Directory of AEC for adults

This third edition published in November 2012
Previous version October 2010
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?
### Same Day Emergency Care Rates 75th Centile and National Average

<table>
<thead>
<tr>
<th>Clinical scenario</th>
<th>75th percentile rate</th>
<th>Current national average rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal pain</td>
<td>40%</td>
<td>35%</td>
</tr>
<tr>
<td>Anaemia</td>
<td>16%</td>
<td>12%</td>
</tr>
<tr>
<td>Bladder outflow obstruction</td>
<td>30%</td>
<td>23%</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease (COPD)</td>
<td>2.1%</td>
<td>1.6%</td>
</tr>
<tr>
<td>Community acquired pneumonia</td>
<td>12%</td>
<td>10%</td>
</tr>
<tr>
<td>Low risk pubic rami</td>
<td>13%</td>
<td>10%</td>
</tr>
<tr>
<td>Minor head injury</td>
<td>64%</td>
<td>56%</td>
</tr>
<tr>
<td>Supraventricular tachycardias (SVT) including atrial fibrillation (AF)</td>
<td>34%</td>
<td>29%</td>
</tr>
<tr>
<td>Transient ischaemic attack (TIA)</td>
<td>30%</td>
<td>26%</td>
</tr>
</tbody>
</table>
# AEC Delivery Network Proposed Timeline 12 Month Programme

<table>
<thead>
<tr>
<th>Months</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
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<th>12</th>
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<td></td>
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<td></td>
<td></td>
<td>Workshop 1</td>
<td>Workshop 2</td>
<td>Workshop 3</td>
<td>Workshop 4</td>
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</table>

### Action periods
- Local teams develop, test and implement changes

### Input and support
- from expert Network Reference Group & national team

### Workshop 1
- Topic specific Webinars, virtual visit series (1-2 x monthly)
- 1:1 team support (Initial site visit with each organisation plus ongoing support to support implementation)
- Topic specific events eg measurement, clinical skills
Clinical Leads

Dr Vince Connolly

Dr Taj Hassan
Models of AEC - the 4Ps

Passive
  receive referrals

Pathway driven
  restricted to particular agreed pathways

Pull
  senior clinician takes calls for emergency referrals

Process driven
  all patients considered for AEC
New Process for GP Assessment and Ambulatory Care

Overarching principle; *Treat all patients as Ambulatory until proven otherwise*

Non-Condition Specific

Rapid streaming process (All patients now seen within 15 minutes)
Nottingham ‘process model’ What Did We Achieve….

We increased the amount of patients discharged with a LOS of less than 11hrs
The **Amb Score**

<table>
<thead>
<tr>
<th>If Score is high, consider re-direct to ambulatory care unit</th>
<th>FACTORS</th>
<th>1 if applicable</th>
<th>0 if not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Age &lt; 80 years</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Has access to personal / public transport</td>
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<td></td>
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<tr>
<td></td>
<td>IV treatment not anticipated by referring doctor</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not acutely confused</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>MEWS score = 0</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not discharged from hospital within previous 30 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>TOTAL Amb Score (Maximum 7)</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Ala L, Mack J, Shaw R, Gasson A. The Amb Score: A pilot study to develop a scoring system to identify which emergency medical referrals would be suitable for Ambulatory care management. *Acute Medicine* 2010; 9: 139 (Abstract)
Simple rules for patient selection

Is the patient clinically stable?

Is the patient functionally capable of being managed in AEC?

Would this patient have been admitted to hospital before AEC existed?

Could the patient’s clinical needs be met better by another service?
1 Senior clinical input is needed at the point of referral, to redirect suitable patients to ambulatory care.
2 Clear exclusion criteria based on the National Early Warning Score (NEWS) should be developed to maximise patient flow to ambulatory care.
3 Where possible, the AEC service should be located close to accident and emergency (A&E).
4 Staffing and resources should be organised to provide rapid assessment, diagnosis and treatment on the same day.
5 The time standards in AEC should match the clinical quality indicators for ED
6 Patients should be informed early in their journey (ideally in the ED or by the GP) that they are likely to receive treatment that day and are unlikely to be admitted overnight, to manage their expectations and those of their family.
7 Secondary and primary care services should be geared around patient needs and work together to provide ongoing care outside of hospital, to avoid a full admission.
8 Staff training is needed across the local healthcare system to ensure that appropriate patients are streamed to ambulatory care.
9 Comprehensive records must be kept and discharge summaries sent to primary care within 24 hours.
10 Providers must work with commissioners to agree how AEC activity will be recorded, reported and funded.
11 Clear measures must be adopted and monitored to assess the impact, quality and efficiency of the service.
Programme measures - tips

Aim for standard cohort wide data collection

Suggested measures are in the guide including:

- Patient experience / staff experience
- Number of non elective bed days used per month
- Number of 0 LOS patients
- Number of medical outliers
- AEC activity (New and follow up)
- Emergency readmissions (7 day)
- Emergency patient flow (4 hour performance)

Use the 7 step model - baseline, frequent measurement, review, use the 7 points rules
Ambulatory Emergency Care
Guide to measurement for improvement

November 2012

An other results Total score = 56.0

- Benefits beyond helping patients
- Credibility of the evidence
- Adaptability of improved process
- Reliability of the system to monitor
- Staff involvement and training to sustain the change
- Staff behaviour toward sustaining the change
- Senior leadership engagement
- Clinical leadership engagement
- Fit with the organisation's strategic aims and
- Infrastructure for sustainability
The EBD Tool Kit

- Introducing the AEC Service - Patient Leaflet
- The Ambulatory Emergency Care Journey
- AEC Short Animated Film
- Using SMS Mobile Text Messaging Feedback
- Patient Experience Questionnaire
- Volunteer’s Log Book
- A day in the life of... To capture staff experience
- Staff Perspective on patient journeys
Chester - Patient Experience

How would you rate the service you received?

"What a fantastic service from a small team efficient, proficient, seamless and supportive from attendance to diagnosis of a stroke I was kep informed by highgly skilled team "I was blown away" by this initiative WELL CHOSEN"

"Experience ruined by having to wait over four hours for tablets from Pharmacy. Inefficiency on a mega scale and completely unacceptable"
Reported benefits of being in the Network

- Investment for a 2.9m bespoke AEC unit (Whittington)
- AEC has really helped patient flow and achieving the target (Kettering)
- 50% of our GP referrals are now managed in AEC (Notts)
- 83% of surgical patients processed via AEC are saved at least 1 night in hospital (Bath)
- 134 patients were seen during our pilot and all admissions avoided (Glos)
Patients face long A&E waits

Written by CARL MUNGAZI

Waiting times at Milton Keynes Hospital’s Accident and Emergency (A&E) department are some of the longest in the country.

That is the verdict of the Royal College of Nursing (RCN), who have highlighted five A&E departments in the south east that have fallen well below the national average. They say the disappointing figures are down to several factors including pressure on staff.

Department of Health figures show that between January 6 and March 31 this year, just 77 per cent of patients at Milton Keynes Hospital A&E were seen in four hours or less. This compares to the national average, for the same period, of 91.1 per cent.

And the RCN issued warnings that A&E waiting times in the south east of England are continuing to rise.

Victoria Couling, an RCN regional officer, said the startling figures showed an urgent need for expansion.

She said: “I think part of the difficulty is the physical size of the department. When it opened the population of Milton Keynes was lower than it is now.

“The problems are about the physical environment and the growth of the city. I know the Trust is aware of the problem and is working to fix it.”

Me Couling also said nurses were working as hard as they could within the A&E department’s constraints.

She added: “The Trust does have plans about re-designing the department but then we will need to have the capacity to take the people being admitted to hospital.

“We know that we have an ageing population and if the community can’t take them in then they will come to the hospital.

“The NHS is going through some major difficulties at the moment. I believe all Trusts want to deliver good and safe care for the patients.”

MK Hospital’s chief operating officer, Darren Leech, said the hospital was tackling the issue and had recently opened an Ambulatory Emergency Care Unit (AECU), where patients needing urgent care can be treated in one day.

He added: “Like many other hospitals, MK Hospital has experienced unprecedented levels of demand from patients visiting A&E during the period of extended cold weather.

“To ensure all our patients continue to receive safe, quality care in a timely way, we have been proactive in making changes to how we see and treat patients, like piloting a rapid assessment model to ensure that our urgent cases, including those patients who arrive by ambulance, are seen quickly.”
June 2013

“Shadow Health Secretary Andy Burnham visited the hospital to see how a new ambulatory care unit, giving patients a "short, sharp treatment", had helped turn around the department”
An initial improvement from 83% to 91% has been followed by a significant run of points above the new average starting on 9th Feb 2014 and a marked reduction in the variation from week to week.
**Impact so far**

- Reduction in medical LOS

- Reduction in hospital bed days
• 1810 patients seen in AEC during the 3 month pilot
• AEC admission rates through the 3 months ranged from 24% - 31%
• ‘0’ Days LoS increased by 6%
• EAU discharge rate increased by 1%
• Average LoS in EAU down by 1.7hrs
• Full year effect on closing beds is 4.13 beds (+4 trolley spaces closed for space to run AEC)
• Full year effect cost saving realised £234,219
• Friends & Family Score of 73
What has happened? – Surgical AEC

- Approximately 140 patients seen per month

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home same day</td>
<td>48</td>
</tr>
<tr>
<td>Home same day after local procedure/dressings</td>
<td>34</td>
</tr>
<tr>
<td>Operation same day</td>
<td>10</td>
</tr>
<tr>
<td>Admit as normal</td>
<td>5</td>
</tr>
</tbody>
</table>

- Minimum of 82% of patients go home the same day and are saved a hospital stay
Why do it?... Staff and pts love it

All aspects of care were very good. The staff was efficient and courteous, the nurses were professional and caring; the doctors were professional, personable and knowledgeable. A lot of good old common sense evidenced throughout.

Everyone was really helpful, friendly and relaxed, which made it very supportive for me.

Everyone was wonderful. Thank you so much for allaying my fears.

Everyone was so helpful; and very kind. I was less stressed after my care.

Got treated fairly quickly because was in pain/bleeding. Didn't have to stay in hospital to have IV antibiotics - excellent. Excellent and sensitive nurses. Got better!

It feels great to provide great quality care without all that waiting around.
Ambulatory Emergency Care
Six Weeks to Launch a New Ambulatory Care Unit
Milton Keynes Hospital

Ambulatory Emergency Care
Integrated Care in Action
Whittington Health

Ambulatory Emergency Care
A Flexible Approach to Ambulatory Care at Pennine Acute Hospitals
The Pennine Acute Hospitals NHS Trust

Ambulatory Emergency Care
The Logical Way to Go
Networking is the key
“Having taken part in the first and now the fifth intake of the AEC network I am very impressed by the way it has grown and developed. The chance for whole team to take a day out to discuss problems and potential solutions amongst themselves and with other units has always been an excellent feature. However the depth of expertise that the network itself has now pooled really does mean that each meeting has the potential to be a master class”.

Acute Physician 2014
The bigger picture

Best Practice Tariffs for Ambulatory Emergency Care

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Published 2nd October 2014

Acute care toolkit 10
Ambulatory emergency care
October 2014

Across the UK, emergency systems are under considerable pressure, with emergency department (ED) attendances and the conversion rate to hospital admission both rising. Some clinical teams across England have recognised that a new approach is needed, and have successfully redesigned their systems to manage demand by implementing ambulatory emergency care (AEC) as part of the solution. AEC has the potential to have a similar impact on emergency care as day surgery has had on planned care.

What is AEC?

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 outpatient services, and that can be provided across the primary/secondary care interface.

Royal College of Physicians (RCP) Acute Medicine Task Force, and endorsed by The College of Emergency Medicine, 2012.

Implementing AEC ensures that, where appropriate, emergency patients presenting to hospital for admission are rapidly assessed and streamed to AEC, to be diagnosed and treated on the same day with ongoing clinical care. Processes are streamlined, including reviews by a consultant, timely access to diagnostics and treatments all being delivered within one working day. This has improved both clinical outcomes and patient experience, while reducing costs.

Effective implementation requires a whole-system approach to include primary care, and community and ambulance services working with the acute site to establish patient pathways.

This approach is based on the Directory of Ambulatory Emergency Care for Adults, which was first published by the NHS Institute for Innovation and Improvement in December 2009; version 3 was published in 2012 www.umbulatoryemergencycare.org.uk/directory.

Clinical teams using this approach report managing significant numbers of emergency patients quickly, without the need for full admission, converting at least 20–30% of emergency admissions to AEC. Pioneers of AEC have achieved good results, with growing evidence of the impact.

Ambulatory emergency care shares many parallels with day surgery, which has experienced enormous growth, achieved predominantly by changes in mindset and simple alterations to the patient pathway, resulting in safer and higher-quality care. Ian Smith, past president of the British Association of Day Surgery.
For the 1st Annual National Ambulatory Emergency Care Conference on 14th October 2014 Central Hall Westminster, London

Places cost £99 plus £6.59 booking fee, to book your place to go: https://ambulatoryemergencycare.eventbrite.co.uk
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