Commissioning a Community IV service

East and South East of England Specialist Pharmacy Services
Medicine Use and Safety Division

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Varied configurations:

- Community (OPAT) specialist IV team Vs District Nursing team

- Integrated or ‘stand-alone’ organisation

- ‘Rough guide’ to Community Health Services

Service Specification

- Often non-existent for community IV service

- Should describe MDT approach to care
  - Specialist IV nurse
  - ID consultant
  - Pharmacist

- Describe the referral criteria?
Service Specification

Consider

• Who is doing the prescribing?

• What documentation is used?

• how communication/review will happen?
  – Virtual ward
  – Face to face meetings
  – Operational meetings
Consider

- Clinical governance arrangements – process and record keeping
- Incident reporting and learning
- Monitor quality outcomes as well as activity
Consider options appraisal for:

• Source of **drugs, diluent and flush**
  – Stock, acute or community pharmacy supplied?
  – Ready to administer?

• Source of consumables
  – Stock or acute supplied?
Community Pharmacy supply for IV

- May be suitable for primary/community based service
- Little experience of IV therapy
- Delay in obtaining stock

**Solution** may be to designate particular pharmacies that can develop the knowledge and skills and maintain a stock
Useful BSAC Resources

• OPAT Best practice recommendations
  http://jac.oxfordjournals.org/content/67/5/1053.full.pdf+html


• OPAT Patient Management System
  http://e-opat.com/opat-pms/
Recurrent costs

*Include:*

- Nursing care
- Drug costs
- Medical care
- Pharmaceutical care
- Flush and diluent
- Consumables
- Pathology

- Other costs: overheads, travel, staff training etc.
WORKSHOP
Who pays?

Clinical Commissioning Groups

- Acute inpatient care
- Outpatient care
  *(unless specialised commissioning e.g. HIV)*
- Community Care
Payment by Results (PbR)

• Currency for admitted patient care - HRGs
  – HD25A Osteomyelitis without complications or comorbidities. Trim point is 69 days
  – PA17B Cellulitis. Trim point is 5 days

• Covers admission to discharge
• Excess bed days
• Also currency for outpatient care – TFCs
How is activity funded?

**INPATIENT**
- PbR Tariff

**Acute OPAT**
- Local Tariff?
- Within PbR Tariff?

**COMMUNITY IV**
- Within block contract?
- Locally commissioned?
Example: IV treatment of cellulitis

Hospital HRG funds for 5 Days (trim point) ++ excess bed days?

Local tariff for OPAT

Community Block contract
• OPAT = half the cost of inpatient
• However, commissioners could be paying 3 times over?
• And more:
  – Increased capacity in the acute for additional activity and income
  – Increased costs in primary care e.g. pathology or prescribing??
Still a good idea?

- Hospital acquired infections
- Patient experience
- Patient choice
- ‘Start smart then focus’

and...... it is cost-effective
Admission avoidance

• Examples are uncomplicated UTIs or SSTIs.

• Primary and community based teams e.g. Rapid response teams

• Readmission avoidance
Admission avoidance

• Ambulatory care pathways or BPTs
  – e.g. JD03A for cellulitis

• Care pathway from outpatient clinics

• More efficiency gains – financially favours community service
Conclusion

- Understanding the funding flows will help clinicians to develop a safe and sustainable community IV service.
- More efficiency gains if you can deliver reduced LOS and admission avoidance.
- MDT working and collaboration are a ‘must do’.