


Ambulatory Emergency Care

The Middlesbrough Experience

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**Ambulatory
Emergency Care
Delivery Network**

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Background to the Organisation

The James Cook University Hospital is a large district general hospital situated in Middlesbrough, and is one of the hospitals that make up the South Tees Hospitals NHS foundation Trust. The hospital provides district general services for a population of around 330,000 as well as providing specialist tertiary services for a wider population of approximately 1,000,000.

In addition to being the main hospital for the population of Middlesbrough, the hospital also serves rural areas and market towns around its southern fringe. Middlesbrough and Stockton are areas of high deprivation. Chronic conditions, such as COPD, are more common than average, as are mental health issues, self-harm and alcohol abuse.

The hospital's Accident & Emergency department has over 100,000 attendances per year. The Ambulatory Emergency Care service has grown from seeing 1,808 patients per year in 2007 to 5,211 patients in 2011.

Developing a New Model of Emergency Care

Starting Off

In 1998, The James Cook University Hospital was already experiencing challenges relating to emergency care that are common across the NHS. There were very high levels of GP referrals to emergency care and the growing demand was leading to a shortage of emergency care beds. This pressure from emergency admissions was leading to the cancellation of a number of elective procedures which, as well as being frustrating for patients, had the potential to jeopardise the Trust's future viability.

Whilst there was significant pressure on the whole hospital, clinical staff were also starting to realise that some patients were remaining in hospital unnecessarily. For example, in the case of deep venous thrombosis (DVT), the average length of stay was nine days, and during that time they required very little nursing and could be treated at home.

At that time, Yasmin Scott was recruited to establish a Medical Admissions Unit. Having been a sister on the Coronary Care Unit (CCU) she was accustomed to having patients quickly diagnosing and treating before sending them home as soon as possible. Yasmin began to consider whether the rapid diagnosis and treatment approach used on the CCU could be successfully applied within an emergency care setting.

Two physicians, Dr Mahir Hamad and Dr Vincent Connolly began to try to understand the why there were delays in discharging patients that had been admitted for emergency treatment. They came to the conclusion that the main reason was cultural – it was simply accepted practice. There were 20 consultants



who had some input into emergency care, each with their own slightly different way of working. There was an overall preference to admit patients rather than risking discharging them too early because of the perceived risks involved. They also found delays in patients getting diagnostic tests in a timely way, and this impacted on the discharge process.

The first service development made was to establish a new pathway for deep venous thrombosis (DVT). Vincent had previously demonstrated that patients presenting with DVT in an emergency setting, could be managed as outpatients, providing there was appropriate infrastructure in place. The DVT pathway reinforced the concept that not all patients needed to be admitted in order to receive high quality emergency care. So what were their results in Middlesbrough?

The team, built on this success by creating a new service to fast-track the treatment of patients with a range of conditions, including DVT, pulmonary embolism and COPD. The key was to manage any risk associated with treating and discharging patients on the same day, and thus allay the anxieties of clinical colleagues. They achieved this by ensuring that a diagnosis was made quickly and the appropriate treatment was started. Patients could then be sent home with a plan, if necessary, to return to the hospital to receive input from a consultant at a specialist clinic appropriate for their condition.

By the late 1990s, James Cook Hospital had unintentionally become a pioneer for a new model of emergency care that would later come to be known as Ambulatory Emergency Care. Over the years the service has gradually evolved and developed to accommodate a wider range of conditions.



Humble Beginnings

The new service, called simply 'The Clinic', had humble beginnings, as Julie Suckling, Directorate Manager of Accident and Emergency at James Cook Hospital explains:

"To start with, it was located in a former storeroom close to Ward One: Our remit was, and still is, to offer patients faster access to diagnostics and same day discharge. The service has now grown beyond anything we could have anticipated. In the case of DVT, for example, at first we had two scan slots, three days a week. Now, we have four scan slots every day. At the same time, treatment of the condition has advanced. Patients with DVT no longer have to have a drip, they can be given anticoagulant treatment and managed in the community, which means they can receive their treatment at home."

Purpose-Built Premises

In 2004, James Cook Hospital opened a new, purpose-built unit to provide same-day diagnosis and treatment of emergency conditions. At first, the unit was hampered by delays in diagnostics, as Yasmin explains:

"Patients on the unit were not given the same priority as in-patients, so staff took to subversion, even dressing patients in pyjamas and dressing gowns so they looked like in-patients in order to get them seen and diagnosed quickly. This situation was not acceptable, so we sat down with the diagnostics teams to explain what we were trying to do and negotiate to be given the same priority as the wards. This has been successful and now, we are able to get same-day diagnostics for most of the conditions we treat."

Today's Ambulatory Emergency Care Unit

Today, the renamed 'Ambulatory Emergency Care unit' which is adjacent to the Emergency Department, is open seven days a week, from 8am to 9pm on weekdays and 8am to 8pm at weekends. The unit has four trolleys, four consulting rooms and a discharge lounge. It treats an average of 23 patients a day. In January 2012, the unit handled 469 of the 2,133 emergency referrals to the hospital – around 22% of all emergency admissions. This is a typical monthly level.

The number of conditions treated in an ambulatory way has grown rapidly. The unit now manages a whole range of medical emergencies, including COPD, cardiac failure, cellulitis, diabetes and low-risk gastro-intestinal bleeds. The teams apply clinical risk scores to identify which conditions can be treated in an ambulatory way rather than taking a specific individual pathway approach. This means that a wide range of conditions and co-morbidities can be treated - an important change of approach that has enabled a significant increase in the number of patients treated in an ambulatory way. The unit handles blood transfusions and a growing number of surgical cases.

GP Support

GPs can telephone the Ambulatory Emergency Care unit after 1pm Monday to Friday, following their morning surgeries, to receive direct advice from consultants on any potential medical emergencies. Both the telephone helpline and the ambulatory care service are proving popular with GPs, who like being able to reassure patients that they will receive a diagnosis and treatment for their condition on the same day.

Critical Success Factors

The team at the James Cook Hospital have identified three important factors for consideration when developing an Ambulatory Emergency Care service;

1. Specialist Support Clinics

One of the primary success factors for the Ambulatory Emergency Care unit has been the creation of specialist clinics that patients can be referred to for further investigation and treatment. Vincent Connolly, Chief of Service Acute Medicine and Consultant Physician explains:

“Patients with a range of conditions are diagnosed and stabilised on the Ambulatory Emergency Care unit. Then, if further treatment is needed, they are referred to one of our weekly ambulatory emergency care clinics, which are held on the unit. These clinics range from gastroenterology through to pleural diseases.

We believe that it is better for specialists to provide treatment for certain conditions, rather than generalists. The result is a better patient experience and improved outcomes. Patients with diabetes, for example, sometimes have a poor experience of in-patient care because not all hospital staff understand how to manage their condition appropriately. However, if there is a specialist clinic, staffed by diabetologists, it becomes more than possible to manage the symptoms of hyperglycaemia in an outpatients setting.”

Day	AM	PM
Monday	1. Nurse Led DVT / PE clinic	1. TIA clinic
	2. Gastro clinic	2. Diabetes and GM clinic
Tuesday	1. Nurse Led DVT / PE clinic	1. TIA clinic
	2. Thromboembolic Disease and Heart Failure clinic	2. Pleural Disease clinic
Wednesday	1. Nurse Led DVT / PE clinic	1. TIA clinic
		2. Chest clinic
		3. GM clinic
Thursday	1. Nurse Led DVT / PE clinic	1. TIA clinic
	2. Thromboembolic Disease and GM clinic	2. Chest and GM clinic
Friday	1. Nurse Led DVT / PE clinic	1. TIA clinic
		2. GM clinic

2. A Change in Culture

The Trust has a deliberate policy of recruiting staff who support its Ambulatory Emergency Care objectives. Yasmin explains:

Our people have a particular mindset... My job is to stabilise the patient and get them safely home.

"Our people have a particular mindset, which is 'I am here to assess the patient and to admit them only if absolutely necessary. My job is to stabilise the patient and get them safely home.' Assertiveness is another important quality. We want staff who are prepared to challenge consultants if they see significant variation in the treatment of certain conditions.

Our culture is to encourage staff to challenge and not to get upset if they themselves are challenged. We have good retention rates and a well-motivated team, so we know it is working. Local GPs are also embracing our new approach to emergency care – it is telling that patients no longer arrive at the hospital with their suitcases."

3. Community Support Services

For the last 10 years, the 'FAST Team' has worked alongside the Ambulatory Emergency Care unit to provide rapid response support services to patients who need them. The team, which includes Occupational Therapists, Physiotherapists, Social Workers and Senior Nurses, carries out mobility assessments on the unit and can visit the patient at home, once they have been discharged, to provide further support if necessary.

South Tees has higher levels of alcohol abuse and self-harm than the national average, and the Psychiatric Liaison Team makes daily visits to the Ambulatory Emergency Care unit to carry out risk assessments with appropriate patients and support them after discharge.

Both services have grown out of the need to help support patients to return home sooner by responding to the causes of delayed discharge.



The Benefits of an Ambulatory Model

Vincent believes that the arguments for an ambulatory model of emergency care are compelling:

"The austere financial climate and rising demand makes admitting all medical emergencies increasingly unsustainable and there is growing recognition that there needs to be a paradigm shift in the way that acute medicine is managed. This has led to an interest in ambulatory emergency care across the NHS. The Department of Health has signalled its support for this approach by introducing the new Ambulatory Emergency Care (Same-Day Emergency Care) Best Practice Tariff from April 2012.

"Most patients prefer to be treated in an ambulatory way if they can."

"The simple fact is this, most patients prefer to be treated in an ambulatory way if they can, as they don't want to be admitted to hospital. Staff like it too because they are providing a fast, responsive service and helping patients to get home quickly. There is compelling evidence that specialists rather than generalists provide better acute care which is why, here in Middlesbrough, our approach centres around the ambulatory emergency care clinics, which treat a growing range of conditions in an out-patient setting

An ambulatory model of emergency care provides more structure and predictability than is usually achievable in an emergency setting. It also provides better training opportunities for junior staff, who work under close supervision of the consultants delivering the specialist clinics. All of these are compelling reasons for developing such an approach to future emergency care."



The Ambulatory Emergency Care Delivery Network

Vincent is one of the clinical leads for the NHS Institute's Ambulatory Emergency Care Delivery Network. The network aims to support organisations to accelerate their implementation of Ambulatory Emergency Care by sharing best practice and supporting one another to adopt new approaches to emergency care. James Cook Hospital has played a central role, sharing both its successes and its challenges with other Trusts. Yasmin points out:

"Massive cultural change like this is not without its challenges. At first, we encountered huge resistance within the hospital and problems in gaining sufficient access to diagnostics. We also faced problems with a lack of sufficient community support services. Our involvement in the network has enabled us to pass on our learning to other organisations and show them how we overcame these and other challenges."

The Future

The Trust is currently working on a transformational project to further develop its Ambulatory Emergency care approach by identifying admission avoidance strategies for an even wider range of patient pathways, including oncology and gynaecology.

Yasmin concludes: "I am proud of the team we have created here and the culture we have engendered. There is a great deal of enthusiasm amongst our staff and a willingness to do things differently. Other managers in the hospital have said to me in the past "I wish we could bottle what you have and sell it." My tips to other organisations setting out on the ambulatory emergency care journey are:

- Be prepared to be challenged.
- Address diagnostics at an early stage.
- Be prepared to adapt and change as you go.
- Foster the right 'can-do' culture.
- **Engage everyone who is going to be affected by the change early on.**
- **Involve your staff in developing the solutions.**

What is Ambulatory Emergency Care?

The traditional model of acute medicine involves the admission of patients to hospital to be assessed by a consultant and facilitate access to investigation and treatment. Ambulatory Emergency Care is based on the idea that medical emergencies can be managed in an outpatient setting, providing that the appropriate support services are available. There is no "one-size fits all" approach and each Trust needs to develop its own ambulatory care model, based on local circumstances and patient need.

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The Consultant's View

Dr Vincent Connolly

"Ambulatory emergency care is about helping hospitals to cope with their growing emergency workload in a practical way.

"I came to James Cook Hospital in 1994 as a senior registrar and became a consultant two years later. My background is in diabetes and, when we first began thinking about our approach to emergency care, I was aware that if someone turned up at my clinic with high blood sugar, I would look to manage them as an outpatient. However, if the same person turned up at A&E, they would be admitted and started on intensive intravenous therapies. In other words, the treatment a patient received was based on where they went rather than what they actually needed.

"Treating emergency conditions in an out-patient setting is all about managing risk. We do that here in Middlesbrough by providing access to specialist knowledge and support in a series of weekly clinics. This gives staff the confidence that patients can be safely managed outside the hospital.

"One of the main challenges that we have had to overcome is our relationship with diagnostic teams. They tended to follow a very traditional approach and it took some negotiation for us to convince them that what we wanted to do was an appropriate way to manage patients. We don't find ourselves having these discussions now as they can see the benefits for

Don't be frightened to innovate and change what you are doing. You will reap the rewards."

"Ambulatory Emergency Care is a positive experience for patients, whose emergency episode can be dealt with in a few hours. It is positive for the Trust, with more than 20 patients per day being taken out of the normal emergency pathway. And it is positive for staff, who feel energised by doing something new and different, and who have fantastic opportunities for career development.

"Our involvement with the Ambulatory Emergency Care Delivery Network has been great as it has given teams the energy and confidence to forge ahead with even greater changes.

"My main piece of advice to other Trusts embarking on this journey would be: don't be frightened to innovate and change what you are doing. You will reap the rewards."



Ambulatory Care

The GP's View

Dr Nigel Rowell, The Endeavour Practice, Middlesbrough

"The Ambulatory Care Unit works brilliantly for conditions that require daily outpatient treatment, such as heart failure, which is treated with intravenous diuretics. It is, in effect, a day hospital. Patients have daily contact with a consultant who monitors their condition. In the past, someone with DVT would have spent days lying in hospital awaiting their scan. Now, they are scanned on the same day and treatment gets underway immediately. It is a much smarter way of working and patients like it. They prefer being able to go home rather than being admitted to hospital.

"The key to all of this is rapid access to diagnostics. If someone comes to me complaining of back pain, I am concerned about possible spinal cord damage. I want them to be seen by a consultant quickly to rule this out. This is where the Ambulatory Care Unit is a real benefit

"I regard the growth of Ambulatory Emergency Care as a good thing but I do have a word of warning. It is worth remembering that GPs are running at capacity, as well as secondary care. There is no point simply transferring the workload from secondary to primary care – for example, by sending a patient home and specifying that the GP must visit them.

We all have to work smarter. For GPs, this might mean asking social services to support patients, making increased use of telecare, or asking community matrons to undertake some of the workload. It would also be good if hospital consultants were to reintroduce domiciliary visits, as we had 20 years ago. The support of a community geriatrician or oncologist would be invaluable."



Julie Suckling

"I have worked on the Ambulatory Emergency Care unit since it was first set up in 1995. I started as a healthcare assistant, now I am managing the unit and A&E.

"There are several factors that have contributed to the success of ambulatory emergency care here in Middlesbrough – strong leadership, receptiveness to change and a passionate desire to improve care for patients. We have learned as we've gone along and adapted to make things work.

"As managers, we lead by example and don't ask colleagues to do what we wouldn't want to do ourselves. It is a very democratic and supportive environment. Staff at every level are given autonomy and encouraged to challenge decisions if they don't agree with them. We have engendered a culture of mutual respect.

"Ambulatory emergency care is all about ensuring patients are managed in the most appropriate way by providing senior level decision-makers at the front of house. We aim to assess every patient within 15 minutes and to have them seen by a doctor within one hour.

"The approach is not without its challenges. As with every part of the NHS, we are striving to deliver a good and effective service at the same time as making greater efficiencies. Growing demand from an ageing population will put the service under even greater pressure as time goes on.

"However, patients really like ambulatory emergency care and this is reflected in the results of our patient satisfaction surveys. They like the fact that they can be seen by a senior clinician and decisions made quickly about their care. There is faster access to diagnostics and, for people who work, it is great not to have to be admitted to hospital to receive the treatment they need.

"I am proud of the fact that we put patients first and listen to what they want. We have developed a fantastic team here in Middlesbrough and I love working for the Trust. There is a real commitment to change."

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The Nurse Practitioner's View

Karen Ewart

"I have worked on the unit for 10 years. It has expanded a lot in that time – now we also take medical, surgical, urology and vascular patients, as well as patients with chest pain.

"This is a bright, open clinic and we have a really dedicated team. We always have at least one consultant on the unit, as well as a nurse practitioner or clinical sister, a band 5 nurse and a healthcare assistant. From 1pm, all of the telephone calls received by the bed bureau are triaged from here.

"It is fast-paced and hard work and you have to be able to think on your feet to work here. But, we have great team rapport and a good working relationship with the doctors. We are encouraged to ask questions and given lots of training opportunities. A lot of us are Advanced Life Support trained and several of us are working towards Nurse Prescriber status.

"On an average day, we treat between 20 and 30 patients, as well as handling follow-up reviews and scans. You always want to make sure the patients get everything they need done quickly and that can be challenging sometimes. We can't always get blood tests back as quickly as we'd like, but we walk them down to the lab to speed things up.

"The feedback we get from patients is overwhelmingly positive. They don't want to be in hospital and they know if they come in here we can get them sorted out and get them home."



Ambulatory Care

The Clinical Matron's View

Debbie Christian

"When we first set up the Acute Assessment Unit, as it was then, we couldn't always process patients as quickly as we wanted to, there were a lot of waits. Sometimes, we would send them home and organise for diagnostic tests to be done the next day, but we wouldn't tell the diagnostic team that they were outpatients. Of course, we got "found out" in the end but we sat down with diagnostics and explained why we'd been breaking the rules. Once they could see how this approach would help us to reduce length of stay and allow us to admit only patients who really needed to be in hospital, they came on board with the idea and things began to improve.

"We now provide a seven-day service, with diagnostics available every day. We have six ultrasound slots per day and the flexibility to book more. CT scans are available at any time and we can take patients directly to the X-Ray unit. When the unit first opened, we had to send a request for diagnostics and await a response. But, meeting them face-to-face and explaining what we were doing and why made a huge difference. We now have a very good relationship with the diagnostic teams and they do their best to accommodate whatever we need.

"I interviewed patients on the unit recently as part of our work with the NHS Institute. The feedback was very good. Patients like the speed of investigations. The fact that the unit opens early in the morning and into the evening means that they can have the treatment they need without it impacting on their working life. Patients also praised the fact that the unit holds take-home medications, so they are not forced to wait around for prescriptions before they can go home.

"I would say that a good team is critical for an approach like this to work. We respect each other's opinion, no-one's views are discounted. And, there is nothing that I would ask a healthcare assistant to do that I wouldn't do myself.... if I was free, I would make a bed, I wouldn't wait for a healthcare assistant to do it.

"You need an area that is fit for purpose, as environment is important. We are now in the right place – next to A&E and radiology – and with the right facilities. We are used to taking a proactive approach to "pull" patients through the system faster. Our staff will phone and chase up scans whereas the culture in other parts of the hospital is to wait.

"My advice to other Trusts is that you need to build good relationships with other divisions, such as radiology and pharmacy, and having face-to-face discussion is the best way to do this. You also need buy-in from your whole team so that you are all working towards the same goals.

"There will always be some people who don't see the benefits of what you are doing and you can't expect things to run smoothly all the time. But, you need to be prepared to get up again if someone knocks you down and carry on. When you see the benefits to patients at firsthand, it makes it worthwhile."

