

# Effectively Planning to Keep People out of Hospital

**“..Behold the Throne of Chaos and with him  
Sable-vested Night The consort of his Reign..”**

Milton, Paradise Lost

**Adrian Baker**

**Paul Leak**

**Simon Steer**

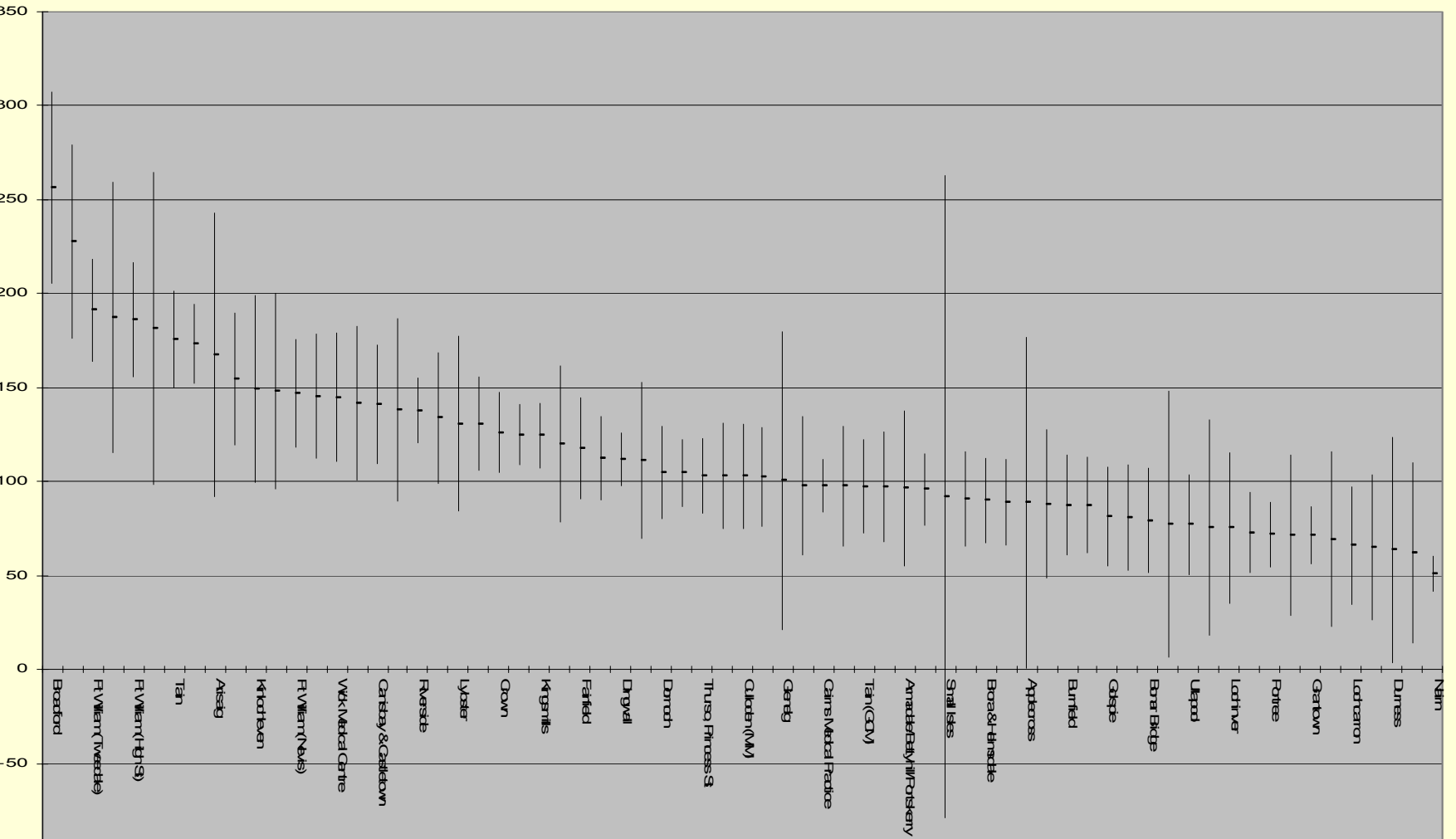
# Use of resources & Clinical variation. 500%(!)

- Lowest EEA (>65)
- Save 1,787 admissions
- 28,141 bed days saved
- £7.335 M Saved

- Highest EEA (>65)
- An extra 3,542 Admissions
- 59,264 extra bed days
- £16, 017 M extra costs

# Practice Variation 2003 - 2005

## EEA Gen Med per 1000



# MINORITY REPORT

Prediction prior to admission

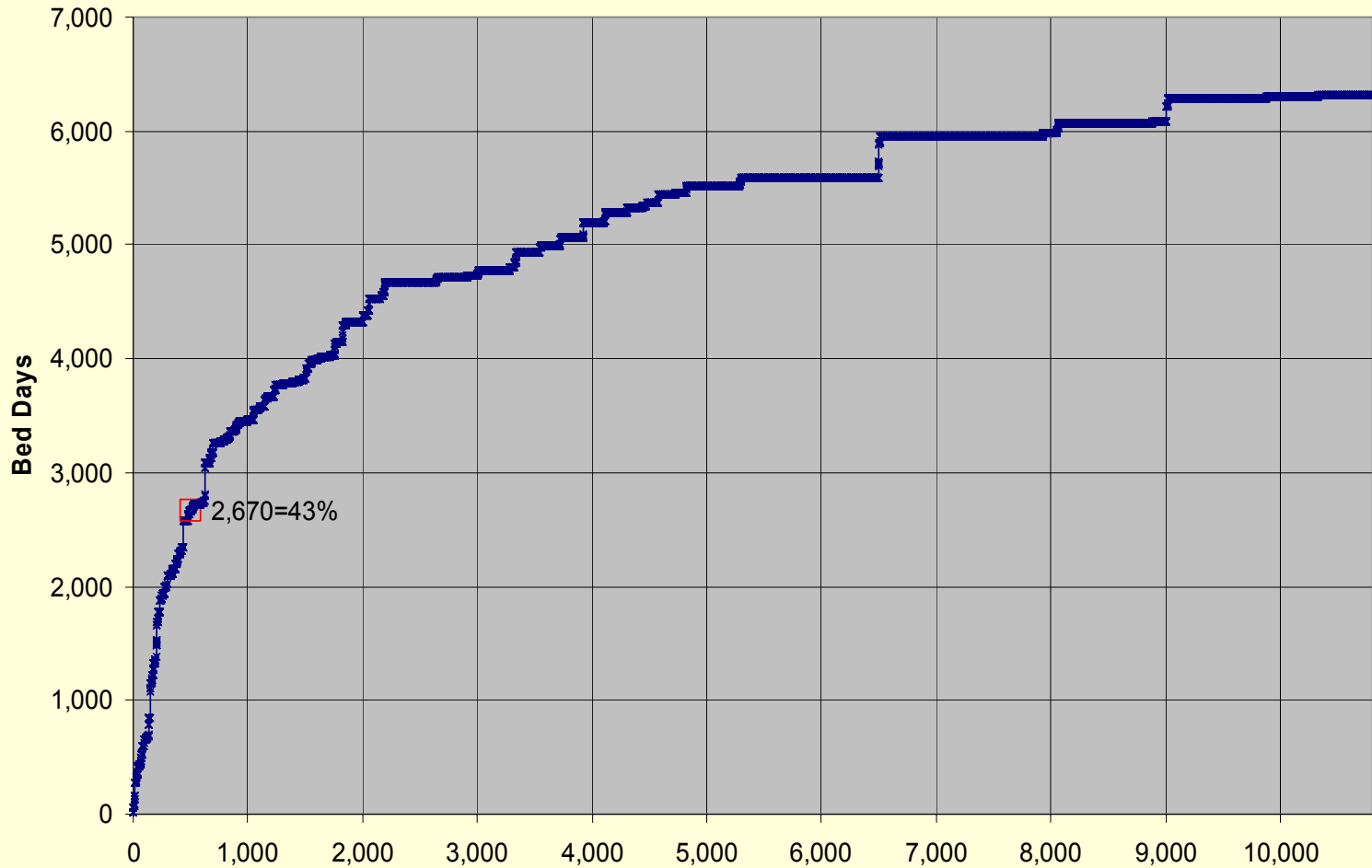


# ANTICIPATING

Casefinding – Who, What, Where?



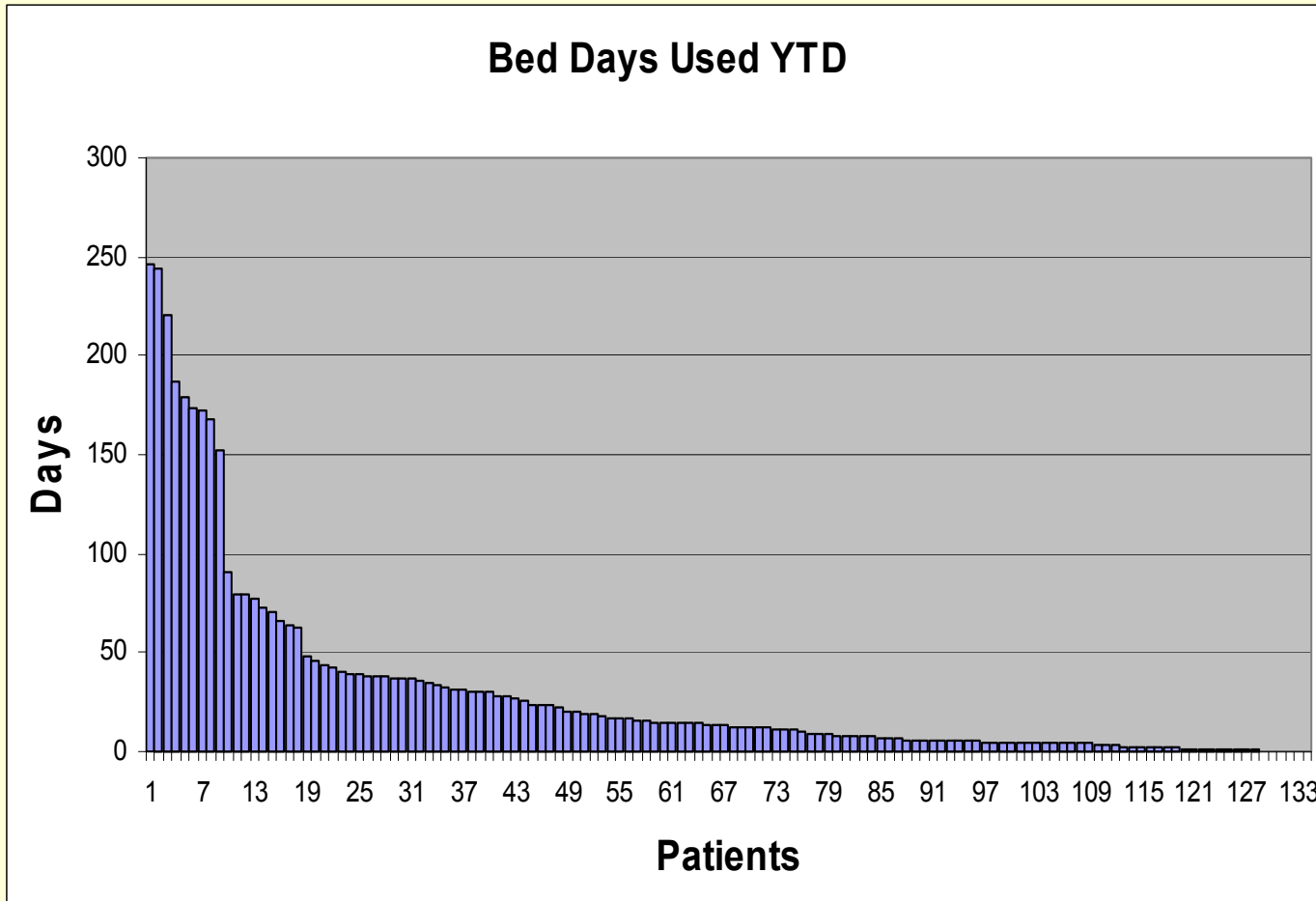
# The Nairn Case Finder



# April 06 – Dec 06

## Bed Days Used by Top 5%

134 Patients Admitted



# Risk Scoring How it works in reality



# The Anticipatory Care Plan (ACP)

- Carer or Cared for status, what happens ?
- Acute medical problem
- Acute surgical problem
- Discussion of condition by professional
- Preferred Place of Care
- Resuscitation status

# Case Manager & Care Assistants

- Overview
  - eSSA & ACP
  - Complete EQ-5D
  - Who, where, how, what, why, when
- Coordinating and reviewing role
- Income maximisation

- With the patients
- Hands on care
- Coached & educated by
  - Nurses, CMHT, Physio, OT, Dietetics, SALT, GP's, **social services**
- nutrition problems, falls, early warning, enhancing safety

# The Nairn Anticipatory Care Pilot. (Winter 2006.)

## Inputs

- Non Recurrent Investment= £125k
- To pay for:
  - 1.2 WTE Case Manager(Nurse/OT/SW);
  - 1 WTE Junior Physio;
  - 0.75 WTE Senior OT;
  - 2 WTE Care Assistants;

# Measures

## Outcomes

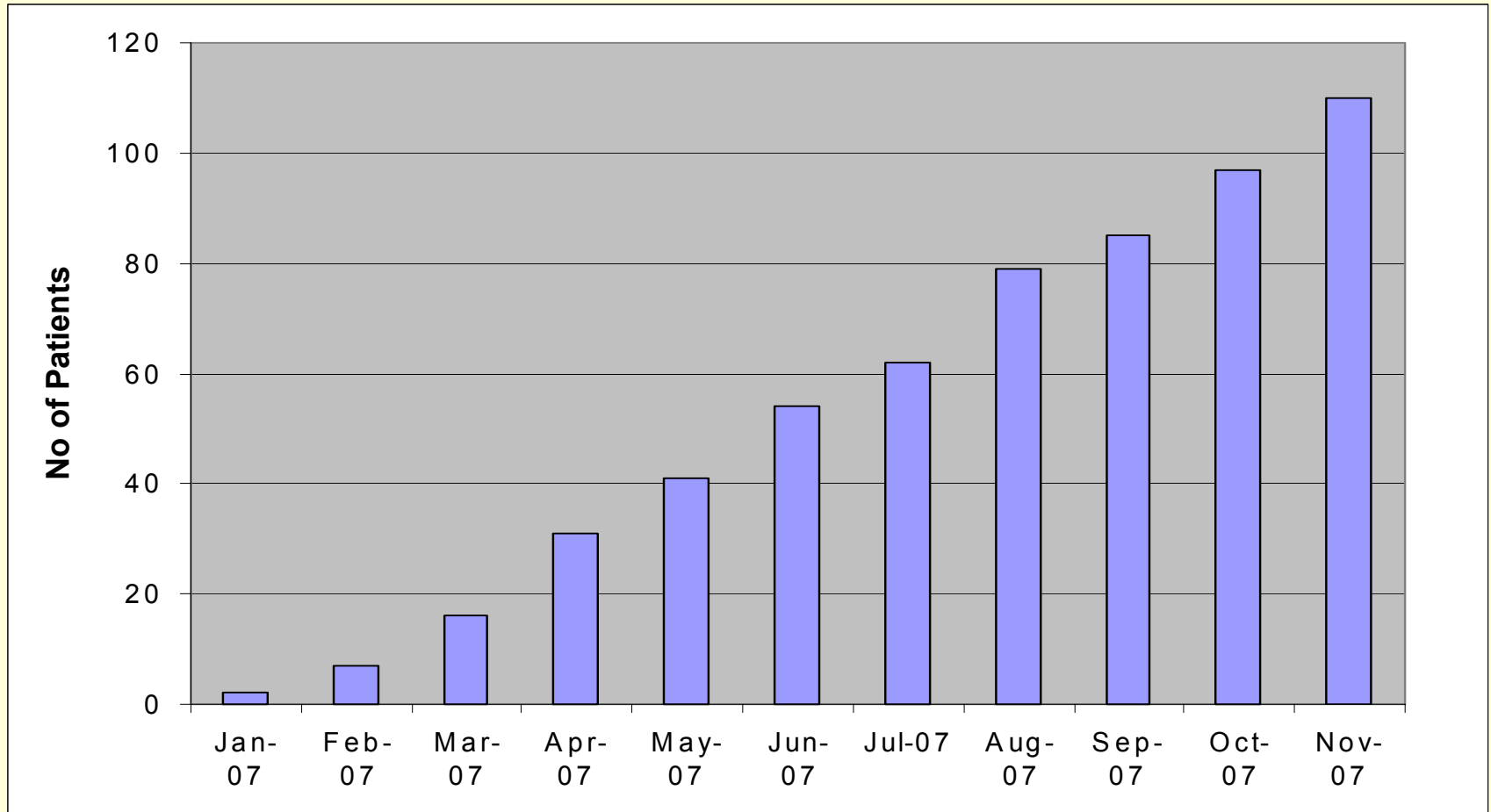
1. Health Status: EQ-5D
2. ACP was it followed?
3. Preferred Place of Care. Did we deliver?
4. Qualitative: Interviews

## Outputs

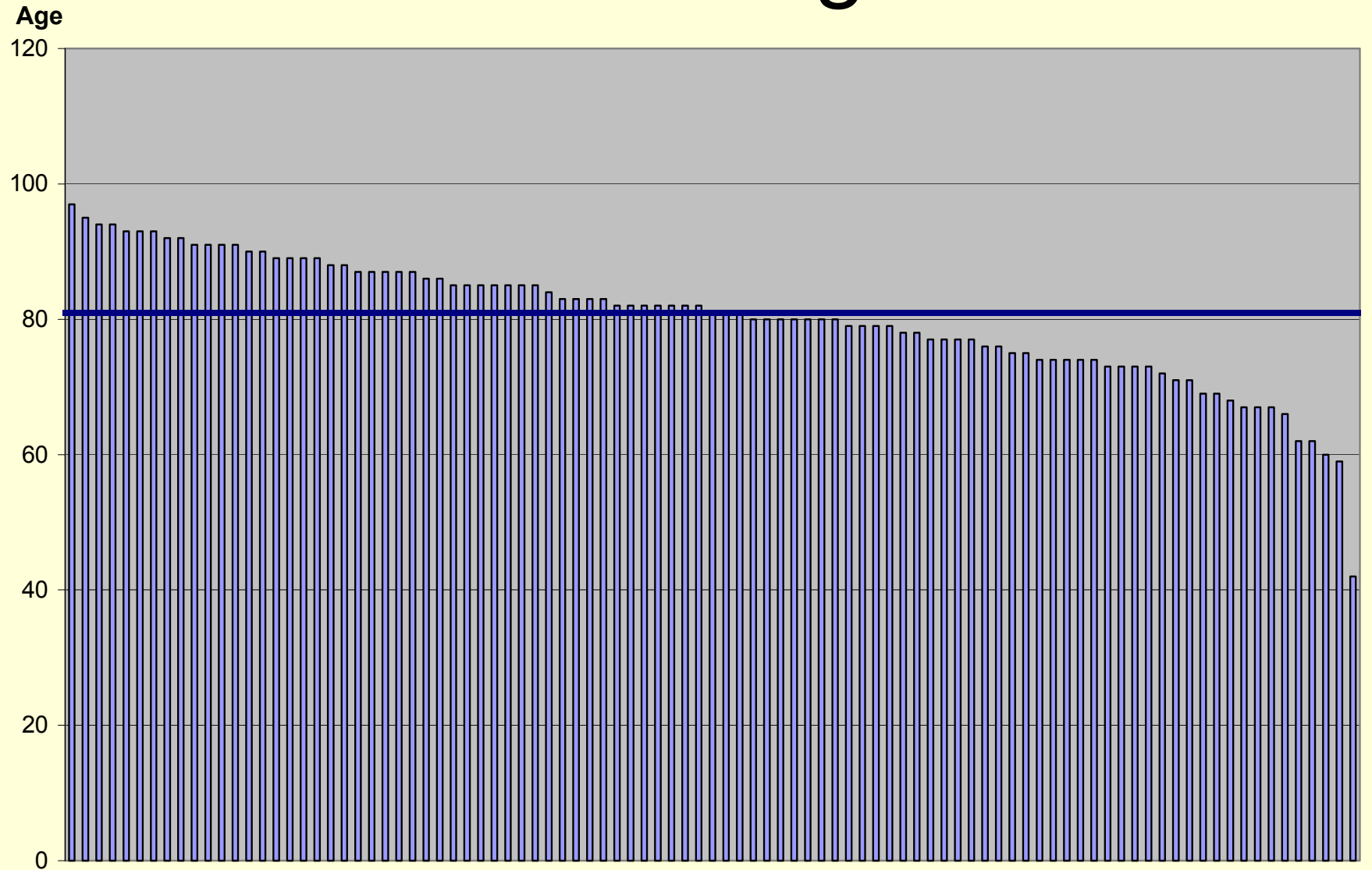
1. Bed Day rate
2. Admitted rate
3. Admission rate
4. Re admission rate
5. Delayed Discharges

# ACP Cohort

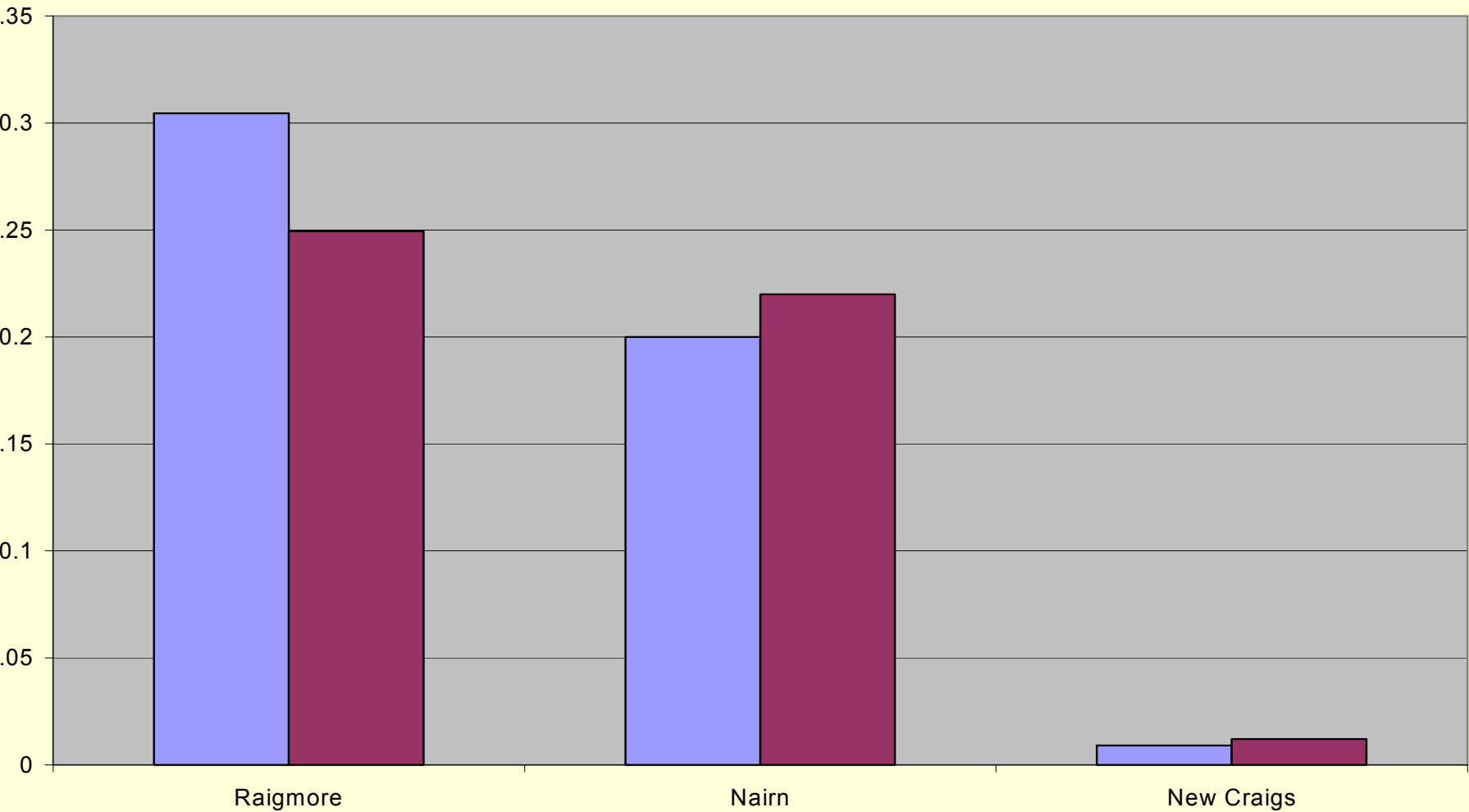
## Care homes 1<sup>st</sup> then Casefinding



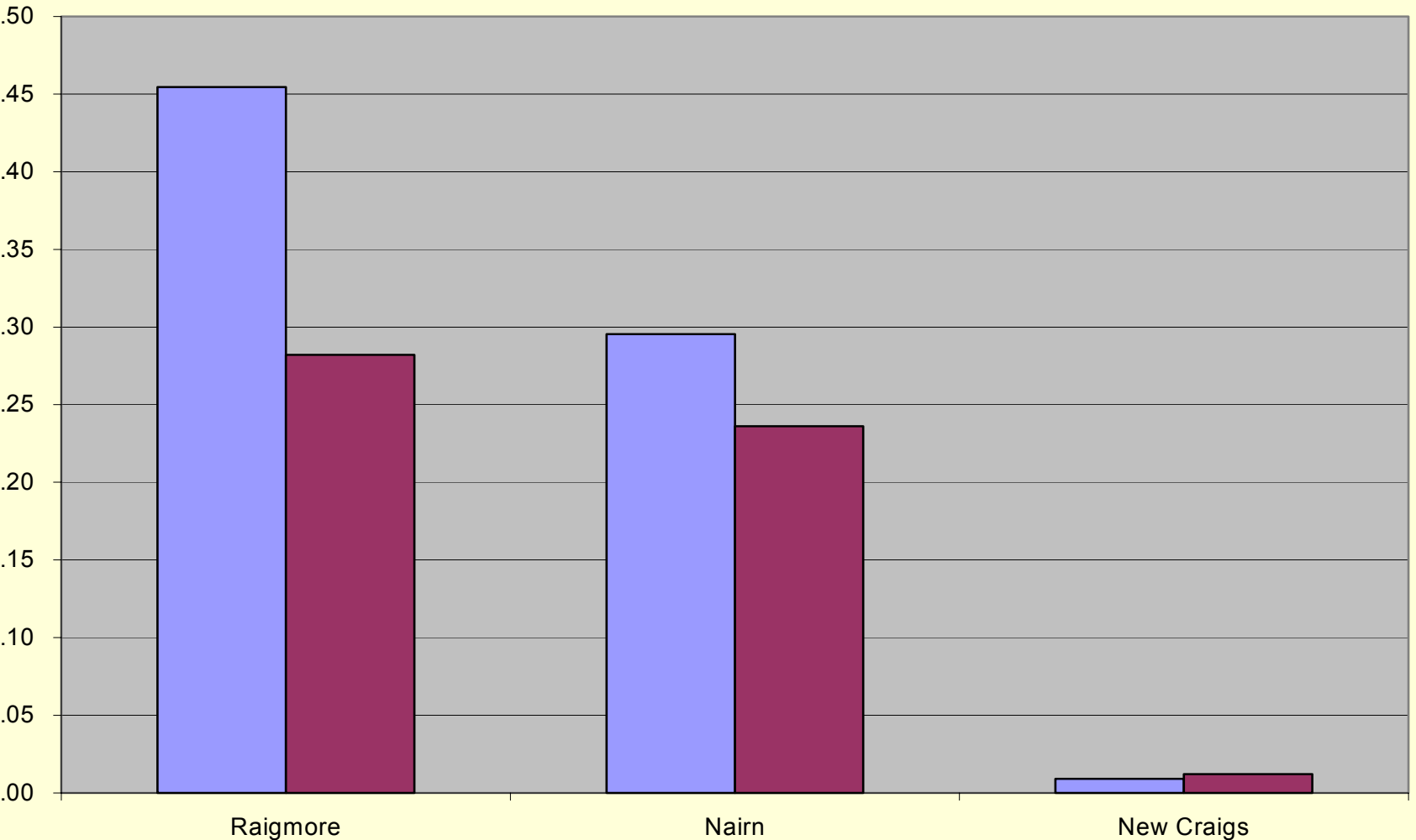
# ACP Cohort: Age Profile



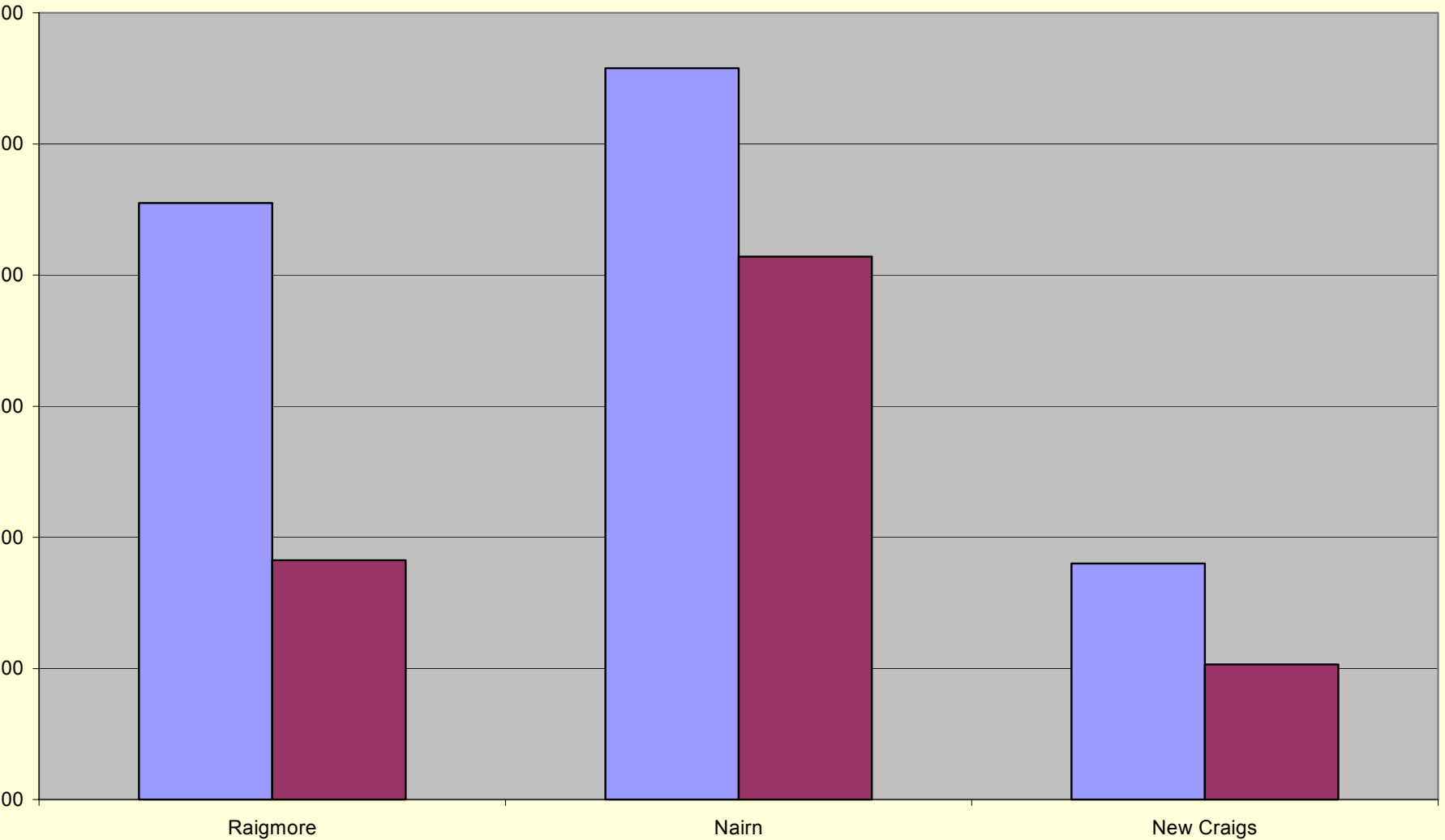
# Interim Results: Change in Patients Admitted



# Interim Results: Change in Admission Rate



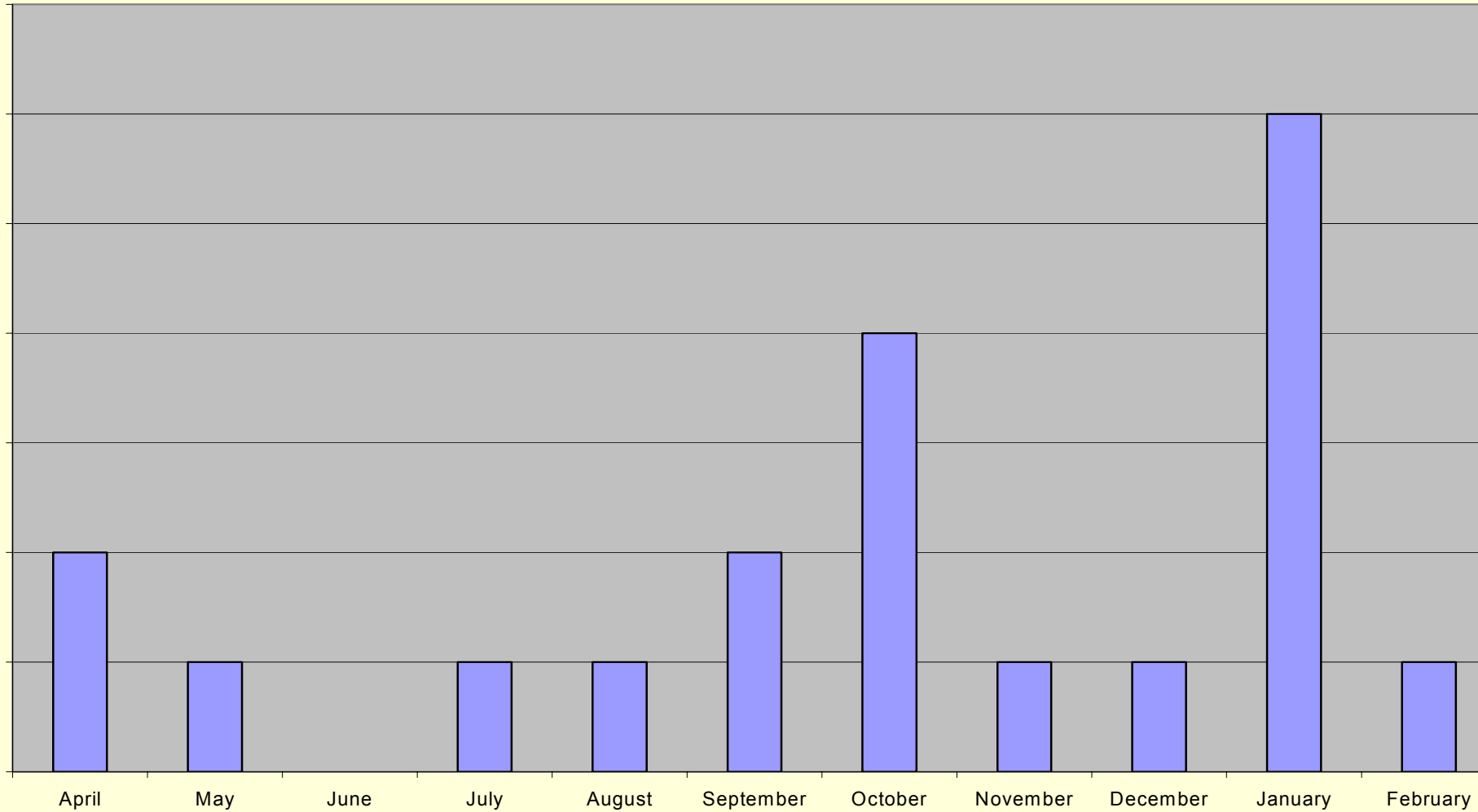
# Interim Results: Change in Bed Day Rates



eSSA



# Partnership, cyclical co-operation?



3 March 2008 05:02 1349 [NAIRNADMS.csv](#)  
 3 March 2008 05:02 2121 [NAIRNDISC.csv](#)  
 3 March 2008 05:02 5020 [NAIRNINPS.csv](#)

	CHI Number	Risk Score	Name	Address	Postcode	Adm Specialt	Adm Consultan	Adm Date	Bed Days 12m	Bed days	GP Name
R	'290825902	33.87%				GP	DR A BAKER	07-Mar-08	6		90 DR A C STANFIE
G	'210542904	27.87%				MED	DR S K BAL	07-Mar-08	6		130 DR A ADAM
G	'170123911	18.81%				SURG	MR D IRVING	08-Mar-08	1		1 Dr Sue Fowie
G	'120631907	38.72%				MED	DR G HULKS	08-Mar-08	5		5 DR C Z MACAUL
R	'300135909	17.48%				GP	DR A BAKER	10-Mar-08	3		41 DR C Z MACAUL
R	'150623909	18.45%				GP	DR A BAKER	11-Mar-08	2		2 DR A C STANFIE
G	'240852908	26.72%				MED	DR SR THOMAS	11-Mar-08	2		7 Dr Comelia Feath
G	'300135909	17.48%				MED	DR SR THOMAS	11-Mar-08	2		41 DR C Z MACAUL
G	'060111902	14.67%				MED	DR GF FRANKL	12-Mar-08	1		29 DR C Z MACAUL

# Evolution - 2008

- Casefinding – ongoing work as the cohort changes. Green cross alerts, Legal issues..
- Prevention of admission, rapid OT & input
- Rapid discharge, adaptations, OT, Physio
- Step up, step down home care
- GP & Community nursing referrals

# 80 Yr Old Non-Smoking Unmarried Female with a Stroke Living In a Care Home

## Before

## After

2005/06 & 2006/07:

- 13 Admissions in Raigmore
- 24 Bed Days in Raigmore

10 Months 2007/08:

- 4 Admissions in Raigmore
- 3 Bed Days in Raigmore

# 78 Yr Old Married Male Smoker with Hypertension, CHD, Diabetes, Heart Failure & Stroke Living at Home

## Before

2005/06 & 2006/07:

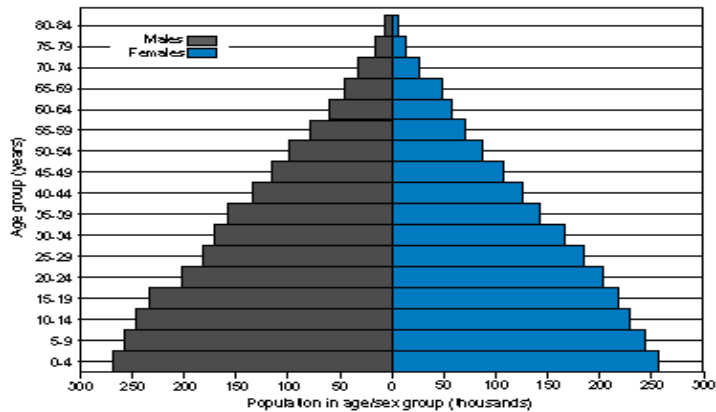
- 3 Admissions in Raigmore
- 44 Bed Days in Raigmore
- 1 Admission & 1 Transfer to Nairn
- 39 Bed Days in Nairn

## After

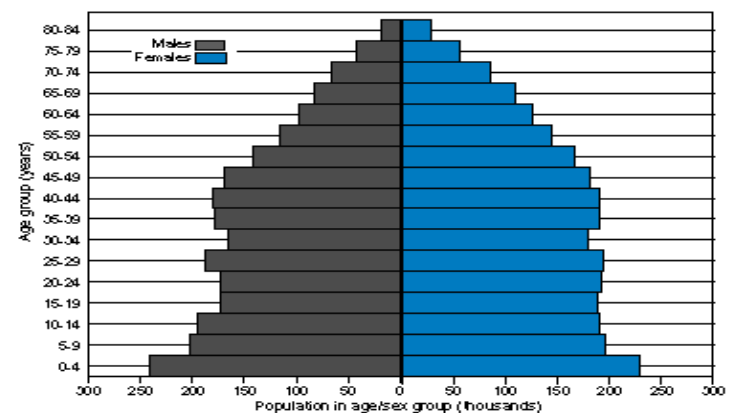
6 Months 2007/08:

- 1 Admission to Raigmore
- 1 Bed Day in Raigmore

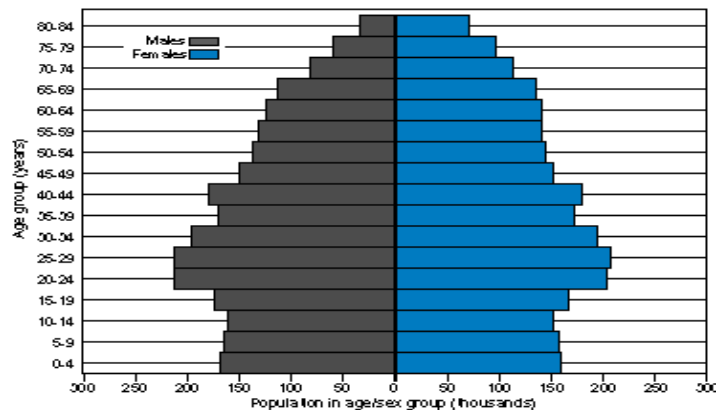
# Pyramid to Oil Tanker



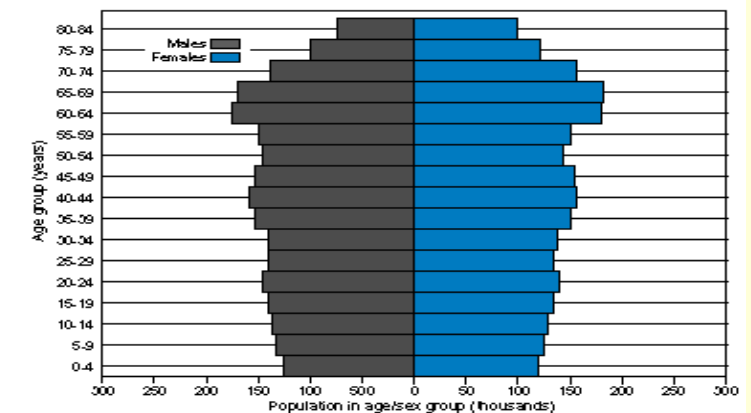
1911



1951



1991



Projection to 2031

# Focus on this

3am, 80 years old, sore leg

Can I ?.....Do I need to ?

- Assess and keep at home with appropriate input?
- Admit to Community Hospital?
- Admit to a Consultant bed?

**What does the patient want?**

# To Prevent This

