CCG name: North East Hampshire and Farnham CCG		
Case study title: 30 Day Readmissions Audit		
CCG case study number: (specify 1 to 5)	*x* of 5	**Word length for this case study** (up to a maximum of 3,000 words in total across the submitted case studies)
Does the case study provide core evidence?	Y/N	**If yes, state domain criteria by deleting as appropriate:**
Does the case study provide supplementary evidence?	Y/N	**If yes, state for which domain criteria:** 1.3, 2.2, 3.1, 3.2, 4.3

Patient groups	**Please tick all relevant:**
• Mothers and newborns	x
• People with need for support with mental health	x
• People with learning disabilities	
• People who need emergency and urgent care	x
• People who need routine operations	
• People with long-term conditions	x
• People at the end of life	x
• People with continuing healthcare needs	x

Description:	
1) Context: • **Why did you do it?** • **Who was involved?** • **When?** **2) Action** • **What did you do?** • **How did you do it?** **3) Impact**	As part of its commitment to patient safety and improved qualities of patient care, North East Hampshire and Farnham CCG organised a 30-day readmission audit, completed retrospectively conducted in June 2012. This formed part of a contractual requirement placed upon Frimley Park Hospital Acute Trust. The purpose of the audit was to: determine the number of avoidable readmissions, and to highlight key reasons and trends behind readmissions. Commissioners identified the time period to be audited based on a 'typical' week of admissions of both elective and non-elective readmission activity. The audit sample population included: elective and non-elective inpatients, targeting all readmissions from the week commencing 4 July, 2011 and week commencing 3 October, 2011. The CCG established a clinical team to take responsibility for the review led by a GP Clinician. It included: CCG

	Commissioning Manager, Clinical Director for General Surgery, Community Services Manager, Medical Assessment Unit Consultant, A&E Consultant, Director of Nursing Quality and representation from the Community Medicine Management Team. Action Hospital records, patients' case notes and discharge summaries were identified, reviewed and validated by the review team to decide whether they were avoidable through the actions of the acute Trust, the primary care team, community health services or social services. For each readmission the team completed a proformer and were required to: ✓ Make a decision whether the admission was avoidable through the actions of either the provider, the primary care team, community health services or social services, or a contracted body to any of these organisations; ✓ Examine any actions which could have prevented the readmission by any appropriate agency; ✓ Make recommendations about whether there are particular local problems which contribute to readmission; ✓ Discuss how services might be improved, who needs to take action, and what investment should be made; and ✓ Identify those admissions which are preventable through actions in the community so that a fund is established to tackle those issues and prevent patients being admitted to hospital unnecessarily Impact The audit demonstrated that: - The majority of readmissions were either clinically necessary, related to the management of Long Term Conditions, or were out of the control of the Acute Trust acting on its own. - Readmissions were not necessarily related specifically to the initial patient care provided by FPH and dependent upon the level and type of support available in both primary and community setting. - Notable medical conditions with a high likelihood of readmission include: long term conditions such as

	COPD and Cancer; Falls/UTI and respiratory with specific reference to the elderly population; and frequent flyers, particularly those patients with Dementia and mental health. - A need for enhanced discharge planning between acute, primary and social care with specific reference to the frail and elderly population. The findings formulated an improvement plan to be achieved over the next eight months. This plan aligned to the local CQUIN scheme includes the following priority areas: - enhanced partnership working between Acute and Primary Care Services to facilitate pathway development for patients with COPD - A review of end of life patient pathway - Enhanced discharge planning to include review and update of discharge protocols. For the CCG, this exercise will help us to develop a sound evidence base leading to more effective commissioning of services whilst improving standards of care and support across the whole health economy.