ACUTE CLINICAL OUTREACH

ABMU Health Board

Tony Kluge, Planning and Partnership Manager, ABMU Health Board

Claire Dinsdale, Consultant Community Geriatrician

SUMMARY OF THE PROJECT

What are the aims of the ACO?

- ✓ To keep people from going into hospital unnecessarily and helping to avoid care home placements/keep people at home
- ✓ To support primary care in the management of acutely ill people in the community
- ✓ To explore a model of 'hospital at home', at the interface of primary and secondary care
- ✓ To understand how complex conditions can be managed to best effect though an MDT process
- ✓ To inform future models of care in the community

SUMMARY OF THE PROJECT

What is the ACO?

When fully operational:

- ✓ Team of GPs across 5 days, 9-5, led by the Consultant Community Geriatrician, supported by and aligned with a team of Advanced Nurse Practitioners and the wider Acute Clinical Response Service (ACR)in Swansea.
- ✓ Providing 4 hour response on an outreach basis
- ✓ Providing senior clinical advice to the ACR to maximise efficiency of their service
- ✓ Key links with WAST

Snapshot now:

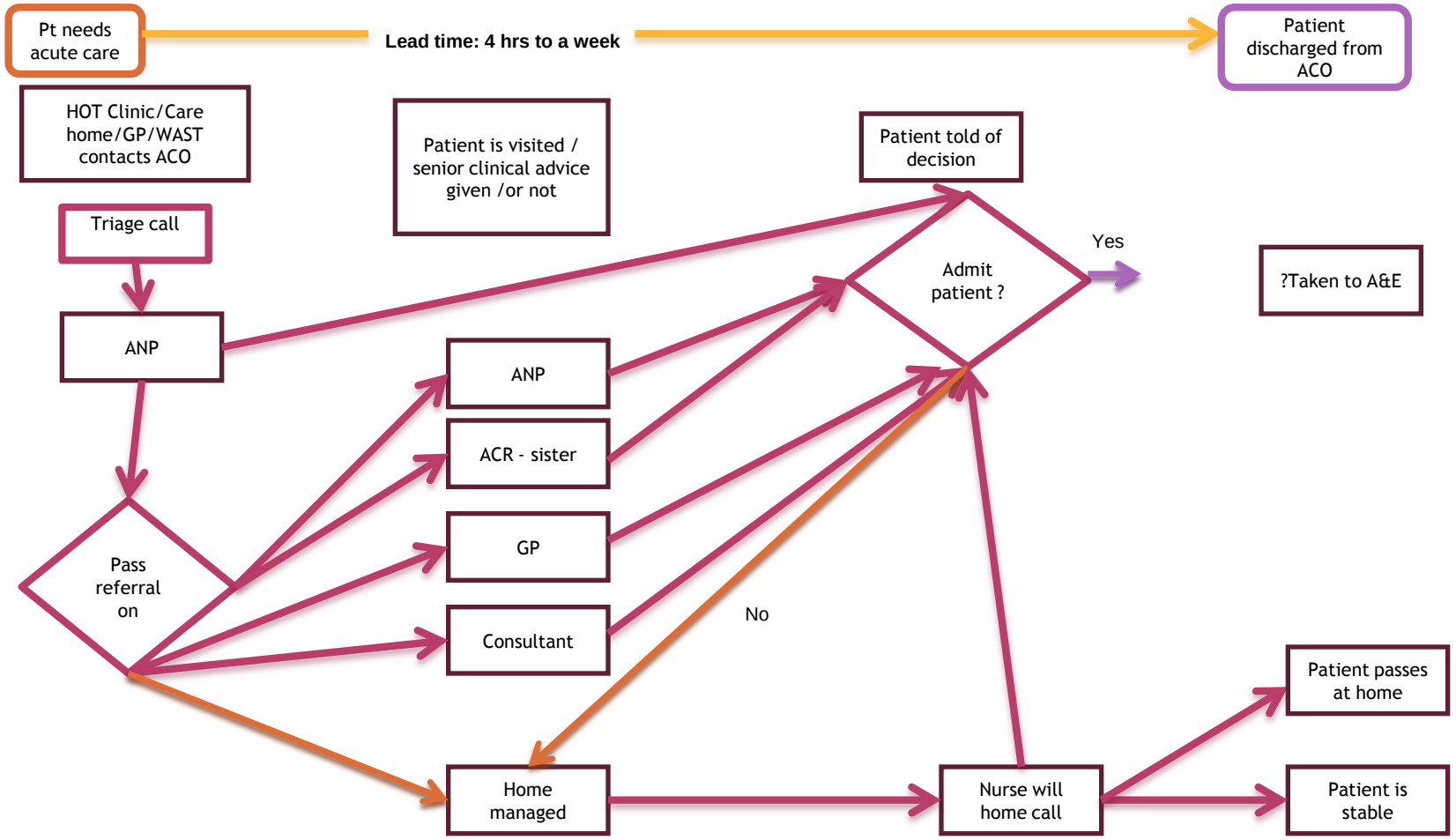
2 GPs across 2 days, Community Geriatrician recently came into the role, new ACR being developed and bedding in.

SUMMARY OF THE PROJECT

Typical cases

- COPD exacerbation
- LRTI's not responding to oral antibiotics
- UTI sepsis
- Heart failure monitoring
- Cellulitis not responding to oral antibiotics
- Dehydration
- Acutely unwell patients refusing hospital admission

Patient Accesses ACO – Process Mapping



WHY WAS IT CHOSEN ?

- ✓ To address issues associated with increasing levels of an elderly population with complex needs.

- ✓ Sustainability: the capacity for primary care to manage people with an acute exacerbation of multiple complex conditions on an ongoing basis.

- ✓ The potential to up-skill GPs in acute complex care for patients and take this back to practices.

- ✓ Urgent significant need to provide care for people out of hospital where appropriate.

WHAT WOULD **SUCCESS** LOOK LIKE?

- ✓ Reduced impact on WAST ➡ A&E as a result of avoidable admissions
- ✓ A true primary/community/secondary care interface between key services.
- ✓ Admission/attendance reductions, bed days saved = potential cost savings

WHAT ARE YOUR **PROCESS** MEASURES?

- Context: Numbers of calls triaged through and seen by ACR (441)
- Total number of outreach contacts by ACO (41)
- Numbers of individuals managed by ACO:
  - at home ACO GP only
  - at home ACO GP jointly with ANP
  - by ACR no GP involvement after triage
  - by ACO GP tel consultation only
- Numbers of calls in total receiving senior clinical input
- Treatment provided
- Diagnostics needed
- Average time taken at patients location/Average time taken on telephone advice

Results are based upon phased implementation through Jun 1 – Aug 31 2016

WHAT WILL BE YOUR **OUTCOME** MEASURES?

- Hospital attendances avoided: **28 (out of 41 seen)**
- Approximation of bed days saved: **465**
- Approximate notional savings resulting: **£93,000 gross notional savings in the first 3 months***
- Practitioner stories…available in droves, showing real care improvements for this group of patients. Patient stories, being collated.
- Work underway to collate other measures such as unnecessary WAST transfers avoided

Unit cost for emergency admission. Acute hospital care costs circa £200 per day (The King's Fund, Data Briefing, December 2011).

**Results are based upon phased implementation through Jun 1 – Aug 31 2016

WILL YOU HAVE ANY **BALANCING** MEASURES?

Agreed at outset, 1000 Lives Service Improvement Team working closely to build process map and re-assess the balancing measures; these are complex in an open system around a service such as ACO.

WHAT DID YOU LEARN ?

- Referrals into the service take time to develop.
- Full recruitment key to obtaining confidence in the service and meet winter pressures.
- It takes longer deal with a patient than first expected.
- Relatively high cost 'savings' can be made.
- GPs play key role in forming the service.
- Unexpected benefits eg training and up-skilling needs in nursing teams.
- Other significant benefits can be gained through developing other service areas but which are too big for this pathfinder to tackle.

MINISTERIAL PRIORITIES

- Support the aim to achieve service sustainability; in particular with regard to WAST, Emergency Departments, Primary Care and Integrated Health and Social Care Teams.
- Improving access; Patients should be better able to access services more appropriate to their needs, in the community and at home.
- Move services out of hospitals into community settings by allowing the treatment of patients at risk of being admitted to an emergency department to be treated at home where appropriate.
- Also addressing some of the key areas set out by Cabinet Secretary for Health Well being and Support

  - *Making linkages across different parts of the health and care system work better*
  - *Delivering the shift of services, with resources, to out of hospital setting, focussed around the needs of the public*
  - *More integration of services*
  - *Reducing variation, improving consistency and embedding innovation that's worked at pace*

NEXT STEPS

- Recruit remaining 2 GPs
- Continue to develop relationships and undertake communications to further increase referrals
- Plan for winter pressures.
- Continue to fine tune working practices.
- Investigate how length of treatment changes as experience grows
- Investigate why # bed days saved is down in August and therefore 'savings' reduced – is a new balance measure needed?
- Further embed measures to inform the development of the service around what works/has the greatest impact/greatest return on investment
- Refine the infrastructure such as IT to make the most of the efficiencies to be gained by service
- Obtain patient feedback

Discussion – 21st Sept 2016

- In effect, a hospital at home service; 3 advanced nurse practitioners, up-skilled GPs, COE consultant based in community – providing medical input into community nursing team
- Up-skilled GPs + time+ resource for complex care – can transfer skills back to practice
- Aim is to adjust patient flow and reduce impact on ED, USC admissions and WAST
- Improving primary / secondary care interface
- Referrals into service takes time:
  - To embed service
  - To train to competences
  - Requires trust and confidence to build
  - Better to build gradually and get the right people in post
- Longer consultation and management times for patients than initially expected – but can properly manage patients through holistic approach to care
- Reduction in hospital admissions – assessed through traffic light system for referral criteria with severity of illness /frailty
- Part of whole system approach to sustainability – risk of negative impact on primary care if no extended PC team to manage significant workload of PC
- Concern expressed about taking GPs out of the system to manage a relatively small number of patients. Potential for GPs to manage complex patients if given more time and interface support
- Mixing skills across 1ry / 2ry interface, ie true shared care, with integrated mechanisms for managing high risk patients; Vanguard sites in England have complex care teams, including GP members.