

A Real Alternative to Emergency Admission

The Health and Re-enablement Team (HaRT)

THE TASK

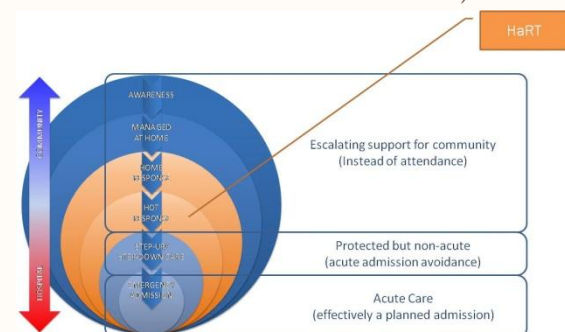
The PCT's plan targeted further reductions in the cost of emergency admissions. This was no mean feat because:

- the acute trust had in the last twelve months reduced its admission rate from 30% of A&E attendances to around 18% and
- analysis of demand showed five years of growth in A&E attendances, with a 6% increase in 'major' presentations.

The acute and primary care trusts determined to work together to find cost-effective alternatives to emergency hospital admissions.

ORGANISING WITH PURPOSE

Two Responsible Officers were appointed. They began by bringing together isolated initiatives to create a team with one objective.



Integrated Conceptual Model

This clinical team mapped the many of unscheduled care services into a simple conceptual model. It highlighted a no-man's land between traditional primary care and emergency secondary care.

To be sure that they were right, the team studied data from existing initiatives and commissioned two audits: (i) 1,000 sequential A&E attendances, and (ii) 380 sequential admissions.

The work exposed the fact that out of core hours, patients, primary care clinicians and care providers could not access a meaningful alternative to an admission via A&E.

Specifically at least 27 avoidable admissions occurred each week as a result of:

- i) inadequate GP support for care homes;
- ii) patients experiencing an exacerbation of a long standing condition; or
- iii) a change in personal circumstances rendering the home environment unsafe.

A CLINICIAN-LED SOLUTION

With support from Saigei two GPs who had been working in A&E took the lead. They brought together representatives of the out of hour's service, the ambulance service, intermediate care, therapy services, pharmacy, microbiology and Adult Social Care.

Together they agreed to adapt staffing models, systems and working practices to create a co-ordinated response for patients referred to A&E for admission.

Their aim was to provide these patients with a fast and integrated response that would allow them to be cared for at home appropriately and safely. They called this integrated response the Health & Re-enablement Service (HaRT).

HOT RESPONSE FIRST

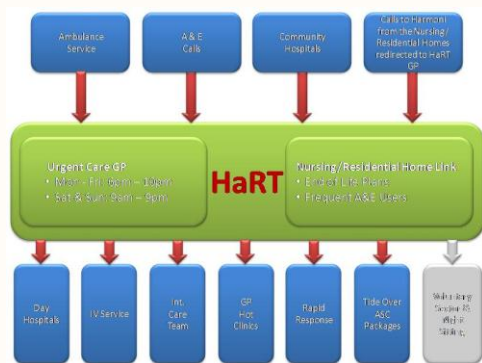
The HaRT function began by concentrating on a hot-response to patients being waved on to A&E for admission.

Based on the evidence from the two studies the team outlined criteria for recognising patients who could most likely be managed safely and appropriately at home:

- i) those from nursing or residential homes
- ii) elderly people over 85 years

- iii) recent discharges from hospital
- iv) high intensity users of urgent care services
- v) individuals with a fragile home situation
- vi) patients at the end of their life

Patients meeting these criteria are referred by the Ambulance Service, Out of Hours GPs, Care Home staff and A&E staff to the HaRT team which coordinates an integrated response, avoiding admission where appropriate.



- responding to Cat B, C and appropriate Cat A calls from the ambulance service;
- responding to direct calls from the public;
- advanced care planning for residents systematically in place at three care homes.

Going forward, the service is targeting sizable savings for the PCT:

Estimated Value of Hot Response (flexed by % of Opportunity & Value)		
20%	50%	100%
£727,094	£1,817,736	£3,635,472
£632,256	£1,580,640	£3,161,280
£537,418	£1,343,544	£2,687,088

THEN PLANNED ALTERNATIVES

As the hot-response service stabilised, the team turned its attention to those patients admitted via A&E at the end of their lives. The typical experience was neither peaceful nor dignified.

Together the team resolved to support local care homes, their residents and their relatives in preparing properly for the end of life. A rolling programme was initiated, starting with the higher referring homes.

Care home staff are now trained and supported in helping patients and relatives articulate Enhanced Care Plans that protect the patient's dignity. Then, when the moment comes, HaRT clinicians are there to support the home and the relatives in honouring the patient's wishes.

MEASURING OUTCOMES

HaRT was launched in December. By March it had achieved real outcomes for patients:

- 133 admissions prevented (average emergency HRG in patch: £1,466);

Estimated Value of Advance Care Planning (flexed by number and value)			
ACPs in place (Annual)	200 (-20%)	250	325 (+30%)
Estimated Cost	£4,883	£976,600	£1,220,750
	£4,151 (-15%)	£830,200	£1,037,750
		£1,220,750	£1,586,975
		£1,037,750	£1,349,075

FURTHER INFORMATION FROM

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