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Outline

- NHS Scotland
- Community Ward in practice
- Study design
- Patient level costing (PLICS)
- Results
- Limitations
- Conclusions
NHS Scotland

- 5.3 million people
- 14 health boards provide primary and secondary care
- 7 special boards, (Ambulance, NHS 24, Health Scotland, State Hospital, Health Improvement, National Services, Waiting Times Centre.
- 161,656 staff (headcount)
• 3 virtual wards covering Ayrshire.
• 3 pairs of a GPwSI in Anticipatory & Intermediate Care and a Community ANP (Advanced Nurse Practitioners).
• Working with patients to help them manage their condition and reduce the need for preventable admissions to hospital.
• “Community” because it allows the patient the comfort and stability of their own home
• “Ward” because, although virtual, it works the same as a hospital ward, with team members conducting a daily ward round to review patients’ needs and progress.
• Medical first–responder service Mon to Fri to ensure continuity of support and that ACP plan adhered to.
• Referrals from GPs and hospital consultants as long as a patient’s registered GP practice was participating in the service.
• Patients (age>16) with long term condition(s) predisposing them to, or likely to future result in, recurrent or extended hospital admissions:
  • Exacerbations of COPD; HF; a progressive neurodegenerative condition or recurrent symptomatic UTIs (many of these patients having SPARRA scores>50%);
Community Ward in Practice - 3

• Tailored solution believed likely to work – medication change, self management, enhanced monitoring.
• Solution put into an Anticipatory Care Plan, enhanced/integrated clinical management plan (held in paper notes and electronic Key Information Summary).
• Plan adapted over time, responsive to the patient’s needs.
Study design

• 142 CW cohort matched to a control group on basis of age, sex, locality, SPARRA, number of long term conditions.
• Patient level data for both cohorts extracted for A&E, and emergency (unscheduled care) for 6 months prior to and after admission to CW.
• Emergency (unscheduled care) costed on basis of patient level costing (PLICS)
Patient level costing (PLICS)

- Transparency around cost drivers across speciality and hospital site.
- Responsive to length of stay.
- Covers range of activity – acute inpatient/day-case.
- Calculated unit costs by allocating fixed and variable costs to patient activity.
- Cost on admission and by day for medical, nursing, pharmacy etc.
- Costs for theatre time by procedure/high costs items.
Results - 1

- CW cohort across three areas achieved reductions in **A&E attendances** of between 45%-54% (control 25%-37%).
- CW emergency (unscheduled) hospital **admissions** fell by 45%-50% (control 30%-38%).
- CW cost reduction was £400,000 (control £227,000).
- Greater impact where optimal service access to most appropriate patients in regions where GP Partnerships most engaged.
Results - 2

• Separate qualitative study found:
  – Trustworthiness of CW clinicians 98.8%;
  – Overall Satisfaction with CW care provided 98.3%;
  – Respect to patient 97.7%
  – Access to care 97.7%
  – Provision of information (97.1%) &
  – Involvement in care decisions (90.7%)
Limitations

• Small sample.
• Robust matching but difficult to control for all bias/confounding factors.
• Impact on social (long term care).
• Reflects the real world realities of short term funded pilots.
Conclusions

• Decline in hospital activity (resource) across CW areas.
• Cost effective and appropriate use of scare health resources.
• Achieved patient-centred care; popular with patients, relatives, primary and secondary care healthcare staff.
• Sufficient time for proactive intensive medical support and problem solving, developing enhanced ACPs that actually worked.
• Targeting support to the most appropriate (and costly) SPARRA patients.
Example of the partial cost-benefits of targeting care to just one Community Ward patient:

75 year old patient with advanced Parkinson’s Disease, Diabetes and recurrent urinary and intra-abdominal sepsis. Admitted to the North Community Ward on 13/12/12 as an alternative plan to NHS Long Term Care, agreed with his Consultant Geriatrician, having previously required hospital inpatient care for 4 months in 2012. An ACP was designed for him based on his history and supported by regular CW clinician visits. One year later, he hadn’t required a single admission to hospital. As one patient, NHS bed occupancy cost alone to NHSA&A from 13/12/12 over one year would have been (if one were to take a long term care NHS bed costing ~£250 a day) £91,250 for one patient (excluding the potential that the patient might have been transferred into an Acute hospital bed at any point at ~£400 a day).
Outcomes for Community Ward Patients in the 6 months before and 6 months during Community Ward intervention compared with a local, age and SPARRA-matched control patient cohort receiving conventional NHS care.

### NHS Ayrshire and Arran Acute Activity
Community Ward intervention group versus SPARRA matched control cohort

#### Table 1 - Six months from date of entry to CW service

<table>
<thead>
<tr>
<th>Number in cohort</th>
<th>Number of Patients Attended</th>
<th>Total Number of Attendances</th>
<th>Number of Patients Admitted</th>
<th>Total Number of Bed Days</th>
<th>Total Cost</th>
<th>Number of Patients Attended</th>
<th>Total Number of Attendances</th>
<th>Number of Patients Admitted</th>
<th>Total Number of Bed Days</th>
<th>Total Cost</th>
<th>A&amp;E Attendances</th>
<th>Emergency Admission</th>
<th>Bed Days</th>
<th>Total Cost</th>
<th>CW Total Saving</th>
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<tr>
<td>East CW</td>
<td>47</td>
<td>37</td>
<td>164</td>
<td>38</td>
<td>142</td>
<td>790</td>
<td>£345,929</td>
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<td>90</td>
<td>27</td>
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<td>35</td>
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<td>128</td>
<td>40</td>
<td>110</td>
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<td>64</td>
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<td><strong>6 months from date of entry to CW service</strong></td>
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</tbody>
</table>

**Total Cost** calculated as the sum of A&E Attendances, Emergency Admission and Bed Days.
Do you have a problem in your life?

No.

Then don't worry.

Yes.

Can you do something about it?

No.

Yes.