NHS
North West

Care & Resource Utilisation

"Admit to Assess"
or
"Assess to admit"

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Acknowledgement to
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UM Data Analysis

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Questions to ponder …

- Do we care about our patients ?
- Do we really know what happens through their journey ? (non elective pathways is clearer but electives?)
- Does the journey reflect what Patients need when they need it ?
- Or the way we choose to provide it ?

Why Change?

- Rising expectations
- The demographic challenge
- Revolution in medical technology
- Continuing variations in safety & quality of care
- Targets

PMDU review key findings

- Current LDP activity plans leave too much activity to be done in 2008/09.
- A challenging referral-to-treatment (RTT) milestone is needed for March 2008.
- Pathways that end in admission are the biggest challenge.
- Measuring the delivery of 18w is a substantial challenge for the NHS.
- Delivering 18w in a reformed NHS will require improved PCT commissioning and excellent DH/SHA leadership.

Activity Profiles, monitoring and financial adjustments

Commissioners will agree with providers monthly forecast levels of activity for both elective and non-elective care, the "activity profile". For elective care the activity profile will be based on both expected volumes of new referrals and the reduction required in existing waiting lists to allow providers to deliver 18 weeks in a sustainable way. The activity profiles will include upper limits for:

- conversion rates
- average cost per unit level of activity
- rates of consultant to consultant referrals

Commissioners and providers are expected to meet monthly to review actual activity against forecast activity and the activity metrics, and to revise the activity profile as appropriate. The activity profile should be adjusted to reflect any pattern of increased referrals or changes in conversion rates which arise from an improved quality of referrals. Where the agreed limits for activity metrics are exceeded investigations will be conducted and limits revised if appropriate.

Where activity conducted exceeds the limits agreed in the activity profile, the commissioner will be able to apply a financial adjustment to tariff payment. There will be no basis for any financial adjustments to be applied where providers only vary activity in response to activity required for new referrals.

Prior approval schemes

Commissioners will be able to define prior approval schemes in line with the following key principles for prior approval published with the Operating Framework:

- The majority of PA will be at group level, on groups of patients, where commissioners and providers agree in advance how to manage patients or pathways. It is expected that such schemes focus on procedures of limited or low clinical effectiveness. Under such arrangements, providers do not need to get PA on each individual patient; instead, they agree to treat all patients to the agreed protocol, so in effect patients are automatically approved. Commissioners can retrospectively audit activity to ensure adherence to the agreement.

- For low volume and/or high-cost complex pathways, PA at individual level may be appropriate, where providers must get agreement before initiating treatment on a specific patient. Clear agreement over where such PA is required and how clinicians should communicate with patients affected is required.

Breaches of prior approval will be reviewed at monthly review meetings and providers will have the discretion to apply financial adjustments in relation to payment.

Utilisation management schemes

Commissioners and providers are required to participate in utilisation management reviews given reasonable notice by the other party. Any utilisation management schemes need to adhere to the principles outlined in the Operating Framework.

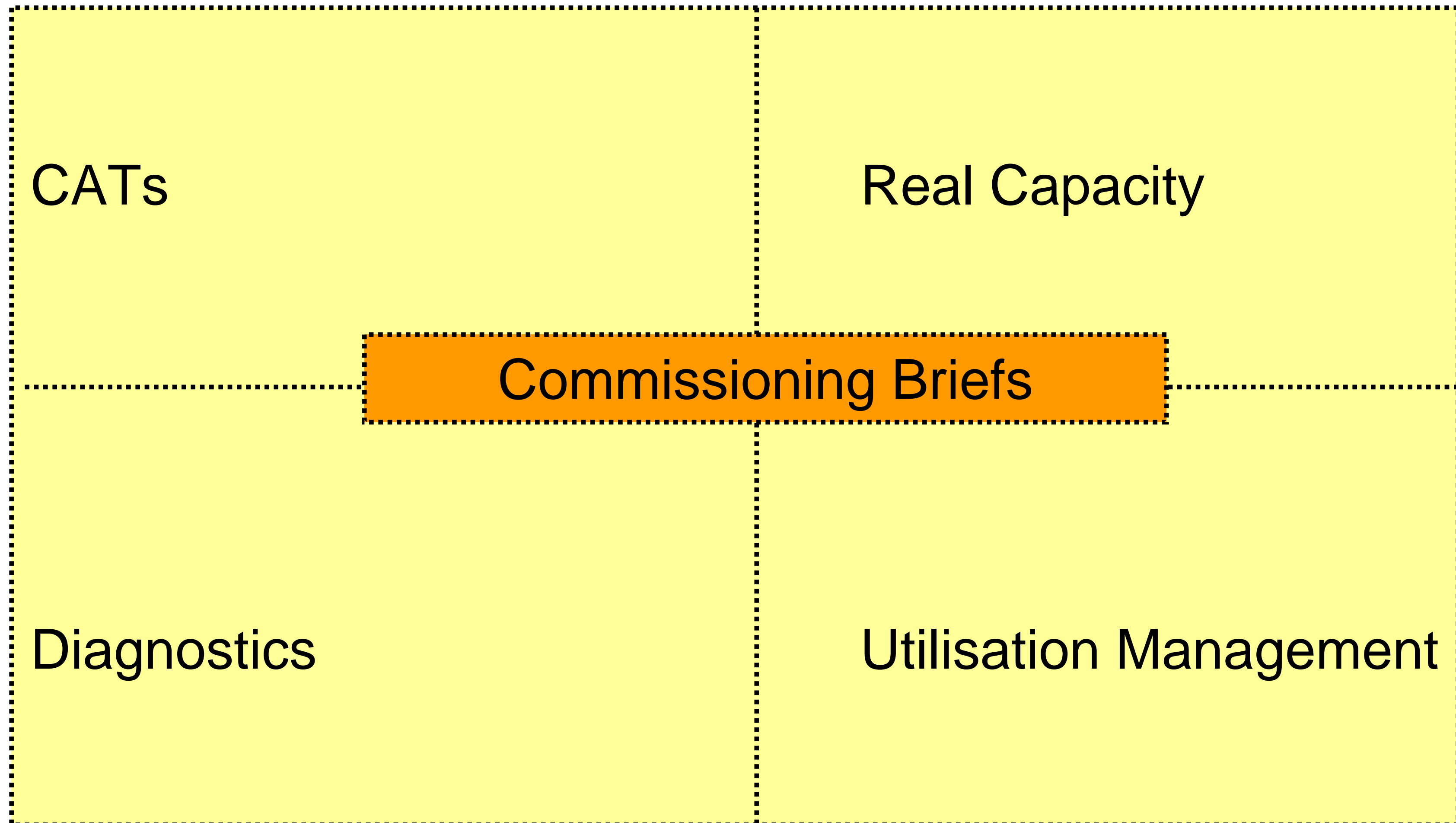
Utilisation Management schemes (UM) enable commissioners and providers to look at the reasons why there is 'over-utilisation' of healthcare resources, and can be used as a service development tool to:

- redesign services (e.g. where the patient care package received could have been effectively provided within a less acute setting)
- highlights gaps in primary care resource
- target and reduce delays which add no value to the patient
- release beds

In co-operation with commissioners, providers may be asked to:

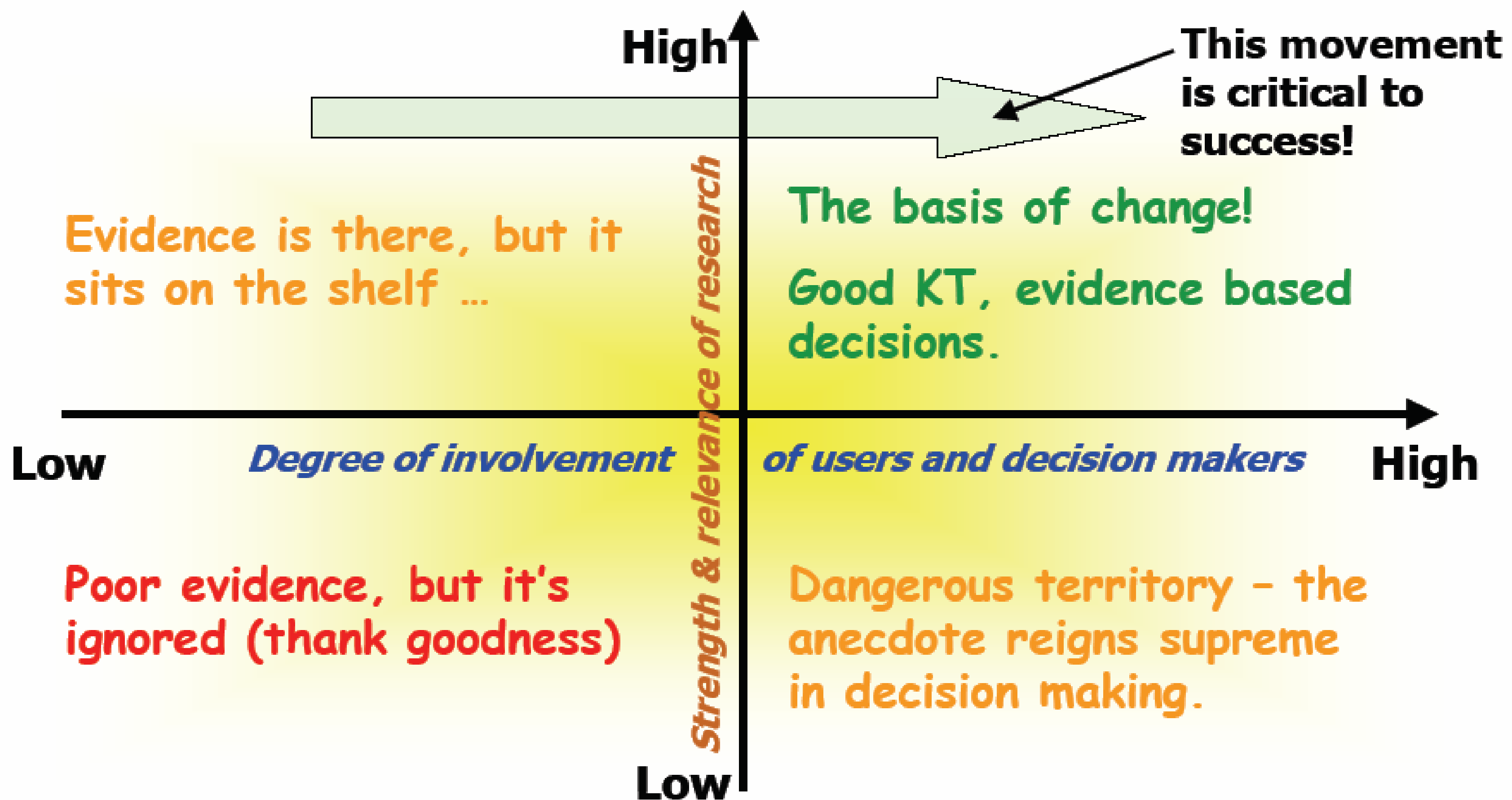
- share appropriate, timely data with commissioners to inform UM
- share details of patients (including access to patients notes) for the period of the review
- allow review teams access to the relevant premises to carry out the review
- allow the data from the UM to be shared with key stakeholders (e.g. GPs)

Integrated Approach
The whole is greater than the sum of the parts

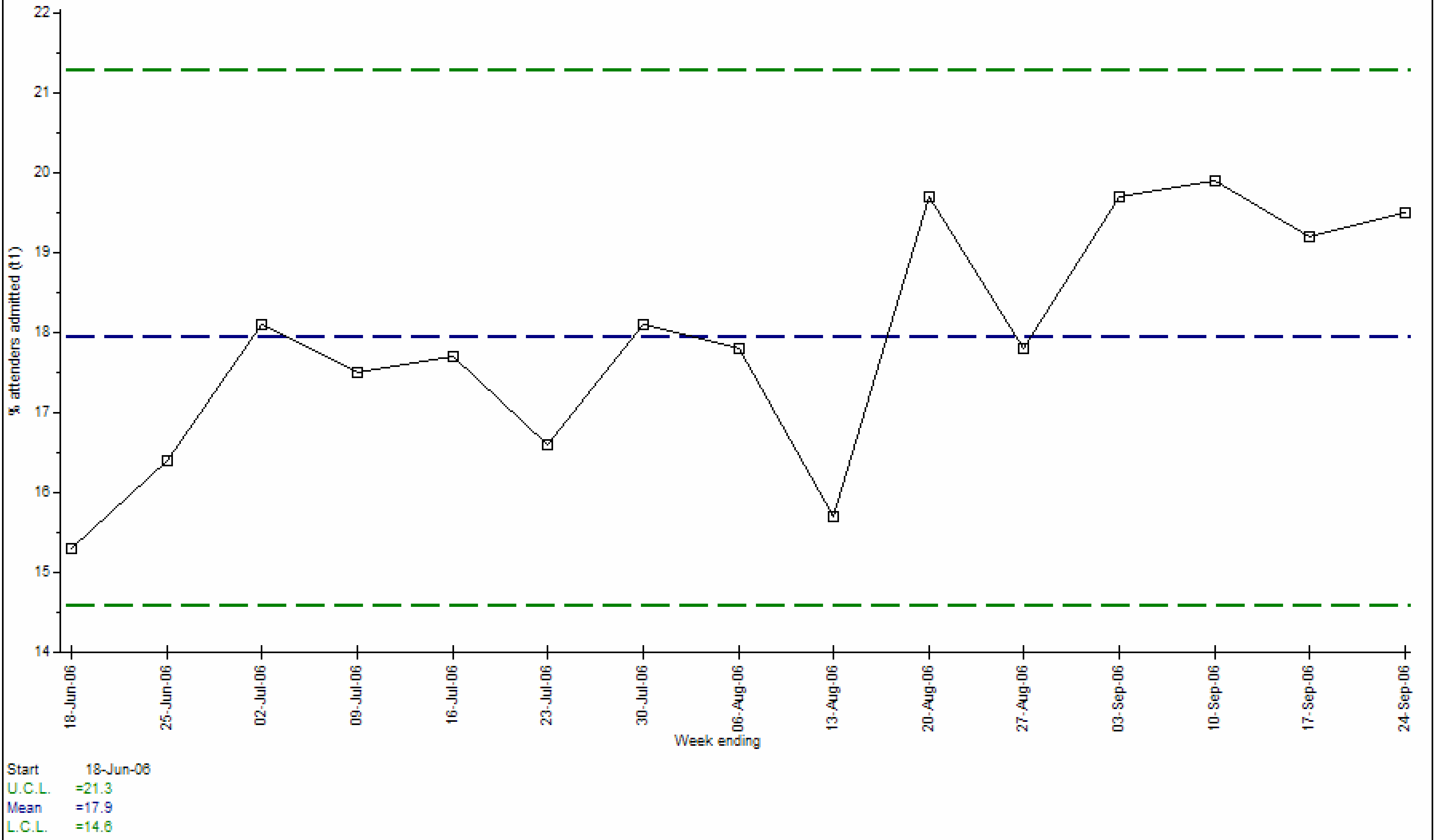


What & How to Change

Data to Information to Knowledge

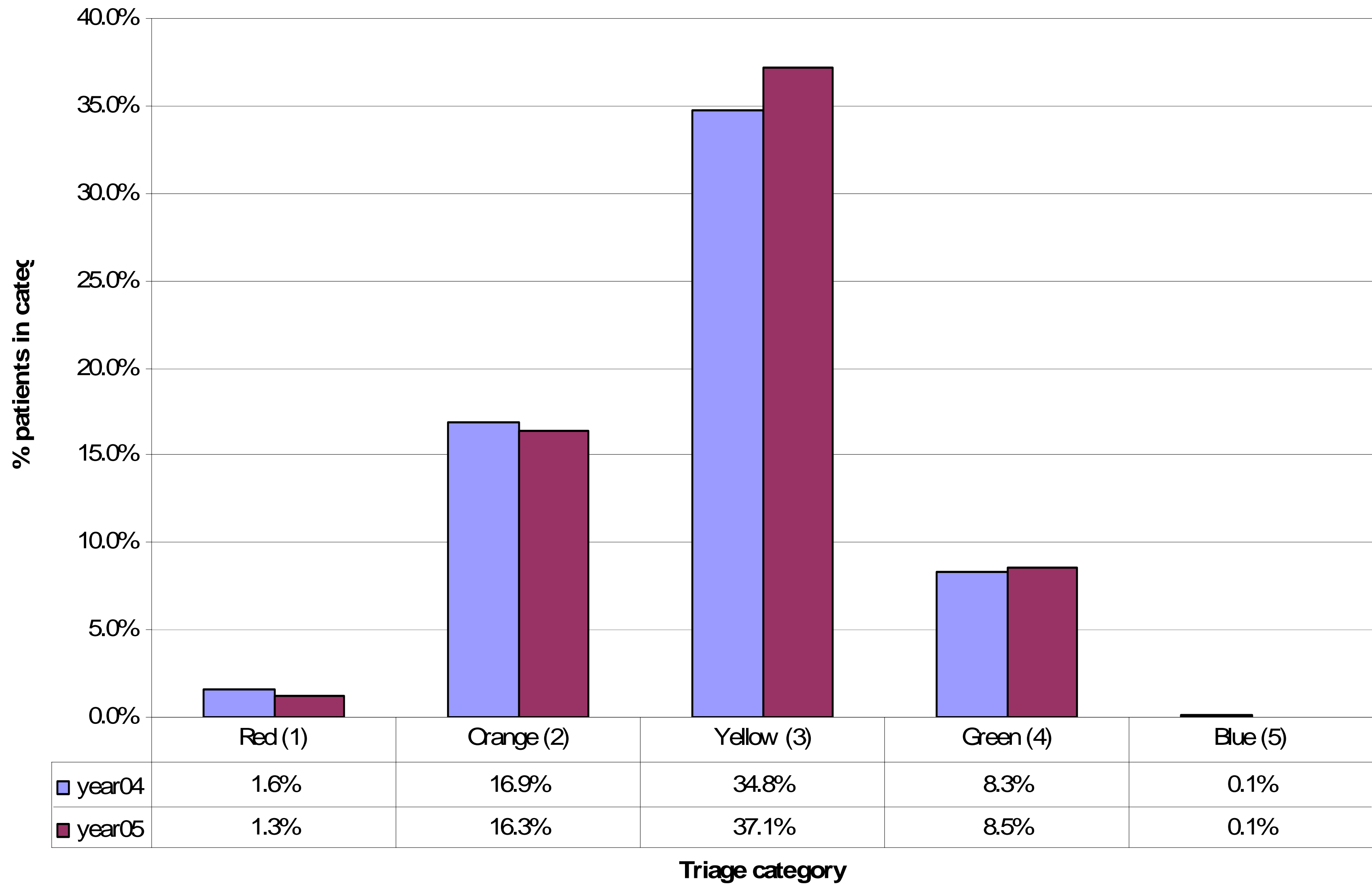


Establish the Facts


% attenders admitted (t1)
22
21
20
19
18
17
16
15
14
% attenders admitted (t1)
18-Jun-06
25-Jun-06
02-Jul-06
09-Jul-06
16-Jul-06
23-Jul-06
30-Jul-06
06-Aug-06
13-Aug-06
20-Aug-06
27-Aug-06
03-Sep-06
10-Sep-06
17-Sep-06
24-Sep-06
Week ending
Start 18-Jun-06
U.C.L. =21.3
Mean =17.9
L.C.L. =14.6

Why do we admit an increasing proportion of patients?

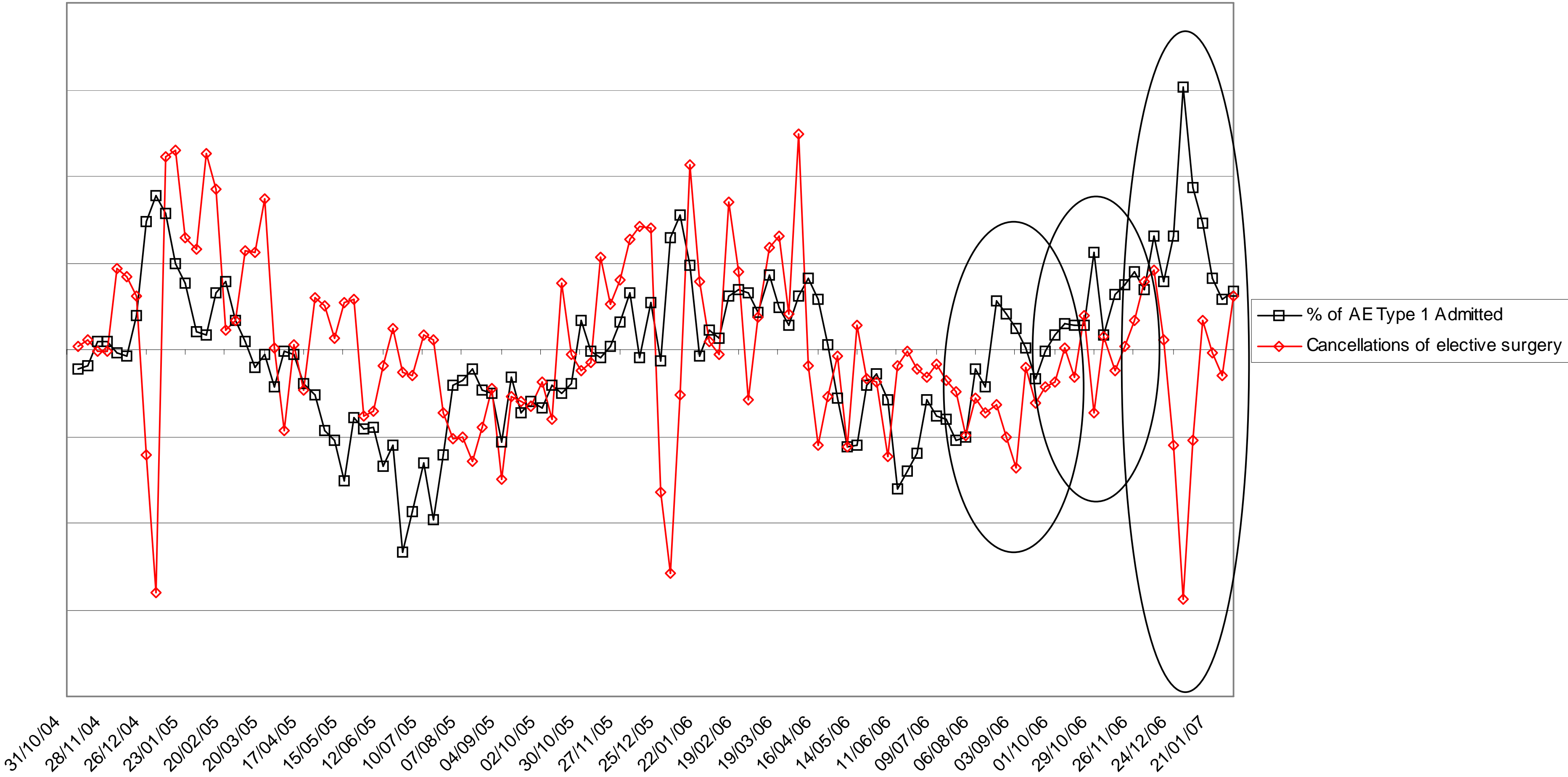
- Is it that patients are sicker or more complex?
- Is it a lack of appropriate primary/social care resource?
- Are there too many services – confusing patients, GP’s and AE staff?
- Is there a lack of understanding of what level of care can be provided in the community?
- Are existing services available at the right time?
- Is the response too slow to prevent admission?
- A need for diagnostics?
- Can we identify early enough those who have potential for alternative management?



Triage acuity 04 v 05 (n=8607)
% patients in categ
40.0%
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
Red (1)
Orange (2)
Yellow (3)
Green (4)
Blue (5)
year04
1.6%
16.9%
34.8%
8.3%
0.1%
year05
1.3%
16.3%
37.1%
8.5%
0.1%
Triage category

NHS North West SitRep Analyser: Andy Mullarkey Utilisation Management

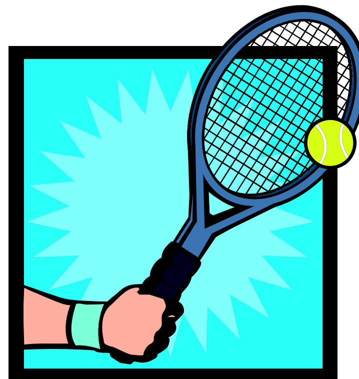
North West: Compare Measures



Non elective efficiency is *THE* key enabler for an 18 week elective pathway

Utilisation Management

UM enhances the information we already have but crucially adds another dimension and provides a link between ‘shop floor’ and ‘strategy’



Utilisation Management (UM) Process

- The UM review process identifies practices, policies, case mix, resource deficit and patient level clinical performances which lead to inappropriate hospital admissions. (A patients-eye view)
- These admissions, determined using the mAEP do not exhibit “intensity of service” or “severity of illness” needs commensurate with acute hospital care. (Best use of resources?)
- Hospitals meanwhile may cancel planned surgery, have extended delays for emergency admission while other “inappropriately admitted” patients occupy hospital beds often receiving care packages that could have been provided at a lower level. (Admissions impact)

The 10 week UM cycle

1. Analysis of 8 “quarters” of A&E data
2. Analysis and interpretation of site specific SITRep data
3. A fourteen-day UM review
4. Interpretation, Feedback and Strategic overview of all the data to Stakeholders
5. Action Planning with Stakeholders - Rapid Improvement Event

Plus LoS data at 6/52

Utilisation Management Reviewers

- UM Reviewers visit all wards & depts which receive admissions to be reviewed
- On the post admission day they examine case notes and gather information ’from the bedside’
- The relevant data in transferred to bespoke software
- At the end of fourteen days consecutive review the data is sent for analysis
- Outputs available within 24 hours of the end of the review phase

Issues "Utilisation management" can address

- **Location of care: Is hospitalisation required?**
- **Duration of care: What length of stay is required?**
- **Need for care: Is the procedure required?**
- ***What type of alternatives to admission are required, when and where ?***
- ***Major focus is usually on location and duration***

Utilisation Management

Definitions

UM Definitions

‘Appropriate’

An admission to which at least one criterion can be applied

(as at noon on the PAD)

UM Definitions

‘Inappropriate’

An admission to which no criteria can be applied

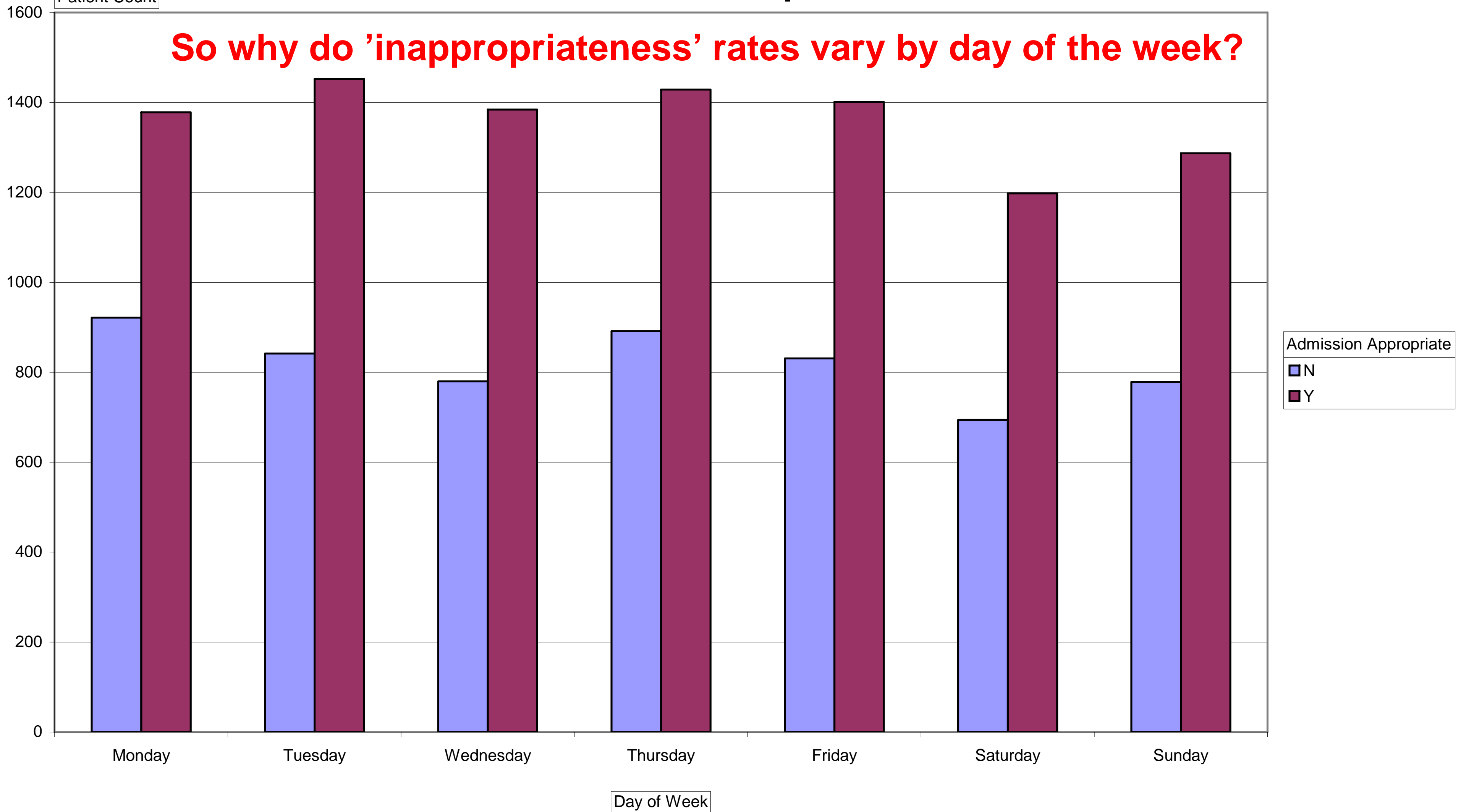
(as at noon on the PAD)

Utilisation Management

examples of documented ‘plans’

- “’Observe’ over the weekend”
- “Patient prefers to wait another 24 hours in case pain returns”
- “In a lot of pain can’t go home”
- “Home to attend party return later” - patient waiting for VQ scan

- **UM Reviewers seek to apply clinically accepted criteria (mAEP)**
- **At the same point in time for each patient**
- **We know UM Reviewer outputs are consistent**



Appropriate v Inappropriate

- Not all ‘appropriate’ admissions have to be in-patients
- Not all ‘inappropriate’ admissions should be discharged
- Shift from the ‘as at noon’ status

UM Definitions

‘Inevitable’

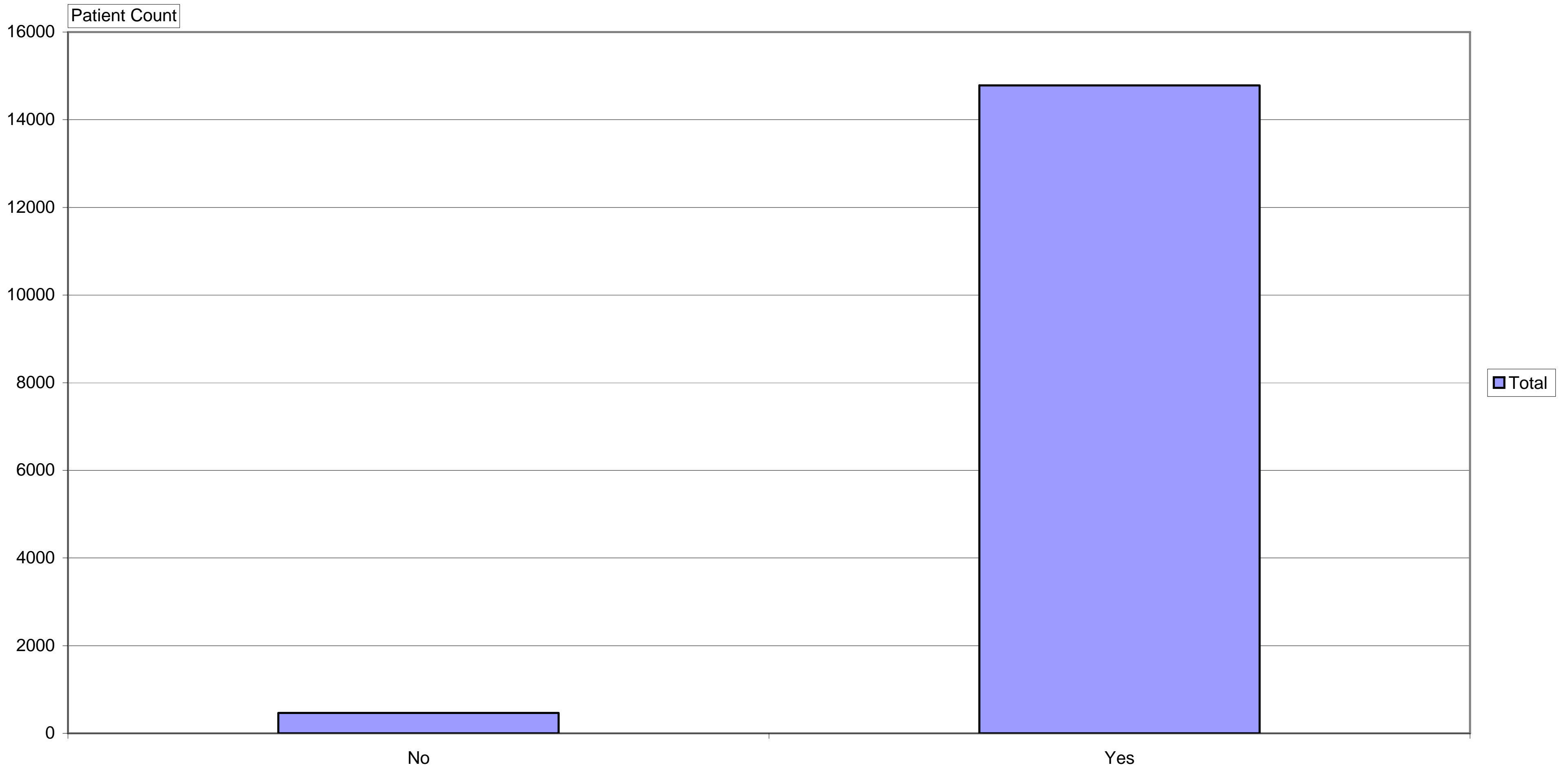
Determined by whether discharge or referral to an alternative is a safe option.

‘Inevitability’ is applied regardless of the ‘Appropriateness’

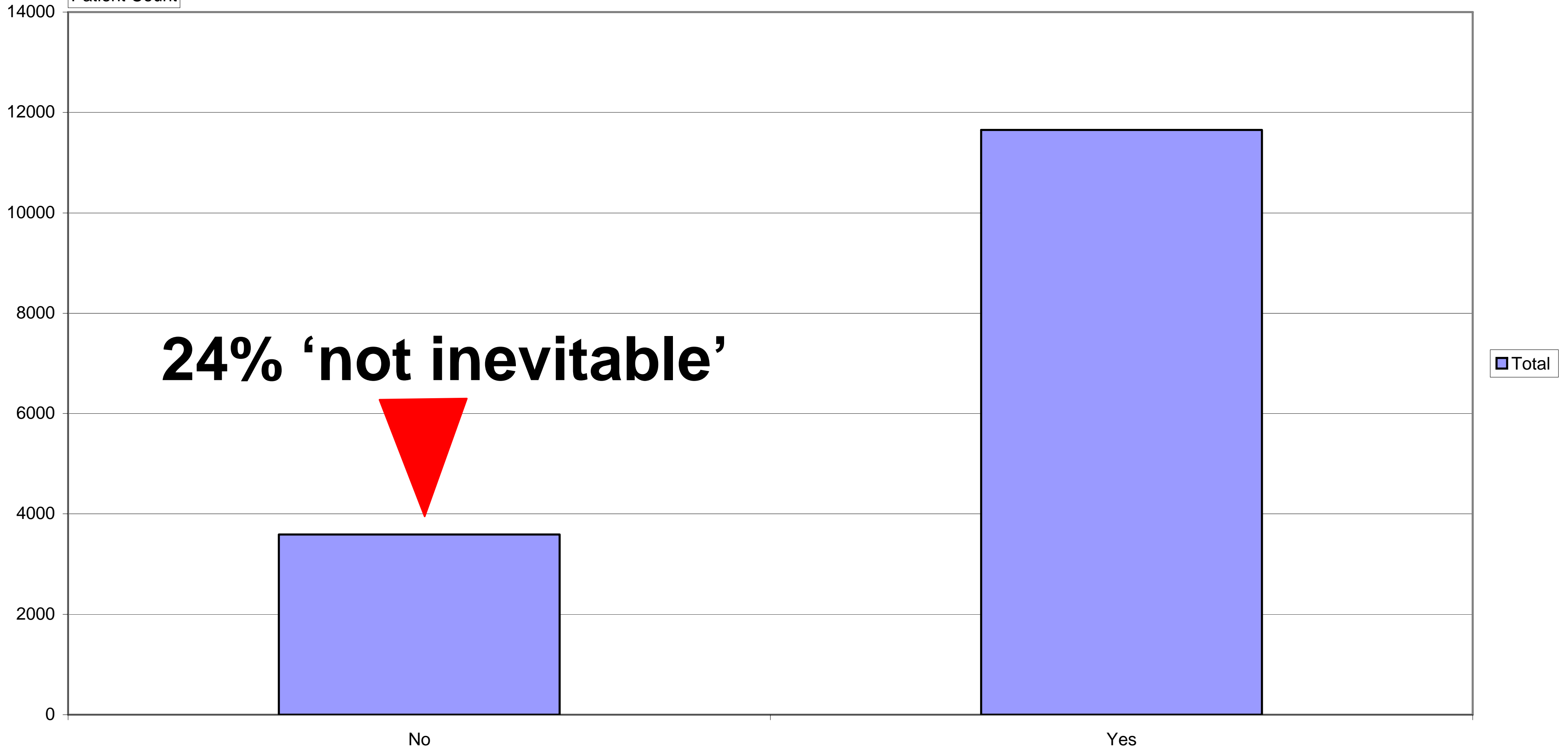
Medical **Nursing** **Social**

Organisation Name (All)

Total



InevitableDTA



Zero day LoS

- Between 16% & 52 % of emergency admissions to acute hospitals are

  inappropriate !

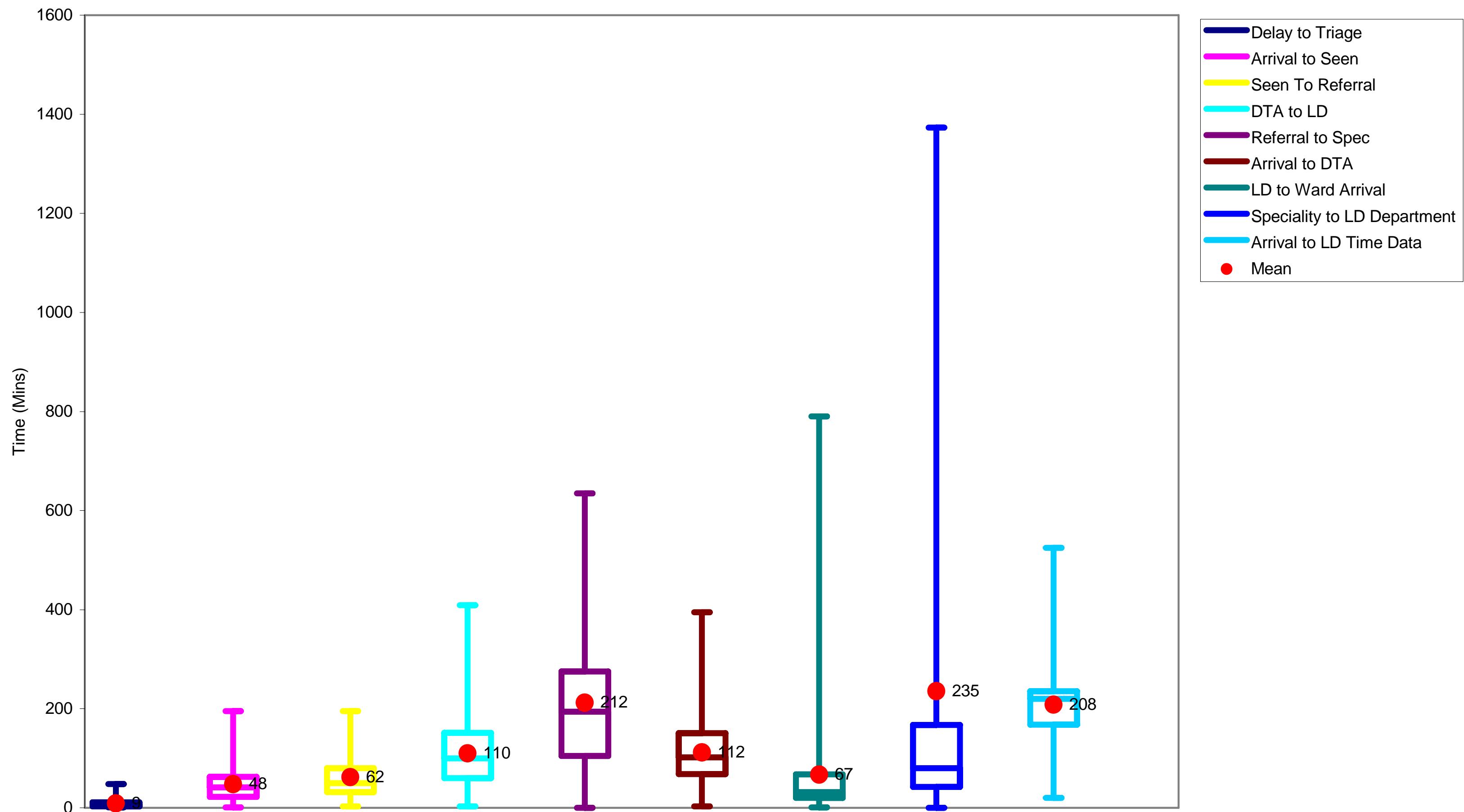
- Those patients either
  - Do not need hospital level care or an alternative
  - Have to be admitted because no alternative currently exists
  - Need hospital level care but don’t get it !

- In each case the UTILITY VALUE of the “bed day” is lost

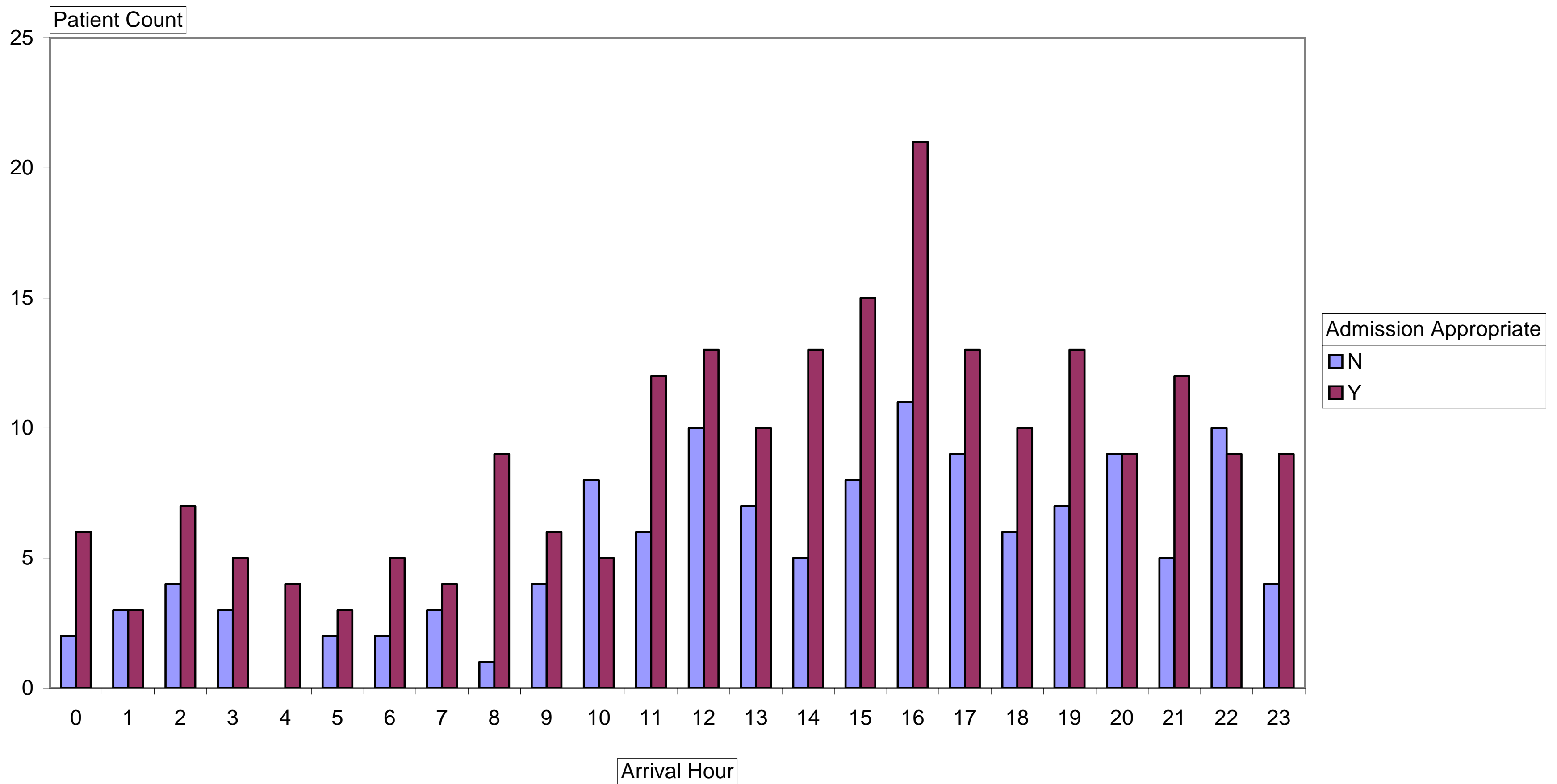
	Appropriate	**Inappropriate**
Inevitable	An **appropriate** admission to an acute hospital bed	An **inappropriate but inevitable** acute hospital admission.
Not Inevitable	An **appropriate but NOT inevitable** admission	An **inappropriate and NOT inevitable** acute hospital admission.

Targeting the reasons why patients are inappropriately admitted

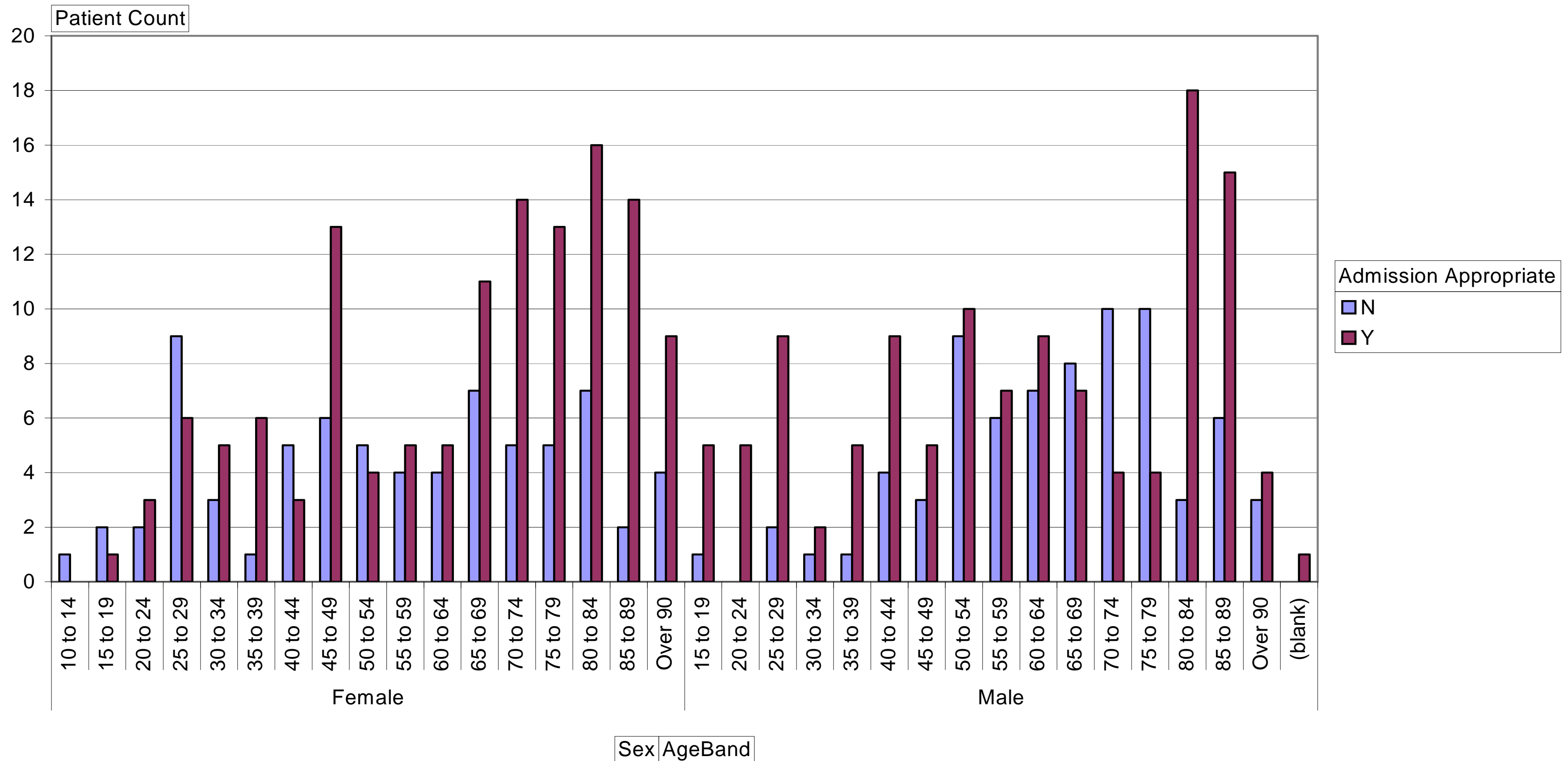
1 Systems still unable to meet 4 hour promise through patient focused means



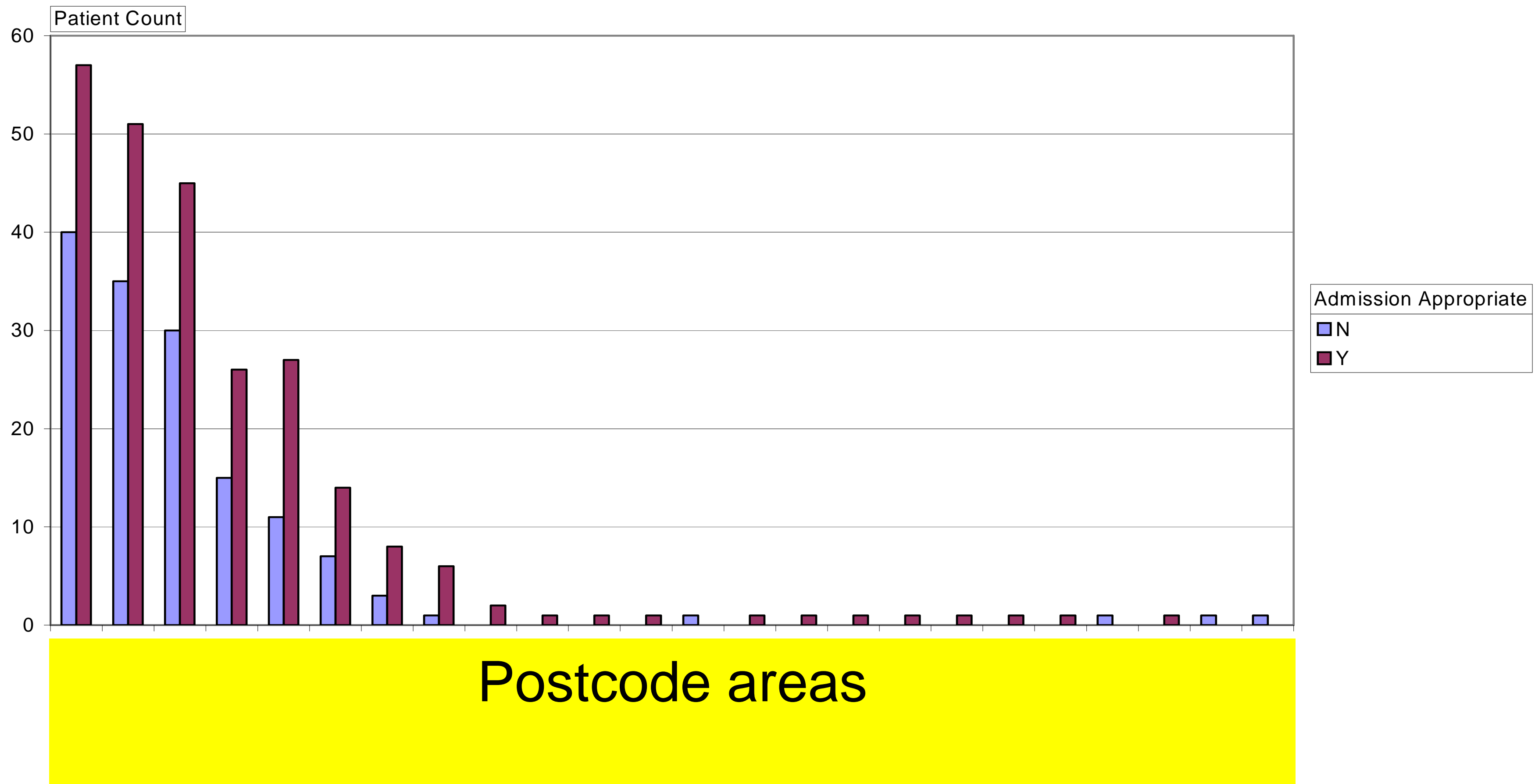
2 There is still a mismatch between services and demand and A&E units are backlogged



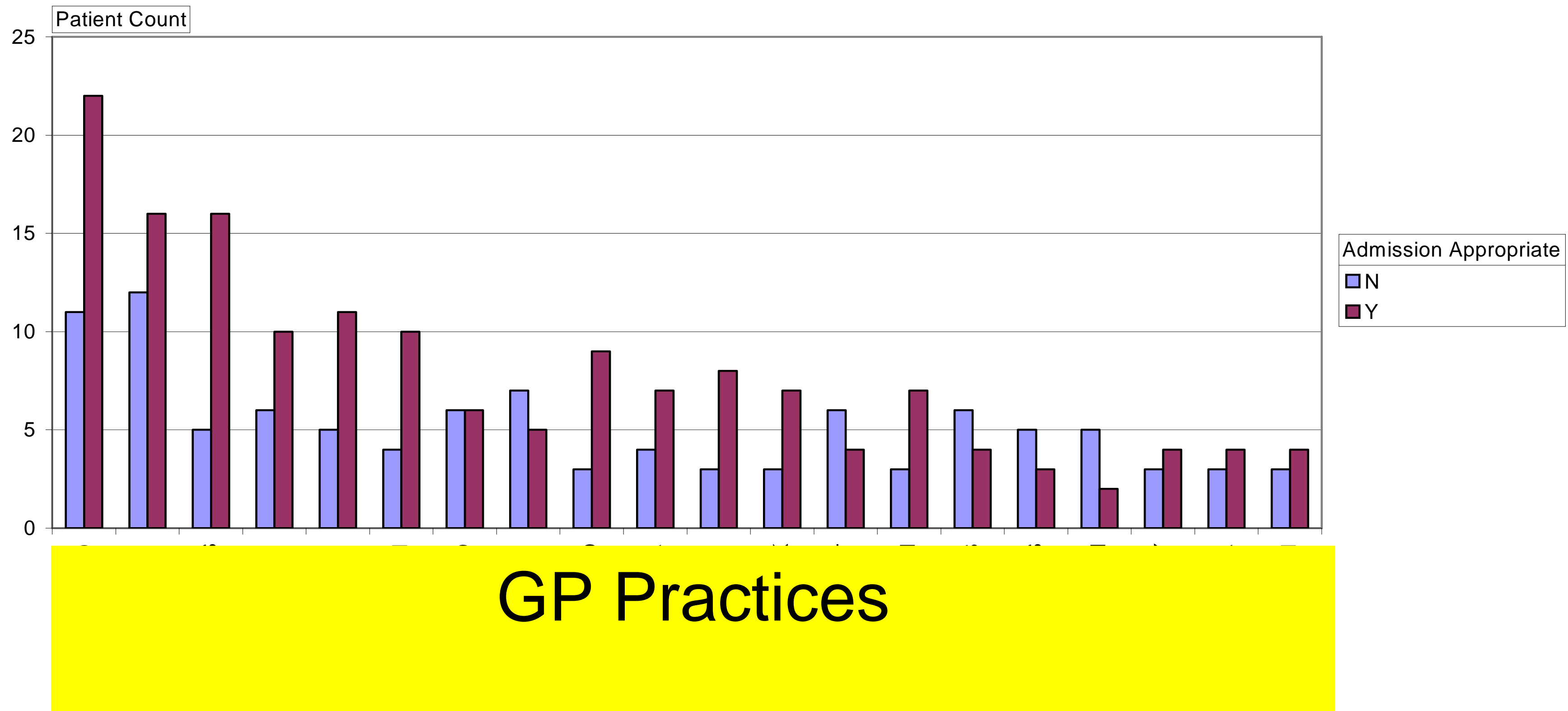
3 Services are disease focused but also need to be demographically focused



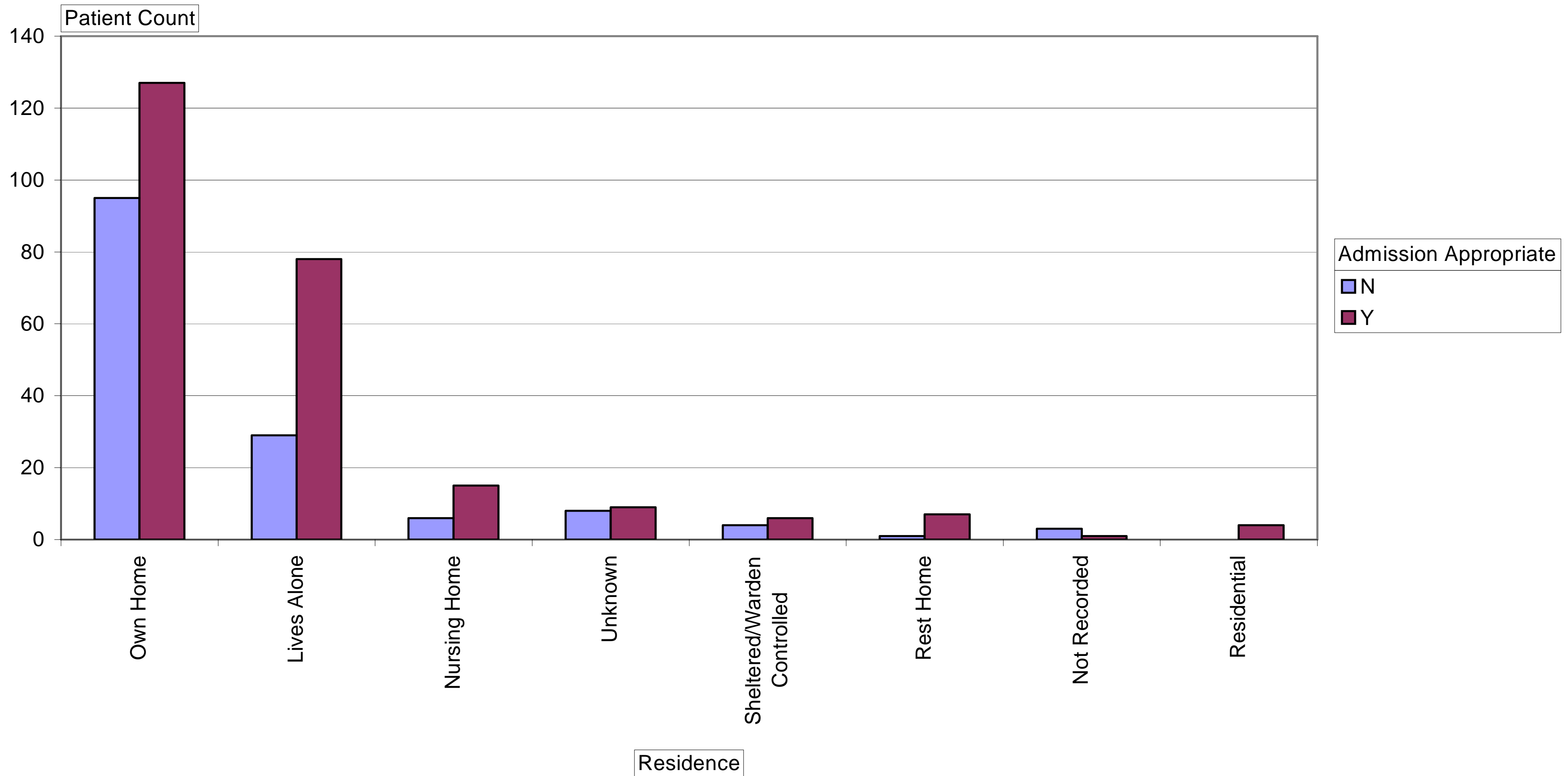
4 Opportunities are being lost to focus case managers on high win localities



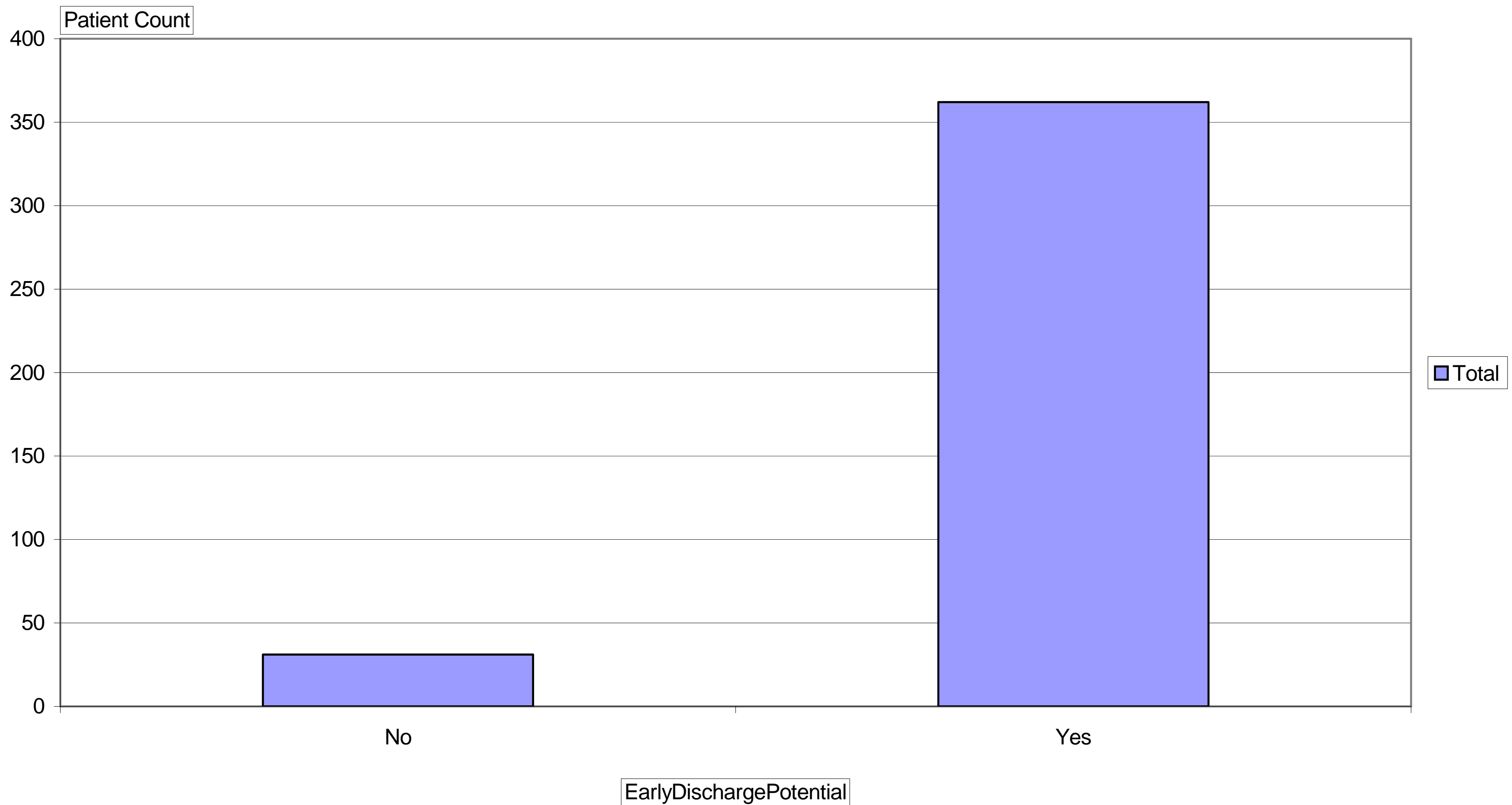
5 There is clear scope to target support at individual Practice populations

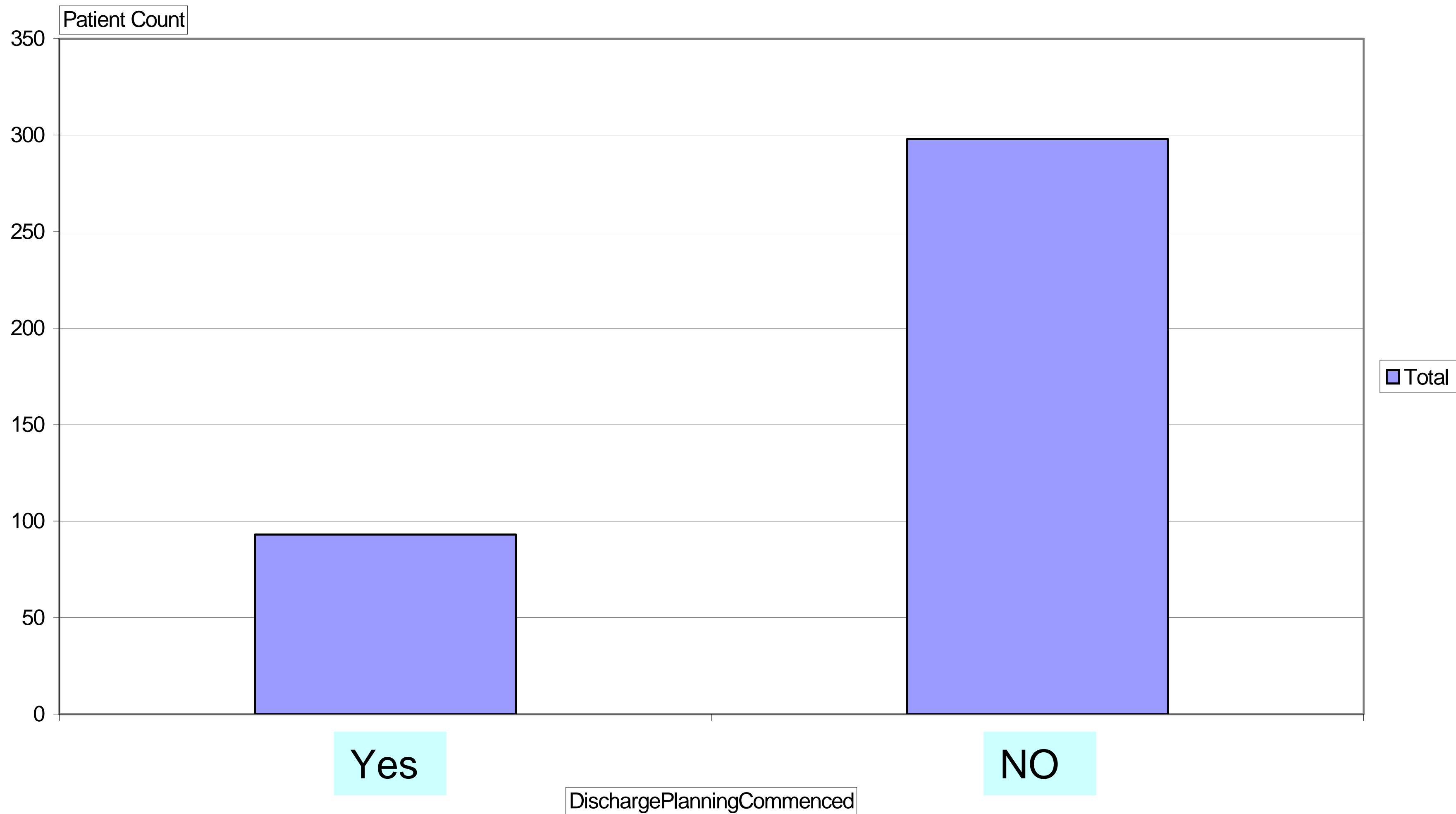


6 Sometimes we are aiming for the wrong target



6 And sometimes even when we know what to do we don't do it …..



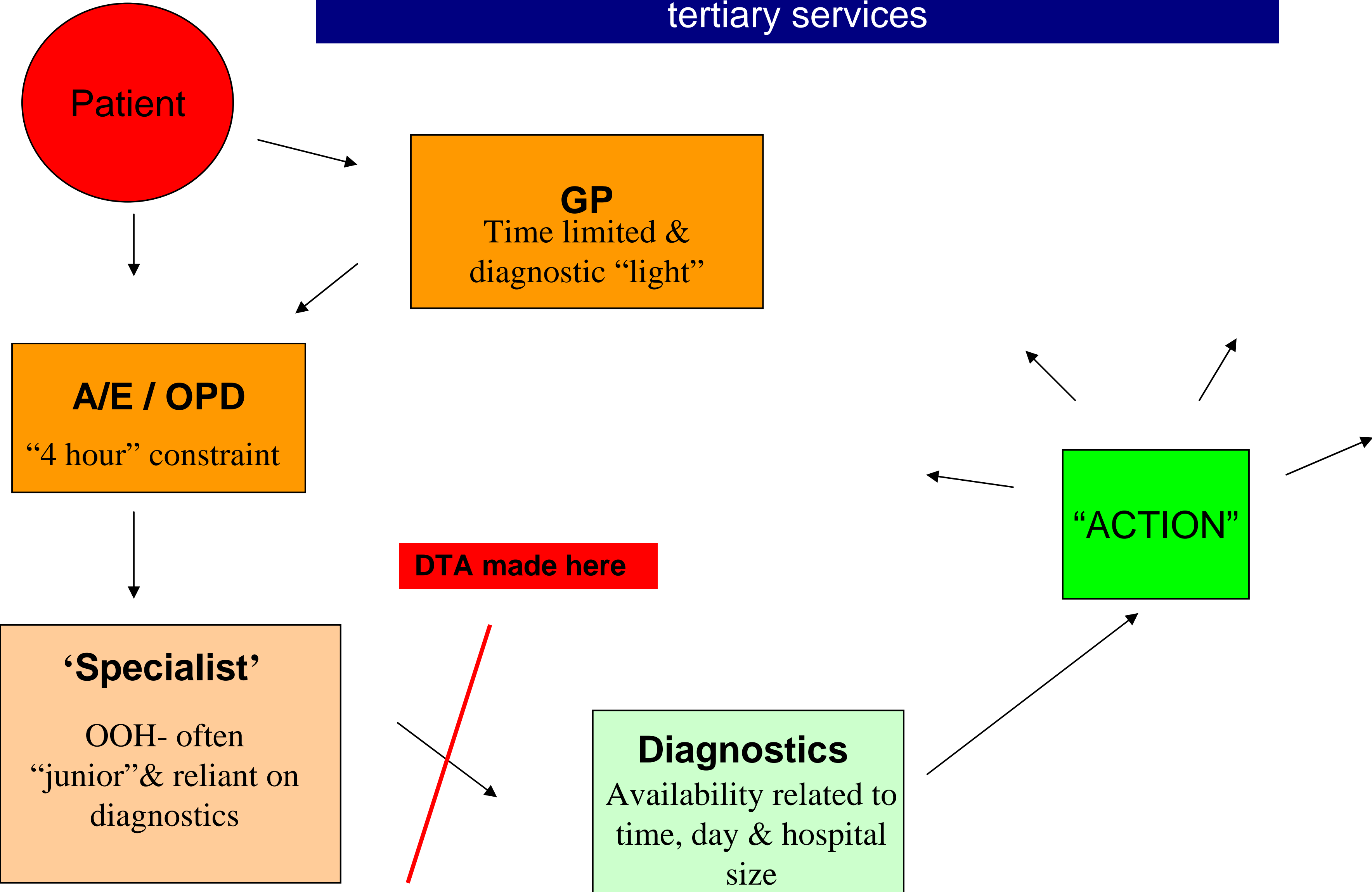

Trust Site (All)
Patient Count
Patient Count
350
300
250
200
150
100
50
0
Total
Yes
NO
DischargePlanningCommenced

Care & Resource Utilisation

Moving to an "Assess to admit"

service from

an "Admit to Assess" system of care

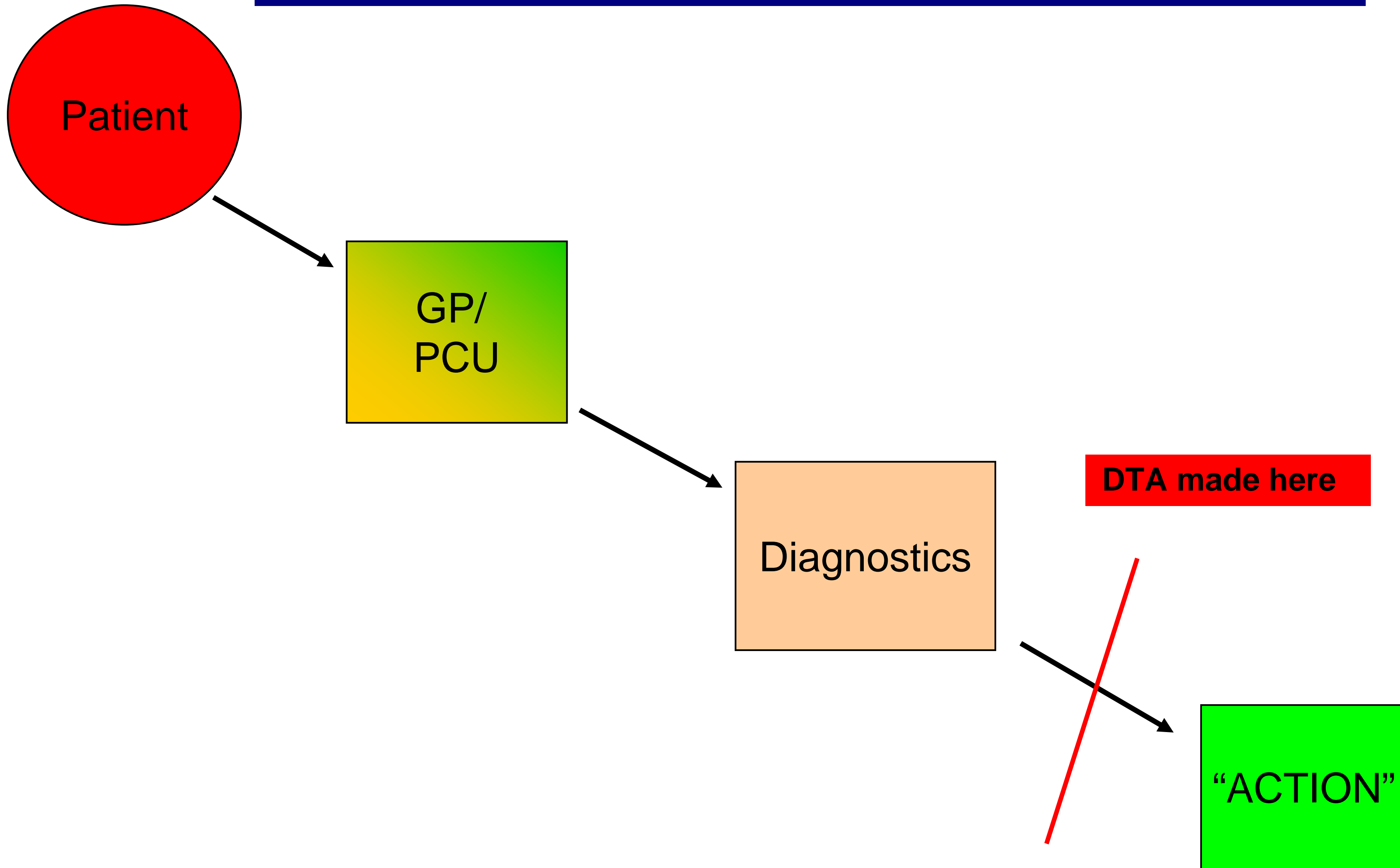

The current pathway for accessing tertiary services
Patient
GP
Time limited & diagnostic “light”
A/E / OPD
“4 hour” constraint
‘Specialist’
OOH- often “junior”& reliant on diagnostics
DTA made here
Diagnostics
Availability related to time, day & hospital size
“ACTION”

Result :

Admit

to

Assess


Evidence-based pathways for accessing
"non critical" tertiary services
Patient
GP/
PCU
Diagnostics
DTA made here
"ACTION"

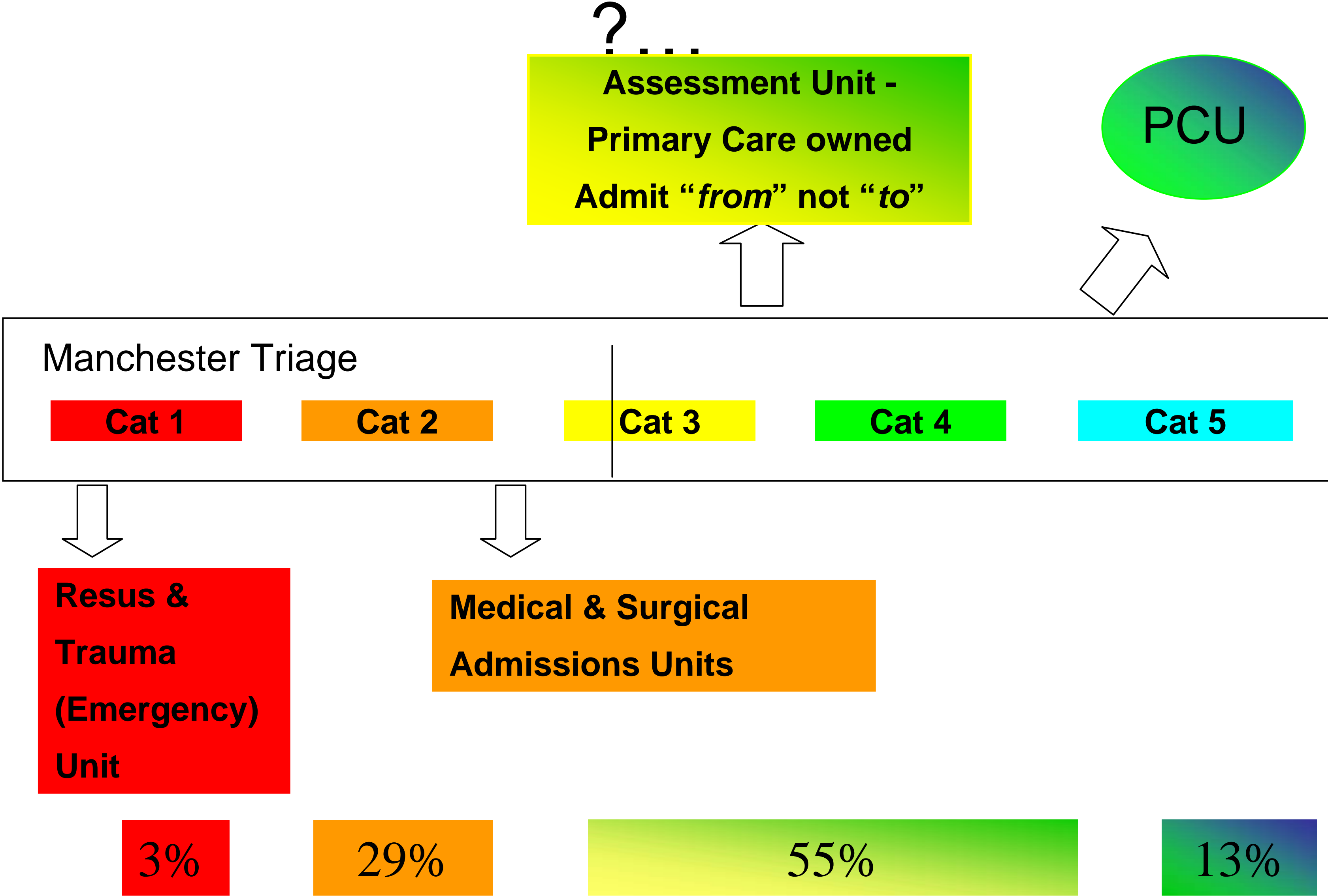
Result :

Assess

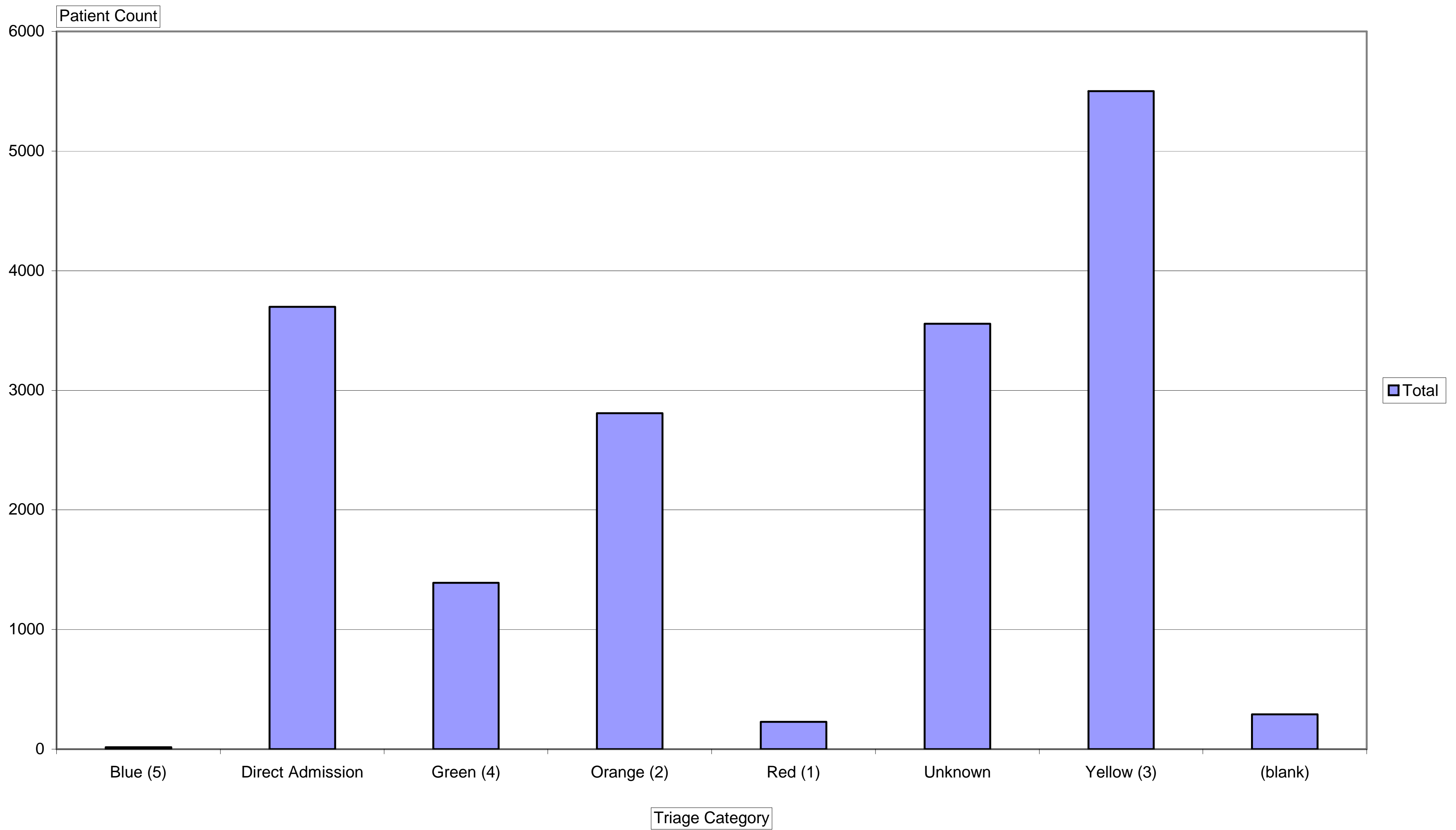
to

Admit

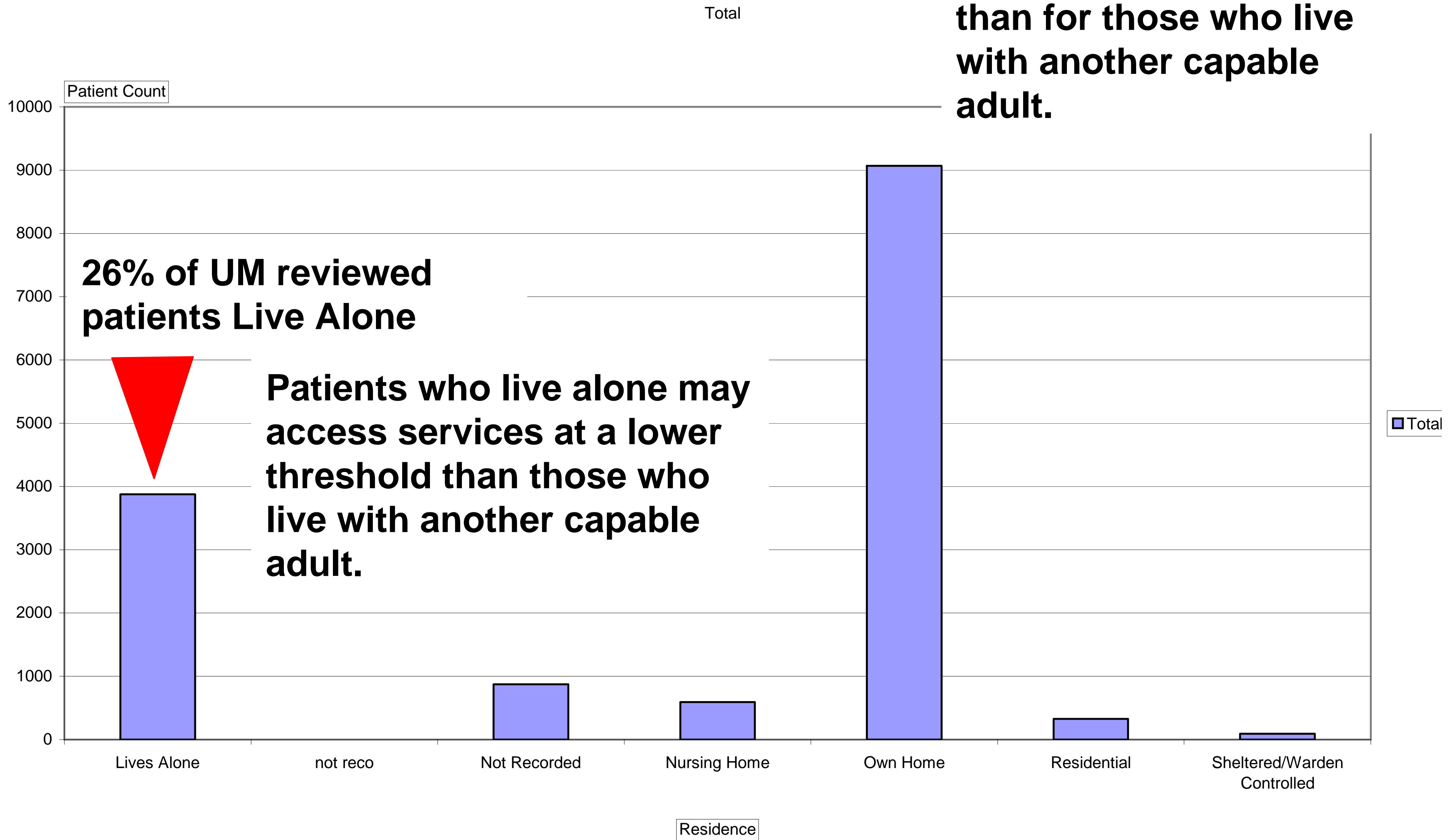
But could YOU make it work like this ?...



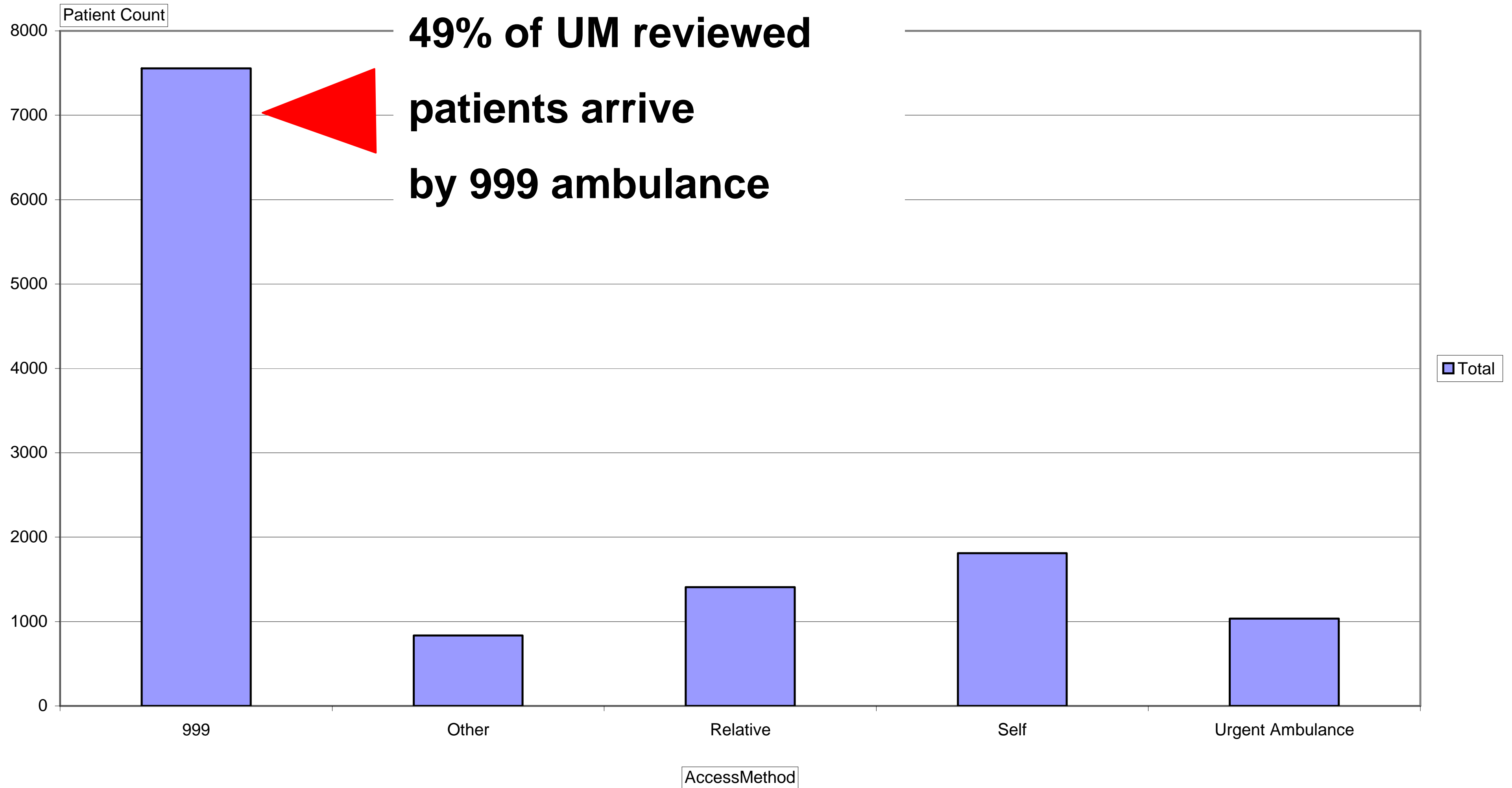
But who can we safely ‘divert’?

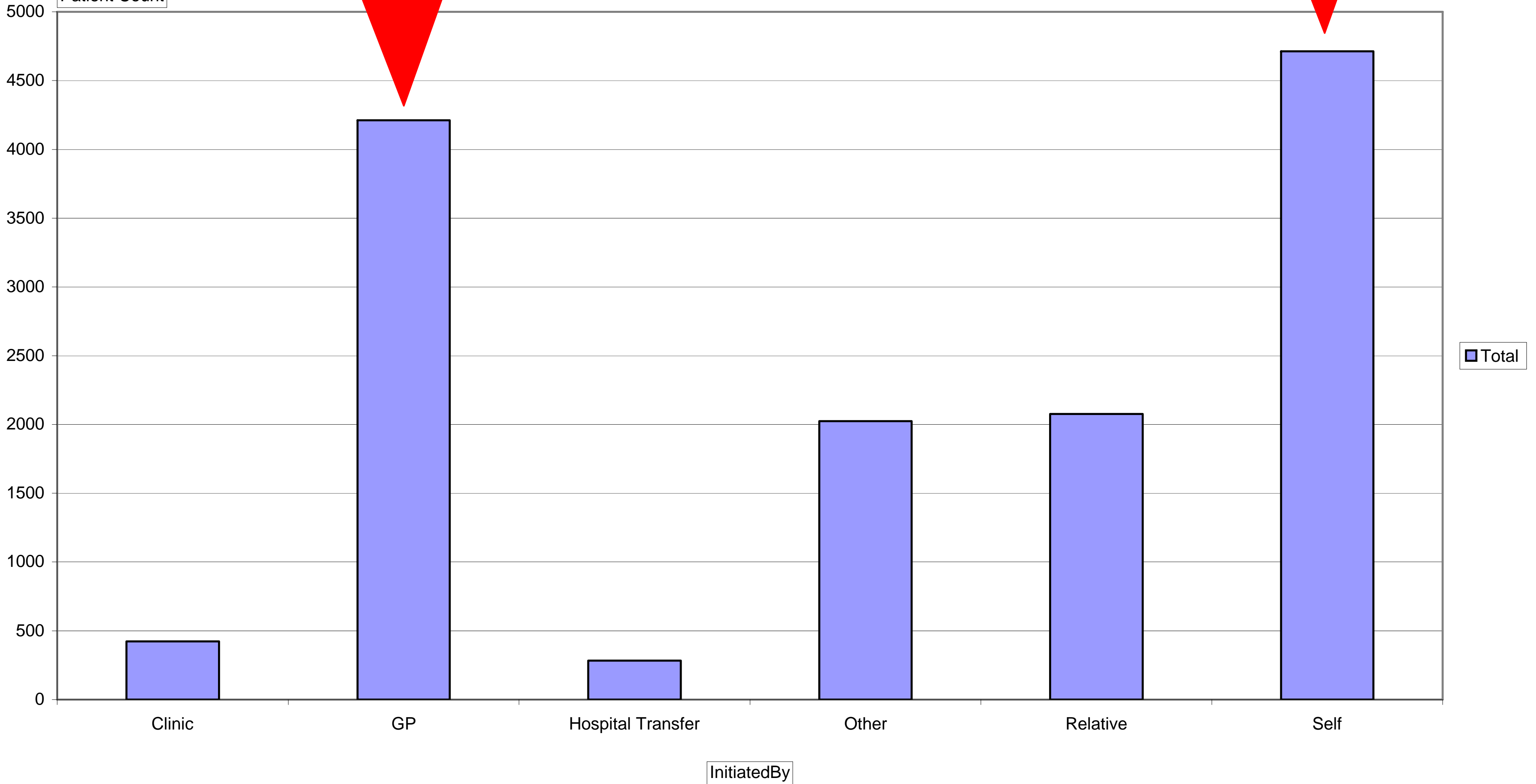


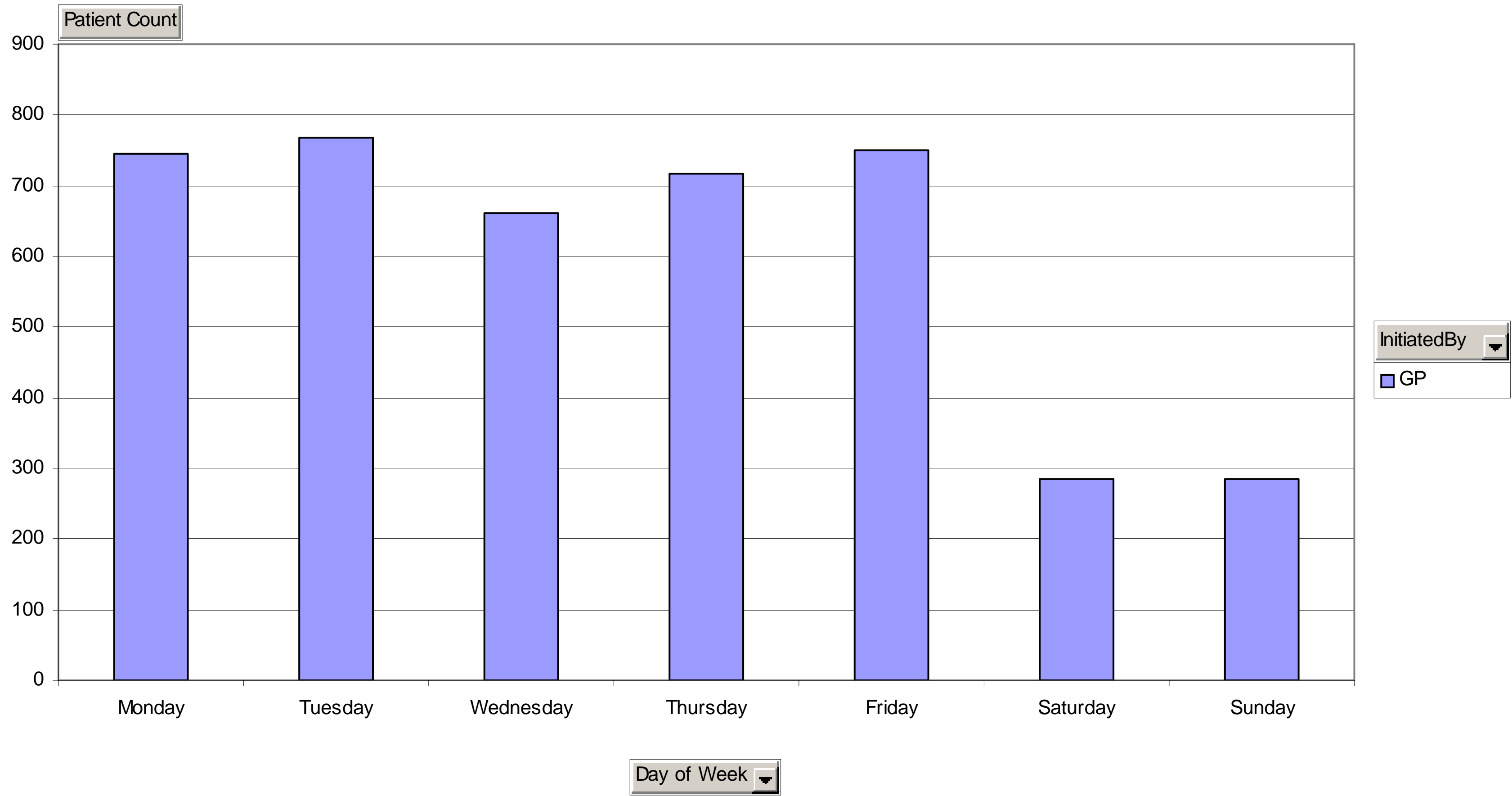
Organisation Name
(All)
Patient Count
6000
5000
4000
3000
2000
1000
0
Total
Blue (5)
Direct Admission
Green (4)
Orange (2)
Red (1)
Unknown
Yellow (3)
(blank)
Triage Category


Organisation Name (All)
Total
Patient Count
10000
9000
8000
7000
6000
5000
4000
3000
2000
1000
0
Lives Alone
not reco
Not Recorded
Nursing Home
Own Home
Residential
Sheltered/Warden Controlled
Residence
Total
26% of UM reviewed patients Live Alone
Patients who live alone may access services at a lower threshold than those who live with another capable adult.
The threshold for discharge for the same cohort may be higher than for those who live with another capable adult.

The ‘initiator’ and ‘mode’ of arrival affect threshold for admission

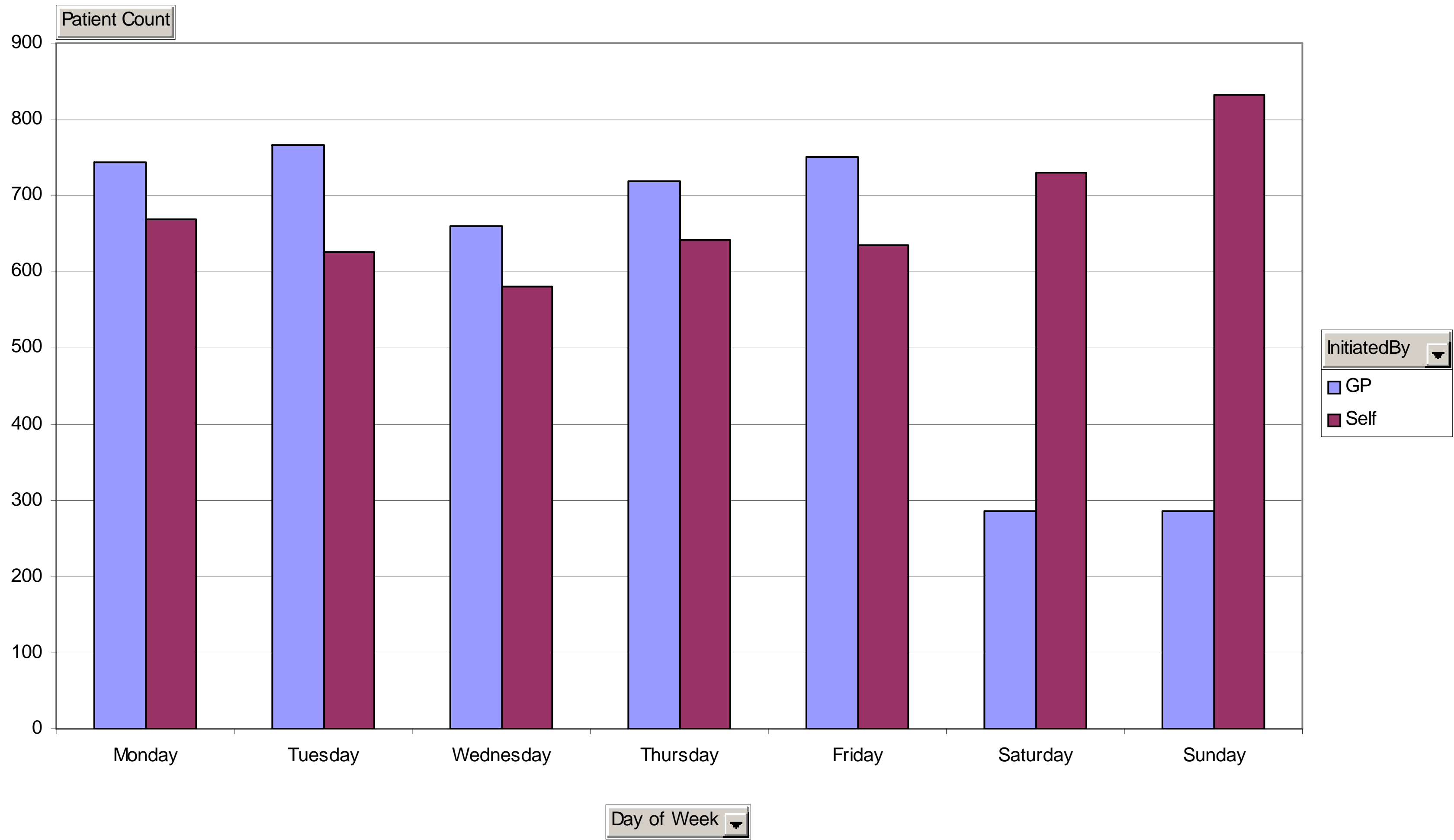


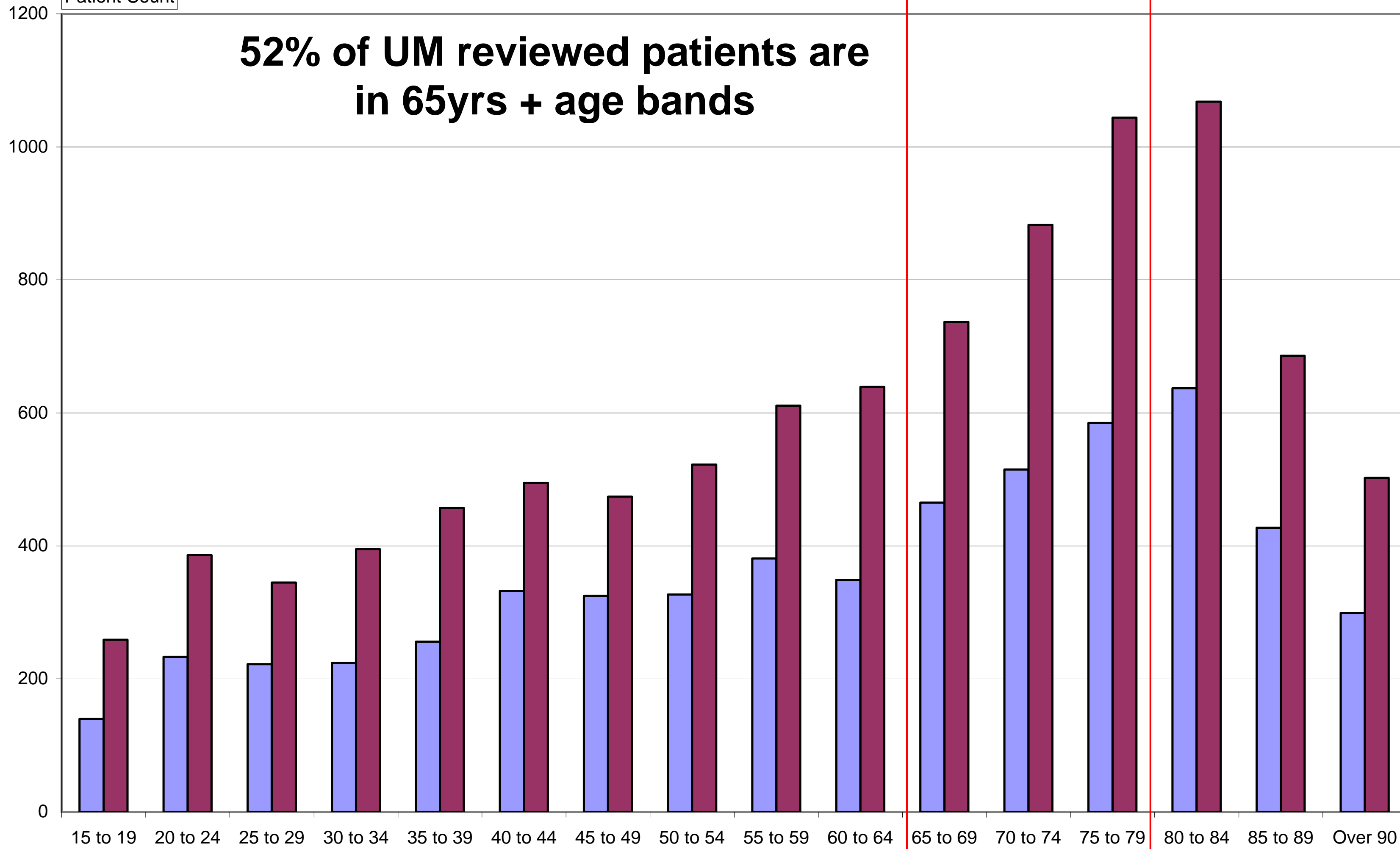

28% of UM reviewed patients are referred by a GP
31% self refer
Organisation Name (All)
Total
Patient Count
5000
4500
4000
3500
3000
2500
2000
1500
1000
500
0
Clinic
GP
Hospital Transfer
Other
Relative
Self
InitiatedBy
Total

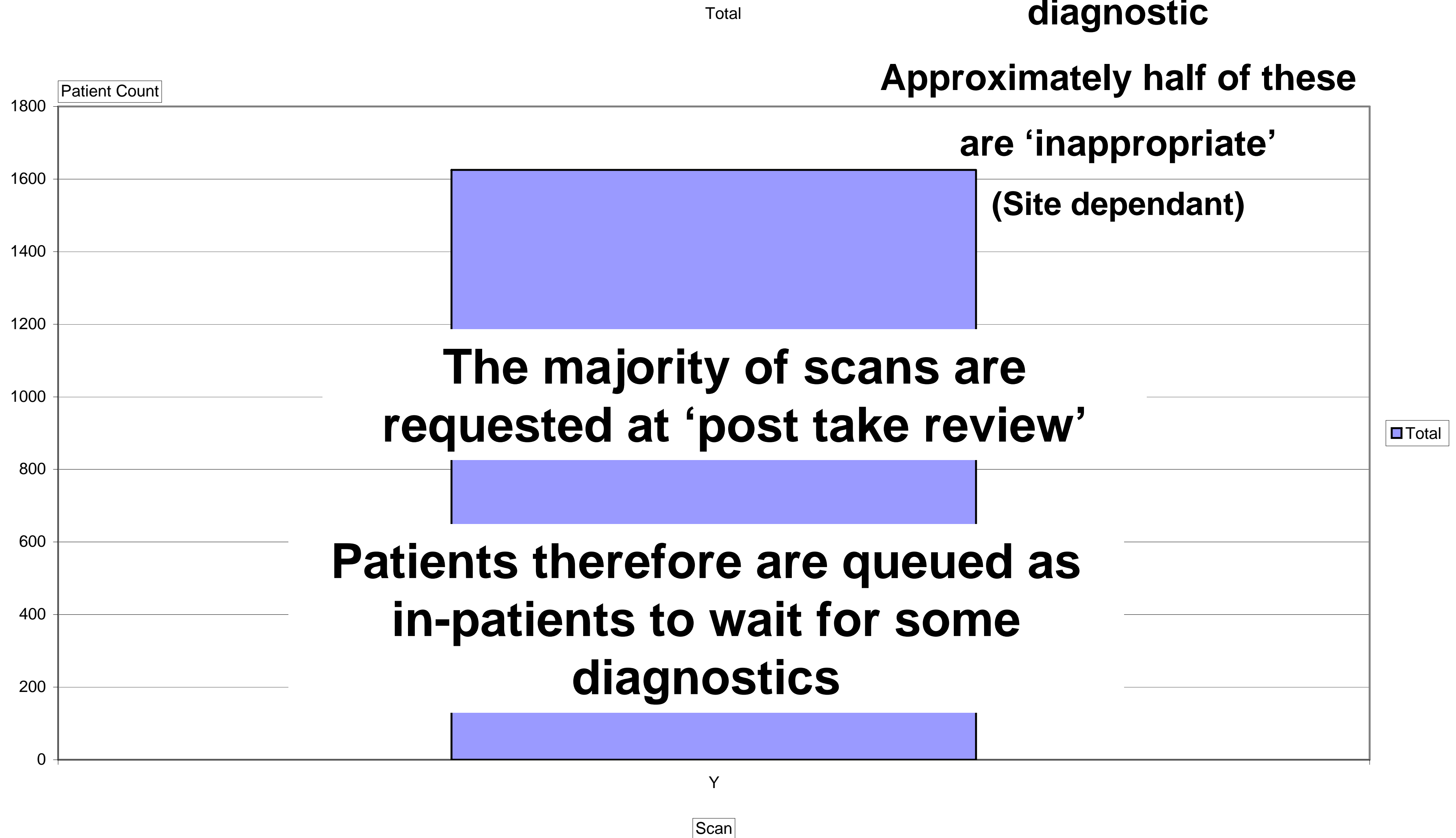

Organisation Name
(All)
GP Referrals by Day of the Week
Patient Count
900
800
700
600
500
400
300
200
100
0
Monday
Tuesday
Wednesday
Thursday
Friday
Saturday
Sunday
Day of Week
InitiatedBy
GP

Organisation Name (All)

'GP' and 'Self' referrals by day of the week




24% of patients are 80 years +
Organisation Name (All)
Patient Count
52% of UM reviewed patients are in 65yrs + age bands
1200
1000
800
600
400
200
0
15 to 19
20 to 24
25 to 29
30 to 34
35 to 39
40 to 44
45 to 49
50 to 54
55 to 59
60 to 64
65 to 69
70 to 74
75 to 79
80 to 84
85 to 89
Over 90
AgeBand
Admission Appropriate
N
Y

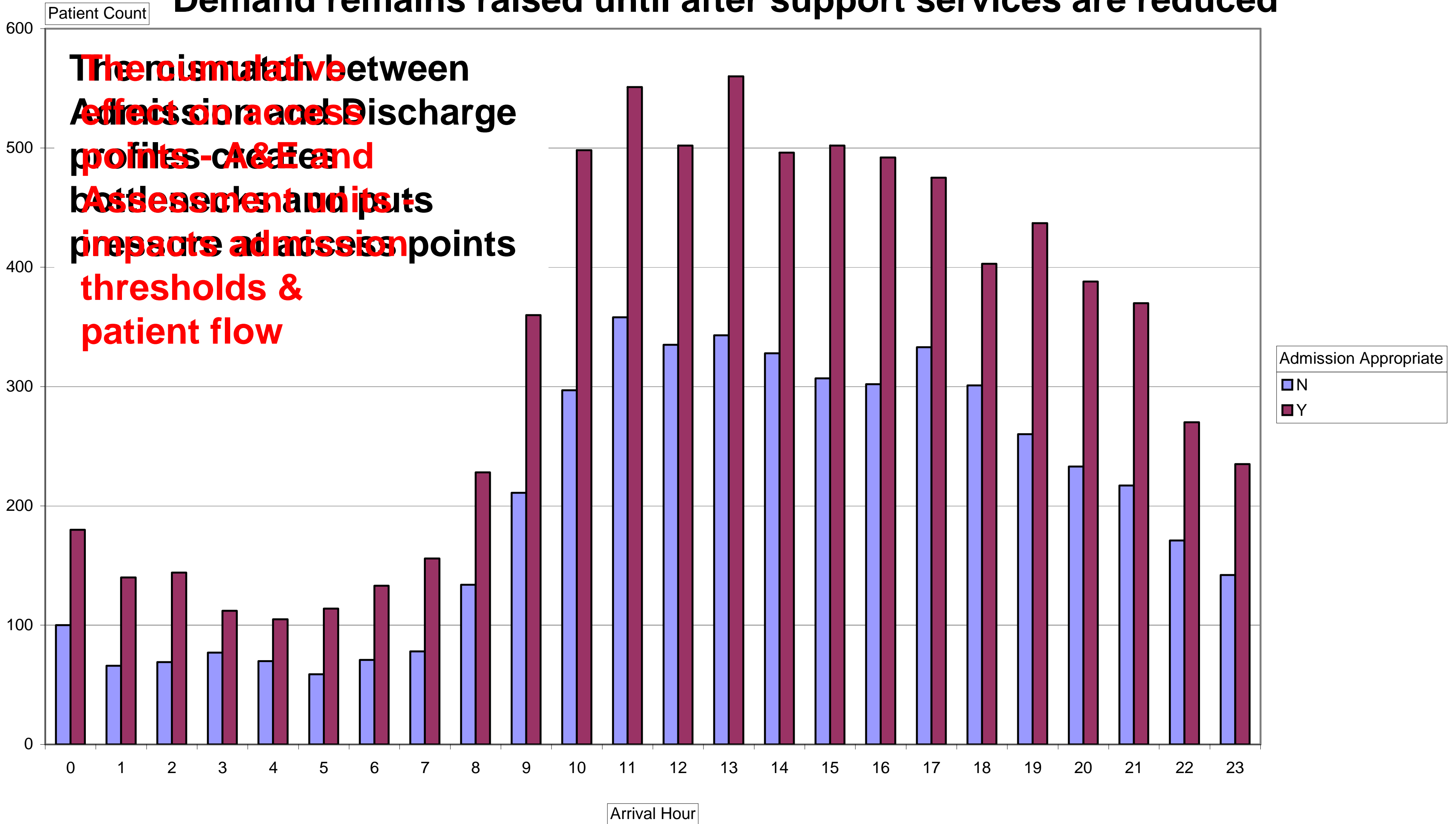


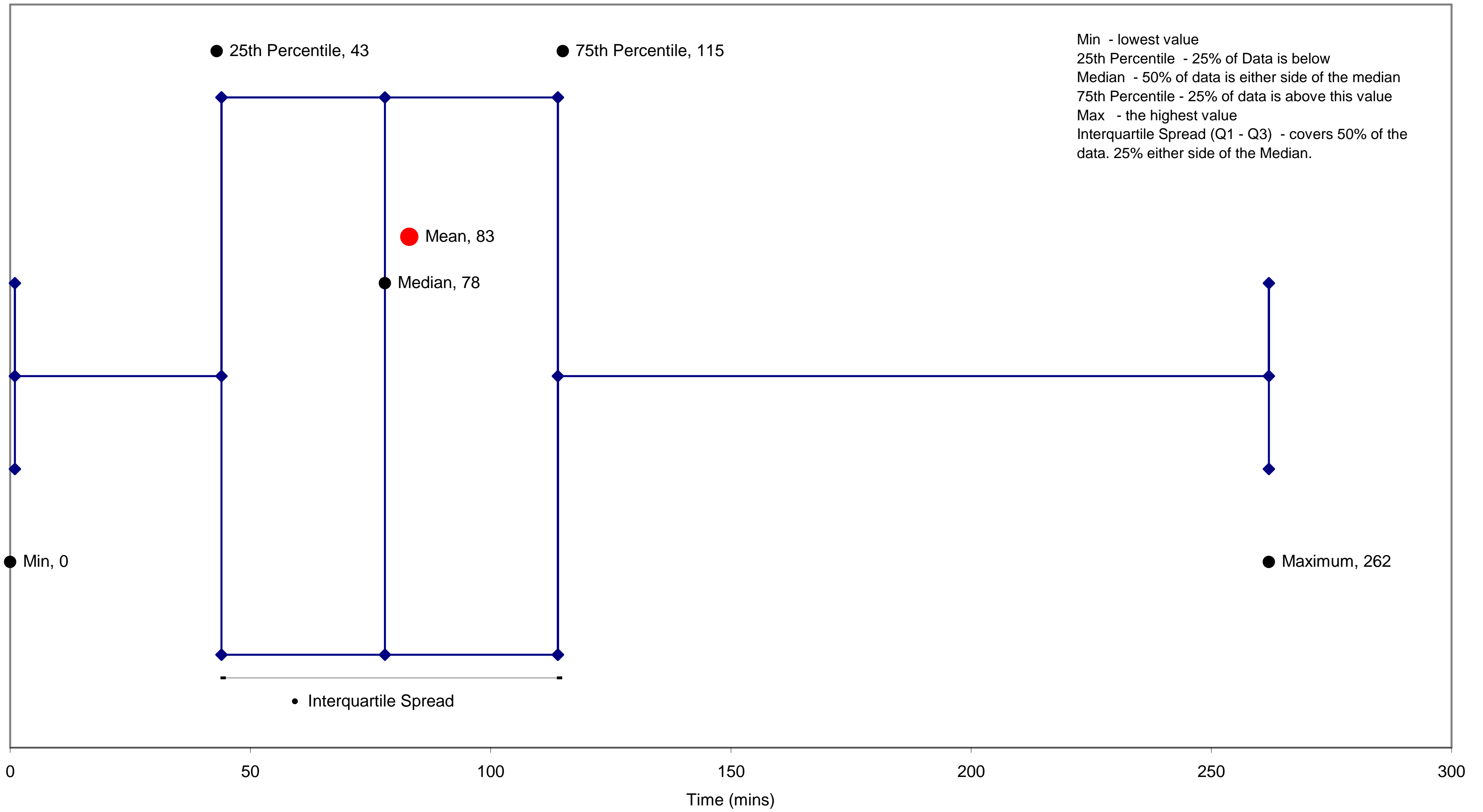
Organisation Name (All)
Total
11% of UM reviewed patients are waiting for a scan diagnostic
Approximately half of these
are 'inappropriate'
(Site dependant)
Patient Count
1800
1600
1400
1200
1000
800
600
400
200
0
The majority of scans are requested at 'post take review'
Patients therefore are queued as in-patients to wait for some diagnostics
Total
Y
Scan

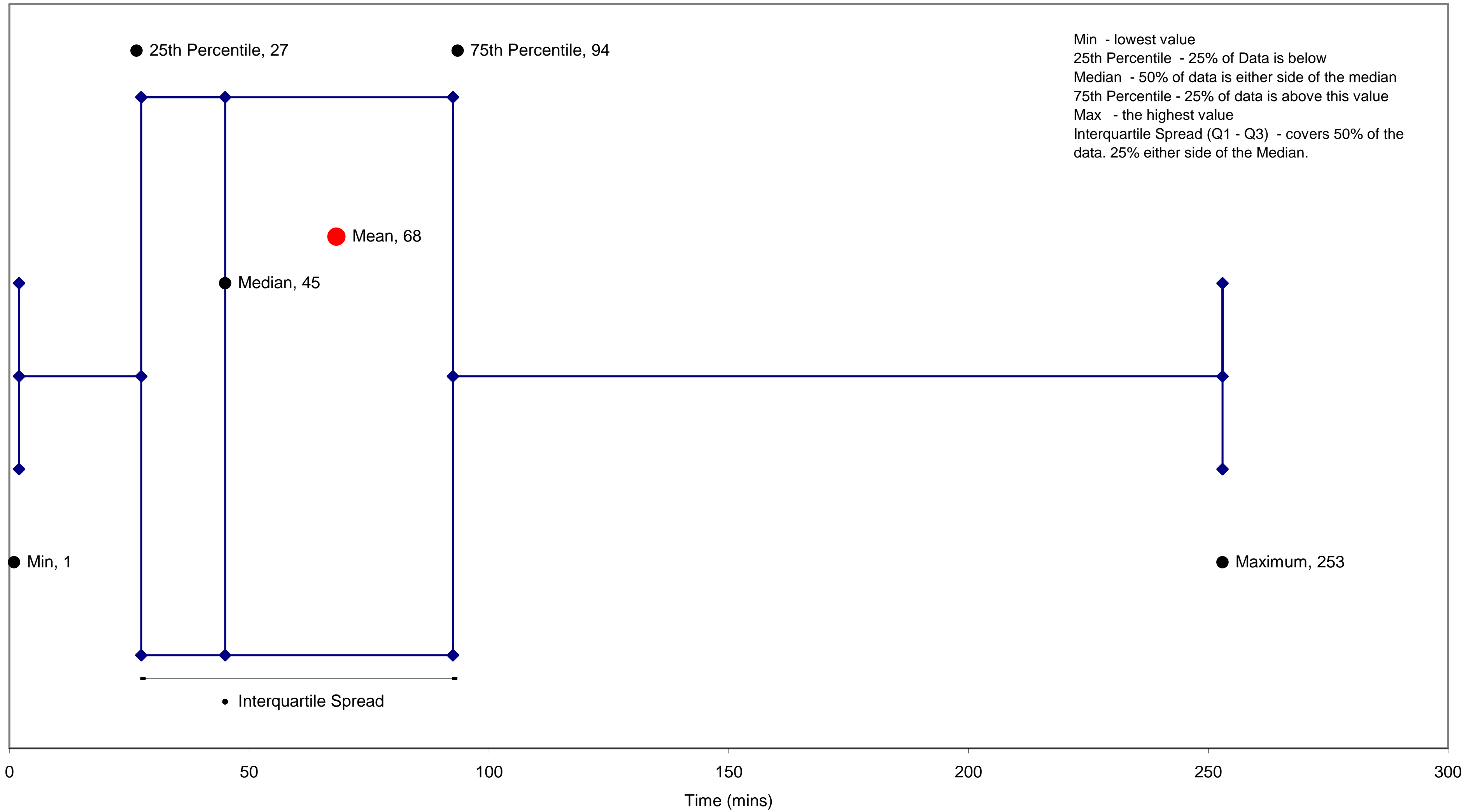
Demand for resources increases significantly from 08:00hrs

Organisation Name (All)

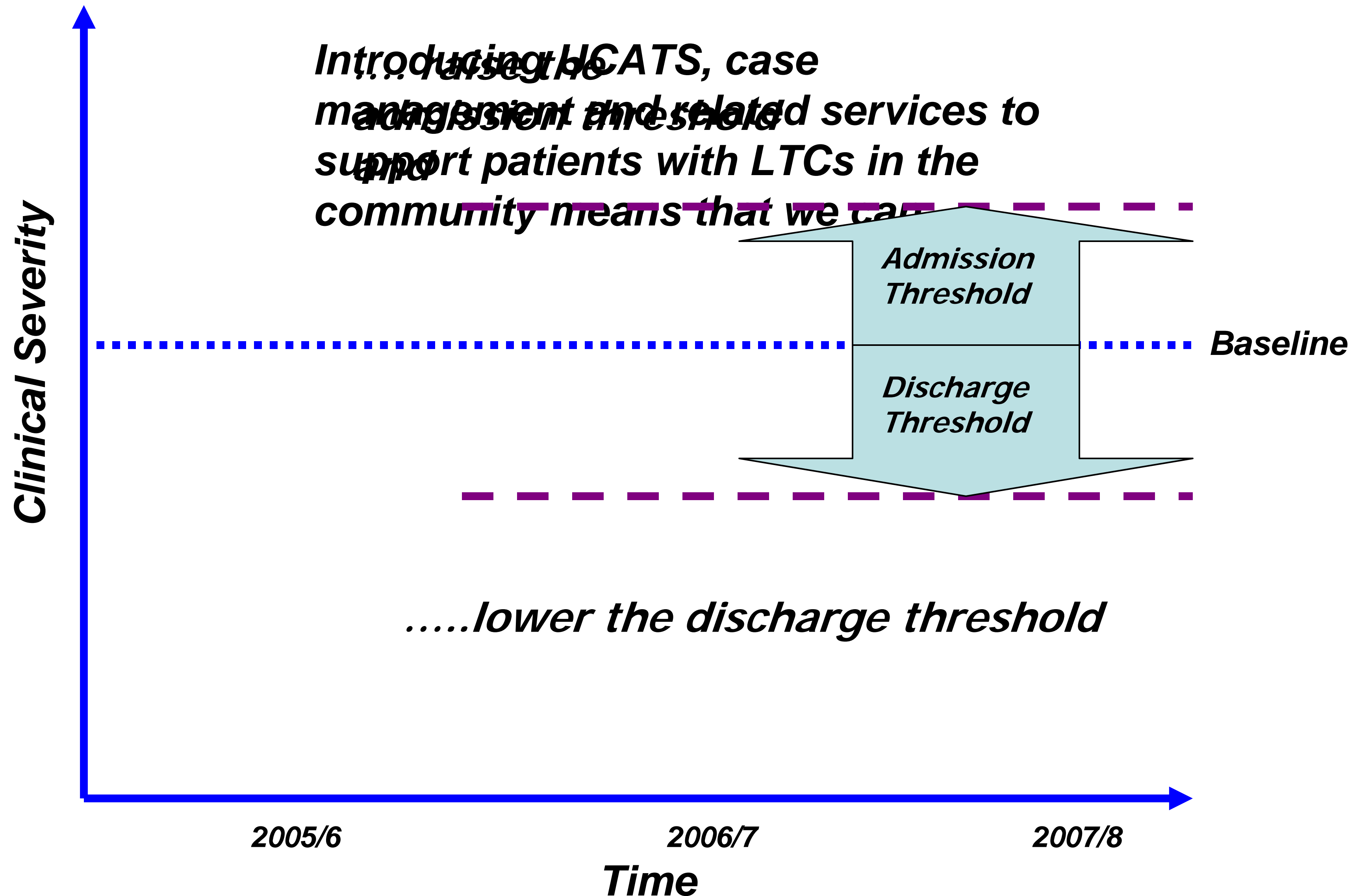
Demand remains raised until after support services are reduced



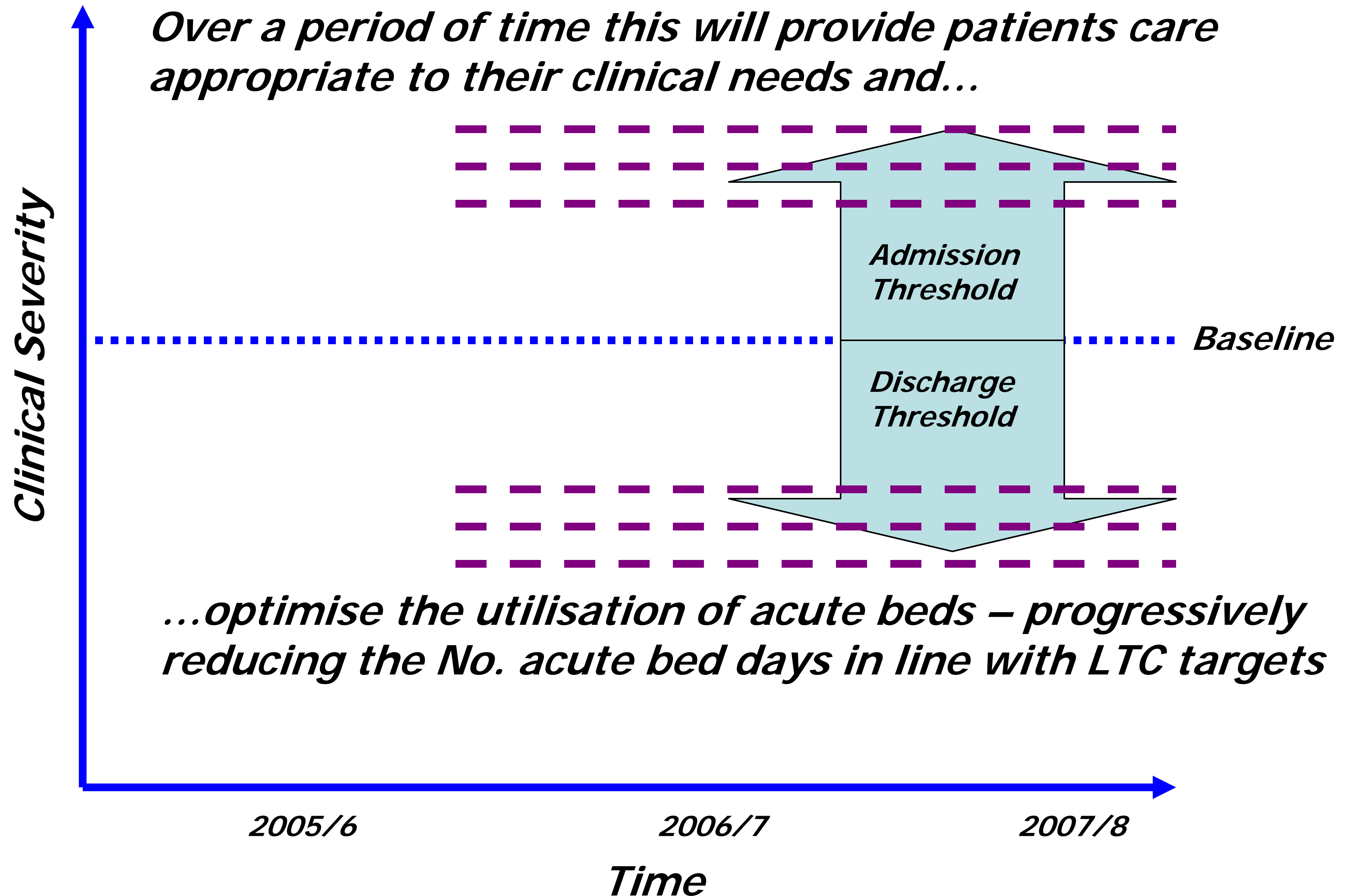

Arrival to Seen Chart
25th Percentile, 43
75th Percentile, 115
Min - lowest value
25th Percentile - 25% of Data is below
Median - 50% of data is either side of the median
75th Percentile - 25% of data is above this value
Max - the highest value
Interquartile Spread (Q1 - Q3) - covers 50% of the data. 25% either side of the Median.
Mean, 83
Median, 78
Min, 0
Maximum, 262
Interquartile Spread
0
50
100
150
200
250
300
Time (mins)


Seen To Referral
25th Percentile, 27
75th Percentile, 94
Min - lowest value
25th Percentile - 25% of Data is below
Median - 50% of data is either side of the median
75th Percentile - 25% of data is above this value
Max - the highest value
Interquartile Spread (Q1 - Q3) - covers 50% of the data. 25% either side of the Median.
Mean, 68
Median, 45
Min, 1
Maximum, 253
Interquartile Spread
0
50
100
150
200
250
300
Time (mins)

NON - ELECTIVE THRESHOLD MANAGEMENT – *Implications*



NON - ELECTIVE THRESHOLD MANAGEMENT – *Implications*



Where to focus

- Data/documentation
- Demographics
- Diagnostics
- Discharges

Utilisation Management Next Steps

- NW UM Unit
- Continue to refine the UM review process
- Run ‘Acute’, ‘DoC’ and ‘Elective’ reviews concurrently
- Piloting Intermediate Care & Rehab
- Add Children, Mental Health

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