Reducing Non-Elective Hospital Admissions in Patients with Complex Needs

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BACKGROUND

Too many people are being admitted to hospital who could have been managed in the community with timely and proactive access to the right support and care. These patients are typically older, often frail with pre-existing conditions putting them at higher risk of hospitalisation.

Frequent admissions can have a negative impact on health and wellbeing, reducing independence and confidence in managing their own health and care needs. Once out of hospital, their care is often fragmented as they navigate between different services leading to poor experience and disjointed care.

AIM

To reduce non-elective hospital admissions for patients with complex health and social care needs in the Gosport area.

MEASURES

PROCESS MEASURES
- No. of patients supported

OUTCOME MEASURES
Primary:
- Number of non-elective Hospital Admissions

Secondary:
- Emergency department (ED) attendances
- 999 calls
- 111 calls/Minor Injury Unit (MIU) attendances
- Primary Care Contacts

BALANCE MEASURES
- Cost of service

PATIENT OUTCOME MEASURES
- Qualitative Patient Stories

ACTIONS

COMPLEX CARE TEAM
- Care Planners (x2)
- Health Connectors (x3)
- Admin support (x 1)

HEALTH AND WELLBEING PLAN
- Containing patient centred goals

DIRECTORY OF SERVICES
- Online resource for patients and professionals, detailing local community and support groups.

RESULTS

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Over the first 4 months of the pilot project, 113 patients have been taken on to the caseload. They have been under the care of the team for an average of 9.6 weeks.

Evaluation of the project has shown a statistically significant reduction in hospital admissions, ED/MIU attendances and 111 calls.

LEARNING

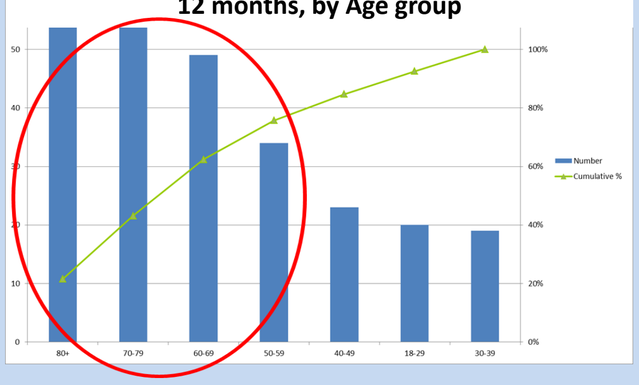
Flexibility
In setting up this pilot, we originally planned to focus our efforts on frail patients. Our analysis found that a large proportion of the patients with multiple admissions were not necessarily frail but were suffering from other long-term conditions. We therefore had to modify our target group and approach.

Start small, scale up
Starting small has allowed us to assess the effectiveness of our concept before committing more resources

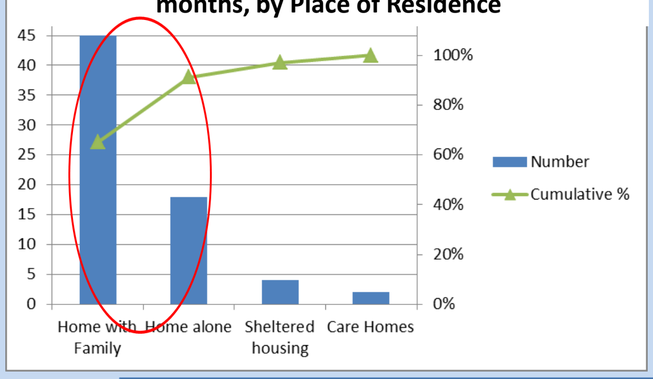
IDENTIFYING THE PROBLEM

The Willow Group is a GP practice in Gosport, run by Southern Health NHS Trust, with a patient population of 40,000. The practice was used as a pilot site for Southern Health and Fareham and Gosport CCG to implement a project looking at reducing the numbers of non-elective hospital admissions in their patients. We began by looking at the patients with the highest numbers of hospital admissions and then analysed their characteristics. The findings are summarised in the pareto charts below.

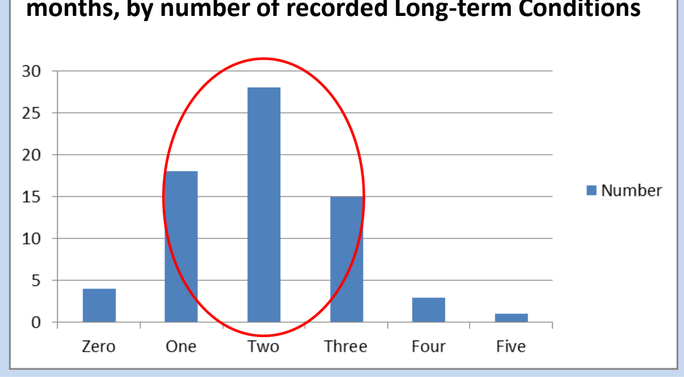
Number of patients with ≥ 4 hospital admissions in 12 months, by Age group



Number of patients with ≥ 4 hospital admissions in 12 months, by Place of Residence



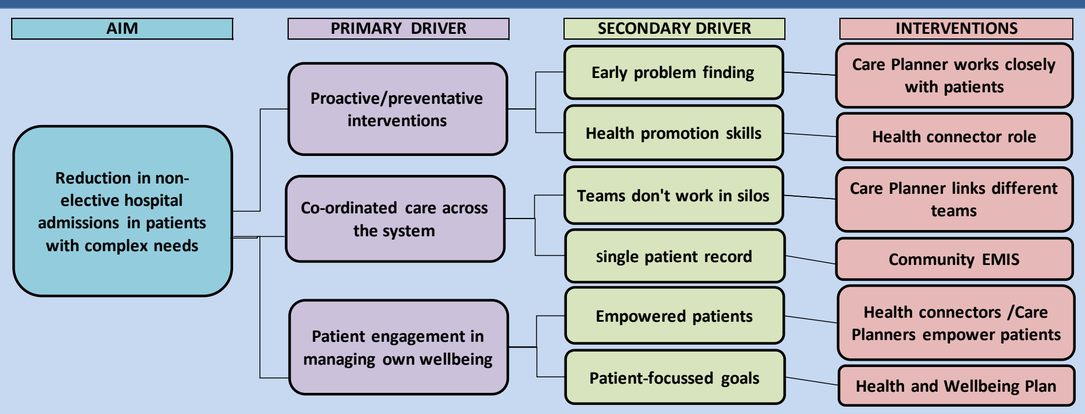
Number of patients with ≥ 4 hospital admissions in 12 months, by number of recorded Long-term Conditions



From our analysis of all patients with ≥ 4 hospital admissions in the past year, it was decided to focus our efforts on those patients meeting the following criteria:

- **Age ≥ 50**
- **≥ 1 long-term health condition**
- **≥ 3 Non-elective hospital admissions in the past 12 months**
- **Not living in a care/residential home**

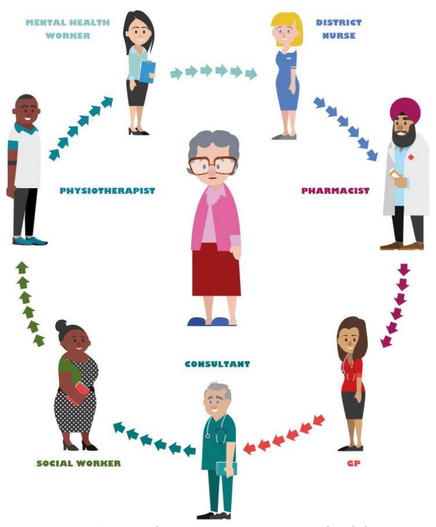
FINDING SOLUTIONS



ACTIONS

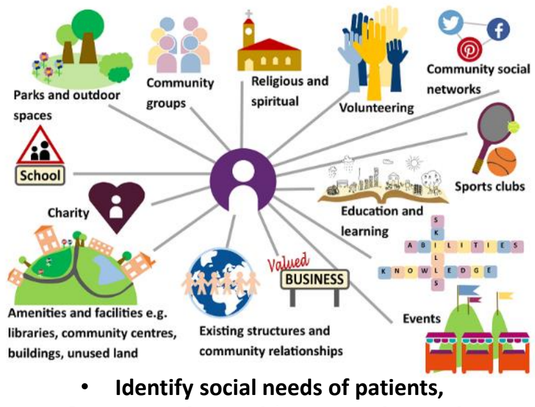
Complex Care Team

Care Planners



- **Identify clinical needs of patients**
- **Co-ordinate care provided by teams already involved**

Health Connectors



- **Identify social needs of patients,**
- **Connect patients with community services**
- **Empower patients to manage own wellbeing.**
- **Produce 'Health and Wellbeing Plan', including patient centred outcomes**

Case Study – Mrs B, 58y old

Background of alcohol dependence, anxiety, depression, social isolation, breathlessness, poor mobility

Mrs B feels trapped in a negative cycle of decline with her anxiety, mobility issues and breathlessness causing her to stay indoors, feeling socially isolated and driving her smoking and alcohol use. She frequently calls 999/111.

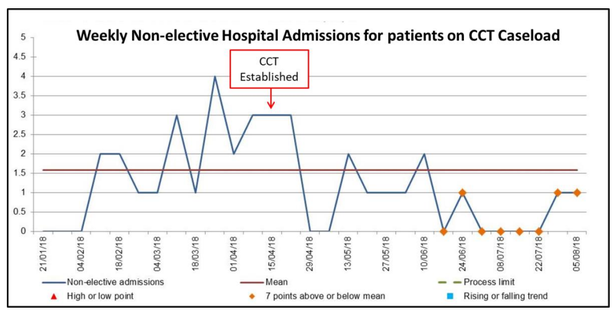
Benefits of the Complex Care Team's involvement:
- Single point of contact for Mrs B, liaising with all the teams involved in her care. Good rapport and patient trust built up.
- Able to spend time with the patient, developing long-term preventative strategies, rather than taking a reactive approach
- Patient empowered to identify and achieve her own goals – e.g. being able to leave the house to achieve daily tasks

RESULTS

The Complex Care Team (CCT) went live in April 2018 and an interim evaluation has just been carried out (August 2018).

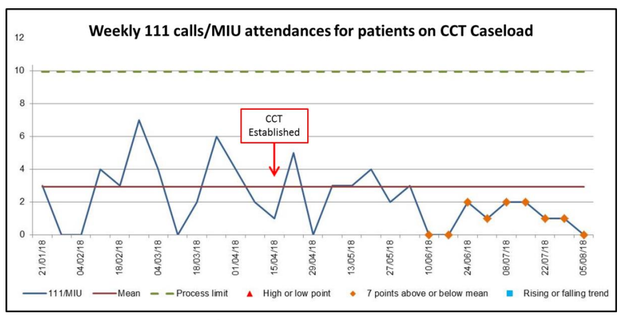
- These Statistical Process Control charts show the effect of the CCTs interventions on different measures for our first cohort of 35 patients. Baseline data was collected for 12 weeks prior to the CCT going live.
- There has been a statistically significant reduction in the number of non-elective admissions, ED attendances, and 111 calls/MIU attendances.
- Numbers of Primary Care contacts have shown a slight (non-statistically significant) increase. This is likely due to patients becoming more aware of the correct channels for seeking help and the identification of previously unmet health needs.
- It remains to be seen what the long-term impact on health service usage will be once patients have been discharged for some time from the service.

Non-elective hospital admissions:



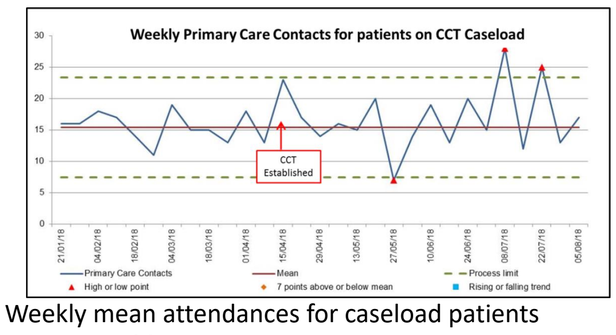
Weekly mean admissions for caseload patients reduced from 1.58 to 0.375 (**76% reduction**).

111 calls/Minor Injury Unit attendances:



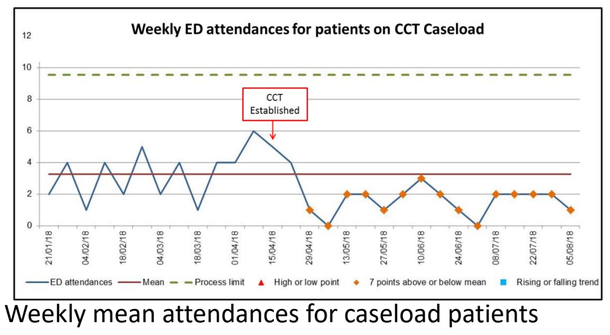
Weekly mean calls/attendances for caseload patients reduced from 2.67 to 1.00 (**63% reduction**).

Primary Care Contacts:



Weekly mean attendances for caseload patients remains stable at 15.5

Emergency Department attendances:



Weekly mean attendances for caseload patients reduced from 3.25 to 1.53 (**53% reduction**).

DISCUSSION

Financial Analysis:
It is projected that, if working to full capacity, the team would be able to work with 422 patients over the course of a year. This would result in a projected reduction in non-elective hospital admissions of 735.

Assuming a cost per non-elective admission of £2,400 and accounting for the annual team costs of £231,227, **an annual saving of £1,531,045 could be made**. This does not account for the additional savings made in reduced 111 calls or ED attendances.

Next Steps:
1. Expansion:
Funding has now been allocated by Fareham and Gosport CCG to extend the service across a wider area, aimed at assisting with the anticipated winter pressures.

2. Patient Feedback:
Pre- and Post-discharge surveys are being completed to assess the effect of the service on Patient Centred Outcome Measures and Patient Activation Measures.