Berkshire

davidoliver372@googlemail.com Follow David on Twitter @mancunianmedic

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ACUTE PERSPECTIVE

David Oliver: The case for transitional post-acute care

David Oliver *consultant in geriatrics and acute general medicine*

Discussions on the resourcing, staffing, and effectiveness of acute hospital care versus primary care often seem to bypass "transitional care," which is provided in the community and at home.

In my clinical day job those services that can help people step down from an acute hospital admission can make a big difference to my patients and provide a vital safety net.

The term "transitional care," as defined by the American Geriatrics Society, encompasses a "set of actions and services" to manage the "coordination and continuity of healthcare as patients transfer between different locations," such as hospitals, nursing and residential homes, the patient's private residence, and primary and specialty care.[1 2]

When I wrote recently about the interface between acute and primary care,[3] several GPs spoke to me of the unfunded transfer or "dumping" of traditionally hospital or specialty based work onto primary care with no accompanying transfer of funding or staffing. They said that patients landing back in the community from hospital have increasingly medically complex conditions, or remain in a medically unstable or recovery phase that might formerly have been supported by hospital teams.

However, as an acute care hospital doctor who publicly supports the GP cause, I don't think that acute care colleagues aim deliberately to push work onto already overwhelmed general practice.

Acute care doctors and multidisciplinary clinical teams are motivated by clinical care, not by arcane contracts and payment mechanisms. We want to do the best for the patients in front of us and the best for all the patients we currently care for. This means prioritising our time and efforts to add the most value from our skills and considering the needs of all the other patients who might need our beds or time, this week or next.

We do this in a pressured and resource constrained environment with just about the smallest per capita bed base among rich nations and with hospitals regularly at 90% capacity or more.[4] In the covid-19 era we do so at particular personal risk and under a unique set of pressures concerning infection control.

We know that many patients would prefer to be at home as soon as they are able or to remain at home and out of hospital. We know the many harms that hospital admission risks, including infection, confusion, and deconditioning if people stay beyond the point of acute inpatient care.[5] We also know that repeated trips to specialty outpatient clinics for people with multiple long term conditions or for simple follow-up assessments and tests after hospital discharge are time consuming and inconvenient for them, and are also environmentally unfriendly, because of the additional travel.[6 7]

Of course, when people are admitted to acute care wards we want them to return home once they are sufficiently stable and to continue their rehabilitation or support outside hospital.[8] And we need to think carefully about who we bring back to follow-up clinics and why—even more so now in the face of the backlog of cancelled outpatient work during the pandemic.[9] Furthermore, primary care delivered as part of the General Medical Services GP contract[10] needs better staffing and more funding, and expectations of what it is asked to deliver need to be more realistic.

In our current climate a focus on better support for patients in those first few days or weeks after leaving hospital, with enhanced capacity in specialty community transitional care, could be a win-win-win for hospital staff, GPs, and patients. It could improve continuity of care and communication, reduce the risk of emergency readmission, help to restore independence,[2 11 12] and fill that contested gap between acute and primary care.

But, as with everything else, it can't work if it is not staffed or resourced properly.

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