Who is really using services and what do they actually want?

Drs Robby Steel
Consultant Liaison Psychiatrist
"PACT", Patient experience and Anticipatory planning Care Team
Department of Psychological Medicine
Royal Infirmary Edinburgh

All health services face rising demand

Scheduled Care

- Operations
- Routine OP Clinics
- Investigations

Unscheduled Care

- ED Attendances
- Urgent OP Reviews
- Unscheduled Admissions

Strategies for reducing demand

- Public Health Approaches
  - Primary Prevention
  - Secondary Prevention
- Health Systems Approaches
  - ↑ role of primary care / community services
  - ↑ efficiency of hospital services
    - ↑ day surgery etc.
    - Improved management of theatres, clinics . . .
- Patient-centred Approaches
  - Supported self-care (health education etc.)
  - Individualised care planning

Individualised Care Planning

- Key Information Summary (KIS)
- DNACPR
- ReSPECT
- Advance Directive
- Psychologically informed, highly individualised collaboratively developed ACP covering self-management ("rescue pack" etc.), SAS, ED and subsequent acute hospital management . . .

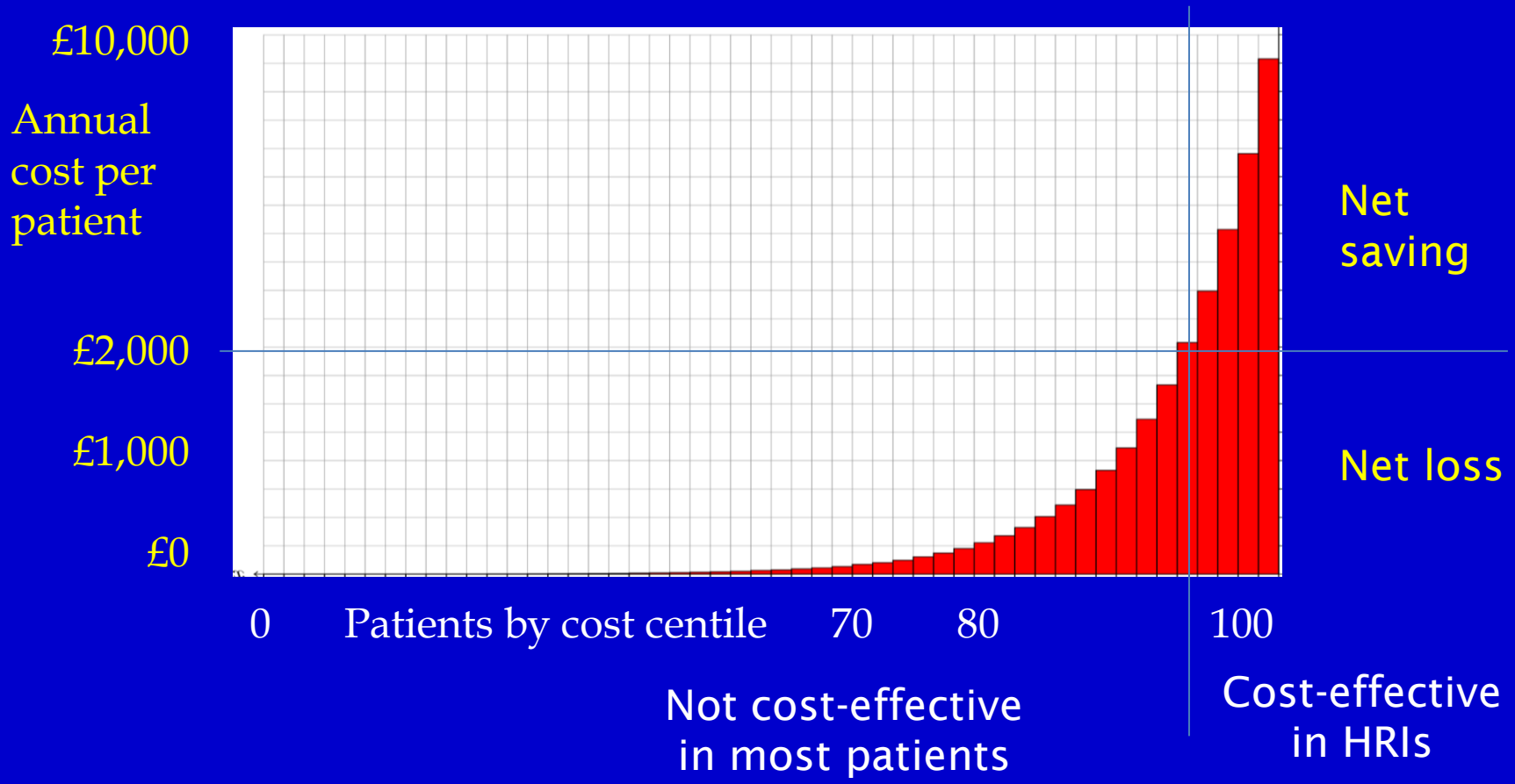
Anticipatory Care Planning

- An established intervention
- Trials in a range of healthcare settings
- Demonstrated to ↓ use of unscheduled care
- Patient-centred & empowering

BUT

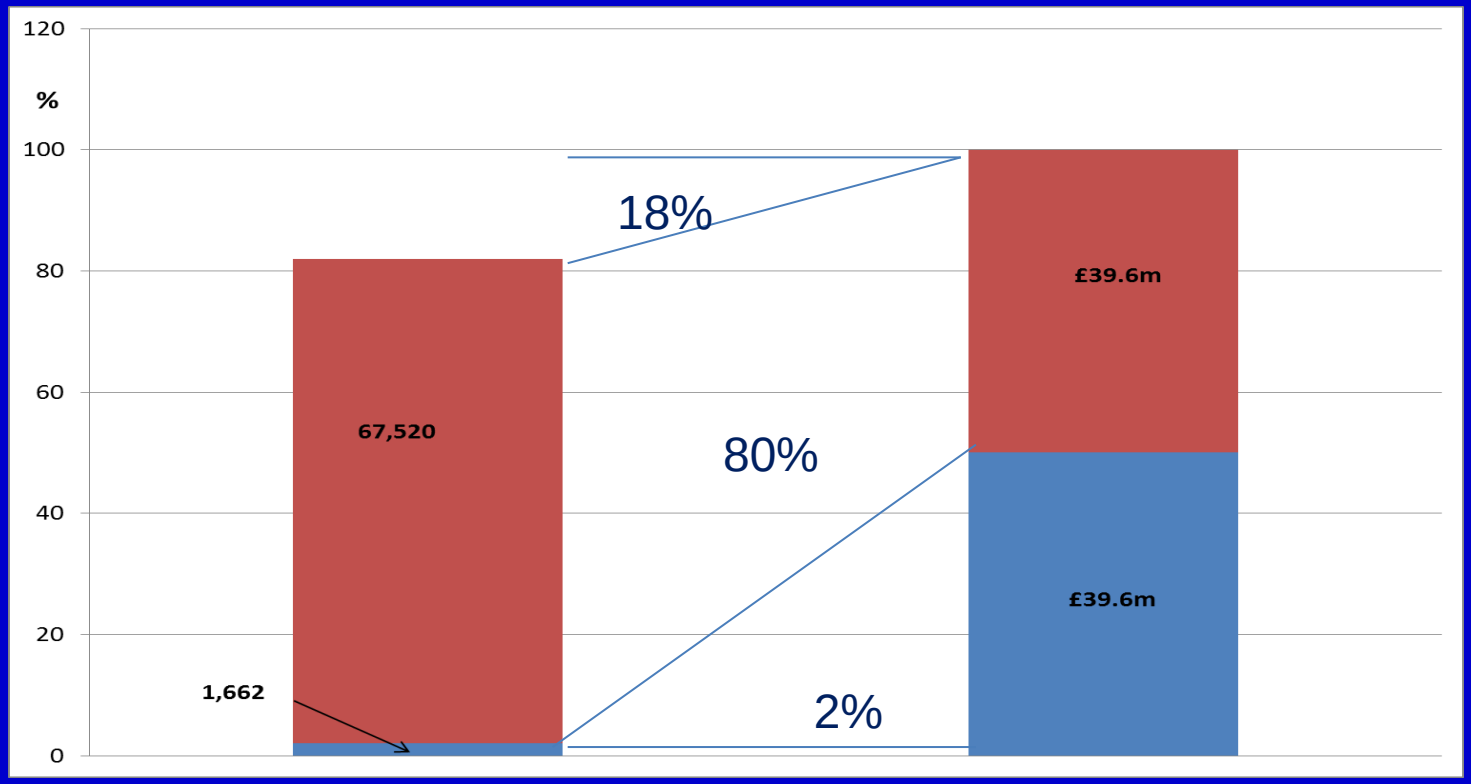
- Requires knowledge of local services
- With complex patients it is labour intensive and therefore expensive
- Only cost-effective if well targeted

Intervention ↓ healthcare costs by 30% but costs £600 per patient



Risk prediction is key to effective targeting of interventions

HRIs: example of Midlothian



2% of patients account for 50% of acute hospital & prescribing costs

80% account for the other 50%

18% don't use services

PACT

1. Algorithm identifies “high demand” cohort
2. “False positives” removed
3. Patients triaged according to clinical picture
4. Suitably trained keyworker allocated
5. Keyworker, patient + key clinicians agree individualised anticipatory care plan
6. Care plan shared with patient, hospital & GP
7. Cohort membership reviewed after 1 year

ScottishHealth AWARDS 2016

CONGRATULATIONS

PATIENT EXPERIENCE AND ANTICIPATORY CARE PLAN TEAM

NHS LOTHIAN

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INNOVATION AWARD

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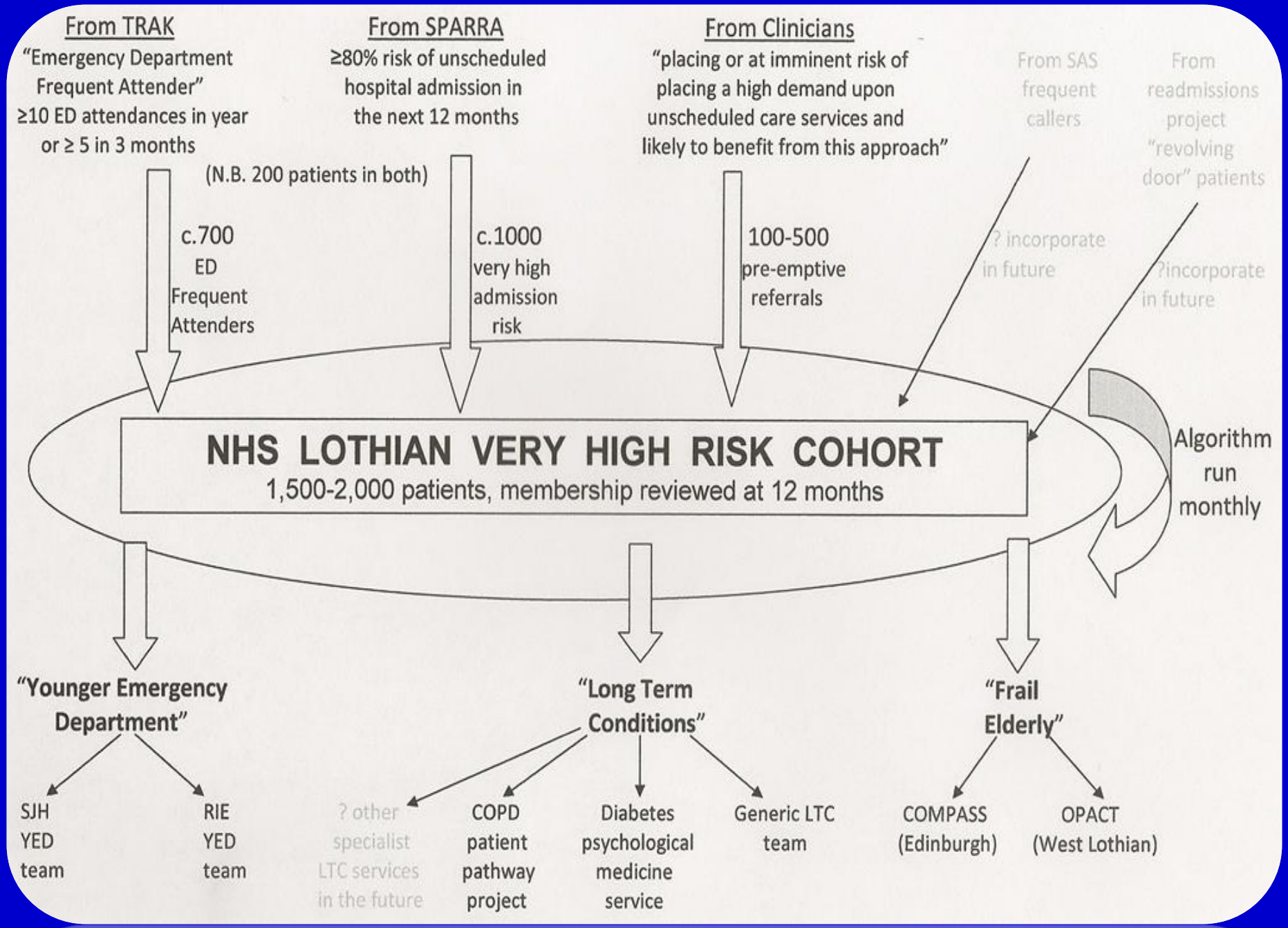
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"Emergency Department Frequent Attender"
≥10 ED attendances in year or ≥ 5 in 3 months
From SPARRA
≥80% risk of unscheduled hospital admission in the next 12 months
From Clinicians
"placing or at imminent risk of placing a high demand upon unscheduled care services and likely to benefit from this approach"
From SAS frequent callers
From readmissions project "revolving door" patients
(N.B. 200 patients in both)
c.700 ED Frequent Attenders
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100-500 pre-emptive referrals
? incorporate in future
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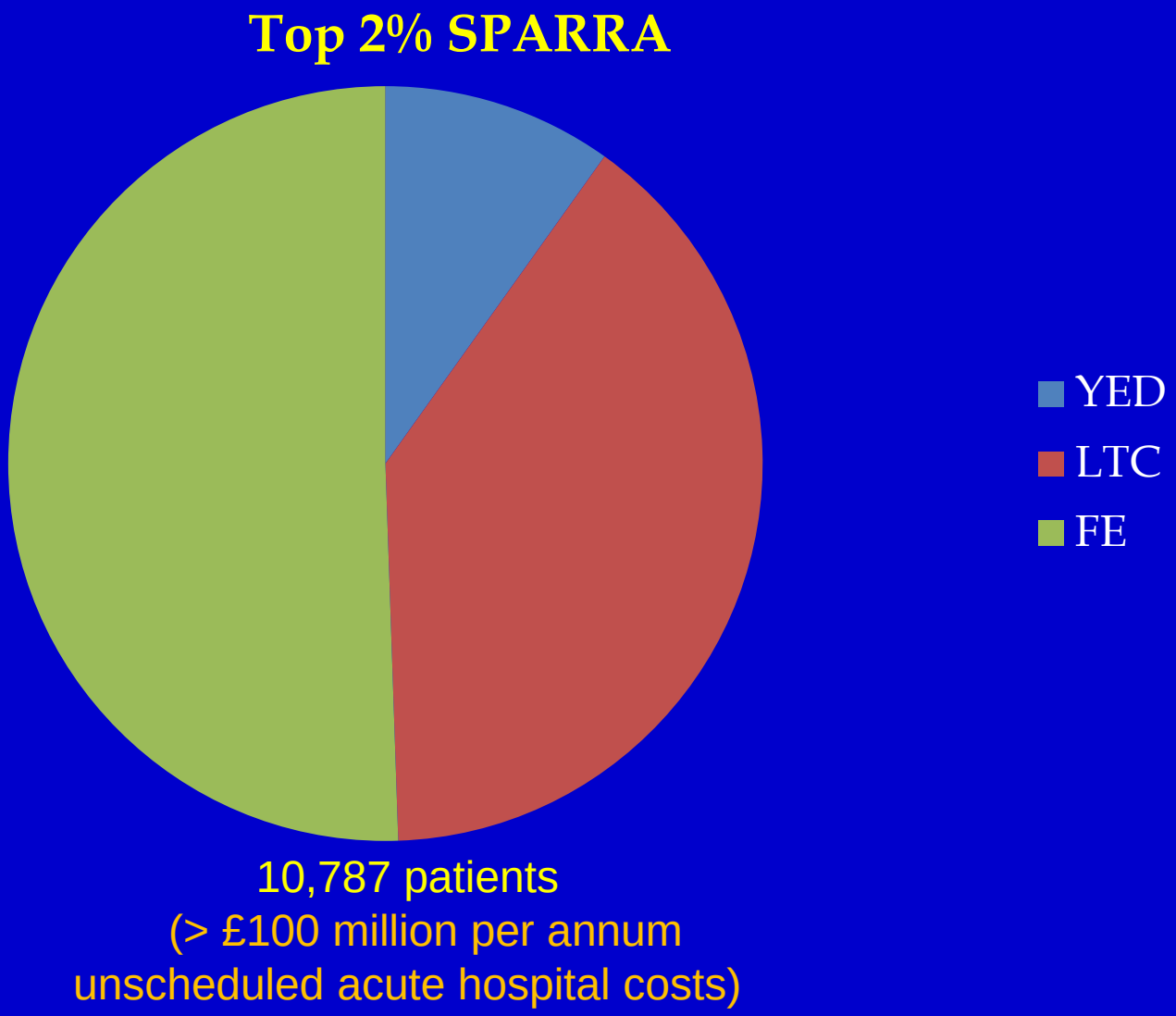
NHS LOTHIAN VERY HIGH RISK COHORT
1,500-2,000 patients, membership reviewed at 12 months
Algorithm run monthly
"Younger Emergency Department"
"Long Term Conditions"
"Frail Elderly"
SJH YED team
RIE YED team
? other specialist LTC services in the future
COPD patient pathway project
Diabetes psychological medicine service
Generic LTC team
COMPASS (Edinburgh)
OPACT (West Lothian)

Identifying HRIs: SPARRA

Scottish Patients At Risk of Readmission/Admission

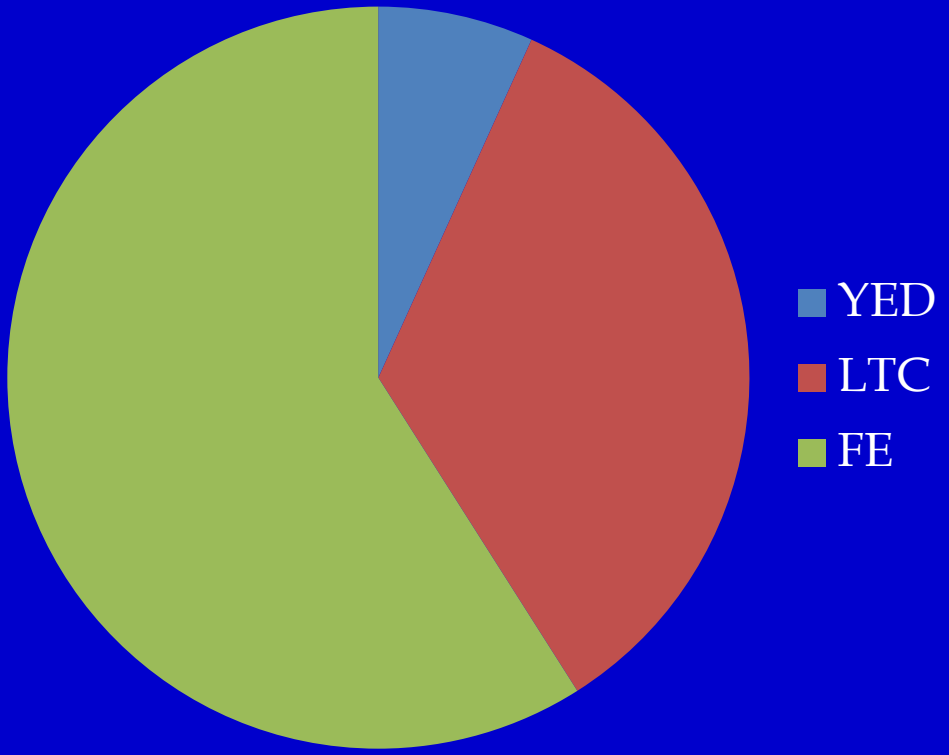
- Centrally developed algorithm
- Analyses everybody with a CHI number
- Calculates individual risk of unscheduled hospital admission in next 12 months (expressed as %)
- 3 clinical populations of High Resource Individuals (HRIs)
  - Younger Emergency Department (YED)
  - Long Term Conditions (LTC)
  - Frail Elderly (FE)

HRI patients in Lothian: 3 populations



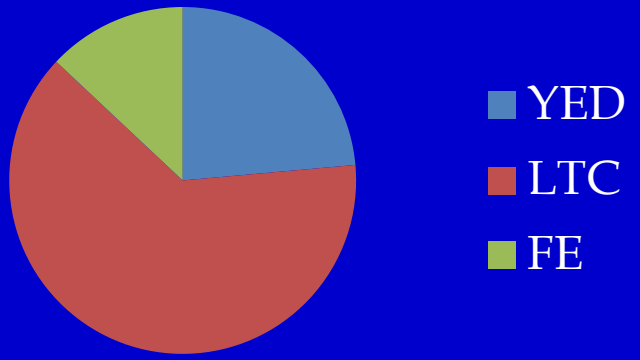
HRIs & vHRIs : Lothian patient numbers

Top 2% (excluding vHRIs)



8,804

Top 0.25% "vHRIs"



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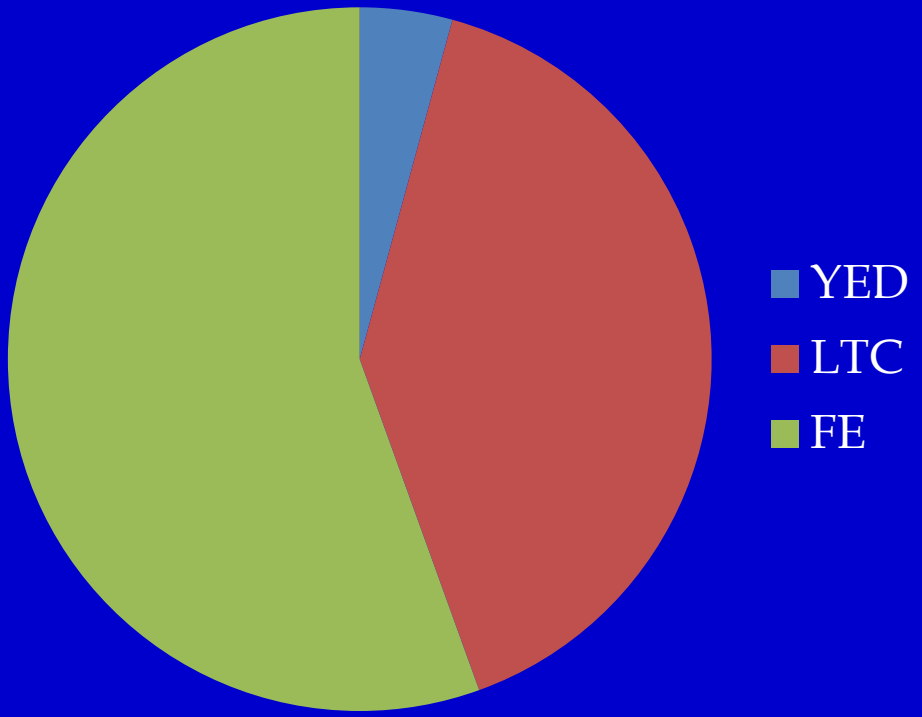
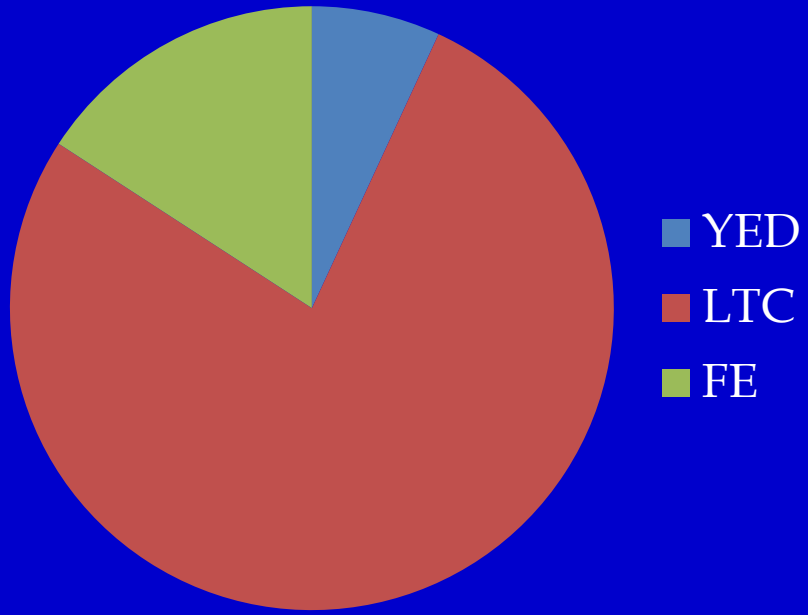
HRIs & vHRIs: Lothian acute care costs

Top 2% (excluding vHRIs)



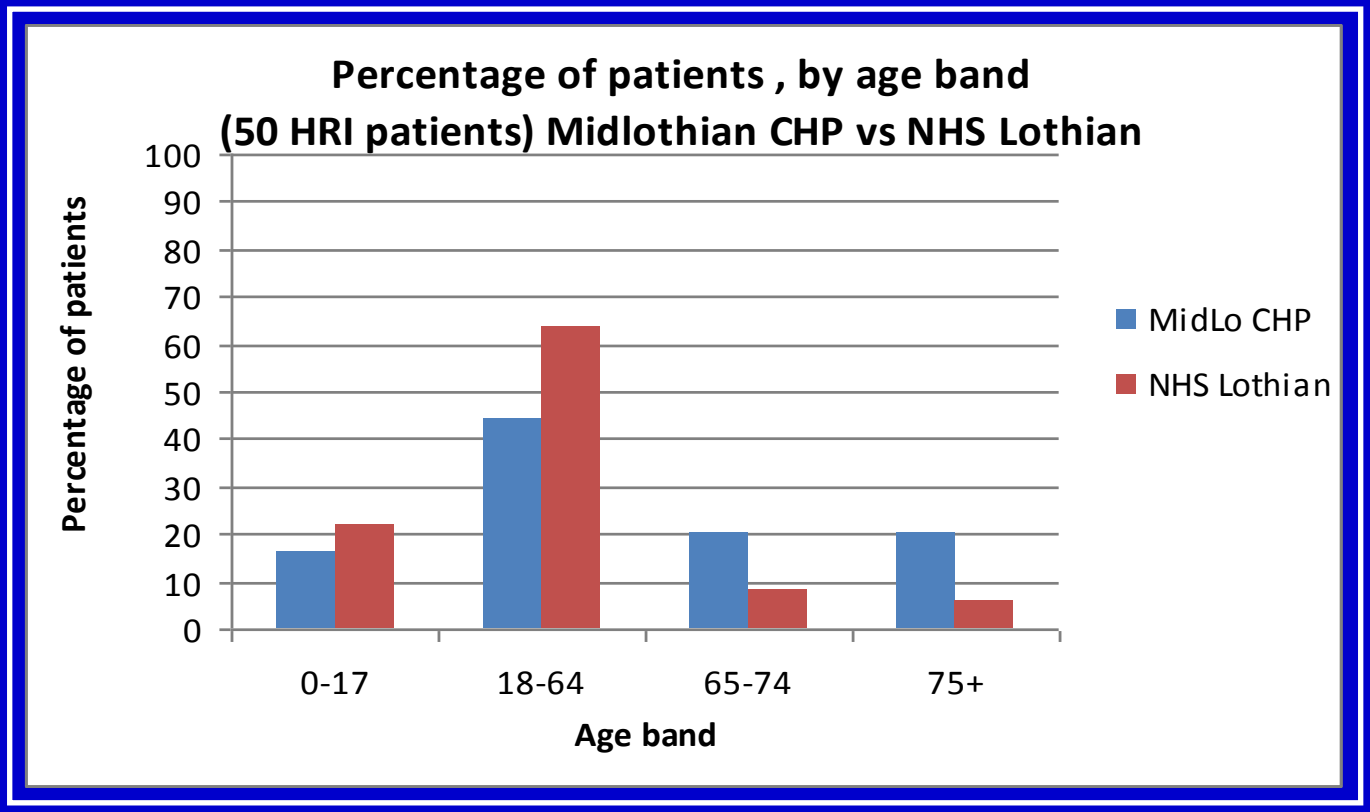
8,804 patients

vHRIs



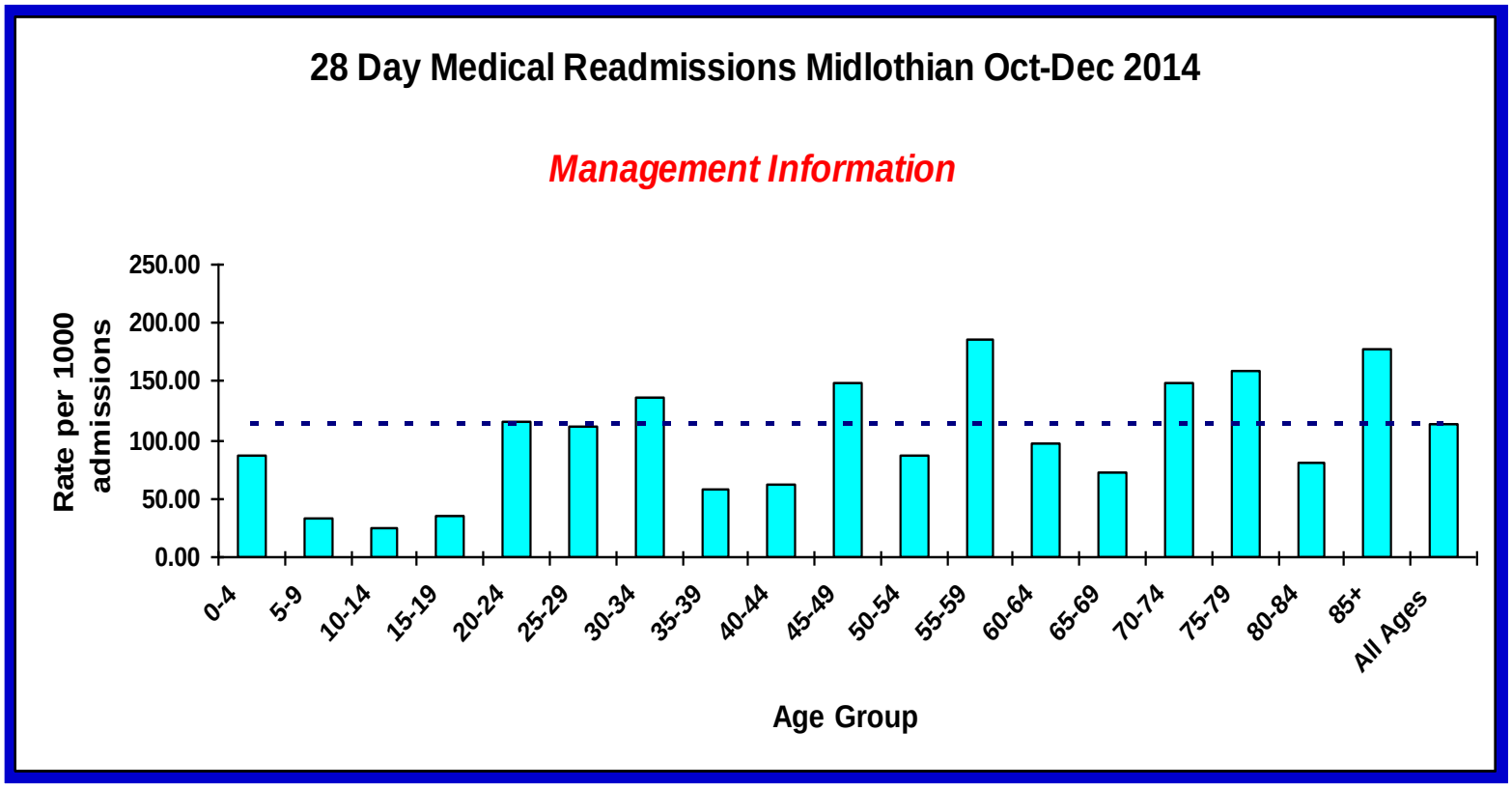
1,985 patients

Very HRI: Midlothian's top 50 patients

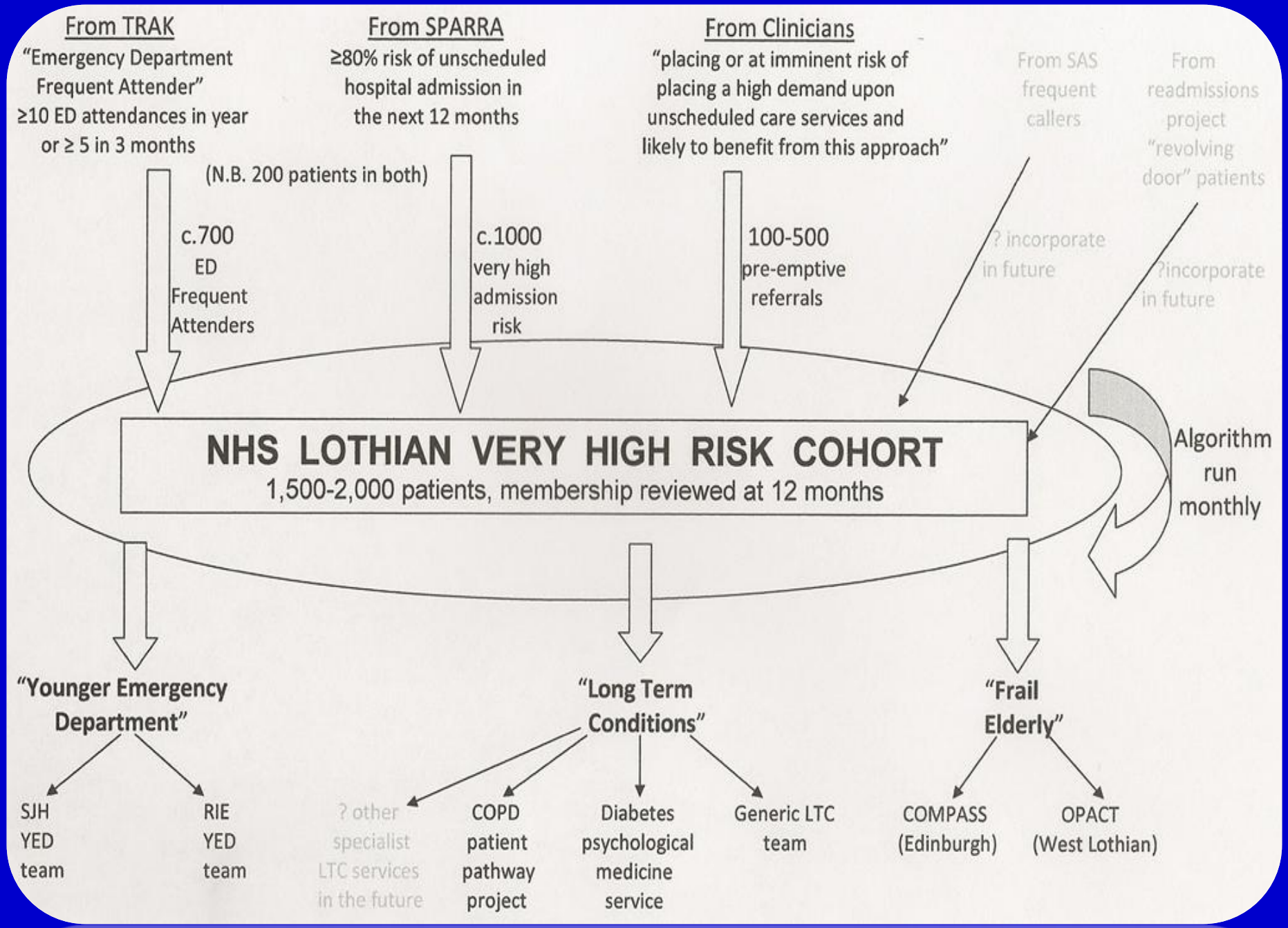


Very highest cost individuals: YED + LTC predominate

Very HRI: Midlothian's readmissions



"Revolving door": no single group predominates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Conclusions from Pilot

1. The model is workable
    1. Algorithm does identify vHRIs
    2. Engagement in ED/acute wards is effective
    3. Patients & referrers like it
2. The approach is cost effective
    1. ED/acute admissions ↓ by 35%
    2. £2.4 million demand ↓ for £400k investment
3. The algorithm addresses inequalities

More detailed evaluations planned

1. Financial modelling: acute hospitals
   - 12 months prior to entry
   - 12 months in cohort
   - 12 months post-cohort

(with baseline trend establish by historic model)

2. Impact upon other services: GP, SW
3. Patient satisfaction /experience
4. Referrer/collaborator satisfaction

What next for PACT?

1. ↑ capacity of ED frequent attender service
2. LTC service to bridge hospital-community divide (Liaison ψ to work with GPs)
3. Network of local, cluster/locality based demand reduction initiatives
4. Share lessons with other regions
5. National ACP hosted on Patient Portal

Wider Context

- "Realistic Medicine" advocates patient-centred care
- New national algorithm for "HHG"

  Akin to SPARRA but for "High Health Gain"

  1. End of Life Care
  2. Complex Care
  3. Single Episode of Intensive Need
- New GP contract will remunerate ACPs

Any Questions ?