‘Treat and Street’ - Ambulatory Emergency Care.
What is it and why do we need it.

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Clinical Lead – Delivering Quality and Value
NHS Institute for Innovation and Improvement
Ambulatory Emergency Care

What is it?
• Primary Care?
• Community Care?
• Simplistic shift?
• Or a new way of integrated working?
• Akin to the development of Day Case Surgery
Acute medical care
The right person, in the right setting – first time

Report of the Acute Medicine Task Force

Royal College of Physicians
What is Ambulatory Emergency Care?

RCP (L) Acute medicine taskforce:-

Ambulatory care is clinical care which may include diagnosis, observation, treatment, and rehabilitation, not provided within the traditional hospital bed base or within the traditional out-patient services that can be provided across the primary/secondary care interface.
RCP Acute Medical Care
‘Emergency Floor’
Delivering Quality and Value
Directory of Ambulatory Emergency Care for Adults
Categories of Ambulatory Emergency Care

1. Diagnostic exclusion group
   - Eg chest pain rule outs etc (many already in place)

2. Low risk stratification group
   - Eg low Rockall score GI bleed

3. Specific procedural group
   - Eg effusion drainage

4. Infra-structural group
   - Eg care home admissions
Ambulatory Emergency Care

Why do we need it?

- Acute care activity
- Demographic shift
- Changing capacity
- Understanding bed swings
Emergency Admissions England 1998 to 2006

Admissions

Year


? Impact of 4 hour target
Actual and Predicted Age Distribution UK, 1981 to 2056
Average daily number of available beds England, 1987-88 to 2006-07
In-day variation mismatch admissions & discharges

Emergency admissions and discharges by hour of day for week beginning Monday 01/10/07 EKH

In-day Emergency bed swing = 33
Day to day emergency bed swing

Average daily emergency admissions = 160

Average daily emergency discharges = 160

190 bed swing
Consequences of admissions & discharges variation mismatch

Backlog guaranteed:
- Patients stored in ‘Assessment Units’
- A&E flow compromised
- Patients to the wrong wards
  - Outliers

Additional Cost:
- Overtime, locum, agency and opening wards

Quality
- HSMR and harm events
- Patient and staff experience
Total In-patients
Pareto: cumulative beds occupied by LOS

Pareto of the cumulative emergency bed nights occupied
EKH 2007

- 5% of patients who spend 26+ nights occupy 37% of bed nights.
- 80% of emergency patients who spend 7 nights or less occupy 30% of the bednights.
- 50% of patients who spend 2 nights or less occupy 10% of bednights.
Managing Length of Stay

- Maximise ambulatory care
- Green bed days vs red bed days – flow management – making it happen!
- Complex support needs – but how much is hospital based decompensation?
Ambulatory Emergency Care

How to do it:

• Opportunities
• Implementation
  – Structure – physical and organisational
  – People and behaviours
  – Processes – bundles + safety

• Measurement
  – Activity metrics
  – Outcome metrics
  – Balancing metrics
Critical Success Factors

• Engaging clinicians
• Focus on quality and safety
• Whole system planning
• Horizontal integration
• Joint clinical, managerial and financial governance framework
• Aligning financial incentives
## General Medicine

<table>
<thead>
<tr>
<th>Condition/scenario</th>
<th>HRG codes</th>
<th>OPCS 4.3</th>
<th>% potential ambulatory care primary ICD10 coded admissions</th>
<th>Specific safety issues (not exhaustive)</th>
<th>Links to clinical evidence and best practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deep vein thrombosis</td>
<td>E21</td>
<td>U11.2</td>
<td>Very high - &gt;90%</td>
<td>Thrombophilia or possible malignancy</td>
<td>Procedures for the outpatient management of patients with deep venous thrombosis <a href="www.brcshguidelines.com/pdf/dvt_220506.pdf">link</a></td>
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<tr>
<td></td>
<td>E20</td>
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<tr>
<td>ICD10</td>
<td>I801, I802, I803</td>
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<tr>
<td>Pulmonary embolism</td>
<td>D11</td>
<td>E92.4</td>
<td>High - 60-90%</td>
<td>Massive vs non-massive pulmonary embolism. Thrombophilia or possible malignancy.</td>
<td>British Thoracic Society (BTS) guidelines for the management of suspected acute pulmonary embolism <a href="www.brit-thoracic.org.uk/c2/uploads/PulmonaryEmbolismJUN03.pdf">link</a></td>
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<tr>
<td></td>
<td>D10</td>
<td>U07.1</td>
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<td></td>
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<td>E91.1</td>
<td></td>
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<td>ICD10</td>
<td>I269</td>
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<tr>
<td>Pneumothorax</td>
<td>D49</td>
<td>E91.1</td>
<td>Low - 10-30%</td>
<td>Primary pneumothorax only. Clarity of success of aspiration.</td>
<td>BTS guidelines for the management of spontaneous pneumothorax <a href="www.brit-thoracic.org.uk/c2/uploads/PleuralDiseaseSpontaneous.pdf">link</a></td>
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<tr>
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<td>D48</td>
<td>T12.2</td>
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<td></td>
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<td>T12.3</td>
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<tr>
<td>ICD10</td>
<td>J931, J938, J939</td>
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<td>Condition/scenario</td>
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</tr>
<tr>
<td>ICD10</td>
<td>No specific ICD10 codes</td>
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</table>
Outcome measures

The LHSCC will need to monitor the effect of delivering the directory on patient flows and on its impact on the local health and social care economy. A range of outcome measures will be required, including:

- patient morbidity
- patient mortality (28 days – not just in-hospital mortality rates)
- institutionalisation rate (the percentage of patients not discharged to their usual address)
- lost work days
- re-admission rates (7 day and 28 day)
- patient experience - for example, the efficacy and availability of the contact point can be monitored by patient satisfaction surveys and recording any unprompted 999 calls or attendances at accident and emergency departments.
# South East Coast Strategic Health Authority Opportunities Assessment

## Clinical Scenarios and Emergency Care Admissions

<table>
<thead>
<tr>
<th>Clinical Scenario</th>
<th>No. of Adj. Ad. - Low</th>
<th>No. of Adj. Ad. - Upper</th>
<th>% of total admissions (low)</th>
<th>% of total admissions (upper)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total admissions</td>
<td>267,712</td>
<td>267,712</td>
<td>1.2%</td>
<td>2.4%</td>
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<tr>
<td>GS01 Acute abdominal pain not requiring operative intervention</td>
<td>3,146</td>
<td>6,292</td>
<td>1.1%</td>
<td>2.2%</td>
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<tr>
<td>TO02 Appendicular fractures not requiring immediate internal fixation</td>
<td>2,894</td>
<td>5,787</td>
<td>1.1%</td>
<td>2.2%</td>
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<tr>
<td>GM11 Chest Pain</td>
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<td></td>
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<tr>
<td>GS01 Acute abdominal pain not requiring operative intervention</td>
<td>2,894</td>
<td>5,787</td>
<td>1.1%</td>
<td>2.2%</td>
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<tr>
<td>GM13 Appendicular fractures not requiring immediate internal fixation</td>
<td>2,739</td>
<td>4,109</td>
<td>1.0%</td>
<td>1.5%</td>
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<tr>
<td>GM31 Falls including syncope or collapse</td>
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<tr>
<td>GM24 Cellulitis</td>
<td>1,865</td>
<td>2,798</td>
<td>0.7%</td>
<td>1.0%</td>
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<tr>
<td>GM29 Deliberate self harm</td>
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<td>GM08 Lower respiratory tract infections without COPD</td>
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<tr>
<td>GM10 Supraventricular tachycardias</td>
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<tr>
<td>GM15 Seizure in known epileptic</td>
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<tr>
<td>GM14 First seizure</td>
<td></td>
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<tr>
<td>Total Emergency Care Admissions</td>
<td><strong>34,469</strong></td>
<td><strong>59,423</strong></td>
<td><strong>12.9%</strong></td>
<td><strong>22.2%</strong></td>
</tr>
</tbody>
</table>
South East Coast Strategic Health Authority Opportunities Assessment

Institute for Innovation and Improvement

Crude rate per 100,000 resident population

Primary Care Trust

Crude rate per 100,000 resident population

Brighton & Hove City
East Sussex
Eastern Downs & Weald
Hastings Coastal & Rother
Medway
Surrey
West Kent
West Sussex
SEC SHA Area Total
EKHUT Combined Medicine Admissions (Excl ZLOS)

Number of admissions by site

Month

Site 1
Site 2
Site 3
EKHUT Combined Medicine
Zero LOS Admissions

Month

Number of admissions by site

Site 1
Site 2
Site 3
Launch Directory
Acute Physician
ECC

Number of admissions by site

Month
EKHUT Combined Medicine

LOS (Excl zero LOS)

<table>
<thead>
<tr>
<th>Site</th>
<th>Month</th>
<th>Average length of stay (Days)</th>
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<tbody>
<tr>
<td>1</td>
<td>Nov-04</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Jan-05</td>
<td>8</td>
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<td></td>
<td>Mar-05</td>
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<td></td>
<td>May-05</td>
<td>4</td>
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<td></td>
<td>Jul-05</td>
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<td>2</td>
<td>Nov-04</td>
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<td>Nov-05</td>
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<td></td>
<td>Nov-05</td>
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</tbody>
</table>

Month
EKHUT Combined Medicine
Discharges with LOS >20 days

Number of discharges by site

LOS Board

Site 1
Site 2
Site 3

Month

Number of discharges by site
Managing Length of Stay

- Maximise ambulatory care
- Green bed days vs red bed days – flow management – making it happen!
- Complex support needs – but how much is hospital based decompensation?
Summary

• An enabling document
• Focussing on the patient’s outcome, safety and experience
• Evaluate current opportunities
• Select a small ‘set’ and build on success
• Horizontal integration – true joint working
• Joint clinical, managerial and financial governance

• **NOT** – a demand management tool
• **NOT** – a performance management tool
• **NOT** – a simplistic shift tool