Correspondence

EPICENTRE – Delivery of high quality acute medical care without transfer to hospital

N Rajaiah, HK Kainth, T Knight & SC Sandwell

The NHS Five Year Forward View focuses on expansion and development of community services and out-of-hospital care. Hospital at Home is a concept that provides acute active treatment that would traditionally be provided in an inpatient setting, involving nursing staff and therapists. As well as being financially favourable, it is important to acknowledge that often, for a multitude of reasons, people prefer to remain at home rather than be admitted to hospital for treatment. The COVID-19 pandemic has further reiterated that patients are at risk of nosocomial infection. More importantly Hospital at Home care has consistently been associated with greater satisfaction compared to acute hospital care for both patients and their family members.

The traditional model of care delivered by Acute Internal Medical (AIM) specialists sits within the confines of a hospital. Our skills are critical within the community setting and although unique and novel, we want to share an innovative and essential acute care model for providing medical care for acutely unwell patients in the community. The EPICENTRE model was launched in November 2020 led by Dr Sarb Clare and Prof Dan Lasserson.

It involved AIM registrars working alongside established community admission avoidance teams with Acute Physician remote support. Patients were referred from General Practice, ambulance services or other community teams. The process of assessing, testing and treating patients was similar to the traditional hospital model, using physician/nurse-led assessment, point of care blood tests (POCTs) and point of care ultrasound (POCUS) in place of X-ray imaging. The key to success to this project is a senior decision maker in combination with diagnostics at the patient's bedside.

The majority of patients enrolled into the EPICENTRE project were frail and multi-morbid. For this cohort, the convenience of the team coming to them rather than attending the Emergency Department was invaluable. Patients felt more at ease when assessed in a familiar environment, which was reflected in the openness when disclosing symptoms and other personal details. The ability to see blood results and POCUS images real-time empowered patients in shared decision making with regards to their management. Patients and their families felt secure in the knowledge that there was a contact line if there were concerns and the safety net of the emergency services would always remain out-of-hours. Where a patient did require admission, the process was much smoother and bypassed the Emergency Department altogether getting the patient to the 'right place first time'.

For clinicians, the most challenging aspect of the project was adapting the clinical mind set from extensive inpatient investigation to more emphasis on basic clinical assessment. There were fewer distractions when assessing patients in their own homes, compared to a busy hospital environment, and witnessing patients in their usual environment provided crucial information about their functional status and home support. Being able to have candid conversations with patients regarding all of the above, and the availability of POCTs and POCUS strengthened clinician confidence in clinical decision-making outside of their comfort zone. Interestingly, pushing these boundaries had a positive impact when making patient management decisions back in the acute hospital environment.

There has been a huge appetite within the catchment area for access to community health care service with acute physician involvement. Quantifying service outcome measures with this model has proved difficult. By contrast qualitative data from patients has been immensely positive and rewarding to hear. Focussing on a particular cohort of patients may be one way of obtaining more comparable data. Thus far, treatment options have been limited, but expansion of protocols would give access to a wider variety of options, e.g. intravenous therapies. Going forward, the risk of overwhelming the service without appropriate resource investment is a realistic one.

An AIM-led EPICENTRE model could revolutionise health care in England and given the close interaction of acute medicine with community care, this should be an integral part of AIM training to prepare our upcoming physicians with the skills to, not only deliver, but also develop the healthcare services that will be necessary in the near future. We strongly advocate all AIM trainees have clinical exposure within the community setting and we envisage Acute Internists delivering acute care out in the community in the future.

Nithyananda Rajaiah[1]

Harjinder Kaur Kainth[1]

Thomas Knight[1]

Sarbjit Clare[1]

[1] Sandwell & West Birmingham Hospitals NHS Trust

Correspondence:
Thomas Knight,
Sandwell & West Birmingham Hospitals NHS Trust,
Lyndon,
West Bromwich,
West Midlands,
B71 4HJ
thomasknight@nhs.net