Models of Acute Care – What does good look like in Wolverhampton?

Lee Dowson
Divisional Director of Medicine
Royal Wolverhampton NHS Trust
Flow, occupancy and mortality
Background 2014

- Fortress ED with staffing challenges, poor estate and training concerns
- All medical patients admitted through the acute medical unit (AMU)
  - 66% from ED - unchallenged admitting rights to with no feedback loop
  - 33% from GP via AMU clinic (poor access to a bed for treatment)
- All physicians taking equal turns to deliver 2 man rolling post take ward round for AMU ward and clinic – variable engagement and performance
- Large numbers of patients waiting to be seen on AMU at evening handover
- High early discharge rate from AMU
- Traditional medical ward rounds on specialty wards
- Steadily increasing bed base
New Urgent and Emergency Care Centre (UECC)
Physician A and B
Principles of new model

• Unify the admission pathway for medical patients and prioritise according to clinical need – all medical patients come through ED

• RAT and Triage identify unstable patients and facilitate the delivery time critical treatment

• Joint senior decision making to
  – Facilitate right care at the earliest opportunity
  – Share learning to improve performance of ED and Physician A team
  – Facilitate ambulatory care as the default (home first)
  – ‘Lean’ the medical patient pathway (e.g. direct to specialty)
The new model - 7 Days

Physician A
• Acute Physicians + acute minded specialists
• 1 in 12
• ED 10:00 to 21:30
• Working with Reg A
• Handover 21:30
• Sleep

Physician B
• Medical specialty physician
• 1 in 28
• AMU13:00-21:30
• Reg B + junior doctors
  Handover at 21:30
• On call overnight
What Physician A does

• Stabilises patients and ensures safe appropriate transfers
• Early senior decision making facilitates safe, effective and efficient care starting at the front door
• Converts potential admissions to ambulatory pathways
  – Adaptable approach
  – Experts in directory of services including community support options
  – Brokering with specialties (direct admissions and HOT clinics)
What Physician A doesn’t do

• Wait for patients to be clerked
• Disempower ED team to deal with medical problems
• Hand patients back to ED team
• Delay the movement from ED of stable patients who need admission
Total Number of ED Attendances by Month, RWT Jan 2015 - Jun 2018
Number of General Practitioner Referrals Direct to ED (RWT) Jan 2015 - Nov 2017
% of 4 Hour Breaches recorded as 'Awaiting Beds' and 'ED delays' Jan 2015 - Jun 2018

- A&E delays and 1st assessments
- Awaiting bed & no bed available
GP referrals diverted through ED when new unit opened
Average Number of Medical Outliers per day by month Jan 2015 - August 2018

- 24 beds closed (Ward 3)
- 2 beds closed (Ward 87)

Average Number of Outliers
Staff Feedback

How do the following compare in the New ED against the Old ED?

Answered: 19  Skipped: 5

- Safety: Better
- Efficiency: Worse
- Training: Same
- Patient Satisfaction: Better
- Staff Satisfaction: Much Better
Health warning!

- Beware effects on coding
  - Mortality statistics
  - Income
Summary

• Having ED and Acute Physicians working together in the emergency department (with services aligned around the model);

1. Reduces medical admissions (demand)
2. Leads to early senior review and management planning
3. Has been associated with improved flow of medical patients despite a reduction in the bed base
4. Is liked by all staff groups