Acute Care pathways
combine quality and efficiency

G Ramsay

Historical situation

- 3 inefficient district general hospitals
- Massive accumulated debt
- Long waiting lists
- “weak” rating from health care commission

Now

- 1 elective care centre
- 1 acute hospital
- Outpatients and diagnostics on all 3 sites

- Historic debt cleared
- Meeting all access targets
- “good” rating from health care commission

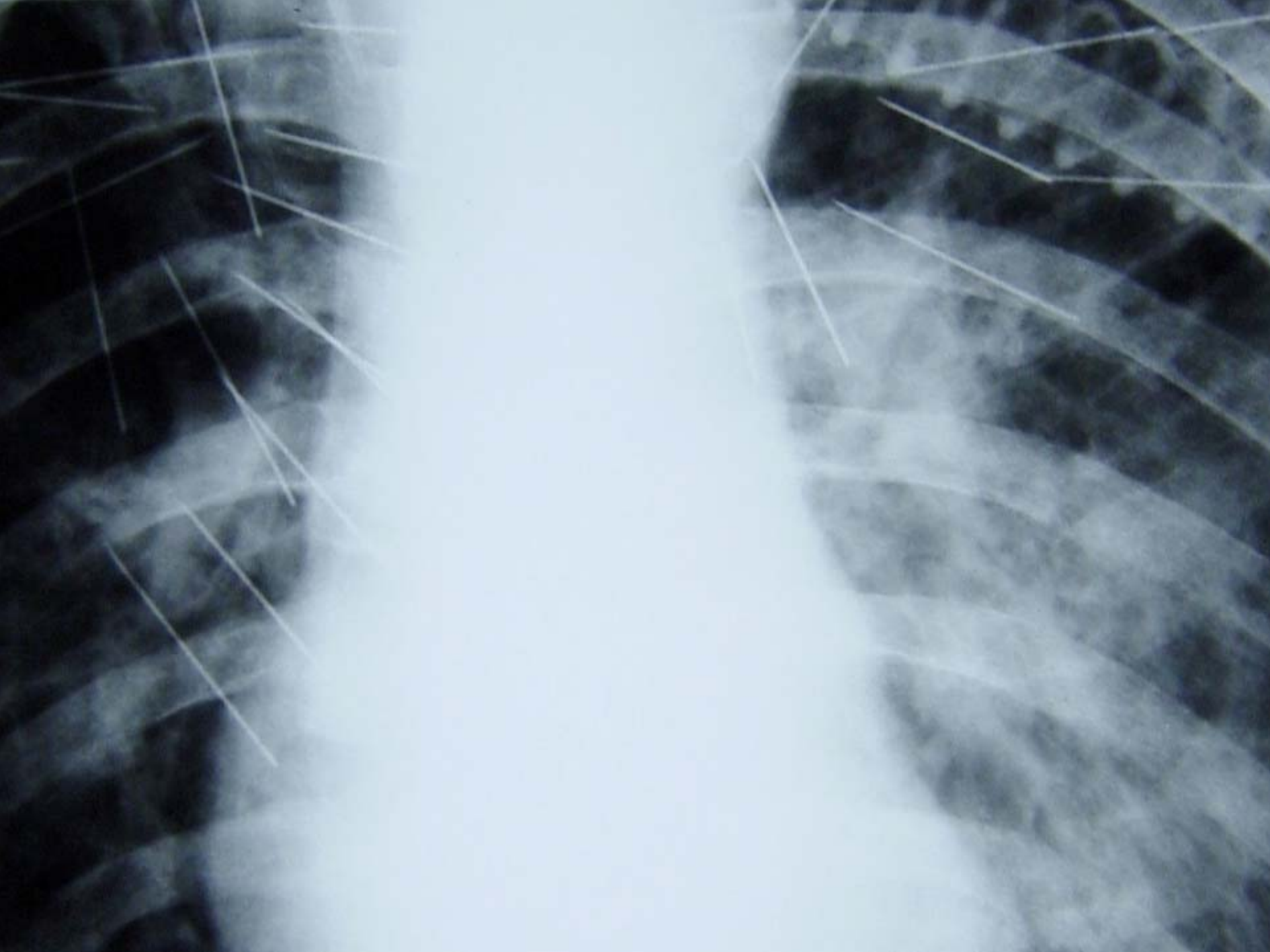
Market situation

Move to a free market

- Practice based commissioning
- Competition from private centres for elective care
- Extended national choice
- EWTD requirements
- Economic downturn

Problems we do not want

- Code Red (no beds)
- Acute admissions spread over several wards
- Acutely ill patients on poorly staffed wards at night
- Cancellation of elective patients
- Disruption of theatre planning
- Junior doctors treating acutely ill patients



- Three separate patient flows
  - outpatient and diagnostics
  - acute
  - elective

- Theory: separation of acute and elective can improve efficiency and quality of care.

Aims

- Efficient organisation of elective care
- Increased bed occupancy (close to 100%)
- Well organised acute care

Requirements

- Establish an Elective Care Centre
- Realise an AAU with diagnostics
- Separate predictable and less predictable care within elective patient group
- Outpatient department with central appointment desks

Elective Care Centre
SACH

- Focussed factory approach
- 3 session days
- Fewer cancellations
- Reduced risk of healthcare infection

Elective Care Centre

- 80% of elective care is predictable and can be planned
- Relatively small bed base required

Acute admissions without disruption of elective care

Acute Admissions Unit

- Modular building with 3 floors
  - 120 beds on 1st and 3rd floors
  - Diagnostic floor including CT scan and 2 cath. Labs
- Adjacent to A&E
- All acute admissions use unit
  - Exceptions
- Completes the acute/elective split

Acute Admissions Unit

- Move to consultant based service
- Development of acute physician role
- Merging of A&E and acute medicine teams
- 24 hour access to diagnostics
  - On-line reporting
- Transfer and discharge before 8pm
- Assessment on A&E
- Admission to AAU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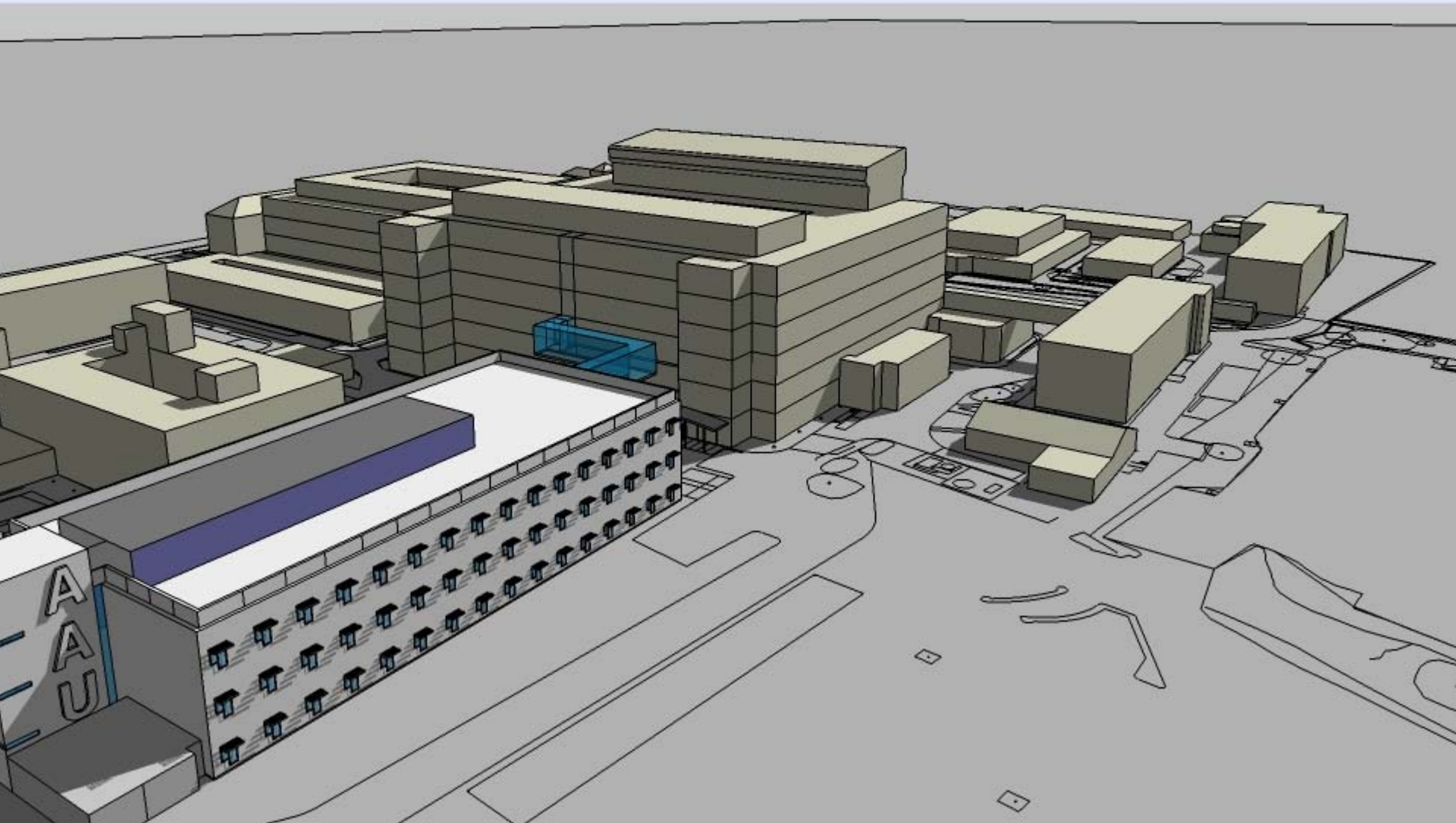
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Patient with dyspnoea

- Cardiology or respiratory?
- Admission required
- Direct to AAU under acute physician
- Diagnostics on AAU
- Consultation easy to organise
- No waiting time on A&E
- Transfer to appropriate specialty ward

Previous experience with an AAU Netherlands

- 66 AAU beds opened
- 145 ward beds closed
- 48% of patients discharged from AAU to home within 48 hours
- LOS acute patients reduced by 1.5 days (40%)
- Reduction of 55 wte (wards and A&E)
  - Investment 4.6m euro
  - Saving 3.25m euro per year
- Increased efficiency for elective cases

What Internal Medicine has agreed

- Consultant working pattern – shifts
- Relationship between A&E and AAU- integration
- Operational policy for Level 1 & level 3
- Speciality and ward-based system
- Cardiology and GI on-call

Consultant Working Patterns

- Integrate acute physicians and other physicians for on-call. Likely 22 in total
- Shift pattern with on-call at night
- 2 shifts 08.00 -18.00, 13.00 – 21.00
- On-call at night provided by person on late shift

Consultant working Pattern

- PTWR of pts admitted 21.00 – 08.00 by physician on-call the following day.
- When doing a shift, consultant spends the whole time in AAU
- Alternating shifts done at weekend.

  Therefore 1:11 weekends + 1:22 weekday nights

Consultant Duties

- Directs and supervises junior doctors
- Sees all patients within 30 minutes of admission
- Early decision making with patient “disposal” decided
  - Home
  - Level 1 (<24hrs)
  - Level 3 (<48hrs)
  - Speciality Ward

Surgery in the AAU

Clinical Input

Surgeon of the Week

Orthopaedic senior resident free for Trauma

Diagnostics

- ‘Hot’ Radiologist
- Extended Working Day
- Immediate access to plain XR, US and CT (AAU)

General wards

- Nursing numbers and skill mix
- Hospital at night
- Flexible bed allocation with buffer beds
- 24 hour warning of transfers

Bed requirements

Bed requirements

- LOS medical acute admissions
  - January/February 8.6 days
  - March- 5.3 days

- 65 patients per day @ 8 days 520 beds
- 65 patients per day @ 7 days 455 beds
- 65 patients per day @ 6 days 390 beds
- 65 patients per day @ 5 days 325 beds

Early results

- Emergency patient flow up 5%
  - and income circa £5 million pa
- Beds reduced by 80
- LOS reduced by 40% for emergency admissions
- Staff reduced by 200 netto
  - reduced cost of £7 million pa
- EWTD compliant without investment
  - avoided cost of £4.5 million
- Reduced capital charges on closed buildings
  - revenue saving of £5 million pa
- Ability to sell land released on partially closed site
  - capital release of circa £23 million

Service changes

- 24 hour rotas
  - Cardiology
  - Gastroenterology bleeding service
  - Vascular surgery
- Consultant presence in AAU
  - Surgery
  - Medicine
  - Specialty rounds twice daily

Summary

- Revenue benefit £19.5 million recurrent
- Capital benefit circa £23 million one-off
- **Patient benefit**
  - Seen by consultant early
  - Treated in new and clean environment
  - Increased patient satisfaction
  - Reduced LOS
  - Better and broader specialty services available 24/7
  - *Complication rate?*
  - *Mortality?*

Thankyou