Complex -Acute Response Team (C-ART)

Introduction

C-ART service has been developed with local stakeholders, building on the work of the Primary Care Homes in Thanet. This is part of an integrated pathway approach to support, in particular but not exclusively, holistic care for frail patients. The service was founded by Dr Ash Peshen in partnership with KCHFT, has been evaluated by University of Kent and demonstrated qualitative and quantitative impact on patient care, experiences, and inter-professional support. This was followed by recognition at national level and recently was further highlighted by the NHS England Primary Care during the Pandemic
https://www.england.nhs.uk/integratedcare/case-studies/caring-for-people-most-vulnerable-to-covid-19-in-thanet-nhs-kent-and-medway/

The typical needs of a frail patient with multi-morbidity, polypharmacy, and complex psychosocial circumstances with crisis, requires an expertly led, timely response as well as holistic needs assessment with multidisciplinary support for the medical and personal needs. By working across Primary, Community, Acute, Urgent, Voluntary care providers, the C-ART Team is able provide the seamless service and bridge each organisational offer to meet the patient needs in their own homes, care homes and review patients in hospitals when admitted as well as facilitate early discharge where appropriate. In particular, the frequent flyers with the help of all involved professionals are better supported for future care. C-ART Team prides in supporting End of life Care in the community for this cohort of patients.

C-ART GP supports the MDT which consists of ACP, Nurses, Carers, Physiotherapist, Occupational Therapists, Health Care Assistants as well as attending the Frailty and CDU Board Rounds at QEQM Hospital to enable early discharge and ongoing support. We respond to Ambulance calls, Care Homes and any community clinical needs with complex needs that are within our referral criteria. We also support the 15 bedded KCHFT Led community unit at Westbrook House for patients requiring step-up and step-down facilities. During the pandemic, C-ART provided extra support via completing Treatment Escalation Plans (TEPS) to Care Homes patients as well any such complex patients in the community.

Initial review of local services indicates that they are all under pressure; patients are not always seen by the most appropriate practitioner in the most appropriate place. Some patients are being admitted to hospital who could have been cared for in their own home. Some patients are taken to hospital by the ambulance service because there is no alternative option.

As such there are a number of key drivers for the C- ART service including[1]:

- Fragmented acute response services in primary care, community services, social care, the ambulance service, and secondary care.
- Multiple handovers for patients impacting on both length of stay, missed communications and the patient's experience.
- A lack of knowledge/understanding of the range of provision and services available.
- Gaps and overlaps in provision across all settings.
- Poor communication at both patient and organisational level.
- Inconsistency of the care delivered.
- Workforce pressures across all organisations and sectors.

Reference
[1]: Kent and Medway CCG

- Poor A&E performance at QEQM
- A number of beds being used for non-acutely ill patients. The recent audit showed 300 across EKHUFT of which there are circa 66 beds in QEQM.
- There is a need to reduce the number of attendances, admissions and LoS.
- There are circa 838 attendances in 6/12 where there was no significant investigation, 50% of these had no diagnosis; 204 of these patients are aged over 75yrs.
- There is an average of 2,000 attendances per month with 2 or more LTCs.
- There is an average of 154 non elective admissions per month with 2 or more LTCs.

Currently there are a range of acute response services, some of which can be characterised by their lack of integration with each other in all health and care sectors.

Aims of the service

The primary aim of the C-ART is to enhance the level of integration of health and care services to ensure a more timely and appropriate service response for:

(i) Those patients who are in the community and are at risk of attendance/admission to hospital.

(ii) Those patients who have arrived in A&E and could be cared for in the community.

(iii) Those patients who DO NOT wish to be admitted to hospital for further management or need end of life care at home with acute medical crisis.

(iv) Provide enhanced support to Care Homes particularly at weekends and bank holidays as well as some patients whose GPs are managing them at home but need medical support at home.

(v) Facilitate early discharge of medical patients from hospital where appropriate and via established networks virtual support of the relevant consultants for the patients on C-ART list on any given day.

C-ART aims to deliver:

- A single integrated acute response across a patient pathway.
- A front door single response, which is able to move patients across systems using the most appropriate skills and resources.
- To be able to provide a timely response.
- To reduce multiple handovers between teams
- To keep patients at home.
- To return patients home first or to an appropriate 'bed'

Performance and outcomes

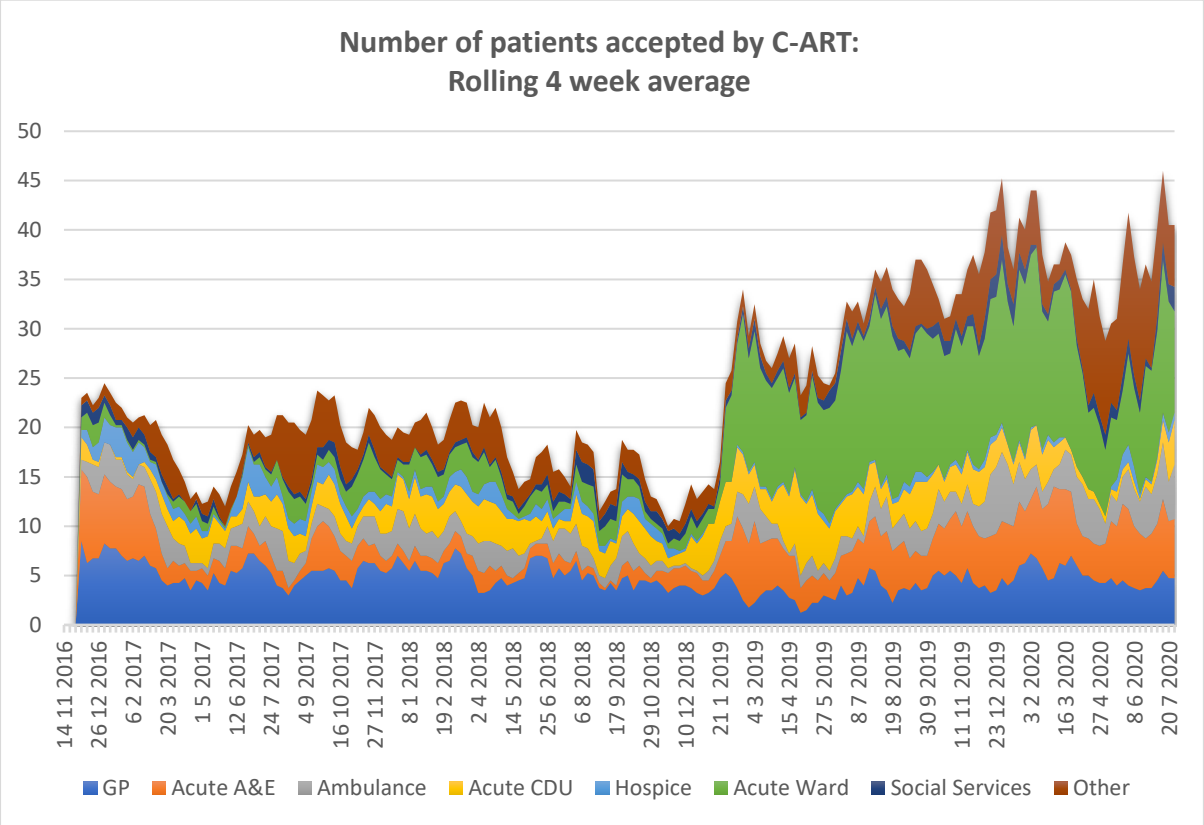
C-ART service was first established in October 2016 as a pilot project. Following an evaluation in March 2017, Thanet CCG agreed to make the C-ART substantive and removed the pilot status. The service has gone from strength to strength and have demonstrated very positive outputs.

TH CIC have reviewed and analysed the data from the start of the service (2016) to July 2020. In total, the service has seen and discharged **5224** patients. The referrals received are from various providers, which include GP, Acute A&E, Ambulance, Acute CDU, Hospice, Acute wards, and Social

Reference

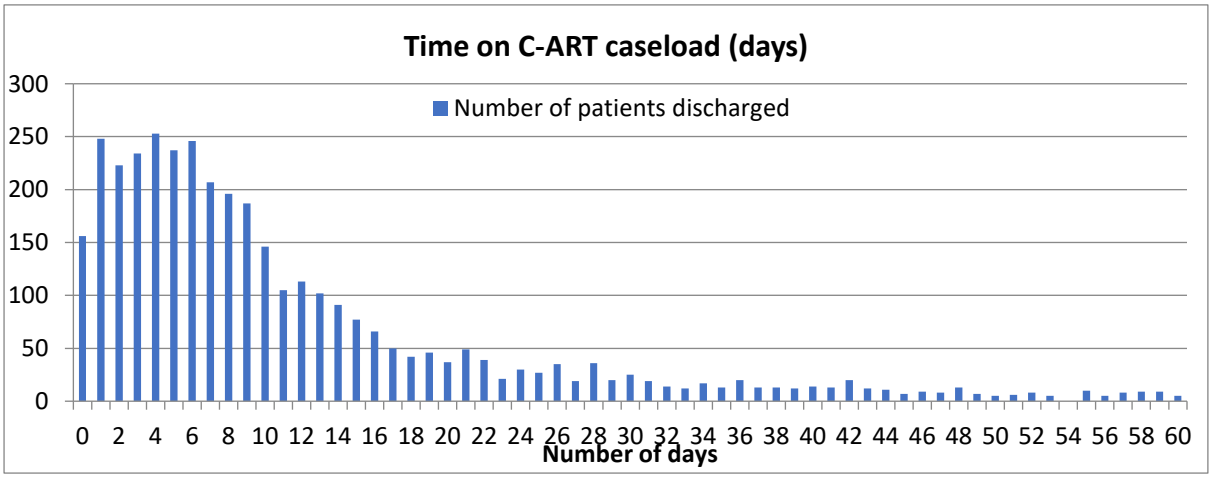
[1]: Kent and Medway CCG

care. On average the service has received 28 referrals per week however there is an upward trend with numbers increasing up to 45 referrals. The graph below shows the overarching trend.



One fifth of the referrals received by the service are from primary care.

The time on caseload varies considerably however majority (53%) of the referrals are seen and discharged within 14 days. The graph below shows the trends.



The team retains patients on their caseload until the patients needs are met, as a number of patients are referred for social care reasons or to the voluntary sector, these patients can remain on the caseload for months, a small number of a patients have been on the service for over a year.

One of the main aims for the service is to avoid admissions, the service has estimated that they have avoided **1485** hospital admissions, this is by accepting ambulance referrals and patients directly from AMU and CDU.

Reference

[1]: Kent and Medway CCG

Another benefit of C-ART is the integration between multiple providers and building strong relationships, this has enabled the teams to understand each and others services in greater detail and therefore ensure patients are referred to the appropriate service in a timely manner.

We regularly have MDT meetings to reflect on our care and learn from any events. We are involved in teaching, training and professionals' action learning.

Future:

The service has been extended for further one year, all partners are working with the CCG to determine the long-term commissioning arrangements. We aim to work with PCN MDM , Community Teams involved with Frailty focus to undertake Comprehensive Geriatric Assessments, Treatment Escalation Plans and reduce futile interventions and enhance quality through what matters to the patient in any given healthcare needs and crises. We know that patients in the last year of life are frequently admitted to hospital but coordinated care with follow up can reduce this burden of suffering and wider health economy impact.

Reference

[1] : Kent and Medway CCG