Acute Physicians: Leading from the Front
Dr David Staples

Consultant Physician in Acute Medicine and Head of Ambulatory Care,
The Royal Derby Hospital.
Director, Aesclepius Ltd.
"Zulus, Sir... a thousand of them!"
HOW A&E ADMISSIONS HAVE RISEN

Millions

Source: Dept. of Health, NHS England

“While demand for accident and emergency (A&E) services has risen considerably over the past 15 years or so, nearly all of this is attributable to increasing activity in walk-in centres and minor injuries units and for the past two and a half years growth has slowed considerably—to just over 1% per year” (Appleby 2013).
“There have been many attempts to divert people from A&E services over many years by providing alternative primary care type services. These schemes appear mainly to increase overall demand, particularly for minor injury and illness, and have also had the effect of creating a highly fragmented system which generates confusion among GPs and other referrers about how and where to access care. There is anecdotal evidence that patients are also confused and turn to A&E services as they have confidence in them and find them easy to access.”

The Royal Derby Hospital
Seizing Control of Your Front Door
Seizing Control of Your Front Door

• Manage admissions from A&E
Seizing Control of Your Front Door

• Manage admissions from A&E
• Manage admissions from the Community
  • GPs
  • ECPs
  • Paramedics
Seizing Control of Your Front Door

• Manage admissions from A&E
• Manage admissions from the Community
  • GPs
  • ECPs
  • Paramedics
• Manage admissions from other Specialties
Intervention:

• Put a senior decision maker at the front door.
Intervention:

• Put a senior decision maker at the front door.

A consultant in the AMU:

Lowers Length of Stay by a mean of 1.3 days. Results in 9% more patient being discharged on the same day of their assessment (95% confidence interval 5.7% to 12.6%, p<0.001) without affecting readmission or mortality.
Role of Senior Decision Makers

• Initiate emergency treatment
  • Sepsis, ACS, UGI Bleed

• Prevent inappropriate treatment / Inx.

• Facilitate urgent investigations

• Discharge those not needing admission

• Stream those not needing ‘Medicine’
Senior Decision Makers

• 300 cases analysed prior to the introduction of consultant led triage
• 300 cases afterwards.
• Spread over the year (100 from June, October and February pre and post).
Reduction in re-attendance

<table>
<thead>
<tr>
<th>Cumulative percentage of patients re-attending:</th>
<th>Pre-intervention</th>
<th>Post-intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within 7 days</td>
<td>3.7%</td>
<td>1.7%</td>
</tr>
<tr>
<td>Within 14 days</td>
<td>6.7%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Within 28 days</td>
<td>11%</td>
<td>4.3%</td>
</tr>
<tr>
<td>Within 3 months</td>
<td>23.7%</td>
<td>6.7%</td>
</tr>
<tr>
<td>Planned re-attendance to ambulatory care.</td>
<td>0%</td>
<td>1.7%</td>
</tr>
</tbody>
</table>
# Process time results

<table>
<thead>
<tr>
<th></th>
<th>Pre-intervention</th>
<th></th>
<th>Post-intervention</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Percentile</td>
<td></td>
<td>Percentile</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median</td>
<td></td>
<td></td>
<td>Median</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25th</td>
<td></td>
<td></td>
<td>25th</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>75th</td>
<td></td>
<td></td>
<td>75th</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time to see clerking practitioner</td>
<td><strong>1:45</strong></td>
<td>1:02</td>
<td><strong>0:48</strong></td>
<td>0:00</td>
<td>3:25</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Time to see a senior doctor</td>
<td><strong>3:58</strong></td>
<td>2:10</td>
<td><strong>0:10</strong></td>
<td>0:00</td>
<td>8:21</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Time to agreed pathway allocation</td>
<td><strong>3:58</strong></td>
<td>0:00</td>
<td><strong>0:10</strong></td>
<td>0:00</td>
<td>8:30</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Care completed on AMU</td>
<td>35.9%</td>
<td></td>
<td>50.8%</td>
<td></td>
<td></td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Admitted to a base ward</td>
<td>64.1%</td>
<td></td>
<td>48.5%</td>
<td></td>
<td></td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

Thanks to Dr Ben Pearson, Royal Derby Hospital 2009
Summary of Outcomes

Reduction in waiting time to see the first practitioner.
Reduction in time to see a senior doctor.
Reduction in time to receive an agreed management plan and pathway allocation.
Reduction in admissions to base wards.
Reduction in re-attendance rates.
Increase in proportion of patients completing care on AMU.
Financial Benefits
Intervention:

- Put a senior decision maker at the front door.
- Manage ED patients referred to Medicine.
Congratulations

WELCOME TO
DUMPSVILLE

POPULATION: YOU
Triage

- GP
- A+E
- Clinic

- Ambulatory Care
- Home
- Short Stay / "..ology"
- Adult First Seizure
- Anaemia
- Asthma
- Cardiac Chest Pain
- Cellulitis
- COPD
- DVT
- Jaundice
- Pneumothorax
- Poisoning
- Headache
- Pulmonary Embolism
- Seizure in a Known Epileptic
- Syncope
- Upper GI Bleed
- Generic ambulants
- Anaphylaxis
- Pleural Effusion
- SVT
The Selection Process

1. Patient arrives in “Pitstop” in ED
2. Seen by Consultant (Middle Grade if no Consultant available)
3. Deemed appropriate for designated pathway
4. All appropriate initial investigations performed
5. Transferred to ACC for further treatment, investigation and follow-up
UPPER GI BLEED

Referral criteria for patients presenting in ED to facilitate their care moving to Ambulatory Care service which will support improved flow in ED

Ambulatory Care is located in the Clinical Decision Unit (within MAU) and opening times are:
- Monday – Friday 9am – 9pm (last referral at 7pm)
- Saturday and Sunday 12pm – 6pm (last referral at 6pm)

**Historical**

<table>
<thead>
<tr>
<th>Inclusion Criteria for referral to Ambulatory Care</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>No History of Cardiac Disease</td>
<td></td>
</tr>
<tr>
<td>No History of Liver Disease</td>
<td></td>
</tr>
<tr>
<td>Not an Alcoholic, IVDU or Homeless</td>
<td></td>
</tr>
<tr>
<td>No LoC/Syncope associated with this presentation</td>
<td></td>
</tr>
<tr>
<td>No Melaena or History of Melaena</td>
<td></td>
</tr>
<tr>
<td>Not on Warfarin</td>
<td></td>
</tr>
</tbody>
</table>

**Examination**

<table>
<thead>
<tr>
<th>Inclusion Criteria for referral to Ambulatory Care</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>No ongoing acute bleed or witnessed haematemesis IN DEPARTMENT</td>
<td></td>
</tr>
<tr>
<td>Pulse &lt; 100</td>
<td></td>
</tr>
<tr>
<td>SBP &gt; 110</td>
<td></td>
</tr>
<tr>
<td>Postural drop &lt; 20 mm Hg Systolic</td>
<td></td>
</tr>
</tbody>
</table>

**Holistic**

<table>
<thead>
<tr>
<th>Inclusion Criteria for referral to Ambulatory Care</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent and Mobile</td>
<td></td>
</tr>
<tr>
<td>Looks like an ambulatory patient</td>
<td></td>
</tr>
<tr>
<td>Ambulatory care would be in Patient’s best interest</td>
<td></td>
</tr>
</tbody>
</table>

If ALL Criteria met and CDU Open/Available:

- TAKE BLOOD FOR initial Profile, FBC, G+S, LFTs, Clotting
- Change EDIS to show patient destination as Assessment - CDU and transfer patient to CDU
Comfortable environment
Ambulatory Care Centre consultation rooms
Ambulatory Care
Outcome
Outcome

ED Performance Jan - June, 2012

<table>
<thead>
<tr>
<th></th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>2011/12 total</th>
<th>April</th>
<th>May</th>
<th>June to 28th</th>
<th>Q1 to June 28</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Within 4 Hours</td>
<td>0.915487</td>
<td>0.932745</td>
<td>0.94815</td>
<td>0.9385</td>
<td>0.9521</td>
<td>0.9529</td>
<td>0.9544</td>
<td>0.9529</td>
</tr>
</tbody>
</table>
Intervention:

• Put a senior decision maker at the front door
• Manage A&E patients referred to Medicine
• Manage community patients
Build a path...
GP

A+E

Clinic

Triage

Ambulatory Care

Home

Short Stay / “.ology”
GP Phone Triage

- Discussion with senior generalist for all incoming medical patients

  – Reduce unnecessary admissions
  – Provide an accessible specialist advice service
  – **Stream patients to the right place, first time**
  – Improve patient flow from A+E to MAU
  – Stop ‘Inappropriate’ referrals
Results: (n=619)

- MAU, 310, 50%
- ACC, 184, 30%
- Avoided, 83, 13%
- DefCDU, 7, 1%
- Clinic, 2, 0%
- A+E, 16, 3%
- DefMAU, 17, 3%
Outcome

39% reduction in overnight admissions from the community (n=1600)
Next Steps...

- Nurse led selection protocols from ED
- ECP led selection protocols
- Paramedic led selection protocols
- Condition specific admissions pathways
- Paperless Ambulatory Care
- Tariff for GP phone advice
- Consultant Performance Metrics
Intervention:

• Put a senior decision maker at the front door
• Manage A&E patients referred to Medicine
• Manage community patients
• Get the finances right
Urgent Care Pathway – Adult, Medicine

~90K Adult Attendances to ED

Self Referrals & Ambulance, 77K

Discharged or external transfer, 59K

Non-med internal transfer, 10K

GP & other, 13K

Direct ad to Med ward, 6K

GP/BB, 11K

15K

Non-med internal transfer, 1K

19K

Discharged, 7K

Discharged, 5K

ED

MAUT/Amb. Assess

13K

Discharged, 17K

Direct ad to Med ward, 6K

11K

Discharged, 2K

MAU

Base Wards

Rehab

Discharged, 2K
**Urgent Care Pathway – Adult, Medicine**

- **ED**
  - Subject to 30% tariff
  - Locally agreed price (ED + top up)

- **MAUT/ACC**
  - **GP / Bed Bureau**
    - Locally agreed price. Higher tariff than ED (due to less work up).

- **MAU**
  - Admissions attract national tariff for an inpatient stay
Financial Impact

Locally Agreed Tariff for MAU attendees

Commissioners.
Pushing more activity through MAU triage = increased cost, BUT saving made through avoidable admissions is greater.
Therefore: \textbf{Attractive to Commissioners}

Hospital.
Increased activity paid at locally agreed tariff but major benefit because of increased patient throughput from ED and 4 hour target effects.
Therefore: \textbf{Attractive to Hospital Management}
Intervention:

• Put a senior decision maker at the front door
• Manage A&E patients referred to Medicine
• Manage community patients
• Get the finances right
• Look to create opportunity from frustration
Opportunity from frustration...

• Orthopaedics
• Urology
• General Surgery
Opportunity from frustration...
KEEP CALM AND COLLECT DATA