NHS
Sheffield Clinical Commissioning Group

Monitoring the effectiveness of the movement of resources from secondary to primary/community care

Governing Body meeting J

4 July 2013

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Key messages

- The CCG needs to be able to demonstrate the movement of services from Secondary care to Primary / Community Care clear, and its beneficial impact on the health of the Sheffield population.

- The overall health and social care system is very complex and undergoing continual change and is subject to many parallel projects / interventions. There is general acknowledgement (Right First Time (RFT) experience) that it is almost impossible to determine the direct cause and effect of specific schemes on the overall system.

Assurance Framework (AF)

Risk Reference (RR) Number: 2012/13 RR Ref 903 (Healthcare Closer to Home)

How does this paper provide assurance to the Governing Body that the risk is being addressed?: This is a proposal to monitor the shift of resources from secondary care to primary /community care (ie closer to home)

Is this an existing or additional control?: Potential to become an additional control

Equality/Diversity Impact

Has an equality impact assessment been undertaken? NO

Which of the 9 Protected Characteristics does it have an impact on?
The proposed monitoring is intended as a high level view only – there may be the potential to drill some of the monitoring measures down to Age / Gender / Ethnicity

Public and Patient Engagement

None planned at this stage

Recommendations
The Governing Body is asked: • Do you endorse and/or have any comments on the overall approach described in the paper? • What additional clinical measures do you think could be included? (ie that are measured, can be influenced, are significant)

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1. Purpose

The CCG has, in line with national policy, expressed a clear objective to be able to demonstrate the movement of services from secondary care to primary / community care. Given the more emergent data flows in primary and community care, the CCG needs to be clear about the measurement of such a move and its beneficial impact on the health of the Sheffield population.

The CCG also wishes to be able to demonstrate this success to the public in simple understandable terms.

2. Introduction

Following a number of initial exploratory conversations and further discussions with a range of staff including portfolio staff, public health nursing, locality management, RFT programme management, public health, contracting, and finance, this paper sets out a proposed approach.

The RFT programme is looking primarily at the secondary care aspects of the system – the initiation for this piece of work was primarily to understand the primary care aspects. It makes sense to have an agreed system wide approach to monitoring impact shared by the CCG and RFT project.

3. Context

3.1. System complexity

The overall health and social care system is very complex and undergoing continual change and is subject to many parallel projects / interventions. There is general acknowledgement (RFT experience) that it is almost impossible to determine the direct cause and effect of specific schemes on the overall system (we rarely have an adequate control population against which to make a proper research based evaluation or comparison). We need to take a mix of reported experience, anecdote and measureable indicators into account.

3.2. Evaluation of local schemes

We have looked at the reported work around the impact of the following schemes: Dykes Hall Multi Disciplinary Team pilot, Lowedges/Batemoor/Jordanthorpe project – the schemes are felt to be beneficial but difficult to measure benefit conclusively.

3.3. Risk Stratification scores

Risk scores can be used to identify a population who should be on a programme – they cannot be used to track the progress of an individual patient. The risk stays the same (although in theory if ALL admissions stopped for an individual there would be a gradual decline in their score over two years) – we are exploring further our understanding of the

dynamics of changing individual circumstances and the impact on individual CPM risk stratification scores

3.4. Ambulatory Care Sensitive (ACS) admissions

40-50% of emergency admissions are ACS related, of which 31% have Hypertension recorded as an underlying condition – what can primary care do for these patients to help reduce emergency admissions? (note: Hypertension is also an underlying factor in 23% of Non ACS emergency admissions).

3.5. Research Evidence about Hypertension (HT)

Taking a system-wide approach to increased hypertension management could significantly contribute to outcomes, the costing model for CCGs attached to the current National Institute for Health and Care Excellence (NICE) hypertension guideline suggests that by applying national assumptions to the Sheffield population circa £3m savings (net of increased treatment costs) are available from more effective HT treatment from reduced stroke and Coronary Heart Disease (CHD) events alone. The national assumptions may or may not be true of our population but it illustrates the point that there is a potentially significant short term contribution to cost savings as well as health benefits available.

We have especially compelling evidence available in relation to the elderly in particular. A landmark randomised control trial called HYVET (hypertension in the very elderly trial) returned some dramatic results and overturned received wisdom from achieving increased BP control in the age 80+ group relative to the norm, in terms of reduced acute events and death, and reduced adverse effects from treatment.

<u>HYVET results</u>

At two years, mean BP was 15.0/6.1 mm Hg lower in active-treatment group than in placebo group resulting in …

- 30% reduction in the rate of fatal or nonfatal stroke
- 39% reduction in the rate of death from stroke
- 21% reduction in the rate of death from any cause
- 23% reduction in the rate of death from cardiovascular causes
- 64% reduction in the rate of heart failure
- Fewer serious adverse events were reported in the active-treatment group

3.6. Primary care clinical measures and primary care interventions

Are there existing Quality and Outcomes Framework (QoF) indicators that are clinically significant, something that primary care can actively influence, affects a significant population, is measureable and measured in QoF?

3.7. QoF 13/14 Quality and Productivity (Q&P)

This is an opportunity to set something that primary care can address city-wide that is consistent with the overall direction of travel.

3.8. 2013/14 Quality, Innovation, Productivity and Prevention (QIPP) schemes

These are already largely built around RFT and reducing emergency ACS admissions.

3.9. RFT Programme Dashboard Monitoring

We have discussed the proposals for RFT monitoring and looked to recommend and build consistency – the RFT measures are largely ACS emergency admissions related.

3.10.Other Patient Clinical Measures

We need to explore other patient clinical measures (eg Death rates <75), the Health outcomes framework, and involve Public Health.

3.11.Patient Experience Measures

There is an opportunity to link with RFT work around these

4. Approach

- To have a few simple high level indicators
- To cover the whole system – the population as a whole, primary care, community services, hospital care
- To be focussed as much as possible on patient health outcomes and patient experience
- To reflect a mix of clinical, psychological wellbeing and social factors – these all impact on health and we have selected indicators which reflect those aspects we feel are most relevant, and have a research basis to support their significance.
- To use a marker clinical condition(s) which can be measured as a vertical slice throughout the system (suggested use of Hypertension which underlies many other conditions)
- Some of the indicators may be expected to reflect a positive change in a relatively short period of time (months), others over a longer time period (years) – we need some more work to say what is realistic for each
- The approach is summarised in the proposed Monitoring Model (see Appendix 1)

5. Recommendations

The Governing Body is asked:

5.1 Do you endorse and/or have any comments on this overall approach?
5.2 What additional clinical measures do you think could be included? (ie that are measured, can be influenced, are significant)

Paper prepared by Mark Wilkinson, Head of Informatics

On behalf of Ian Atkinson, Accountable Officer and Dr Tim Moorhead, CCG Chair

24 June 2013

Monitoring the Shift from Secondary to Primary / Community Care

v1 - 24/6/2013 - CCGIU MW

Aim

To demonstrate the effective movement of resources from Secondary care to Primary / Community Care, and its beneficial impact on the health of the Sheffield population

To have an agreed system wide approach to monitoring impact - shared by the CCG, Right First Time (RFT)

Approach

To have a few simple high level indicators covering key dimensions across the system

To have a vertical clinical slice that can act as a measure of success across the system (using marker of Hypertension which underlies many other conditions)

The Monitoring Model

	Clinical			**Psychological Wellbeing**	**Social Factors**
	Marker condition : **Hypertension**	**Generic**		**Anxiety & Depression**	**Isolation**
		Quality	Flow		
Population		Death Rates <75 (amenable to healthcare)			
Primary Care	QoF Hypertension indicator(s)	QoF indicators (tbc)		QoF Hospital Anxiety and Depression Scale (HADS) scores (note superceeded by new QoF approved tool?)	Check Social Isolation measure & recording used within Primary Care
Community	Prescribing measure available (tbc)				CareFirst indicator?
Hospital	Emergency admissions Ambulatory Care Sensitive (ACS) Hypertension related (Spells, Nights, Cost)	Emergency Readmissions Hospital Mortality Ratio	Emergency Admissions (Spells, Nights, Cost) of which ACS Hospital Average Length of Stay Delayed discharges	HADS scores (note superceeded by new QoF approved tool?)	

Further work

1. Need to identify, implement? and incorporate Patient Experience measures (eg friends & family test for certain services?) - opportunity to link with RFT
2. Review NHS outcomes framework indicators
3. Identify which Quality Outcomes Framework (QoF) indicators are clinically significant, something that Primary Care can actively influence, affects a significant population, is measureable and measured in QoF – where an improvement at individual level & population level measured via QoF represents a clinically real & worthwhile improvement (and is there a corresponding measure in hospital?)
4. Explore SystemOne records for community - are there any measures that may be relevant to Generic and/or hypertension columns?
5. Explore new QoF approved tool for Anxiety & depression
6. Check Social Isolation measure & recording used within Primary Care
7. Need to make allowance within indicators for anticipated population changes where it would impact on the measure over time (eg use rates, not just absolute numbers)