



The Global Language of Business

Reducing readmissions through collaborative working

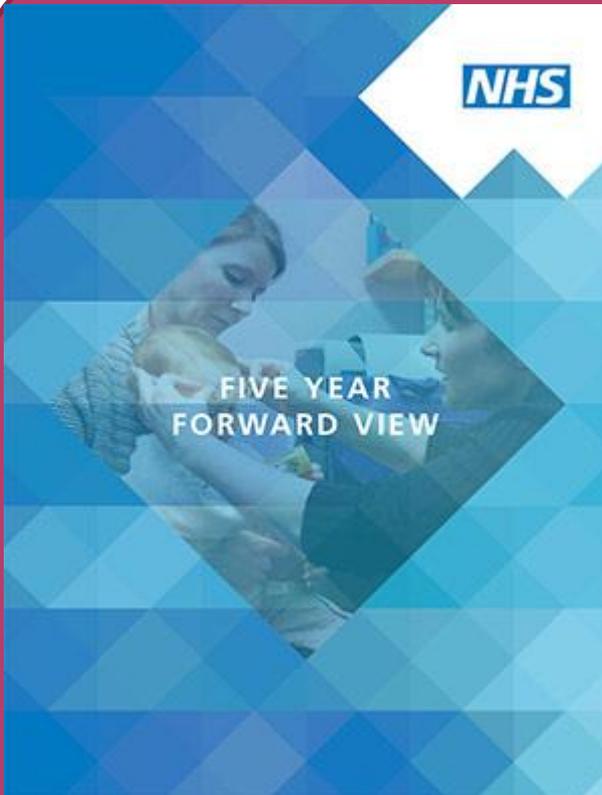
Chris Wood, Chairman, Burton Hospitals NHS Foundation Trust
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Reducing Readmissions through collaborative working

Chris Wood

Chair Burton Hospitals NHS
Foundation Trust

NHS Five Year Forward View



- Moving from an organisational focus to a system-wide perspective
- Working closely with local partners, including primary care, social care and community services
- Developing integrated service models that span organisational boundaries
- Providing service through horizontal networks with other acute hospitals

THE COMMON AILMENT IN HEALTH

- Rising unplanned admission rates and readmission rates are a worry to the health service in the NHS
- Various studies have been done here in the UK from Nuffield Foundation to the Kings Fund to NHS bodies over the causal factors but the evidence for any one causal factor is limited and inconclusive.
- The same issue is generally effecting major health systems around the world, with differing health systems, so free at the point of use is not necessarily significant.

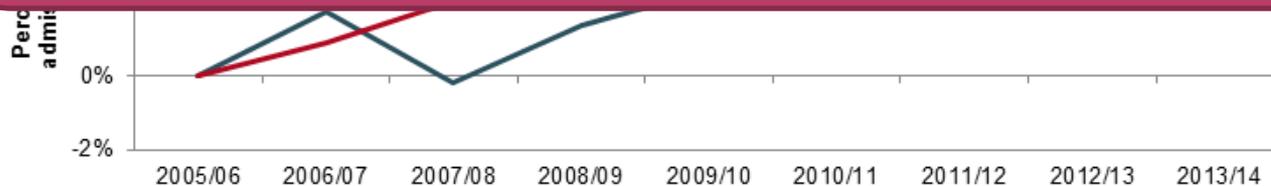
RISING DEMAND + NEW CHALLENGES

evidence for
better health care

nuffieldtrust

Total percentage change in emergency admissions, compared with 2005/6

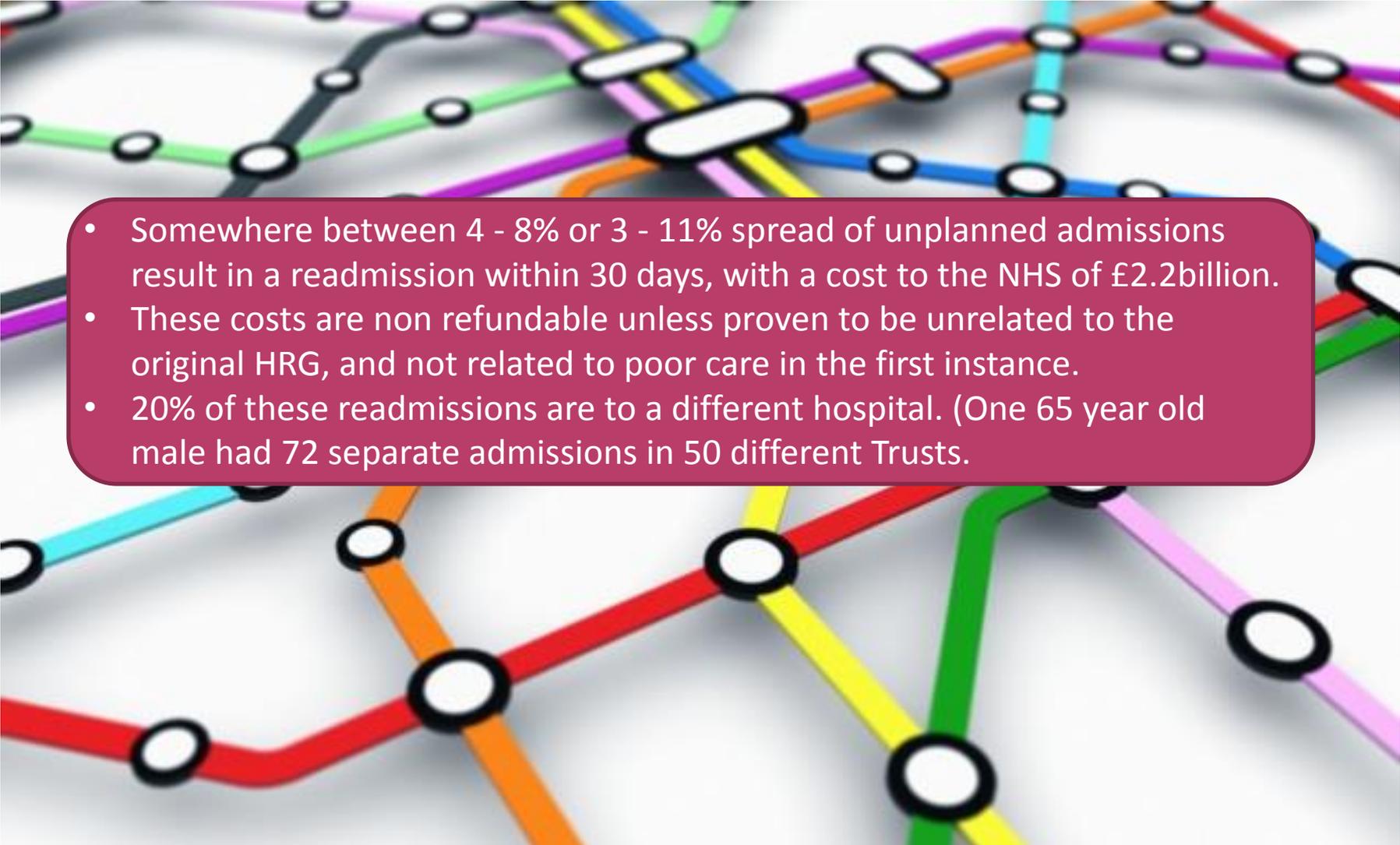
- The average increase in admissions in England over the last 5 years has been 5 - 7% and rising
- Unpredictable admissions represent about 65% of bed days in England, with a significant effect on costs, ability to deliver efficiencies, stresses in delivering consistent quality and the disruption to elective care.
- Majority of unplanned admission are the elderly with co-morbidities, and bed days occupied by the over 75's rose by 2\3 in the last 10 years
- Acute hospitals in England are running at an average of over 90% capacity, which has an effect on quality, on cost and compliance.



Sources: Various end of year reports from www.infoandstats.wales.nhs.uk and HSCIC.

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MOBILITY and the PUBLIC PURSE

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- Somewhere between 4 - 8% or 3 - 11% spread of unplanned admissions result in a readmission within 30 days, with a cost to the NHS of £2.2billion.
 - These costs are non refundable unless proven to be unrelated to the original HRG, and not related to poor care in the first instance.
 - 20% of these readmissions are to a different hospital. (One 65 year old male had 72 separate admissions in 50 different Trusts).

UNINTENDED CONSEQUENCES



There is evidence that patients that are readmitted have a longer length of stay than for their first admission, and that providers with lower than average length of stay for first admissions have higher readmission rates!

Therefore reducing admission rates can reduce length of stay, whereas reducing average length of stay without tackling readmission rates may have the medium term impact of increasing length of stay.

SOME AGREEMENT – (but the debate goes on)

- It is universally agreed that readmission rates can be reduced through:
 - Improving surgery and focusing on the readmission rates of different surgeons
 - Reducing hospital associated infections
 - Health Assessment, planning and improvement
 - That post discharge care plans are in place and patients, families and carers are organised to provide support for 14 days beyond discharge.
 - Developing a personalised health care programme for people seen in medical outpatients and frequently admitted
 - Structured discharge planning is effective in reducing further admissions
 - Integration of hospital and community. Evidence that higher community beds the lower the readmission

However the NHS seems to be suffering from paralysis by analysis
So evidence based it seems unable to confront the glaringly obvious



US COMPARISONS

- 20% of hospitalisations are followed by readmissions in 30 days and 90% are unplanned.
- 40% of admissions are unplanned and are rising. The analysis in the US is that 75% may be preventable through improving aftercare upon discharge



US APPROACH

Prevention



- How well a patient transitions from acute care to another setting:
 - Patient home
 - Rehab Centre
 - Nursing Home
- The key is to communicate more than just clinical information.
- Developing the use of electronic health records which has still eluded the NHS and combined with Health Information Exchange.
- Enables any provider of care to share clinical information and diagnosis, treatment plans and medication lists.
- Medical history is important but so is a history of medication non-compliance, or non attendance, or social conditions such as mobility. Care Plans are designed to keep the patient healthy.

DELIBERATIONS

My contention is that:

Patient re-admissions are a bi-product of the first admission



Improving the shared use of patient data and information

Developing a more consistent approach to patients, including common language and communication.

SHARING WHAT WE KNOW

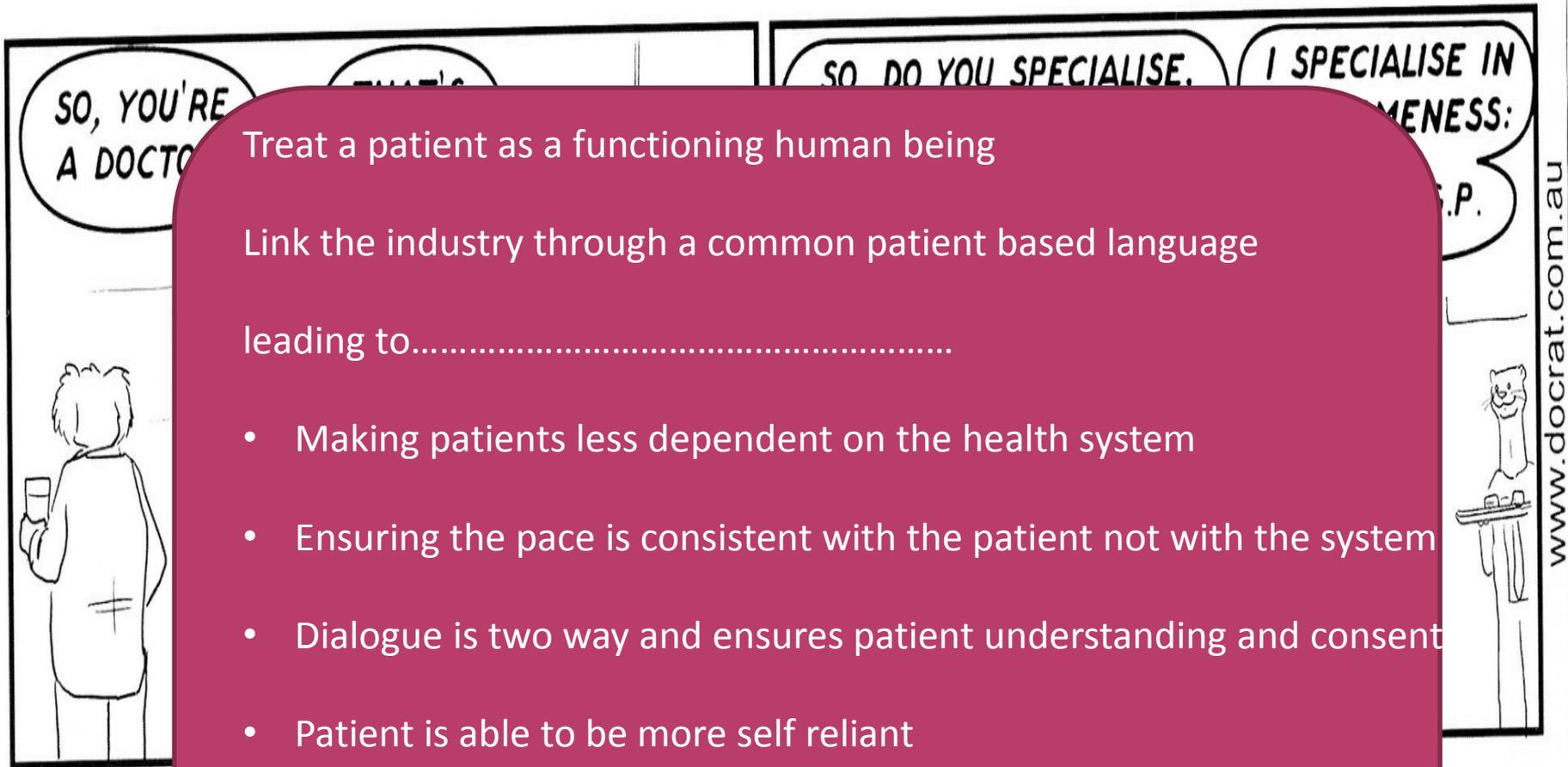
Movement from raw data to patient intelligence informatics

Nationally accessible patient record accessed through a secure exchange

leading to

- Improved understanding of the pathways and proper commissioning
- Community based pre-assessments for patients
- Improved ambulance rapid response care and decision making
- Improved and proactive discharge arrangements for patients
- Shared patient specific care plans for families and support agencies

SHARING WHAT IT MEANS



Treat a patient as a functioning human being

Link the industry through a common patient based language

leading to.....

- Making patients less dependent on the health system
- Ensuring the pace is consistent with the patient not with the system
- Dialogue is two way and ensures patient understanding and consent
- Patient is able to be more self reliant
- Inter-operability is more robust

Thank you for the opportunity
and for listening