reduction in length of stay and has met with high patient satisfaction. Since the services inception there has been a 31% reduction in admissions to hospital. There has been high patient satisfaction with the service with comments emphasising how supported and empowered patients feel.

Further information:
Email: julie.mountain@nhs.net
Contact phone number: 07957378734

Torbay Integrated Care

Summary:
Torbay Care Trust has created five local zones, through which all community health and social care services for adults are delivered and commissioned. Within each zone, district nurses, social workers, physiotherapists, occupational therapists and an intermediate care support worker together form an integrated team, managed by one person. These teams use a pooled budget to commission whatever care is needed, while following a single assessment process. Each team has a health and social care coordinator, a new role performed by a nonprofessionally qualified member of staff, who liaises with users, their families and other team members to arrange care and support. A weekend working pilot scheme started in late 2009.
By bringing together local teams of health and social care staff, Torbay Care Trust has successfully provided cost-effective services for an elderly population. Torbay needs substantially fewer hospital beds for older people than other areas in the UK, has virtually eliminated delayed transfers of care from hospital to community care, and improved access to intermediate care such as physiotherapy.

Results:
Torbay Care Trust has reduced its use of hospital beds, virtually eliminated delayed transfers of care between organizations and improved access to intermediate care.
• Compared to its benchmark group, Torbay uses only 47 percent of the emergency bed days for people aged over 85 who require two or more admissions.
• Delayed transfers of care from hospital to community care have fallen to only 6 per 100,000 for those aged 65 or over (in the year to April 2008), compared with a median figure of 24 for England.
• By October 2008, 97 percent of care packages were in place within 28 days of assessment, compared with 67 percent in April 2006.
• Urgent cases have access to occupational therapists, physiotherapists, and district nurses within three and a half hours, with other cases seen within five working days.
• User and staff satisfaction have both improved.

Further information:

Bromley PACE: Post Acute Care Enablement Service

Summary:
PACE proactively identifies, and facilitates the immediate discharge, of medically stable inpatients whose needs do not require the intensity of care provided by an acute hospital and can be safely met in the community. PACE operates from 8am-8pm, 7 days per week, providing short-term, holistic care until the patient is independent or another community service can meet their needs. The ethos within PACE is to tailor services to the individual and provide both health and social care closer to people’s homes, thereby reducing the length of acute hospital stay and potentially preventing admission to longer-term care.
The objectives of PACE are:
• To proactively identify inpatients whose clinical needs do not require the
intensity of care provided by an acute hospital and who, with appropriate support in their homes, can be discharged from hospital immediately

- To provide health and social care to patients in their homes until such a time that they are independent or can be appropriately managed by another community service
- To enable and support SLHT to manage the timely discharge of patients thus decreasing the length of patient stay and increasing acute capacity
- To mitigate the risks of an acute hospital admission
- To provide a high-quality patient experience by delivering seamless, well-coordinated health and social care

Results: The end result in simple terms is that PACE patients spend an average of 3 fewer days in hospital and consistently report an 85% level of satisfaction with the care they receive from the PACE Team.

Further information: Andrew Hardman
Email: Andrew.hardman@bromleypct.nhs.uk

REDUCTIONS IN READMISSIONS

Leeds
Community Cardiac service

Summary: The Community Cardiac Service has developed across the city over the last five years as a result of recommendations within the National Service Framework for CHD (DH 2000) and Nice Guidelines for Heart Failure (2003), which outline menu based packages of care to provide patients following acute cardiac events, and those with a diagnosis of heart failure, accessible and high quality care. In response to ‘Our care, our say’ (DH 2006) services were developed within the community setting, increasing accessibility and patient choice. Prior to this service developing patients were discharged from hospital with no follow up at home, often having to travel some distance back to the hospital for their rehabilitation or aftercare.

Results: Now well established, the service plays a key role in enabling the Leeds Health Community to deliver high quality CHD services. The work of the team is also contributing positively to the health economy by decreasing dependence on secondary care services. Since the service was established, the admission rate for heart failure has been steadily falling, with 922 admissions in 2005 to 468 admissions in 2007. The readmission rate for heart failure has also been falling, from 15% of total admissions to 6% in 2007, showing that patients are well supported and monitored within the community, enabling better self care and early identification of deterioration of their condition.

Further information: Email: julie.mountain@nhs.net
Contact phone number: 07957378734

Pennsylvania, US
Geisinger Health System – Care co-ordination

Summary: Geisinger’s health plan is an integral part of its system, covering nearly 230,000 members. In 2006, it launched a series of developments designed to improve quality of care and give better outcomes for patients, while simultaneously lowering costs. One of these initiatives – called “ProvenHealth Navigator” (Geisinger’s patient-centered medical home program) – attempts to gain better coordination between the various elements of the care delivery team and the provider, as well as a greater emphasis on individuals’ health. Physicians and practices are encouraged to participate through an incentive scheme. Beginning with three pilot sites, the program has gone through four phases and now covers
around three quarters of sites, primarily in Geisinger’s community practice sites. There is now round-the-clock access to primary and specialty care services, enhanced by the use of technology. Each practice site has one or more nurse care coordinators, along with a “personal care navigator” function to respond to consumer inquiries. With an emphasis on proactive, evidence-based care, the program aims to reduce hospitalization, promote health and optimize the management of chronic disease. It also offers care management support and home-based monitoring of patients with chronic disease.

Some of the notable features involve:
- Picking out future high users
- Monitoring patients at home
- Incentives for doctors

### Results:

Amongst the early benefits is an overall 20 percent reduction in hospital admissions along with a 7 percent saving in total medical costs. In the longer term, patient health status, population health metrics and efficiency are being tracked.

- For the first three phases, patients receiving the medical home initiative compared very favorably with a control group of Medicare patients:
  - Admissions were 23 percent lower
  - Re-admissions were 23 percent lower
  - Emergency room visits were 9 percent lower
  - In-patient costs were 17 percent lower
  - Total costs were 3 percent lower

- Some of the most successful sites in the program have shown up to a 50 percent reduction in hospital admissions and an 80 percent drop in hospital readmissions.

### Further information: