PACT
Patient experience and Anticipatory Care Planning Team

Dr Eleanor Halloran
Consultant Liaison Psychiatrist
Edinburgh
Project proposers

- Dr David Caesar
- Clinical Director
- Emergency Medicine

- Dr Robby Steel
- Consultant Liaison Psychiatrist
- Royal Infirmary of Edinburgh

- Dr Carl Bickler
- GP Clinical Lead: Long Term Conditions, ECHP

- Dr Lisa Carter
- Primary Care Physician
- Emergency Department, RIE
The Team

RIE:
• Wojtek Wojcik - Liaison psychiatrist
• Michele Open – ED consultant
• Annette Cosgrove – Senior charge Nurse ED
• Catherine Moar – Alcohol liaison nurse
• Joyce Follan- Lead Mental health Nurse
• Jim Marple – G.P

WGH:
• Eleanor Halloran Liaison Psychiatrist
• Werner Pretorius Liaison Psychiatrist -Diabetes
• Janine Ferguson  Mental health nurse - Diabetes

Medical secretary – Michelle Daly

Data manager – Chris Cooper
Patient Level Costings and Financial analysis - Christine.mcgregor@scot.gov
What We Do:

- Anticipatory Care Planning
- Patients identified using risk stratification data
- High risk of unplanned admission or emergency department attendance to acute hospitals.
PACT AIMS

• To optimize patient care
• To incorporate patient experience / improve self management
• To reduce ED attendance
• To reduce admissions
ANTICIPATORY CARE PLANS

- Widespread recognition of the potential benefits of ACPs
- Using locally for clinician referred ED patients - can involve case management / brief intervention / treatment
- Few studies looking at patient outcomes and cost effectiveness of ACPs.
PACT

• Cohort reviewed after 1 year

• Database to evaluate outcomes
Plan for this talk

• How cohort is identified - Risk stratification
• PACT Intervention groups
• Examples of care planning
• Reflections from patients /clinicians
• Prelim analysis
SPARRA is an algorithm for predicting a patient’s risk of emergency inpatient admission to an acute hospital in a particular year.
SPARRA

- Age, Sex, Deprivation
- Number of previous emergency and elective admissions
- Total bed days accumulated in the 3 years
- Time since last emergency admission
- Principal diagnosis
- Number of diagnostic groups (co-morbidity)
- Emergency admission rate (standardised) for Gp practice
High resource – Scotland
Hospital based and GP Prescribing Resource
102,628 (2%) consume £2.6bn the other 4,322,546 consume £2.6bn
“Emergency Department Frequent Attender”
≥10 ED attendances in year or ≥ 5 in 3 months

≥80% risk of unscheduled hospital admission in the next 12 months
(N.B. 200 patients in both)

“placing or at imminent risk of placing a high demand upon unscheduled care services and likely to benefit from this approach”

100-500 pre-emptive referrals

Frequent readmissions
≥10 ED attendances in year
1,000 very high admission risk

“revolving door”

Algorithm run monthly

NHS LOTHIAN VERY HIGH RISK COHORT
1,500-2,000 patients, membership reviewed at 12 months
Scottish patients by category and SPARRA score - 2016

- Younger ED
- Long Term Condition
- Frail Elderly
Younger ED cohort - presentations

32% alcohol
18% self harm
10% subs misuse
7% abd pain
4% Primary mental health reason
LTC COHORT
MAIN
PRESENTATIONS

18% COPD
12% DIABETES
8% ABDOMINAL PAIN
4% ASTHMA
PACT

• 1. Algorithm identifies high risk cohort

• 2. Patients triaged according to clinical picture

• 3. Suitably trained keyworker allocated
• 4. Keyworker + patient + key clinicians agree individualised anticipatory care plan

• 5. Care plan shared with patient, hospital / Gp
Engagement challenges

• Appointment sent with explanatory letter
• Opt in letter
• Opportunistic
• Specially written software to allow staff to identify, in real time, which patients from the cohort are in hospital and where
Blank care plan

• Patient details
• GP
• Other contacts
• Diagnosis
• Medication: as per ECS
• Background

• Guidance during consultation

• Patient experience

• Who to contact on discharge

• Please note this care plan is a guide only, and its contents should be overridden when in the best interests of the patient. Always seek real time ED physician advice when there are management difficulties. It is good practice to always check current accuracy of information with patient, GP letter, KIS and hospital medical notes.

• DATE FOR REVIEW
• Some younger ED care plans are focused on risk management - consistency of care

• Some involve using the mental health nurses skills in brief interventions to enable patients to engage in self care and engage with services that may benefit them.
Example from Younger ED group

- 12 Professional meetings and case conferences
- 300+ emails
- Regular updates and review of care plan
- Currently on version 15 of care plan
- Now has consistency of approach
Risks

• If not admitted how does the patient cope with their distress
• Options- increase input from appropriate community or outpatient resources
• PACT team input in ED
• Liaison Psychiatric input
• 3rd sector- Cyrenians, Samaritans etc
LTC GROUP

- COPD - anticipatory care planning and augmented out-of-hospital management
- Diabetic psychiatry service
- LTC “general”
Patient experience

• Individual guidance / experience
• Lack of continuity / mixed messages
• Challenges of changes in service delivery
• Feedback to A&E or ward teams on what goes well or not
Clinician reflections

• Seeing patients who would not otherwise be referred - undiagnosed psychiatric disorder / adjustment issues / MUS/SSD

• Getting an view of the patient’s perspective
Proposed Evaluation

1. Financial modelling: acute hospitals
2. Impact upon other services: GP, SW
3. Patient satisfaction /experience
4. Referrer/collaborator satisfaction
Early evaluation of ACPs

- Hospital based activity was extracted for ACP cohort for 6 and 12 months pre and post ACP plan.

- Activity data costed using patient level costing by Scottish Government.
Early evaluation of ACPs – 6 months

• Positive findings 6 months pre and post:
  – Based on 400 patients.
  – A&E attendance declined by 31%, resource use fell by £76k.
  – Emergency inpatients admissions fell by 33% and occupied bed days by 17%.
  – Corresponding resource use fell by £468,000.
Early evaluation of ACPs – 12 months

• Positive findings 12 months pre and post:
  – Based on 205 patients.
  – A&E attendances declined by 34% and resource use by £79k
  – Emergency inpatient admissions fell by 43% and occupied bed days by 32%.
  – Corresponding resource use fell by £810k.
£6 reduction in clinical demand for every £1 invested.

- ED reduced demand + Reduced admissions = £78,853 + £810,412 = £889,265 for 205 patients = £4,338 per patient

- PACT has completed and uploaded care plans for 577 patients, hence annual saving = 577 x £4,338 = £2.5million for an investment of £400k
This is prelim analysis

- Need to compare with robust control group to attribute impact to Pact
Cautiously optimistic

- Decline in emergency inpatient specialities are those which cohort would tend to use frequently – toxicology.

- Decline has been maintained over 12 months for sample cohort.
• Updates next year.....