Acute Care At Home Service (ACAHH)
Southern HSC Trust

Soo Hun
HSCB Northern Ireland
The Approach for ACAH

- Consultant-led community service for acute, non-critical care in community setting - operational from 22/09/14.
- Older patients in own home/Nursing/Residential Home
- 2 hours from referral to assessment (target met in 95% of referrals)
- Comprehensive Geriatric Assessment and Rapid Access to Diagnostics and Labs = an inpatient ward
- Average LOS 4-5days
- Daily MDT meeting with relevant members of the team
- Strong Interfaces with existing Community services for handover of care
Criteria

Inclusion

- Over 65 years (Under 65 considered on individual basis if hospital admission would be detrimental)
- Any patient not deemed critically unwell
- Patients must have been assessed as requiring acute care i.e. deemed to be at the point of hospital admission.
- Can be managed safely in a community setting

Exclusion

- Requires resuscitation
- Chest Pain
- Acute Surgical or Orthopaedic Crisis
- Stroke
- Haemostasis / GI Bleeding
- Mental Health – picked up through Home Treatment Crisis response
Innovation in Care

- Integrated approach
- Open honest discussion re: care
- Extending/enhancing AHP and nursing roles

Collaborative working

Shared vision and goals

- Vigorous recruitment to have right staff
- Both acute and community care experience
- Can do attitude

Team members

Communication strategy

- High quality and effective care
- Shared goals

- Comprehensive strategy linking primary, statutory, community and voluntary sectors
Phased Approach to Implementation

**Phase 1**
22nd Sept '14

- 17 GP practices (pop 99,000, >65 pop 13,500)
- Nursing Home (36 Homes, 1500 beds)

**Phase 1(b)**
1st May '15

- 21 GP practices

**Phase 2**
10th May '16

- 42 GP practices (240,000, 37,500 over 65 years)

**Phase 3 (a) – Mar - Apr '17**

- 52 GP practices, pop o+40,000 > 65 +5,400 (3/4/17)
- +5 more Nursing homes in Total of 230 beds (13/3/17)
Prevention of Admission vs Facilitation of Discharge

<table>
<thead>
<tr>
<th>Month</th>
<th>Early Discharge MGMT (TI)</th>
<th>Prevent Hosp ADM MGMT (TI)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jun-16</td>
<td>14</td>
<td>78</td>
<td>92</td>
</tr>
<tr>
<td>Jul-16</td>
<td>9</td>
<td>51</td>
<td>60</td>
</tr>
<tr>
<td>Aug-16</td>
<td>5</td>
<td>64</td>
<td>69</td>
</tr>
<tr>
<td>Sep-16</td>
<td>21</td>
<td>74</td>
<td>95</td>
</tr>
<tr>
<td>Oct-16</td>
<td>20</td>
<td>84</td>
<td>104</td>
</tr>
<tr>
<td>Nov-16</td>
<td>27</td>
<td>86</td>
<td>113</td>
</tr>
<tr>
<td>Dec-16</td>
<td>24</td>
<td>105</td>
<td>129</td>
</tr>
<tr>
<td>Jan-17</td>
<td>32</td>
<td>123</td>
<td>155</td>
</tr>
<tr>
<td>Total</td>
<td>152</td>
<td>665</td>
<td>817</td>
</tr>
</tbody>
</table>
## Discharge Outcomes

<table>
<thead>
<tr>
<th>Discharge outcomes from 1st July 2016 to 31st January 2017</th>
<th>Number of Patients</th>
<th>% of total number discharged</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Number of discharges</td>
<td>547</td>
<td>100%</td>
</tr>
<tr>
<td><strong>No change to existing care requirements</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>425</td>
<td></td>
<td>79%</td>
</tr>
<tr>
<td>New or Increase to existing package of care</td>
<td>23</td>
<td>4%</td>
</tr>
<tr>
<td>Required new placement to NH/RH</td>
<td>5</td>
<td>1%</td>
</tr>
<tr>
<td>Required admission to hospital</td>
<td>74</td>
<td>13%</td>
</tr>
<tr>
<td>Deceased</td>
<td>19</td>
<td>3%</td>
</tr>
</tbody>
</table>
# Impact on Nursing Home bed days

<table>
<thead>
<tr>
<th>Period</th>
<th>Total bed days per year</th>
<th>Indicative cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct 13 - Sept 14</td>
<td>10369 (baseline)</td>
<td>£3,836,530</td>
</tr>
<tr>
<td>Oct 14 - Sept 15</td>
<td>9158</td>
<td>£3,388,460</td>
</tr>
<tr>
<td>ACAH service started end of Sept 14</td>
<td>&gt; 10% reduction of bed days from baseline</td>
<td>Saving of £448,070</td>
</tr>
<tr>
<td>Oct 15 - Sept 16</td>
<td>7705</td>
<td>£2,850,850</td>
</tr>
<tr>
<td></td>
<td>&gt; 20% reduction of bed days from baseline</td>
<td>Saving of £985,680</td>
</tr>
</tbody>
</table>

## Potential impact on Acute Bed Days
- Year 2 - 671 referrals accepted
- Per patient (based on ICD10 audit) = 671 x 6.8 days; 4563 potential bed days saved in year
Outcome of Audits

- Health & Social Care Board (Commissioner) completed complex discharge audit in July 2016

  *Outcome of audit:*
  ACAH service managing very complex caseload with acute needs, equivalent to an acute hospital ward

- ICD10 coding audit of 250 ACAH patients in April 2016

  *Outcome of audit:*
  Patients under ACAH service with same clinical coding have shorter LoS than in Acute Hospital - **5.7 days vs 6.8 days**
Service User Feedback

“The Acute Care at Home service has been the best service development in years” Carer’s Forum representative

“Very Rapid Response, within a matter of hours, we were very impressed and felt well supported” Patient’s daughter

“We found the staff always extremely helpful, they were very attentive to each of the patients the cared for in the Home” NH Manager

“To be treated in her own environment saved my sister’s mind from all the mental turmoil of being moved to hospital” Patient’s Sister

“Excellent service, reassuring for GPs to be able to discuss cases with Consultants” GP
Future plans

- Further integration of service to embed into practice.
- Roll out all service users in Trust area (Early 2018).
- Future planning for staff education linking with Universities and Clinical Education centre.
- R&D:
  - Involved in Multicentre RCT with Oxford University
  - Comprehensive evaluation report
  - Quantitative and qualitative study into patient experiences of ACAH model
THANK YOU

soo.hun@hscni.net

acutecare.home@southerntrust.hscni.net