White Paper

Right Care, Right Place, Right Time

Patient-centred high quality care can save money.

September 2009

Lord Darzi's Next Stage Review asks the NHS to improve quality and outcomes and give people a greater degree of control and influence over their individual health and healthcare. It calls for the NHS to provide safe and effective healthcare services that are personal to each individual and to do this in the context of rising demand on health services.

Delivering this will require clinicians and managers to address a core issue: does the NHS always provide people with the right care in the right place at the right time?
The answer currently is no. Too many people find themselves on acute wards waiting for a social services assessment or a discharge plan. Too many people with long term conditions are inappropriately admitted to hospital when they could be better served through alternative models of care. Too many stay on a hospital ward because sub acute care in intermediary care beds or step down facilities just do not exist in their local area.

It is time for the NHS to take an evidence-based approach to measuring whether individual patients are in the right place to get the right treatment and whether services are configured in-line with demand. Supporting clinicians with evidence-based tools can make their decisions more robust and transparent, and more consistent across the organisation. This in turn will support care planning and resource utilisation, providing the hard evidence to tackle bottle-necks in the system. It will also support commissioning by providing data about the extent to which existing resources are appropriately used and therefore how services might be better delivered or designed.

Neil Spragg, VP Business Intelligence and Commissioning at McKesson, argues that putting the patient at the centre of care in this way can potentially deliver significant savings, demonstrating that safe, patient-centred high quality care saves money.

The challenge of delivering appropriate care

On any hospital ward there will be patients with different needs. Some who are acutely ill and need intensive nursing; some who are critically ill and need transferring to an intensive care unit; some who are ready to go home and are just waiting for their medicines and a discharge letter; and others who have somehow got stuck, waiting for a social services assessment, say, or an intermediate care bed.

It is the same in the Community. Some patients in intermediate care beds would be better off at home; some patients at home really need hospital care. Some are just fine where they are.

Nurses with years of ward experience have seen patients coming into hospital because the district nursing service was unable to provide support at home and watched as the elderly patient stayed on the ward only because there was no intermediate care bed.

Looking across the system, too, it is clear that there are wide disparities in how beds are utilised. The array of length of stay statistics for routine procedures highlights this in stark fashion. For a fractured neck of femur the range is 10.9 days in the best performing Trusts to 44.5 in the lowest performing Trust. Patients undergoing a hip replacement will spend an average 7.4 days in hospital in the best performing Trusts but 29 days in the lowest.

Each of these extra days comes with a financial cost to the NHS and a risk of infection and loss of independence to the individual patient.

We know that only a proportion of patients in a care setting at a given time will be in the appropriate place to receive the care they need. There are two challenges to overcome here: defining which patients are in the right place and providing appropriate care for those that are not. Meeting these challenges will improve not only individual care but offer a chance to make significant cost savings too.

Who decides where's best?

Deciding who is in the right place and who needs to be in a different care environment is a clinical matter. In a high quality, personalised health service such decisions should be evidence-based.

Computer technology now offers the opportunity to apply some rigour to these decisions by giving health professionals access to the evidence base and tools that help them apply it to individuals. Such systems put the patient at the heart of the health system and play to the strengths of expert clinicians.

What clinicians cannot do, however, is overcome the barriers that prevent patients moving to the appropriate place. This is a management task, whether it is commissioning intermediate care services or creating systems for nurses and social services staff to communicate effectively.

The same computer tools however, that can support clinical decision-making can also support managers by giving them the hard management information they need to commission more effectively.

Putting the patient at the centre of care

Clinical decision-making support tools put the patient at the centre of care. They start at the bedside, asking the clinician to answer questions about the patient. What symptoms do they have? What test results? When these answers are validated against an evidence database, they provide an objective basis for assessing symptoms, what level of care patients require and where they should be to receive this. The sum of the answers adds up to a decision: this patient with these symptoms at this severity should be in a particular setting.

So, for example, a patient with respiratory symptoms and low blood oxygen should be in hospital with access to certain equipment and medication. A patient with less severe symptoms may be fine in an intermediate care setting with two hours a day nursing care and an hour a day therapy.

A good system will give the nurse access to the evidence. It will allow the clinician to write notes about what should happen to the patient next and to record any of the factors delaying a move to a more appropriate setting. It will offer scope for clinicians to use their judgment to over-ride the system.

It is the same scenario in the community where a community matron might use a system in case management, assessing not only whether patients are well enough to be at home but also whether the skills and support is available in the community to make this safe.

Delivering data to the heart of management decisions

Individual patient assessments completed by nurses and therapists using clinical decision support systems can be aggregated so that managers can pull reports from the data.

A unit manager might want to know how many patients' discharge were delayed because they were waiting for a social services assessment. Evidence-based systems can answer this. They can answer questions such as how many patients last month needed an intermediate care bed? How many beds were, in fact, available? And how many of these were anywhere-near the patient's home? How many patients exceeded the average length of stay for a given procedure? And why?

This is powerful management information that can be used to support the business case for service redesign.

There are other benefits too. Systems provide an audit trail for how decisions to discharge were reached based on the best clinical evidence and therefore they may be useful in answering patient complaints and litigation. In Trusts that have used such systems, clinicians report feeling empowered by having their clinical judgements validated and more able to move patients to appropriate care settings where this is in their power.

Right care, right place, right time

Validating appropriateness of care is all about high quality care for individual patients. Getting this right may also deliver real benefits for the NHS by providing the hard data needed to underpin decisions on service redesign and recommissioning. As David Nicholson, NHS chief executive has made clear in his warning to the NHS over future funding levels, considerable efficiency savings will be needed from 2011 onwards. Getting a grip on appropriateness of care and resource utilisation would be a good start to delivering this.

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McKESSON

Empowering Healthcare

McKesson UK
European Headquarters
Warwick Technology Park
Warwick CV34 6NZ

t. 0870 6000 426
e. ukinfo@mckesson.co.uk
www.mckesson.co.uk

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IQWP/MGI-10/09