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NHS Improvement

Can OPAT help deliver the NHS Five Year Forward View?

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Twitter: AntibioticLeeds

UNIVERSITY OF LEEDS

The Leeds Teaching Hospitals NHS Trust

Declarations of competing interests – last 3 years

- Personal & payment
  - Eumedica: Travel grant ECCMID - April-15
  - B.Braun: Travel grant EAHP Mar-15
  - Astellas: AMS Webinar in Jul-15.
  - Astellas: Evening lectures on Fidaxomicin local service evaluation. Sep-14

Themes

- NHS Outcomes Framework
- OPAT – where are we now?
- What is the 5yr Forward View?
- New Care Models & Vanguards
- Sustainability & Transformation Plans
- OPAT tariffs & CQUINs

- Apologies to Scotland, Wales & Northern Ireland for elements of this talk that relate specifically to England because of the commissioning & payment systems.

NHS Outcomes Framework

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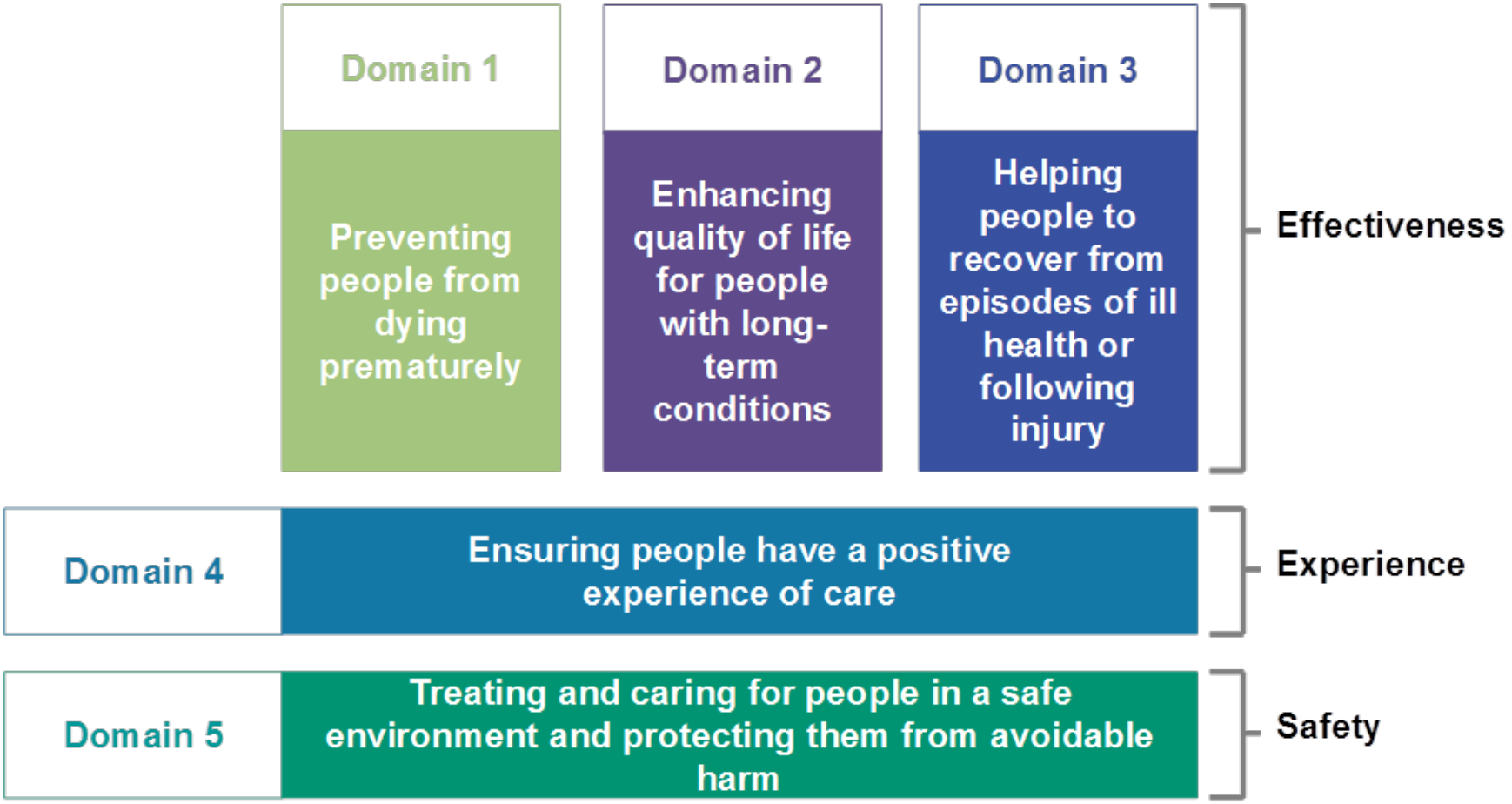

2016-7 NOF drivers for OPAT

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Domain 2: Enhancing QoL for people with long-term conditions (reducing time spent in hospital)

- **2.3 i** Unplanned hospitalisation for chronic ambulatory care sensitive conditions

Domain 3: Helping people to recover from episodes of ill health or following injury

- **3a** Emergency admissions for acute conditions that should not usually require hospital admission

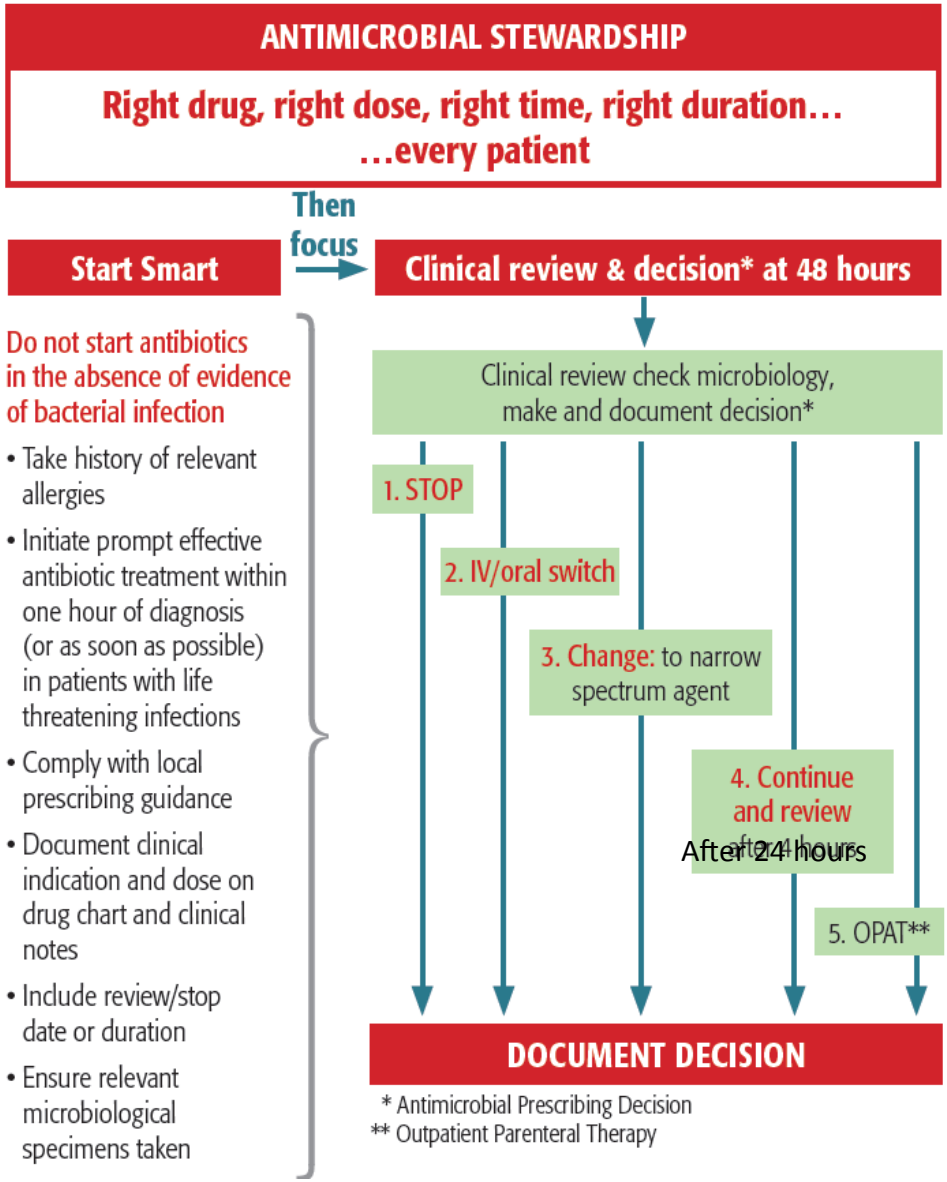
Domain 4: Ensuring that people have a positive experience of care

- **4b** Patient experience of hospital care

Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm

- **5.2** Incidence of HCAI i MRSA ii *C. difficile*

Start Smart then Focus



- OPAT included as an outcome as day 3 review of SSTF.
- Data submitted to PHE as part of the 2016-7 AMR-CQUIN on D3 review outcome (optional) shows only 0.5% is for OPAT (n=111 trusts)
- Considering outcome of D3 review for model hospital indicator (Carter)

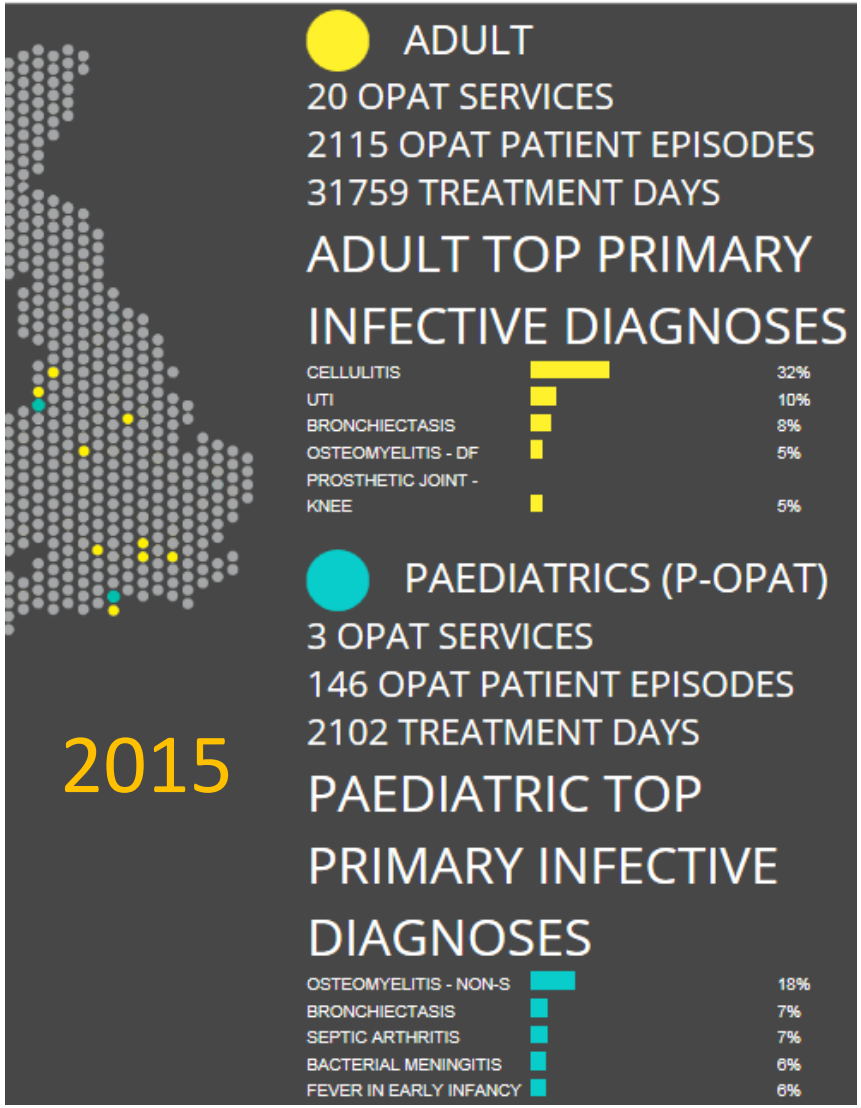
Current status of OPAT in UK

2013 BSAC Survey of 193 Trusts / Health Boards

- 119 (63%) response
- 68% have service
- 82% Hospital based

Only 23 (of 80) OPAT services are submitting data into BSAC OPAT NORS demonstrating ability to free up beds safely

- Need all centres to submit data to maximise opportunity to roll out OPAT



OPAT: clinically & cost effective & safe in UK?

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- Much of the evidence is not from UK
- **Sheffield** (mainly hospital OP) - Chapman (2009 JAC)
  - 334 episodes (2006-8): 87% cure, 6% re-admission, high patient satifaction,
  - OPAT costs: 41% of ID unit, 47% avg Eng costs or 61% HRG
- **Glasgow** (mainly hospital OP) - Barr (2012 IJAA)
  - 10yr = 2638 episodes = 39k days,
  - 92% cure, 9% readmission, only 14 line-infections
- Growing evidence for poorer outcomes in BJI (Mackintosh 2011) & endocarditis (Duncan 2013) to predict difficult patients

Reduction in HCAI with OPAT

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- Available evidence from large OPAT cohorts (predominantly ceftriaxone use) suggests CDI risk is small ~0.1% of treatment episodes across three separate published UK cohorts. Duncan IJCP 2012
- In Glasgow 10 year review of OPAT, CDI risk was quantified as 0.05 events per 1000 OPAT patient-days. Barr IJAA 2012
- Low incidence of OPAT-associated CDI is presumed to reflect lower-risk patients, shorter hospitalization and shorter duration of therapy in ceftriaxone OPAT-treated patients predominantly with skin and soft tissue infection (SSTI). Gilchrist JAC 2015

OPAT standards & best model?

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- Now have UK good practice standards for adults (Chapman 2012 JAC) & paediatrics (Patel 2015 JAC)
- NIHR CIVAS Study – Dr Jane Minton (BMJ Open 2015) presenting tomorrow
  - What is already known about OPAT in NHS?
  - What is the best value NHS service model?
  - What model do patients prefer and why?
  - Recommendations on how to plan NHS OPAT services for the future?

Are IV antibiotics always the best option?

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- **IV – oral switch**: growing evidence for use of highly bioavailable quinolones, rifampicin, clindamycin, linezolid (now cheap), tedizolid (Gilchrist 2015)
- **OVIVA study**: Oral vs IV Antibiotics for Bone and Joint Infections – 1050 pts from 18 UK centres. 12 month follow up. Oct-15 recruitment closed.

www.journalslibrary.nihr.ac.uk/projects/113629/#/

- **New long acting agents** – dalbavancin: single IV infusion lasts 2 weeks for ABSSSI ~£2k. Launching soon. SMC reviewing currently.

Five Year Forward view 2014

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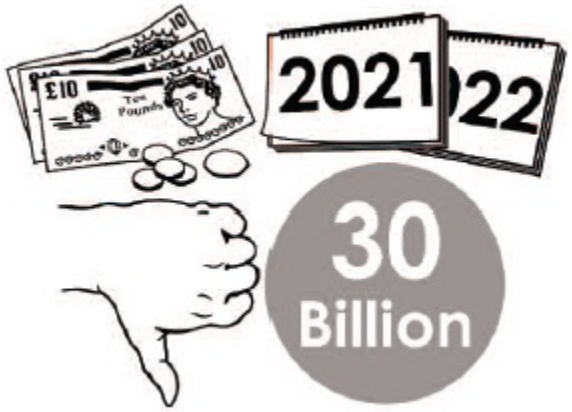
Sets out a clear direction for the NHS – showing why change is needed and what it will look like.

1. Prevention of illness
2. Break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health, between health and social care. New Care Models
3. Using money well – big gap

Sustainability Transformation Plans



NHS Five Year Forward View

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1	Health and wellbeing gap	Radical upgrade in prevention
2	Care and quality gap	New care models
3	Funding gap	Efficiency and investment

Five new care models

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Multispecialty community providers

moving specialist care out of hospitals into the community

Enhanced health in care homes

offering older people better, joined up health, care and rehabilitation services

Integrated primary and acute care systems

joining up GP, hospital, community and mental health services

Acute care collaboration

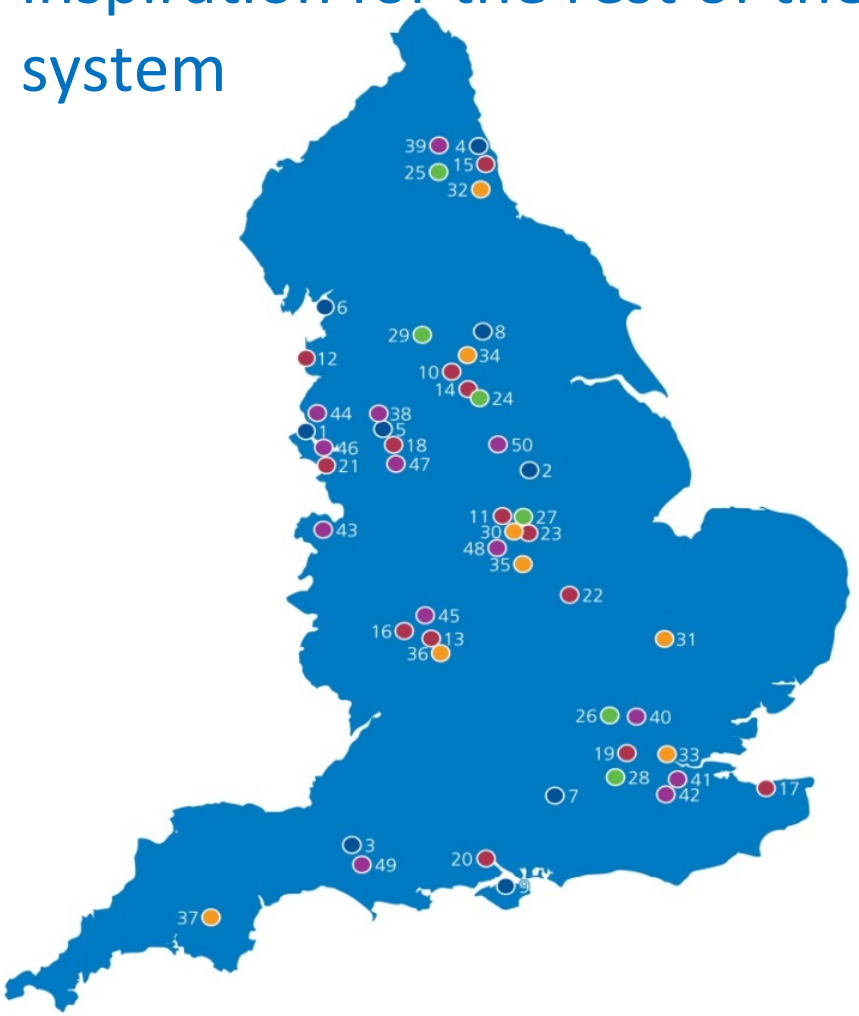
local hospitals working together to enhance clinical and financial viability

Urgent and emergency care

new approaches to improve the coordination of services and reduce pressure on A&E departments

2015: 50 vanguards selected to develop new care models, and act as blueprints and inspiration for the rest of the health and care system

NHS Improvement

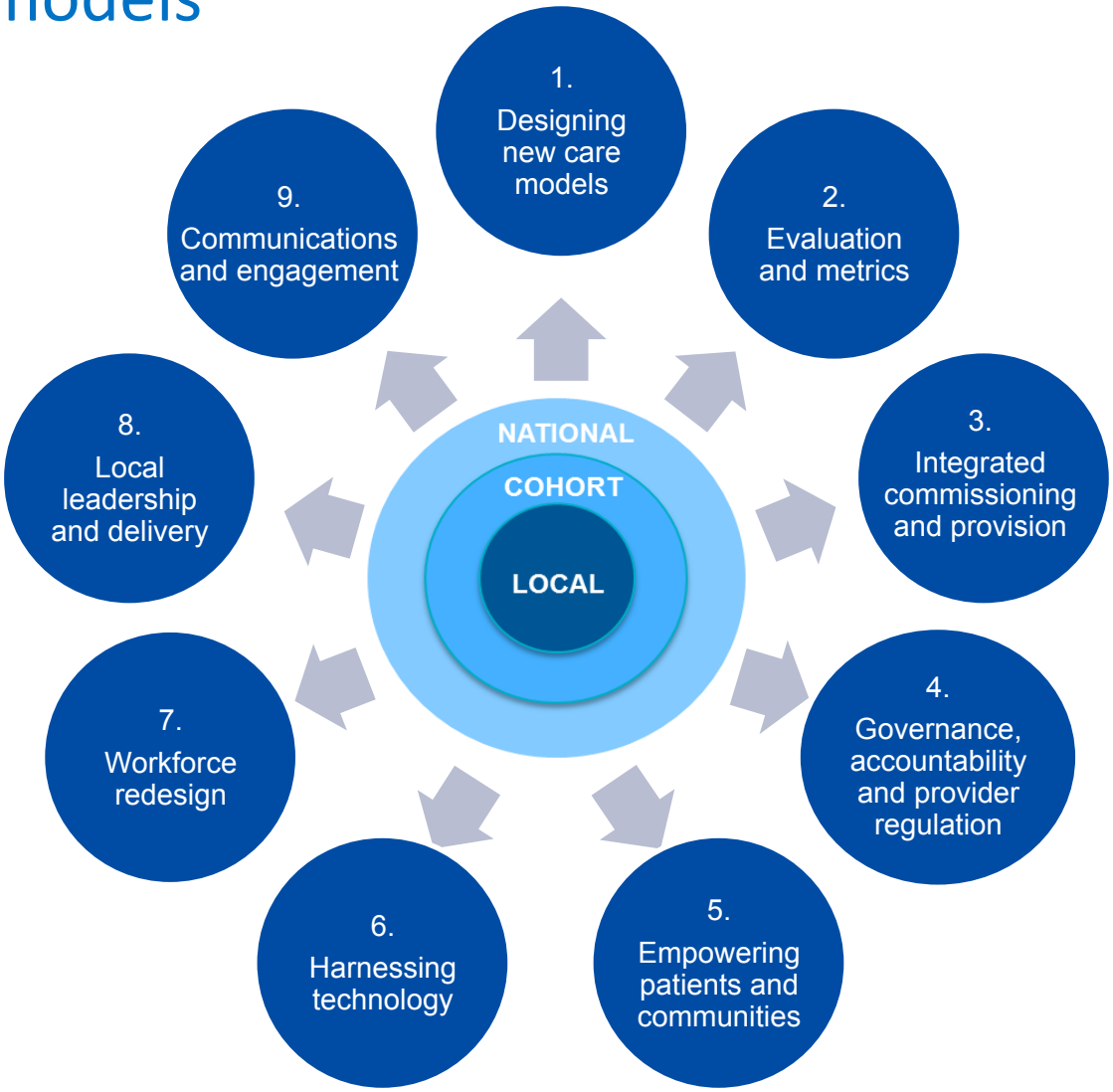


9	Integrated primary and acute care systems
14	Multispecialty community providers
6	Enhanced health in care homes
8	Urgent and emergency care
13	Acute care collaboration

By 2020 NCMs will cover >50% of population.

>5m patients will currently benefit from the first 29 vanguards

The national programme is supporting the vanguards through the key enablers of their new care models

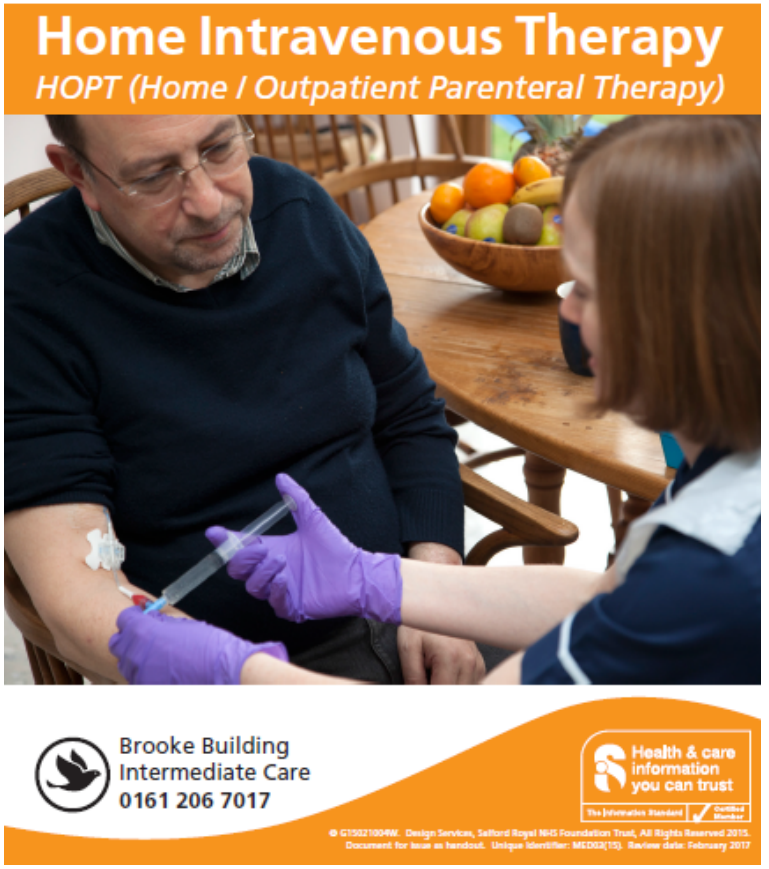


Gateshead Community Administration of IV Medications

- Originally started in 2008 using rapid response intermediate care (RRIC) nurses
  - Treated 125 patients in 6 months saving 1319 bed-days (mainly cellulitis). No re-admissions or line-related problems
- 1st Oct 2016: Vanguard Care Home Programme OPAT pathways for chest infections and urinary tract infections
- Early evidence suggests that 38% can be treated in care home rather than hospital admission
- 2 pathways: GP initiation (step-up) OR hospital initiation (step down) to 24/7 community nursing team
- Contact: ngccg.vanguardcarehome@nhs.net

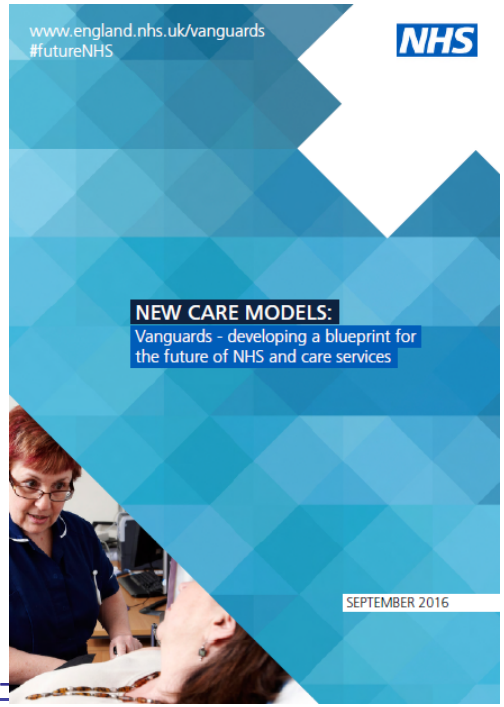
Salford Integrated Care Organisation

- Salford Royal, CCGs and Social Care merged
- Central health & social care ‘hub’, supporting MDT groups of staff and co-ordinating the use of telecare
- Home IV Therapy including OPAT will become a major strand of the vanguard
- www.salfordtogether.com



Vanguards

- Are you in a vanguard area?
- Do you run an OPAT service?
- NCM need your help



www.england.nhs.uk/wp-2015/11/new_care_models.pdf

	Acute care collaboration (ACC) vanguards
38	Salford and Wigan Foundation Chain
39	Northumbria Foundation Group
40	Royal Free London
41	Dartford and Gravesham
42	Moorfields
43	National Orthopaedic Alliance
44	The Neuro Network (The Walton Centre, Liverpool)
45	MERIT (Mental Health Alliance for Excellence, Resilience, Innovation and Training) (West Midlands)
46	Cheshire and Merseyside Women's and Children Services
47	Accountable Clinical Network for Cancer (ACNC)
48	East Midlands Radiology Consortium (EMRAD)
49	Developing One NHS in Dorset
50	Working Together Partnership (South Yorkshire, Mid Yorkshire and North Derbyshire

	Integrated primary and acute care systems (PACS) vanguards
1	Wirral Partners
2	Mid Nottinghamshire Better Together
3	South Somerset Symphony Programme
4	Northumberland Accountable Care Organisation
5	Salford Together
6	Better Care Together (Morecambe Bay Health Community)
7	North East Hampshire and Farnham
8	Harrogate and Rural District Clinical Commissioning Group
9	My Life a Full Life (Isle of Wight)
	Multispecialty community providers (MCPs) vanguards
10	Calderdale Health and Social Care Economy
11	Erewash Multispecialty Community Provider
12	Fylde Coast Local Health Economy
13	Vitality (Birmingham and Sandwell)
14	West Wakefield Health and Wellbeing Ltd
15	Better Health and Care for Sunderland
16	Dudley Multispecialty Community Provider
17	Whitstable Medical Practice
18	Stockport Together
19	Tower Hamlets Integrated Provider Partnership
20	Better Local Care (Southern Hampshire)
21	West Cheshire Way
22	Lakeside Surgeries (Northamptonshire)
23	Principia Partners in Health (Southern Nottinghamshire)
	Enhanced health in care home vanguards
24	Connecting Care – Wakefield District
25	Gateshead Care Home Project
26	East and North Hertfordshire Clinical Commissioning Group
27	Nottingham City Clinical Commissioning Group
28	Sutton Homes of Care
29	Airedale and partners
	Urgent and emergency care (UEC) vanguards
30	Greater Nottingham Strategic Resilience Group
31	Cambridgeshire and Peterborough CCG
32	North East Urgent Care Network
33	Barking & Dagenham, Havering & Redbridge System Resilience Group
34	West Yorkshire Urgent and Emergency Care Network
35	Leicester, Leicestershire & Rutland System Resilience Group
36	Solihull Together for Better Lives
37	South Devon and Torbay System Resilience Group

Sustainability & Transformation Plans

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- The NHS Five Year Forward View Shared Planning Guidance required every local health and care system in England to create a Sustainability and Transformation Plan (STP).
- These will be place-based, multi-year plans built around the needs of local populations.
- STPs will drive transformation in health and care outcomes between 2016 and 2021.
- They will help strengthen local relationships and better enable a shared understanding of how we can best deliver the FYFV.

The 44 English Geographies

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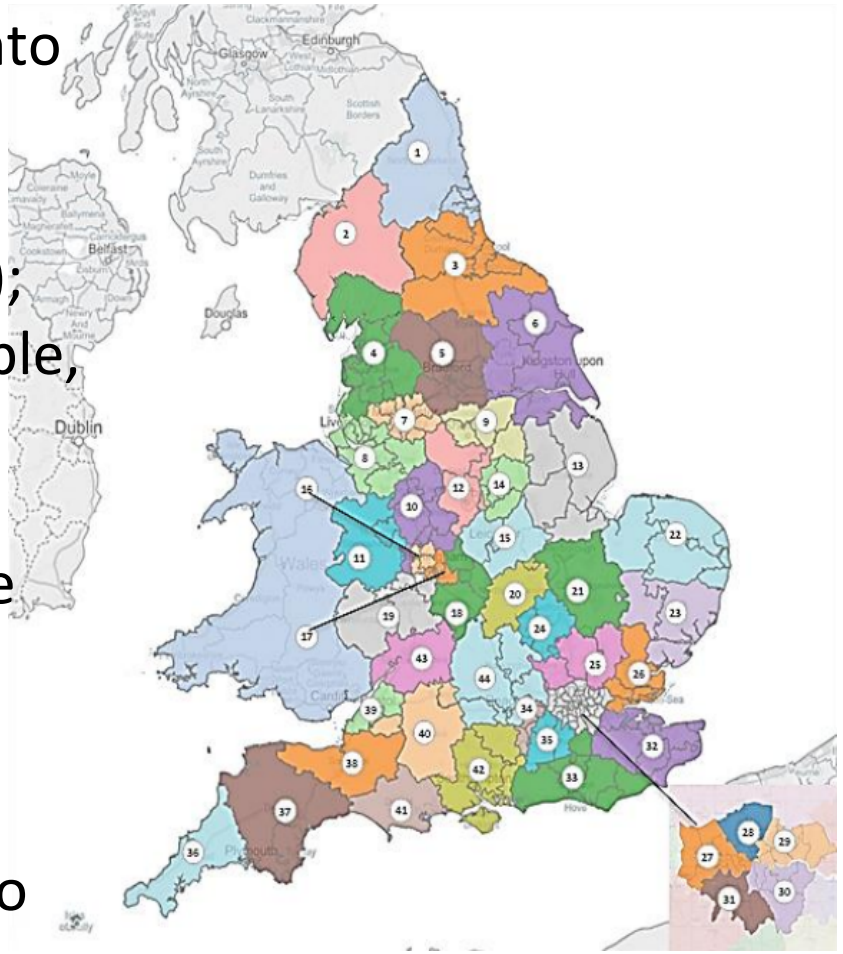
In forming their footprints, local areas will have taken the following factors into account:

- **Geography** (including patient flow, travel, and how people use services);
- **Scale** (the ability to deliver sustainable, transformed, and financially sound health and care);
- **Fit** with footprints of existing change programmes and relationships;
- **Financial sustainability** of organisations in an area;
- **Leadership** capacity and capability to support change.
- **Avg STP** = 1.2m population (300k – 2.8m)



E.g. West Yorkshire & Harrogate

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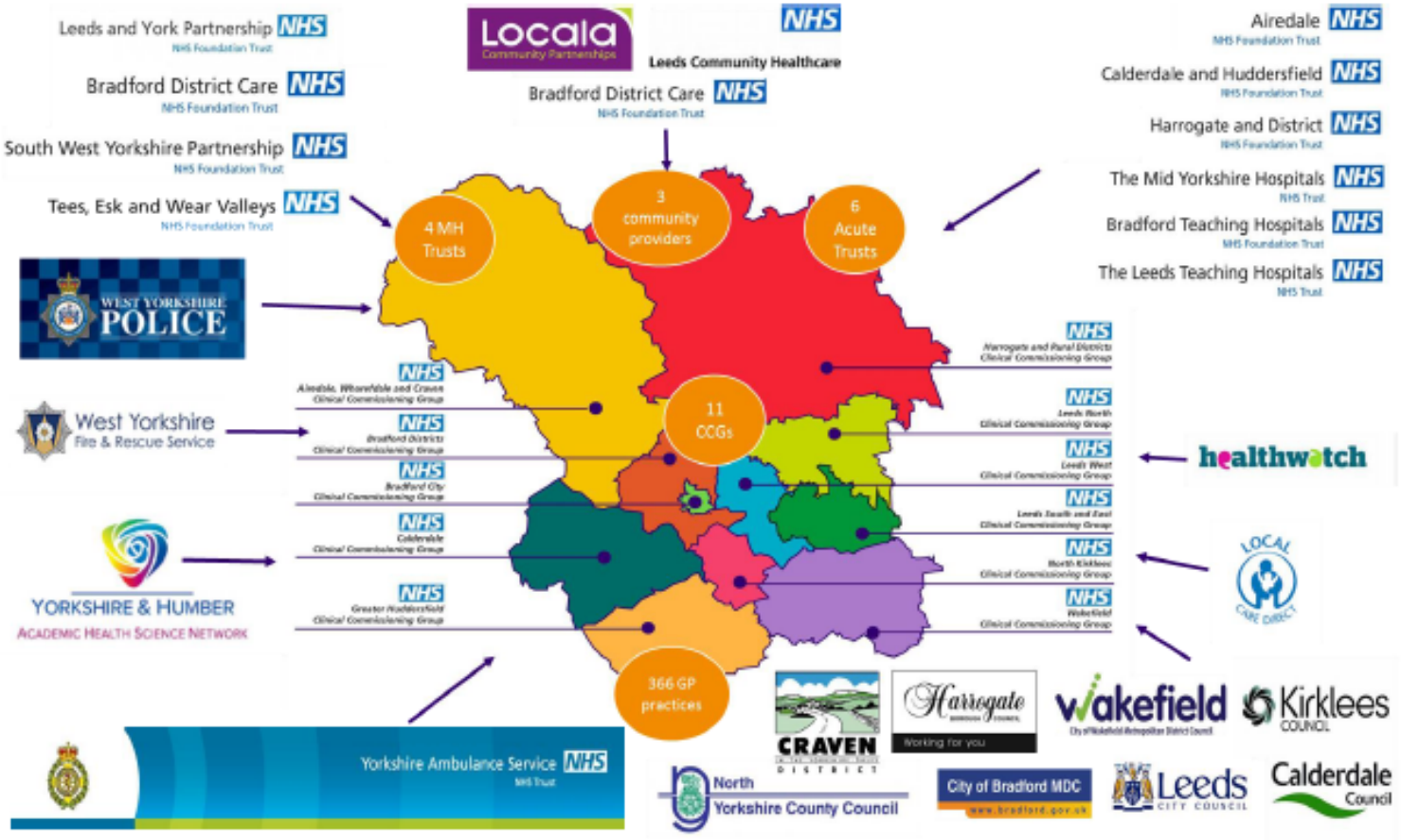
Our health and care economy



- Serving a population of 2.64m
- With a total allocation of £4.7bn across health by 20/21
- And 113,000 health and social care staff

Plus...

- 650 Care homes
- 319 Domiciliary care providers
- 10 hospices

10 big questions – what are the priorities for the STP?

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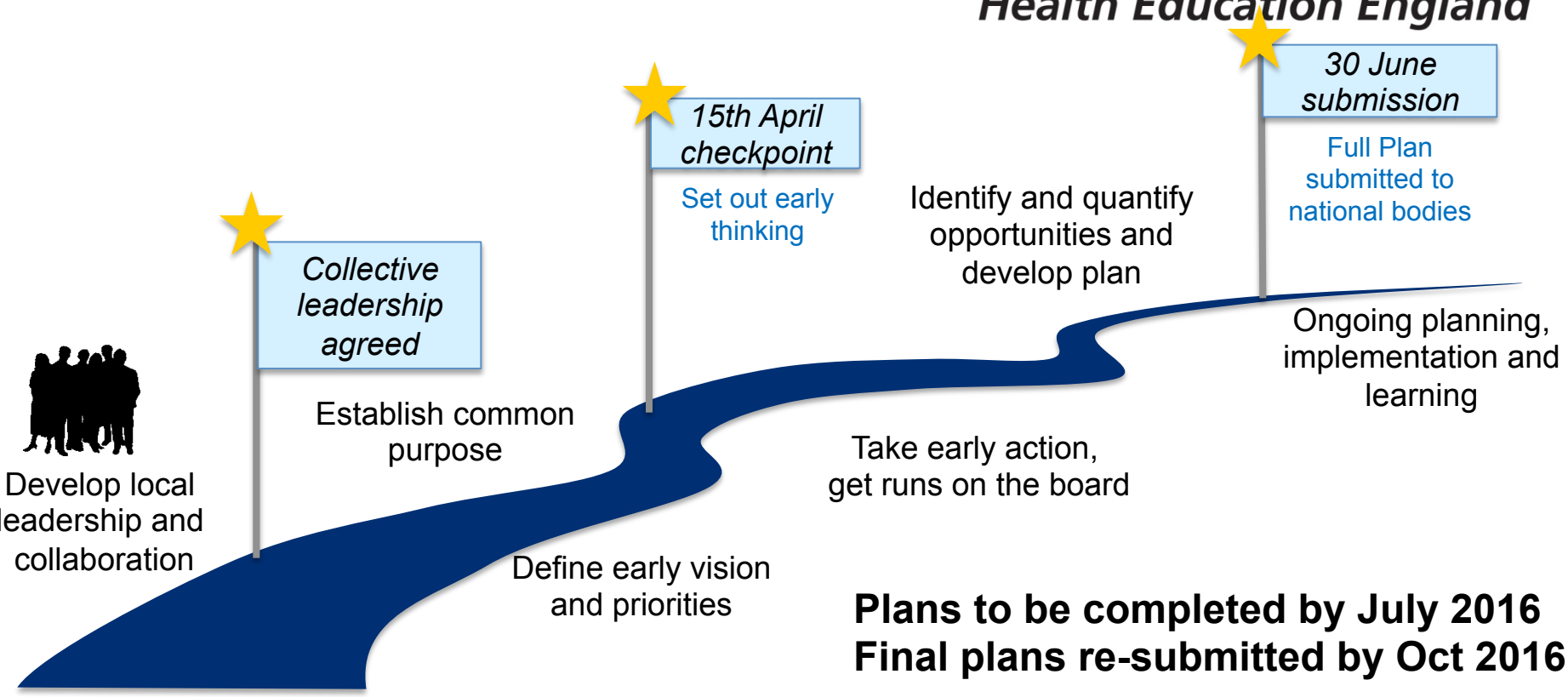
1. **prevent** ill health and moderate demand for healthcare?
2. **engage** patients, communities and NHS staff?
3. support, invest in and **improve general practice**?
4. implement **new care models** that address local challenges?
5. achieve and maintain **performance against core standards** (RTT, A&E waiting times)?
6. achieve our **2020 ambitions** on key clinical priorities?
7. **improve** quality and safety?
8. **deploy technology** to accelerate change?
9. **develop the workforce** you need to deliver?
10. achieve and maintain **financial balance**?

Overview of the process

NHS
Health Education England



Plans to be completed by July 2016
Final plans re-submitted by Oct 2016

Build the leadership → Develop the vision and take early action → Continued implementation

Engagement of staff and communities at every stage

STPs – early impressions

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- Much speculation eg Kings Fund, 38 degrees
  - Focus on reducing costs eg ↓beds, ↓estate, ↓growth in staff costs
  - Limited staff & public engagement
- "If nothing changes" approach equates to massive deficits by 2020/21 eg £876m North-Central London, £712m Birmingham, £809m West Yorkshire using current tariff system
- **Massive opportunity for OPAT expansion**
- www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/stp/

Any STP plans with OPAT

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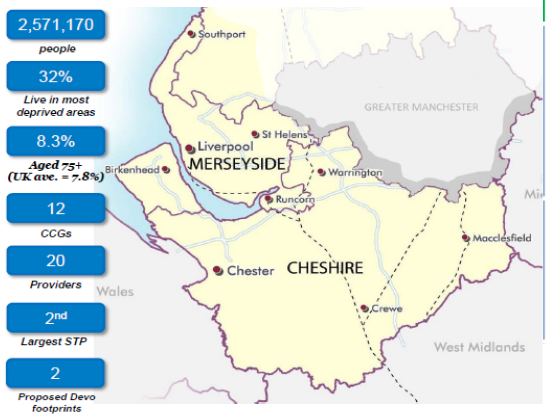
3.3 - Cheshire & Wirral plans - collaborative productivity

Projects	Change Delivered
Cheshire and Wirral Local Delivery System recognises that the projects outlined below focus on a Cheshire and This is to optimise the speed of delivering those benefits. A Cheshire and Merseyside solution will also be consider office and clinical support functions.	
Payroll Workforce, Process & Product	Across Wirral & Cheshire – • Standardise services • Streamline services • Explore the integration and centralisation of teams
Model Hospital & Delivery of Business As Usual Efficiencies	Model Hospital (LOS) Model Hospital (Theatre Utilisation) Model Hospital (New Opat Models) Model Hospital (Other efficiency gains)

Outcomes

Cheshire & Merseyside
Sustainability and Transformation Plan
15 Nov 2016 issue version 4.4



17a. Stabilisation and Transformation of Social Care (Page 3/4) — **Birmingham**

SRO: Peter Hay — **Relevant leads: Alan Lotinga, Louise Collett**

Organisations involved: Birmingham City Council and system partners

Closing the gap
In order to close the Adult Social Care gap, we are considering a range of options and initiatives in Birmingham to further address and manage demand more effectively, and identify further efficiencies. This will be crucially dependent on local system collaboration, and making rapid joint progress with healthcare services towards a much larger, more extensive integration and transformation of the city's health and social care system.

Further Demand Management and Efficiencies:
A number of potential savings initiatives have been identified to close the gap.

These include the closure of adults day services, the reduction in residential respite etc. all underway. However these are dealing with an overspend that is continuing to grow and requires support from the council reserve. We would only propose to add items into this list at the point at which we could show clear net gain.

These are a work in progress and will need to be further validated, and new initiatives identified wherever possible.

A summary position is outlined below:

Proposals (Savings) / New Pressures	2016/17 (£)	2016/18 (£)
Possible Reductions Identified	(12,547,000)	(30,927,000)

Better Care Fund (BCF) schemes:
We are planning to increase our overall investment in BCF schemes in 2016/17, with a total investment of £101.6m for the year. Investments in these schemes will not only help

BCF Scheme	2016/17 Proposed Budget (£)	2015/16 (£)	Increase / (Decrease) (£)
BCF04 – Equipment & Technology (Medequip)	4,649,000	4,584,000	65,000
BCF04 – Equipment & Technology (Medequip)	1,300,000	1,732,000	(432,000)
BCF05 – Care in Crisis / Intermediate Care – Bed Based Provision	1,379,000	1,360,000	19,000
BCF05 – Care in Crisis / Intermediate Care – Social Care Provision	1,415,000	1,395,000	20,000
BCF05 – Care in Crisis / Intermediate Care – Reablement	1,265,000	1,247,000	18,000
BCF05 – Care in Crisis / Intermediate Care – CUR Tool	710,000	700,000	10,000
BCF06 – 7 Day Services	369,000	364,000	5,000
Care Act	3,012,000	2,970,000	42,000
Carer Strategy	1,824,000	1,799,000	25,000
Eligibility Criteria	20,328,000	20,044,000	284,000
Management of Programme	1,025,000	1,011,000	14,000
Community Services	43,163,000	42,530,000	633,000
Reablement – RAID	1,705,000	1,681,000	24,000
Reablement – Communications	47,000	46,000	1,000
Reablement – OPAT	34,000	34,000	0
Non Elective Admission Reduction	6,575,000	6,483,000	92,000

Birmingham

Is it important to have OPAT in your STP plan?

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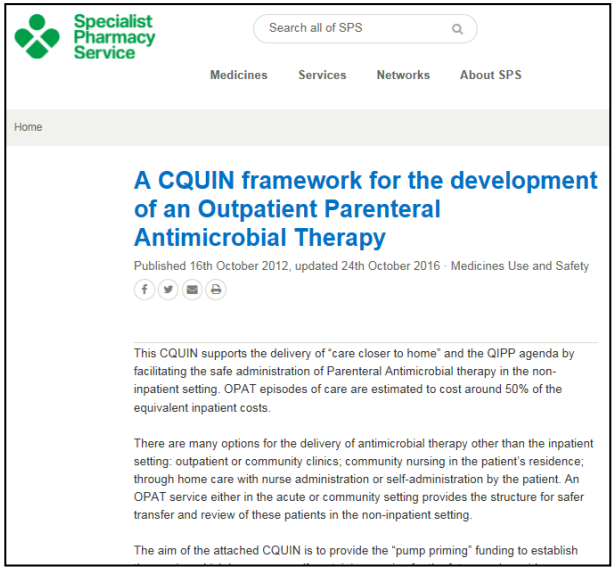
- STP plans are top level. Admissions avoidance & early discharge are key drivers. Detail will come.
- Want to achieve uniformity of provision across an STP patch
  - Single approach within STP patch
  - Flexibility of provision: eg use of local infusion centres
  - eg tertiary centres may not be able to discharge patients if from another CCG / town.
- Do you have an OPAT network for your patch?
- **TALK TO YOUR LOCAL COMMISSIONERS**

Are there other ways to promote OPAT?

London Specialised Pharmacy Services developed a local CQUIN template for OPAT

- Allows pump priming of a service
- www.sps.nhs.uk



Specialist Pharmacy Service
Medicines Use and Safety

How to: Use the CQUIN framework for the development of an Outpatient Parenteral Antimicrobial Therapy (OPAT) service

Introduction

The Commissioning for Quality and Innovation (CQUIN) framework enables commissioners to reward excellence by linking a proportion of providers' income to the achievement of local quality improvement goals.[1]

There are many options for the delivery of antimicrobial therapy other than the inpatient setting; outpatient or community clinics, community nursing in the patient's residence, through home care with nurse administration or self-administration by the patient. A multidisciplinary OPAT service, either in the acute or community setting provides the structure for safer transfer and monitoring of these patients in the non-inpatient setting.

Why don't we have identified OPAT tariffs?

NHS Improvement

How is income generated by outpatient parenteral antibiotic treatment (OPAT) in the UK? Analysis of payment tariffs for cellulitis JAC 2015

G. R. Jones[1], D. V. E. Cumming[2]*, G. Honeywell[2], R. Ball[3], F. Sanderson[4], R. A. Seaton[5], B. Healy[6,7], S. Hedderwick[8] and M. Gilchrist[4,9] on behalf of the BSAC OPAT Standing Committee†

- In-patient 7d uncomplicated cellulitis £1361
- Admission avoidance £2084 (+£723 for hospital)
- Discharge at D2 then virtual ward £1361 (same)
- Discharge at D2 to OPAT £773 (£588 loss)

NHS-Eng best practice tariff for same-day emergency care helps

NHS-Eng: Need OPAT pathways to develop tariffs.

HRG	HRG Name	BPT Clinical Scenario Name	LoS = 0 (£)	LoS >=1 (£)
JD07H	Skin Disorders without Interventions, with CC Score 6-9	Cellulitis	2,342	2,111
JD07J	Skin Disorders without Interventions, with CC Score 2-5	Cellulitis	1,315	1,084
JD07K	Skin Disorders without Interventions, with CC Score 0-1	Cellulitis	684	454

Summary

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- NHS has a funding crisis
- Current tariff-based models are probably not affordable
- Evidence for safe IV treatment at home / OP
- OPAT models being designed for roll out by NHS NCM vanguards & NIHR CIVAS study
- Need to share existing successful models & submit data into BSAC eOPAT NOR
- New STP footprints want a single approach.
- Local engagement is essential.

Thank you

- NHS England: Sam Jones, Matt Bloomer, Mandy Nagra, Paul Twigg
- Leeds: Helen Lewis, Caroline Griffiths, Jane Minton, Kelly Atack, Jo Allen, Leeds CIVAS team, NIHR CIVAS project
- Salford: Paul Chadwick
- NHS-Improvement: Matthew Fogarty, Monique Duffy-Brogen
- PHE: Diane Ashiru-Oredope
- BSAC: Mark Gilchrist, Andrew Seaton, Felicity Drummond

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Yes

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The Leeds Teaching Hospitals NHS Trust