Impact of an Acute Care at Home Service on Acute Services

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AC@HT: Strategic Drivers

Fastest growing over 65 population in NI. From 2015 to 2025 the over 65 years population is set to grow by 30%.

Increasing pressure in ED and Acute care

Increase in people living with LTCs. The SHSCT have specialist COPD, Heart Failure, Diabetes, Stroke services in place.

<table>
<thead>
<tr>
<th>Year</th>
<th>65+ Population</th>
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<tr>
<td>2015</td>
<td>52,871</td>
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<tr>
<td>2025</td>
<td>68,884</td>
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SHSCT - 65+ Population Projections

THE RIGHT TIME, THE RIGHT WAY

An expert examination of the specialist social care governance arrangements and quality of care provision in Northern Ireland

Expert Panel

SYSTEMS, NOT STARS
CHANGING HEALTH & SOCIAL CARE

HEALTH AND WELLBEING 2026
DELIVERING TOGETHER
Southern Trust Approach

- Develop a Consultant led community service to deliver acute, non-critical care in community setting. Operational from 22/09/14.
- Phased implementation
- Available to older patients in their own home or Nursing or Residential Home
- Response target of 2 hours from referral to assessment (meeting this target in 95% of referrals)
- Comprehensive Geriatric Assessment based on Silver Book guidelines involving input from full Multidisciplinary team
- Rapid Access to Diagnostics (MRI, CT scan, Ultrasound, X ray) and Laboratories, same timeframe as patient in an inpatient ward
- Only involved for Acute Care phase
- Average LOS 5days
Critical Factors to Success

- Robust research of available evidence
- Site visits to other established hospital at home model
- Securing senior clinical/management leadership
- Stakeholder engagement – Co-production
- Existing community infrastructure – specialist teams, Day Hospital and Rapid Access Clinics
- Comprehensive communication strategy developed outlining key communication with primary and secondary care, service users and carers and the third sector.
- Detailed implementation plan prior to “go live”
- Appointment of project manager
- Team development - Ethos ‘Can Do’
Innovations in Care

- **Collaborative working**
  - Integrated approach
  - Open honest discussion re: care
  - Extending/Enhancing AHP and Nursing roles
  - Open to challenge

- **Shared Vision and Goals**
  - Team all share vision of high quality, effective care
  - Everyone working towards shared goals

- **Team Members**
  - Vigorous recruitment process to identify the right staff
  - Professionals with experience of community and acute care
  - Enthusiastic, ‘can do’ attitude

- **Communication Strategy**
  - Comprehensive communication strategy linking with primary care and statutory, community, and voluntary sectors
### Criteria

**Inclusion**
- Over 65 years (Under 65 considered on individual basis if hospital admission would be detrimental)
- Live in the Southern Trust
- Patients must have been assessed as requiring acute care i.e. deemed to be at the point of hospital admission.
- Can be managed safely in a community setting

**Exclusion**
- Requires resuscitation
- Chest Pain
- Acute Surgical or Orthopaedic Crisis
- Stroke
- Haemostasis / GI Bleeding
- Mental Health – picked up through Home Treatment Crisis response
The Acute Care at Home Team

- Consultant Geriatricians
- Specialty Doctors + GPSI
- Support Staff
- Healthcare Assistants
- Clerical
- Rapid Access to Community Psychiatric Nurse
- Specialist Nurses
- Staff Nurses
- Physiotherapists
- Pharmacists
- Speech and Language Therapist
- Occupational Therapists
- As and When Band 5
  Bank IV Nurses
- Staff Nurses
- Special Care
- Social Care Trust
Clear lines of Communication

- Telephone referral process
- Daily MDT Meeting using live/real time information
- Electronic Documentation and mobile solutions

All staff has access to laptops and tablets to enable the recording of assessments and case notes in the community setting

Electronic handover for smooth transition of care
## Impact on Acute Bed Days from Nursing Home patients in SHSCT Acute Hospitals

<table>
<thead>
<tr>
<th>Period</th>
<th>Total bed days per year</th>
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<tbody>
<tr>
<td>Baseline</td>
<td>10369 (baseline)</td>
</tr>
<tr>
<td>Year 1 following implementation (36 care homes covered)</td>
<td>9158</td>
</tr>
<tr>
<td>Year 2 following implementation (36 care homes included)</td>
<td>7705</td>
</tr>
</tbody>
</table>

*Reduction of 1211 bed days from baseline*  
*Reduction of 2664 bed days from baseline*
ICD10 Audit

- 250 Acute Care at Home patients coded by clinical coding team.
- Codes compared with in patients in local acute hospital.
- Patients on AC@H caseload comparable with those in Acute Hospital.
- Average length of stay for patients on AC@H 5.7 days, those with same codes in Acute Hospital 6.8 days.

Potential saved acute bed days for domiciliary patients based on figures for Year 1 (1st October 2014 to 30th September 2016) –
161 patients cared for at home x 6.8 days = 1095 acute bed days

Year 2 –
416 patients cared for at home x 6.8 days = 2828 acute bed days
Estimated Impact on Acute Hospital – Year 2
(1st October 2015 to 30th September 2016)

- Total reduction in bed days for NH patients = 2664 days
- Estimated reduction in bed days for domiciliary patients = 2828 days

- **Total acute bed days saved = 5492 days**
- Equivalent to 15 bedded ward in Acute Hospital

- Cost of 15 beds in Acute Hospital = £3,405,040 (Most recent cost of acute hospital bed day costed at £620 per day.)

- Total cost of AC@H service £1,295,752 (this includes total cost of staff, goods and services, travel, transport, equipment etc.)

- **64% reduction in cost by providing care in the community setting**
Health and Social Care Audit

The Health and Social Care Board completed an audit of the AC@H service in June 2016.

Audit Findings

- The AC@H service is managing patients with acute complex needs in the community comparable to patients in the acute setting.
- Rapid response time, including interventions and delivery of equipment
- It was evident care was patient and family centred
- No patient required any Out of Hours interventions during the period of the audit
- Antibiotics were administered for shorter durations than acute hospitals
- Vast majority of patients didn’t require any additional support on discharge
- Improved shared care/confidence with nursing homes
## Discharge Outcomes

<table>
<thead>
<tr>
<th>Discharge outcomes from 1st July 2016 to 31st January 2017</th>
<th>Number of Patients</th>
<th>% of total number discharged</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Number of discharges</td>
<td>547</td>
<td>100%</td>
</tr>
<tr>
<td><strong>No change to existing care requirements</strong></td>
<td>425</td>
<td>79%</td>
</tr>
<tr>
<td>New or Increase to existing package of care</td>
<td>23</td>
<td>4%</td>
</tr>
<tr>
<td>Required new placement to NH/RH</td>
<td>5</td>
<td>1%</td>
</tr>
<tr>
<td>Required admission to hospital</td>
<td>74</td>
<td>13%</td>
</tr>
<tr>
<td>Deceased – supporting</td>
<td>19</td>
<td>3%</td>
</tr>
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Service User Feedback

“The Acute Care at Home service has been the best service development in years”
Carer’s Forum representative

“Very Rapid Response, within a matter of hours, we were very impressed and felt well supported”
Patient’s daughter

“To be treated in her own environment saved my sister’s mind from all the mental turmoil of being moved to hospital”
Patient’s Sister

“We found the staff always extremely helpful, they were very attentive to each of the patients the cared for in the Home”
Nursing Home Manager

“Excellent service, reassuring for GPs to be able to discuss cases with Consultants”
General Practitioner
Contact Details

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