Redesigning the Acute Medical Primary / Secondary Care Interface Results in a 39% reduction in Overnight Medical Admissions from the Community.

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In the current climate of austerity with an ageing population, there are increasing hospital admissions and demands for ever more efficient, cost effective and timely healthcare. The Emergency Department (ED) and Acute Medical Unit (AMU) have been the traditional front line of hospital based acute medicine. However increasing pressure means that new ways are being sought to get the best out of limited resources. A key principle in reducing the burden on an ED and AMU is to redirect patients who do not need to be there. Dedicated Ambulatory Care Centres (ACC) have emerged as a key solution to manage patients who present to ED or via the GP to AMU requiring urgent treatment or investigations but who are well enough to go home that day. In doing so we expect to improve the patient experience, reduce waiting times, free up beds and staff and save money.

The Royal Derby Hospital (RDH) is one of a number of hospitals across the UK that is pioneering a dedicated ACC. As these units are relatively new, work is still ongoing in how best to select and refer the correct group of patients to ACC or, in some cases, send directly home.

Overview

Little evidence exists on the best method to efficiently triage ambulatory patients. At RDH this was initially achieved via a dedicated triage team, led by a consultant, with nurse support, who acted as the gatekeepers to the Clinical Decisions Unit, AMU and admission to specialist wards. Having determined that this process was both feasible and desirable by robust statistical reflection and analysis, this was extended to the consultant job plan. Technology was introduced to ensure that these physicians would work to book time for home with full access to historical radiology, blood tests and clinic letters.

Telephone referrals from the community are now transferred between the hours of 1000 and 1800 was undesirable both from the points of view of patient safety and experience. ED 4-hour targets could often leave GP referred patients waiting for longer before being seen which was undesirable both from the points of view of patient safety and experience.

Intervention Components

Capital Investment.

The old Clinical Decisions Unit was redesigned and underwent a £60,000 redevelopment to make it fit for its new purpose. A great deal of thought was put into the redesign in particular to ensure that the new waiting areas were comfortable, welcoming and informative.

Communications and IT infrastructure.

Phone triage required a small change in the call handling protocols to ensure that community calls were routed to the correct physician and the outcome of that conversation achieved. In order to ensure proof of concept before the dedicated AMU was up and running, a dedicated AMU Ltd, a company owned and operated by one of the consultant physicians of RDH. Having proved that admission avoidance and triaging was both feasible and desirable by robust statistical reflection and analysis, this was extended to the consultant job plan. Technology was introduced to ensure that these physicians would work to book time for home with full access to historical radiology, blood tests and clinic letters.

Staffing.

Ambulatory Care Centre. In addition to making the Centre fit for purpose, investment was made in staffing. Within 3 months, the workforce had increased by over 80%, ensuring the old way of staffing the still same unsustainable. By using a range of core staff of research assistants and introducing an internal cloud based self referral system, open to selected medically qualified staff, a continuous workflow process has been rapidly developed and maintained. Most of the core medical staff still have their ‘day jobs’ and work on for different hours during the week, being paid for the shifts they sign up for. All staff are specifically trained and induced.

Consultant (job plan). Job plans of the 7 consultant physicians at Derby were revised to provide a 5 day a week service taking GP calls from 1000 to 1800 with the option for 2 hours overnight to 0200 if desired. This possibility of working from home maximised the new working practices met with very minimal resistance and was actively welcomed by the majority of the staff concerned.

Improving Patient Experience.

Improved patient experience was placed at the heart of the redesign and focused on three specific areas:

1. Improved environment;
2. Continuous waiting (all day); and
3. Break free time and contemporary decoration.

Clinical pathways.

a. Clear selection criteria to achieve a high percentage of 'easy win patients’

b. Clear in house criteria to prevent inappropriate patients being discharged unseamly to the community. An evidence based discharge checklist had to be completed prior to discharge. Any patients not fulfilling all of the discharge criteria would be admitted to the AMU.

3. Active management of patient and referral expectation.

a. Introduction of best reassuring system to allow patients and relatives to leave the unit when not needed.

b. Guidelines explaining the purpose of the Centre – to get people home safely the same day, and explaining the processes going on behind the scenes and how long these take. We promise the right decision by the end of the day, not in realistic decision in an arbitrary time limit.

c. Existing visitors to the unit to care per patient – not only allows for more patients to be treated in a smaller space, but ‘mystery shopping’ doubles showed that multiple activities actually generate comparable discharge. Whilst patients are often happy to wait for assessment and treatment and understand the processes involved, relatives are less so, especially if they can traverse their concerns off other friends and relations. This simple measure rather surprisingly drastically increased patient satisfaction.

Clinical Pathways from A&E.

Pathways were put in place to ensure that ambulatory patients presenting to A&E were not put on trolleys or in wards but assessed as ‘walking well’ to the new centre knowing that they would most likely be going home. This provided an extremely useful approach to over medicalised and frequently presenting patients and freed up AMU resources for sicker patients.

Before and after

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Effects / Outcome

1. ‘Wanted well’ and those needing ‘rule out’ tests (both which the GP and the consultant did not expect to reveal any pathology or illness, but which needed to be done) could be directed straight to the Ambulatory Care Centre bypassing the triage process on AMU.

2. Patients could be diverted to outpatient clinics if more appropriate, and the GPs felt empowered to make this choice because they had the support of a hospital consultant. At these units are relatively new, work is still ongoing in how best to select and refer the correct group of patients to ACC or, in some cases, send directly home.

3. Patients could be treated in the community by GPs and specialist teams following advice from a consultant physician.

4. Improved patient experience for those attending the Ambulatory Hospital. Patients are seen by the right people in the right setting first time.

5. Admissions during busy times on the AMU (e.g. 1600-2000) could be purposefully avoided by delaying admissions until the following morning for routine but necessary problems (e.g. poisoning, headaches).

6. Complex patients’ best interests could be agreed with joint decision making between the patient, primary and secondary care physicians prior to hospitalization.

7. Pollutive patients could be treated in the community following joint decision making by primary and secondary care.

8. The very small number of GPs who sent patients into hospital as an ‘easy win’ were prevented from doing so. The initial audit performed during the introduction of the new GP telephone triage system showed an absolute admission avoidance rate of 13% which had fallen after 18 months to 10%. This suggests that 3% of patients who would previously have been referred were now being more appropriately treated in the community without any referral to secondary care.

What have we achieved?

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<th>Avoided</th>
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Conclusions

Well designed ambulatory care services have significant potential to reduce short term medical admissions whilst improving patient satisfaction. Senior decision makers are able to significantly reduce hospital admissions and improve the patient journey by triaging community referrals.

1. A 39% reduction in overnight admissions from the community by redesigning the acute medical primary/secondary care interface to ensure senior decision makers are placed at the heart of the gate keeper role.

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