**“How can I help?”**

**A combination of consultant triage and a case-selection model for ambulatory care greatly reduces medical admissions from primary care**

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**AIMS**

Prior to November 2014, Acute Medicine in Nottingham admitted 110 unselected medical patients per weekday. 42% came from primary care. A community-based service staffed by non-clinicians screened requests for admission and diverted only 4-5% to alternative community pathways. Between 8am and 10pm GP admissions came through the Acute Medicine Receiving Unit (AMRU) which was under extreme pressure. Discovery work demonstrated that between 28 and 35% of patients referred by their GP could have been cared for through alternative urgent care pathways. Our goal was to reduce the number of “wrong place” attenders from primary care and therefore release capacity in AMRU to left-shift care processes and convert some patients currently requiring a short stay admission to ambulatory care.

**METHODS**

Acute Medicine opened a consultant-run triage line from 9am to 5pm. Conversations were opened with, “How can I help?” to facilitate senior clinical dialogue about patients whose GPs felt required admission, and thus ensure that the patients ended up in the best place to have the care they needed. Telephone triage formed the cornerstone of a wider collaborative initiative (the Nottingham Care Navigator) to encourage more effective navigation of patients. This combined with our previous initiative where all patients directed to AMRU were considered for ambulatory care rather than limiting this to condition-specific pathways.

**OUTCOMES**

From November 2014, 39 patients per day were cared for through a combination consultant telephone triage and AMRU. The flow chart opposite show the outcomes for every 100 patients.

Through a combination of consultant telephone-triage and case-selective ambulatory care, 42.6% of patients avoided admission altogether. “Wrong place” attendances in AMRU dropped from 28% to <5%. The overall number of GP admissions dropped significantly.

The rate of ambulatory cases discharged directly from AMRU was maintained at 39%, despite the “easy wins” being managed without admission through telephone triage.

In addition, the consequent reduction in pressure on AMRU improved clinical processes cutting time to triage, clerking, investigation and senior review and reducing LoS on the unit benefiting both the patients whose care became “ambulatory”, and those who needed to be admitted.

Consequently patient and staff experience improved markedly and feedback from GPs and physicians was encouraging.

**CONCLUSIONS**

Acute Medicine consultant telephone triage and a case-selection model for ambulatory care has reduced admissions, maintained ambulatory conversion rates and had a transformative effect on the quality and flow in our emergency pathway.

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