Developing Care Outside Hospital

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Version 2.0

Case for change: Improving Continuity of Care

- GPs experience barriers to delivering continuity of care
  (lack of timely information, limited control over community care resources)
- We have the highest rate of nursing home admissions in London
  (but low ALOS)
- Our rate of unplanned hospital admissions is above average for older people and people with LTCs (2000+ admissions could be prevented by better care closer to home)
- Hospital and care home admissions are linked
  (70% of care home admissions follow hospital admission)
- Most people prefer care at home
  (but, for e.g., 60% die in acute hospitals in H&F)

The story so far...
Polysystem programme

- PCFE's
- MSK
- Primary Care
- Rehab
- Diabetes

- 70% Urgent Care
- Capped A&E attendances
- Reduced Admissions
- 36% reduction in OP
- Waiting times 31>8

- QOF+
- Closed 26 beds
- No DTOC's last week

Respiratory

- 2008 Community respiratory consultant to improve diagnosis, management and self-management of respiratory conditions
- Improve case management of patients at risk of admission / rapid discharge

We are now beginning to see the outcomes

- Forecasting a 27% reduction in COPD non–elective activity planned for 2010/11
- Reduction in re-admission rate - 9% planned in 2010/11 as oppose to 27% in 2009/10
- 20% in reduction in OPD activity

Programme Objectives

- To re-orientate the care system around primary care, with GPs holding the central decision making role
- To align incentives for primary care to commission a system that reduces the dependence on the hospital
- To improve the service user experience and the overall health and wellbeing of H&F residents.
- To reduce the rate of unplanned hospital admissions, readmissions, and optimise length of stay for adults
- To reduce the rate of permanent admission to nursing homes.

Our Focus – evidence based approaches to keeping people well at home...

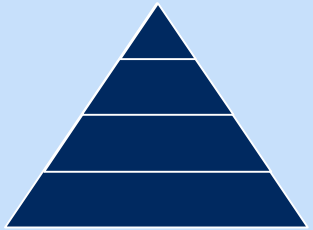
Our work programme is based on evidence from successful approaches (eg., Kaiser Permanente):

- High quality, consistent standards of primary care delivery
- Reliable (predictive) risk stratification and case finding - key to cost effectiveness
- Supporting people to self manage/care and giving extra help before crisis
- Early, proactive monitoring & support at home
- Comprehensive assessment and person centred care planning for those most at risk
- Rapid response (GP / nursing/care/rehab/reablement) when there is a problem

Enhanced General Practice Role

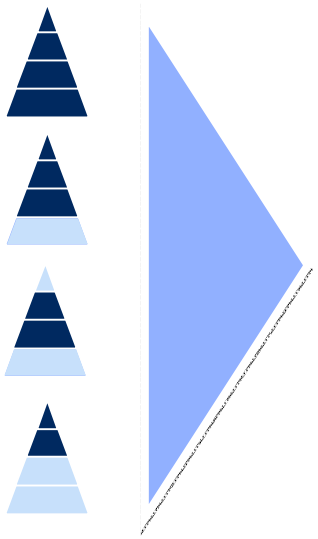
- Best practice chronic disease management
- Pro-active case management of vulnerable
- Leadership and engagement in MDT's
- Rapid emergency response to prevent unnecessary admission
- Active engagement with patients regarding treatment choices
- Flexible and responsive services to all patients
- And the current GMS contract

The continuity of care programme has four key service platforms to improve care through integration and early intervention:



Segments	# of patients in H&F
Very High Risk	1,000
High Risk	Up to 9,000
Moderate Risk	10,000 to 36,000
Independent and well	Remainder (80% of population)

1. **Early identification of people at risk of admission**
2. **EarlyCare – prevention/early intervention thru telecare, hybrid workers, med mgt**
3. **ManagedCare – integrated (health & care) assessment & care planning**
4. **RapidCare – rapid short term (0-8 weeks) response instead of hospital**



Impact evidence

- reduction in nursing care admissions
- 30% reduction in unplanned hospital admissions
- Reduction in readmissions
- Improved satisfaction
- People getting the “right care” across social and health

Managed Care – Key Features

- One point of access, screening, coordination, & budget/resource management for home + community services including home nursing, therapies, continuing care, social care, supported housing.
- GPs able to direct community resources for patients with all major funding streams (social care, continuing care, community health, housing support) combined for consumer at point of entry.
- Care managers with the ability to assess and care plan across supported housing, care, and health needs.
- Integrated assessment and care management allows for home based services to be contracted on a package basis across health & care
- Short term intervention and assessment/management provided by Rapid Care service (and other spec MDTs)

Rapid Care – Key Features

- Rapid response GP service
- One integrated service delivering home based nursing, rehabilitation, and reablement for up to eight weeks: 12/24; 7/7
- Able to assess, treat, care, and assist recovery or end of life care for consumers at risk of admission to hospital or entry to care home
- A ‘reach-in’ to hospital function to reduce LoS / early discharge
- Would control access to residential rehab beds (Farm Lane)
- Includes consultant capacity (geriatrician, old age psychiatry, palliative) to advise, review medications, consult to primary care and give medical assessment where needed

Integrated Care Pilot

- Provider initiative comprising Imperial, CLCH, GP, Social Services
- Alignment of financial incentives across care pathways
- Aligned clinical outcomes
- Jointly developed evidence based clinical pathways
- Creation of joint pool to fund new pathways

ICO

- NWL has a disproportionate spend on diabetes and the elderly. For a pilot of 380,000 the spend on these groups is – (**£187)**
- The IC pilot providers agree the care pathways and the outcomes that they are aiming to achieve for diabetics and the elderly and propose those to commissioners.
- The commissioners reflect the outcome in provider service level agreement and other contracts expecting a decrease of activity they provide in 2011/12 for the diabetics and elderly pilot* population **(£10*)**
- Commissioner reinvest part of this money in the integrated care pilot provider contracts **(-£6.7)**

  - Keeping the balance of part of its QUIPP contribution **(-£3.3)**
- The 6.7 m that will be contributed by the commissioners is divided as follows

  -Additional out of hospital resource for more proactive care and management cost (guaranteed payment) **(-£3.7)**

  - Incentive payment for outcomes (dependant on achieving goals) **(-£3.0)**
- If outcomes are not delivered by the IC pilot, the £3million of incentive funding will not be paid
- Imperial gains greater benefit from reduced LoS

Your thoughts and questions