Transforming the Delivery of Acute Medicine

“Times Now”
Acute Medicine in Wales

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Recent History in Wales

Between 2000 & 2012
• 5% increase in emergency admissions (27% in England)
Between 2009 & 2016
• Total NHS beds in Wales have reduced by 14%
• Acute Medicine beds have reduced by 4%
• Care of the Elderly beds have reduced by 26%
• Over 65’s increased to 18.5% (16.5% in England)

Latest data shows REDUCTION in admissions for chronic conditions and reduced ALOS
Policy Context

- UK Health Spend = 9.78% UDP
- Wales age adjusted health spend lower than England
- Wales protected Social Care funding when England didn’t

Other differences

- Integrated Health System (Primary & Secondary Care)
- No Commissioner : Provider split
- No Foundation Trusts
- No Payment by Results (PBR)
- Prudent Healthcare Policy
- Legal duty of partnership
- Increasing allocations to Integrated Care Fund
- Two significant laws:
  - Social Services & Wellbeing Act 2014

Impact of policy?

- Crude Comparisons

<table>
<thead>
<tr>
<th></th>
<th>Ireland</th>
<th>NHS</th>
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<tbody>
<tr>
<td>% GDP 2014</td>
<td>9.7%</td>
<td>9.9%</td>
</tr>
<tr>
<td>Per Capita Spend 2014</td>
<td>£5082</td>
<td>£3989</td>
</tr>
<tr>
<td>% GDP 2016</td>
<td>7.8%</td>
<td>9.8%</td>
</tr>
<tr>
<td>Per Capita Spend 2016</td>
<td>£5528</td>
<td>£4192</td>
</tr>
</tbody>
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OECD Health Statistics 2014

How does Ireland compare?

Total health spending accounted for 8.9% of GDP in Ireland in 2012, slightly less than the OECD average of 9.2%. Health spending as a share of GDP is much lower in Ireland than in the United States (16.2% of its GDP on health) and in a number of European countries including the United States, France, Switzerland and Germany (all allocating over 11%). The public sector is the main source of health funding in nearly all OECD countries. In Ireland, 66% of health spending was financed by public sources in 2012, slightly less than the average of 72% in OECD countries.

Picking up the story.......

- Progression
  - 1989 Stimulus
  - 2011 Stimulus

Property of NAMP. Not for sharing or distribution
Stimulus for change

Looming Adversity Becomes a Propellant!

Looming adversity pushes you to get better than before!

Giving up - Worst Case Scenario Thinking

Return to Normality

2011/12 in Cwm Taf

- System had recalibrated "normal"
- Performance deteriorating across the board
- Deanery reconfiguration of training looming
- New Chief Executive
- Everything was about A&E

Monday night 10pm phone-call!

2011/12 "Crisis"

If you always do what you’ve always done, you always get what you’ve always got.

So, what did we do?

- Clinical “lock-in”
- No limits identified (financial or otherwise)
- Good data
- Identified questions to be answered
  - How not should
  - When not if
  - Can not can’t
- Executive challenge

Focus on flow
System change

- Process mapping of unscheduled care
- Site based twice daily flow meetings
- Zero tolerance to ambulance delays
- WAST pathways and operational efficiency measures
- Local Authority preparedness
- @home services
- Robust implementation of Choice Protocol
- Nursing homes interventions
- GP access group
- “Phone First!” and redirection to MIU
- Phase 1 Acute Care Physicians
- Therapy Assessment Teams
- Discharge lounges on DGH sites
- CDU/MDU redesign
- Increase in short stay surgery beds
- Daily deep dive by senior team
- >40 day LOS project
- Daily board rounds
- Live bed management system
- AOD
- Criteria led discharges
- Discharge before midday

Warwick Charts

What we already knew…………

- A&E is simply the system barometer
- Most unscheduled care is predictable
- The generalist is the new specialist
- It’s as much about the culture as the interventions
- Get the flow right and everything else follows

Acute Medicine unlocks whole system performance

Before this all started…………

- 1 Acute Physician
- Small Medical Assessment Unit
- Small Medical Day Unit
- ‘Ology’ beds
- Multiple hand-offs
- Safari Ward rounds
- Patients often lost to specialty
- Large numbers of medical outliers
Then what?

- We had the “sign-up” of all Health Boards
- We had the start of a compelling evidence base
- We had national recognition
- We secured a “Spend-to-save” allocation
- We actively recruited
- We developed new roles (ANPs and MTAs)
- We reconfigured wards
- We implemented live bed-management

But by mid 2015 we were suffering significant nurse shortages and had to close 33 beds going into winter!

Medical Outliers

- Weekly count of medical outliers (midnight census)

Another tough winter

Acute Medicine

- Reduced ‘double handling’ of patients by A&E and acute medicine leading to delays
- Skill shortages – developed new posts
- Reconfigured Wards
- Patients with multiple different illnesses weren’t being moved around
- Care was being moved to the patient not patient going from ward to ward
- Quality measures – S.A.M. standards and patient feedback
What happened next..........

- GP Cluster Plans & investment
- Further expansion of the workforce
- Integrated Care Fund schemes
  - Year 1 – Various Projects
  - Year 2 – Stay Well @ Home
- Another winter

And then?

- Performance sustained
- Diagnostic Hub / Danish Cancer model approved
- Capital expansion agreed
- Further appointments made
- Reconfiguration and realignment of primary and social care
- Joint commissioning of care homes
- Alignment of LES & DES
- Investment in Advanced care planning
- Evaluation of Community Paramedic
- Further investment in Clusters
- Strengthened 7-day Psychiatric liaison
- Dementia Village

Lessons Learned

- Spend time honing the questions
- All parts of the system need to change
- You can risk investing your money in acute medicine
- Bed equivalents do work
- GPs love it
- Surgeons want to copy it
- CEOs (if they can be converted) can be your greatest ally

Together stronger