DECISION-MAKER:	SHADOW HEALTH AND WELLBEING BOARD
SUBJECT:	REDUCING ADMISSIONS TO HOSPITAL FROM PREVENTABLE CAUSES OF BOTH PHYSICAL AND MENTAL ILL HEALTH
DATE OF DECISION:	21 NOVEMBER 2012
REPORT OF:	CHAIR, CLINICAL COMMISSIONING GROUP
STATEMENT OF CONFIDENTIALITY	
None	

BRIEF SUMMARY

Southampton City Clinical Commissioning Group will reduce avoidable admissions by improving the management of long term conditions and developing ways of increasing care available in the community. Working as part of the wider SW Hampshire system the CCG has also prioritised ensuring safe, resilient and accessible emergency and urgent care services.

The CCG has outlined its approach to achieving a healthy and sustainable system within its Clinical Commissioning Strategy 2012-17. This prioritises the need to:

- gain more control within the system recognising that the way patients access services in the present system is too random and variable. More systematic arrangements are needed to drive up quality.
- focus service redesign work on strategic priorities in mental health, early years and care for older people. The management of long term conditions in cardiovascular health, lung health, diabetes and mental health will be centred on improving care pathways, including self care, integrated care management and complex needs, but also recognise the links across pathways so that improving one will potentially help with the others.
- bringing it all together through the transformational approach of Integrated Person-Centred Care

RECOMMENDATIONS:

(i) The Board is asked to support the areas of priority

REASONS FOR REPORT RECOMMENDATIONS

1. To improve more appropriate and safer care for patients.
2. To use hospital services more efficiently.

DETAIL (Including consultation carried out)

3. It is increasingly recognised that the benefits of hospital admission have to be weighed against the risks, particularly to frail elderly patients, of hospital acquired infections and general deterioration resulting from moving patients out of their home environment. Modern high tech hospital services are expensive and need to be used by those patients who benefit from them.

4. Southampton City CCG aims to decrease preventable admissions by :

- Developing services that provide an alternative to admission
- Improving the management of patients with long term conditions, who are the majority of patients admitted to hospital by
    - Developing integrated patient pathways
    - Using computer based risk stratification systems to identify those patients who are at risk of admission, and focussing on their care through integrated personal care provided in their own homes
- Improving services for those patients where alcohol plays a part in their illness (Supports priority 2)
- Developing services which enable ill children to be monitored at home
- Improving mental health services

5. **1. Integrated person centred care**

Advances in medical care have increased life expectancy, so that increasingly health services are dealing with long term conditions in relatively elderly patients. The scope of this term has increased, so that it extends beyond conditions such as heart failure, chronic obstructive airways disease and diabetes, but also includes mental illness, cancer (where treatment has improved to the point where patients may survive some years even though they cannot be cured) and conditions such as chronic fatigue syndrome (where we have very limited knowledge of the disease mechanism).

Increasingly, elderly patients are suffering from more than one long term condition. This adds to the complexity of caring for them, and is shifting the emphasis away from the care of individual diseases.

The benefits of seamless patient pathways, so that everyone caring for the patient is working from a common plan encompassing the whole course of an illness from prevention and self-care through to palliative care, have long been recognised. Modern information systems, such as Map of Medicine have made it easier to implement these, and Southampton is at the forefront of this innovation. We are about to implement a care pathway for chronic obstructive airway disease (the most common cause of admission to hospital) and are setting out to improve our diabetic pathways.

What is becoming increasingly evident is that there are substantial benefits from giving patients control over their own illness, and promoting. In addition, we now have a wealth of information available about our patients.

Computerised risk stratification have been developed which enable us to identify the top 5 % of patients who are at risk of hospital admission. 70% of the patients admitted urgently to hospital suffer from long term conditions, and the vast majority are admitted appropriately. By focussing our resources on vulnerable patients we will reduce the numbers of patients deteriorate to the point where admission is necessary.

Hospitals are potentially dangerous places. While the University Hospitals of Southampton Foundation trust has succeeded in controlling the spread of most hospital acquired infections, Norovirus outbreaks occur regularly. Many frail elderly patients do not tolerate the upset of being admitted. People prefer care in their own homes. We therefore want to implement an integrated model of out of hospital care, which will enable more patients to be treated at home. This is an ambitious 5 year strategy that will require cultural changes on the part of all organisations to move to a more pro-active model of care, with patients and carers having more control. Integrated systems of care, with a single system of case management and care plans will require close collaboration across the boundaries of both health and social care organisations, at operational and strategic level. It will require trust across boundaries to be able to share our resources at a time of economic stringency. It will be a challenge, but the rewards for success will be great.

6. **2. Alcohol related hospital admissions**

A key development in the Quality Innovation Productivity and Prevention programme has been the frequent attendee service, focusing on individuals who regularly attend hospital, often needing admission. Intensive support reduces the high impact these individuals have on the wider health economy (ambulance, emergency department, acute wards). There has been an emphasis on the pathway from A&E to the supported day detoxification service help is provided as a starting point to an individual's treatment journey. This helps avoid admissions, and directs the individual the local treatment system.

This work is supported by a team of Alcohol Nurses located within UHS. They work across the hospital but especially in areas where alcohol related admissions are common, such as liver wards and the acute medical unit. They support those who have been admitted, with a view to engaging them in treatment and raising their awareness to the health risks they face. They also provide training to other staff in the hospital to increase screening and prevention.

Screening and brief intervention is being developed city wide, across GP practices, pharmacies, large employees and in young people settings to help raise awareness and stem the long term increasing rise in alcohol related harm. The number of under 18 year olds being admitted to hospital is a concern which is being tackled through a web based and interactive

marketing campaign – Buzz without Booze.

7. **3. Children's Services**

The COAST (children's community nursing outreach and assessment support team) has been piloted in Southampton City since October 2011 to provide a rapid (same day) care for those children who can be cared for in the community with some additional nursing support The service operates and is specifically for gastroenteritis and respiratory infections.

The service has not yet made any impact on admission rates. We are going to change it, raise its profile with hospital and out of hour's services and extend it to 31st March 2013.

The frequent attenders' scheme which commenced in January 2012 identifies children who are regularly taken to A&E at the General Hospital and provides follow up in the community to reduce reliance on hospital services.

8. **4. Improving mental health support**

Liaison psychiatrists work with other clinicians to manage concomitant mental and physical illness. We are using payment incentives (CQUIN) to encourage the development of the service, which reduces the number of patients who present to hospital.

9. **5. Emergency and Urgent care system**

The local health and social care system has been struggling to cope with the demand for unscheduled care. Increases in emergency admissions have been funded to date but the trend is unsustainable. Despite investment, there has been some success in reducing length of stay but little traction in avoiding the need for admission.

Following a prolonged period of underperformance against the 4-hour A&E operating standard, and following discussions with Southampton City CCG, the Board of University Hospitals Southampton (UHS) commissioned the National Emergency and Urgent Care Support Team (ECIST) to undertake a review of the unscheduled care pathway within UHS. The review took place in mid-June 2012 and ECIST's subsequent report made some 25 recommendations which the trust is now implementing. Concurrent with UHS asking ECIST to review the unscheduled care pathway within the trust, the Southampton City and West Hants commissioners determined that it was also appropriate to ask ECIST to review all aspects of the unscheduled care pathway across the SW Hants health and care system using ECIST's established "Whole System" methodology. The initiation of the Whole System review recognised that while there was work to do within

UHS to optimise systems and processes, there were improvements that the wider health and care system needed identify and implement to ensure a fully integrated, efficient and patient-focussed unscheduled
care pathway.

The ECIST Whole System review report made some 29 individual recommendations which have been prioritised into a Whole System Action Plan. This includes areas such as review of pathways for specific conditions such as COPD, dementia and cardiac problems and a focus on those with mental health issues.

A key enablers to help gain control of the Urgent Care system will the effective use of the introduction of the NHS 111 number. The CCG intend to maximise the benefits of the new NHS '111' number for urgent, non emergency, care by using it as a single point of access, for patients and referrers, to a broad range of services that, efficiently and appropriately deployed, will help to avoid the need for patients to be admitted to an acute hospital and to get rapid access to the care they need.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

10. None.

RESOURCE IMPLICATIONS

Capital/Revenue

11. None.

Property/Other

12. None.

LEGAL IMPLICATIONS

Statutory Power to undertake the proposals in the report:

13. None

Other Legal Implications:

14. None

POLICY FRAMEWORK IMPLICATIONS

15. None

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SUPPORTING DOCUMENTATION

Non-confidential appendices are in the Members' Rooms and can be accessed on-line

Appendices

1.	None

Documents In Members' Rooms

1.	None

Integrated Impact Assessment

Do the implications/subject/recommendations in the report require an Integrated Impact Assessment to be carried out.	No

Other Background Documents

Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
NONE	