Treating emergency patients in a day

The Weston Experience
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About Weston Area Health NHS Trust

A District General hospital with approximately 250 beds, serving the population of North Somerset (around 200,000). Weston-super-Mare has a higher percentage of elderly people than the UK average (44% of the population is over the age of 75) and there are also alcohol and drug-related issues.

The hospital’s Emergency Department deals with approximately 50,000 attendances per year. This leads to around 14,000 emergency admissions, with between 30 and 45 patients being admitted every day.
Treating Emergency Patients In A Day
– The Weston Experience

At Weston Area Health NHS Trust, back in 2006, demand for emergency care was outstripping supply on a daily basis. Many patients were having a poor experience and staff were frustrated and demoralised by the situation. The Trust management knew it had to act. It examined the data around emergency admissions and realised that not all of them were appropriate. But, if admission was not the answer, how could it deal with these patients differently?

Deborah Thompson was, then, General Manager for the Emergency Care Division. She discussed the issue with the Clinical Director and they hit on the idea of opening a medical day case unit where patients with certain conditions could be assessed and treated on the same day and then sent home. Deborah explains:

“We looked at what patients needed and there was a very strong case for a medical day case unit. It just seemed a logical way to reduce the number of emergency admissions and improve the experience for patients. We didn’t know what we were creating and we didn’t know what to call it.

At the time, we hadn’t heard the expression ‘ambulatory care’. So, we called our new unit the Assessment Treatment Centre and put up a notice on the board asking if any staff would be interested in helping us to run it. It was to be a six-week pilot. That was five years ago. In 2011, the unit was renamed Ambulatory Care on the back of national recognition of ambulatory care as an approach to emergency care. It has become an extremely busy unit and is contributing significantly to a reduction in emergency admissions.”
National focus

The concept of ambulatory emergency care has become the focus of increased attention across the NHS. The Department of Health is introducing a new best practice tariff related to ambulatory emergency care in April 2012.

As pioneers of this approach to emergency care, Weston is taking an active role in this network and is keen both to share its experiences and to learn from others.

Deborah explains why she believes the concept of assessing, treating and discharging patients on the same day is proving to be so successful for the Trust:

“Everyone wins. The patients love it because they can find out quickly what is wrong and start receiving treatment immediately. No-one really wants to be admitted to hospital so finding out they can go home the same day is a real plus. The staff love it, too, because they can provide fast, responsive treatment that can be followed up, if necessary, by the Collaborative Care Team and Community Services. GPs are enthusiastic because they can refer people to the unit who are not poorly enough to be admitted to hospital but who require urgent treatment that the GP is unable to provide.”

In 2007, the NHS Institute for Innovation and Improvement published the first version of The Directory of Ambulatory Emergency Care for Adults. The directory outlines conditions that it is possible (at least in part) to treat patients in an ambulatory way. To continue its focus on this important area, the NHS Institute recently launched the Ambulatory Emergency Care Delivery Network to support organisations wanting to develop or enhance their ambulatory emergency care services.
A slow start

The unit currently treats 170 patients per month and is estimated to save the hospital around 100 bed days a month. However, it has not always been so successful. The concept of ambulatory emergency care was slow to get off the ground and the Trust’s original plan to have a GP-run unit failed.

“At the beginning, we wanted GPs to run the unit,” explains Deborah, “but we couldn’t generate enough interest to cover the rotas. However, our Clinical Director at the time; Dr Harbans Bhakri was passionate about the idea of ambulatory emergency care and agreed that hospital physicians should provide the medical cover instead. In hindsight, GPs are unlikely to have been able to fully meet the complex needs of patients, so this was the right way to go.”

Foresight

The Trust also struggled to make a business case for ambulatory emergency care, as the Head of Financial Planning, Nick Mortell, points out:

“When we launched the pilot, it was difficult to convince the Trust to invest in a unit whose sole aim was to reduce admissions, thereby reducing its income. In the long-term, we were fairly sure that the Trust would benefit from fewer admissions and reductions in length of stay, but this required a leap of faith, as we couldn’t offer any assurances. In the end, the PCT agreed to pump prime the initiative.”

Deborah adds: “The commissioners at the time had the foresight to see that this would work for the benefit of the Trust and the wider health economy. I was able to see the potential benefits quite clearly and made a strong argument for the new approach, backed by our Clinical Director. Within two or three weeks, it became very clear to everyone that the new unit was helping us to avoid admissions.”

Developing the service

When it started out, Ambulatory Care (then known as the Assessment Treatment Centre) was just a bay within a ward, run by Carina Thompson, a Senior Nurse on secondment from elsewhere in the hospital. Evidence that the unit was having an impact within weeks of its launch helped Deborah to make a case for the pilot to be extended from six weeks to a year.

“I looked at the activity of the unit during the pilot and forecast that the new unit would be able to handle 1,200 patients in its first year (in the event, it was 1,207). To work with the commissioners on a local tariff, I added up our staffing costs and divided this by the number of patients we would see. I realise now that I should have included the cost of equipment, consumables and other services in this figure, too, as they were quite significant. I would advise other organisations to make sure they include all
of the costs, not just staffing costs. I also failed to appreciate that doctors on the unit need to bring patients back in for follow-up appointments, so you need to allow for follow-ups as well.”

The PCT agreed to provide funding for a further year but, still, the unit was not on a permanent contract. This only came in 2010/11. Deborah comments:

“One of the main challenges all the way along has been keeping the Ambulatory Care function going, particularly in the first three years. It was always on the cusp of being a “service cull”, but we have succeeded in convincing commissioners and the executive team that it is a necessary service and now we have the evidence to prove this.”

**Reduced costs**

As the Ambulatory Care unit has reduced demand for emergency admissions, the Trust has been able to reduce capacity, which has brought down costs. It now has 100 fewer beds than in 2009.

Deborah attributes this reduced demand, in part, to the work of the Ambulatory Care unit and the Collaborative Care team (CCT), which began working alongside Ambulatory Care in October 2010. The CCT, which includes 21 whole-time equivalent nurses, OTs and physiotherapists, provides care in the patients’ own homes to avoid emergency admissions and hospital readmissions and to support early discharge. Once patients leave the Ambulatory Care unit, the Collaborative Care team can provide up to five days’ care at home, if necessary. While they are being cared for by the CCT, patients remain under the care of the consultant on the Ambulatory Care unit. After five days, patients who require on-going support are referred to Community Services.

**Extending opening times**

Today, Ambulatory Care at Weston is a far cry from its humble beginnings as a couple of beds on a side ward. After moving three times to different locations around the hospital, it is now co-located with the Emergency Department. The unit has 15 beds, with separate bays for male and female patients. A movable wall allows staff to maximise capacity, whilst meeting the requirement to provide single-sex wards. There are also recliner chairs and a four-bedded clinical room for assessment and taking bloods. Staffing is provided by two registered nurses, two non-registered nurses, a staff grade doctor, a junior doctor and a consultant.
The unit is open from 10am to 7pm, Monday to Friday. The Trust recently piloted an 8am to 8pm opening and is considering how it could open the unit over the weekend. Deborah points out:

“When we have audited hospital admissions, we can clearly see that there are avoidable admissions when the Ambulatory Care unit is closed. We are looking at ways of extending opening hours and we have also recently begun a system whereby patients who are well enough to go home can be discharged from the Emergency Department and asked to return to Ambulatory Care the following day. We hope to begin scheduling patients into the unit at specified times in the near future.”

Rapid pace of development

The pace of change has picked up in the last 12 months. Deborah comments:

“The Ambulatory Care unit evolved even faster in 2011, galvanised by our involvement in the NHS Institute’s Ambulatory Emergency Care Delivery Network. Our priorities now are to develop the role of registered nurses so that they can undertake tasks that can currently only be performed by doctors, such as prescribing. This will help to reduce delays. We are working with the ambulance service to encourage them to refer category C patients (non-time critical) directly into Ambulatory Care rather than the Emergency Department. We are also reviewing our staffing in the face of increased demand and our changing case mix. In particular, we will be recruiting a manager for the service to release time for Carina, our senior nurse, who has been having to undertake managerial tasks. The new manager will also facilitate Ambulatory Care and the Collaborative Care Team working together more effectively as a team. We are also recruiting an administrator to free up nurses’ time to deal with more patients.”

Feedback from patients who attended an Experience Based Design Approach workshop [www.institute.nhs.uk/ebd] indicated that many people were not sure what the term “ambulatory care” meant. In response, the Trust designed a patient information leaflet which explains the concept of same-day assessment and treatment without admission to hospital.

Celebrations

The success of the Ambulatory Care unit is a cause for celebration at Weston. Deborah says:

“I am proud of the way the patient experience has improved and the fact that we have managed to achieve our aim of reducing emergency admissions. We rarely have to admit a patient from Ambulatory Care into the hospital.

“We have been very lucky with Carina, who runs the unit - she is so caring and compassionate. Patients imagine the worst when they suddenly
become very sick. It makes such a difference to them to be seen, assessed, diagnosed and treated the same day, they think it is fantastic. Staff on the unit get such excellent feedback, they started asking patients to sign their comments and to include a contact telephone number as they thought managers would think they had written the comments themselves!"

**Challenges**

As with any new service, there have been challenges to overcome along the way. As it has developed, the Ambulatory Care unit has become a victim of its own success. Deborah comments:

“...When you set up a new service, you can’t plan for the new demands that you will create. At the Ambulatory Care unit we found that wards began referring patients to the unit for post-discharge follow-ups. Very quickly, this could have taken up all of our capacity so we have put in place controls to reduce the number of follow-ups from in-patient admissions. These need to be managed in a different way. We have also seen a big increase in demand for infusions for rheumatology patients. Previously, these patients were sent to the hospital in Bristol for admission, but now they are routinely referred to Ambulatory Care. This is creating huge demand that needs to be managed more effectively. We plan to create a service within the rheumatology department that can administer infusions. Based on our experiences in managing demand, my advice to other organisations would be ‘be clear about your treatment criteria and bear this in mind as your service develops’."
Key Learning

Weston is keen to share the lessons it has learned with other organisations that are just beginning their ambulatory emergency care journey. One of these is not to be too specific about which patient pathways are appropriate for Ambulatory Care:

“We began specifying which types of patients were suitable to refer to Ambulatory Care,” explains Deborah, “but we found this built in a constraint as our colleagues then wouldn’t refer other patients. So, we prefer to specify who we won’t see (i.e. children under 16, people with psychiatric conditions or anyone with cardiac chest pain) so that everyone else can be triaged through the unit.”

The Trust also noticed that Ambulatory Care operates far more effectively when co-located with the Emergency Department. Deborah says:

“The unit has moved several times to different locations in the hospital. When it was located next to the Emergency Department, we noticed an immediate improvement in communication and patient flow between the two units.”

Staff in Ambulatory Care have access to the Emergency Department’s computer system and patient tracking boards. If they identify a patient who they believe could benefit from ambulatory care, they can proactively approach the Emergency Department.

Deborah concludes:

“Our work with the Ambulatory Emergency Care Network, which is run by the NHS Institute, has shown us that there is no single “right way” to approach ambulatory emergency care. There are a number of Trusts in the network and every one has a different approach – all are equally valid. To be most effective, you need to design your service according to the needs of your patients. It is good to learn from other people but, ultimately, you know your organisation and local population best. Our Ambulatory Care unit and Collaborative Care Team fulfil our aims of admission avoidance and supporting patients to maintain their independence in their own homes.”
Janet Poole, 64

What brings you to Ambulatory Care today?

I came into Oncology yesterday and they referred me here today. I developed an infection after chemo and I’ve been very uncomfortable and need to have treatment to ease the pain in my stomach.

What do you think of the unit?

The Oncologist I see comes from Bristol and he said I’d have to be in hospital overnight – I suppose that’s how they do it in Bristol. But, the unit here in Weston said it could be done in one day if I waited until today. I was really pleased. I didn’t want to stay in hospital overnight. The last time I had this done, I was on a ward overnight having half-hourly observations. It was so busy and I felt really unwell afterwards. As long as you’re OK, it is much better to go home – you can rest better and relax better.

I’ve received wonderful treatment in Weston Hospital and had a very pleasant experience on the unit today. There is a nice atmosphere and you don’t feel afraid to go in. The staff are very nice and you feel that they have more time for you. I was surprised that they could treat me within a day but really pleased. It means I should be well enough to visit my son next week. I suppose it frees up a bed for someone else who needs it, as well. If I have a problem again, they’ve said I can just ring Oncology and come onto the unit again to get it sorted out.

Neil Hallworth, 49

Why were you referred to Ambulatory Care?

My GP sent me for a blood transfusion. Last time I was admitted to the ward and spent 24 hours in hospital. The blood infusion was done overnight and I didn’t get any sleep because they kept coming to take my blood pressure all through the night. It seemed like a very long night and I was exhausted the next day.

What has been your experience of the unit?

This is my first time here and I’m very impressed. It is a lot more relaxed than being on a ward and it’s much more pleasant to be able to go home in the evening. They always worry at home so it’s better for my family too.

Why do you think it works so well?

People like Carina. You could do with more like her in the NHS. That’s why it’s a success. Also, it’s quick and they keep you informed. Last time I sat in A&E for two hours before I went up to the ward. I didn’t know Ambulatory Care existed before today.
Ambulatory Care
The Nurse’s View

Carina Thompson, Senior Nurse, Ambulatory Care Unit

“I am passionate about ambulatory emergency care. If it were my mum or dad, I’d want there to be a facility like this where they could be seen, have access to MRIs/CTs, bloods, whatever they needed, be diagnosed and for their treatment to begin on the same day.

“Patients get better in their own environment. A lot of them who come here are anxious. I want to get them sorted out quickly, to put their minds at rest. If they need a lumbar puncture, I want them to have a lumbar puncture, be reviewed, diagnosed, treated and then go home as soon as clinically suitable. They can come back the next day if they need further treatment. People start to feel better straight away when you tell them they can go home.

“We try to make the atmosphere here as relaxed as possible. Patients are allowed to use mobile phones so they can text or talk to their family and friends. Crucially, this means that loved ones can ring them direct so they are not sitting at home worrying about what is going on. If I can give patients a blanket and a nice cup of tea, tell them what is going on and keep them updated throughout the day, the relationship with them is so much better.

“Quite a few of the patients we see are elderly. In the past, they would try anything to avoid coming into hospital and, so, they were leaving it too late and only coming in when they were really poorly. But, word of mouth is helping to spread the news that they can come in and be treated on the same day. I have noticed that patients are now coming in much sooner, which is better for them and means fewer complications, so less drain on resources.

“I have a close working relationship with the Collaborative Care Team, they are based on my unit so I can talk to them and arrange for them to go round and check on a patient when they go home. We’re not talking about a complex social care package many months down the line here, but a friendly face who, maybe, has been to see the patient on the unit and can then follow up within a day or so to make sure they’re OK when they get home.

“Ambulatory emergency care has been a long time coming but the benefits of it are huge. It keeps Accident and Emergency free for acute emergencies and the wards free for poorly patients. Patients who are well enough can come in here and have the tests they need and the treatment they need and then go home.

“I don’t deny there are challenges. It can be hard for doctors to discharge patients on the same
day as they tend to want to keep them under observation for at least 24 hours. You need to encourage them to come over to a new way of thinking. I show them what we've done before and explain to them that I've talked at length with the patient and they understand their condition and, if they suddenly get worse, they will come back. The doctors are getting more confident at discharging patients. Sometimes doctors are reserved about discharging patients when they are not sure of the appropriate care or treatment that is available for them in the community. This is where the Collaborative Care Team really helps as they can get the patient a safe haven bed in a local nursing home to provide their care while they are properly assessed.

“Attendance at the Ambulatory Care centre can seem costly, as patients in Ambulatory Care still receive all of the scans and treatment that they need, but the difference is that it is done within a day. This means we avoid admissions, which frees up acute, surgical and medical beds. In addition, patients are less likely to pick up hospital-acquired infections when they’re treated on the same day and, so, develop fewer complications as they recover in their home environment. I always remind people that there is a patient behind all of the statistics and arguments. It comes down to this: this is the way that I would like to be nursed if I needed it. Rapid access to senior clinicians and same-day treatment is the way forward.”
Ambulatory Care: The Consultant’s View

Parag Singhal, Clinical Director

Parag is one of three physicians who provide medical cover for the Ambulatory Care unit. He has been involved with the unit since its outset.

“We began the Ambulatory Care unit as a pilot and our first challenge was how to implement the idea from a nursing and medical perspective. It would be a very different experience for patients, and, for us as consultants, taking the decision to send patients home same-day created anxieties and challenged our traditional approaches.

“Initially, we concentrated on very simple conditions, such as DVT or Cellulitis. However, as the unit has grown and our confidence has increased we have tackled more and more conditions until the Ambulatory Care unit as it is today has become a major force within the hospital. Now, we are treating patients with conditions that I wouldn’t have imagined could be treated in an ambulatory setting. For example, we now routinely assess, diagnose and treat patients with a pulmonary embolism on the same day. Previously, these patients would have been admitted and stayed in hospital for about three days. Another example is patients that need either a pleural (chest) or ascitic (abdominal) drain. These patients are referred to us by their GPs, who have established the need for an intervention. We then diagnose the problem and treat the patients that day. Before we were able to offer this service, patients would have been admitted for a couple of days. More importantly, patients with conditions like this experience high levels of discomfort and anxiety, so receiving prompt effective treatment makes a big difference to them and really improves their quality of life and experience of health care. “Our common aim is that anyone who is walking (“ambulatory”) should be assessed and treated on the unit. The mindset of the unit is “this patient has to go home today.” The unit closes at 7pm and it is only under exceptional circumstances that a patient gets admitted to the hospital. Most consultants expect to be able to observe a patient on the ward for at least 24 hours so this is a very different approach for us, but we have risen to the challenge.

“To make a unit like this succeed, you need strong leadership – whether it is from a nurse or a doctor – and Carina’s passion to make patients welcome and help them to feel better has been fundamental to the growth of the unit. Therefore, my advice to any other organisation looking to adopt a similar approach would be “choose a senior nurse who is passionate about this approach and who wants to make it succeed, as the interaction between nurse and patient is key.”
You also need a team of consultants who believe in the idea and who have the confidence to discharge patients on the same day. Their confidence will grow over time but you need to choose confident consultants at the outset, as processes are only as good as the people who implement them.

“I am proud of the patient feedback that we receive on the unit. It is extremely rare for us to have a complaint. In the future, I would like to see even more conditions treated in an ambulatory setting and for the unit to be open 24-hours a day, seven days a week. I would like GPs to be actively involved on the unit, too. The NHS does not have the resources to fund indefinite numbers of hospital beds, so if we can find effective ways to avoid hospital admissions, that has to be a good thing for everyone.”

Ambulatory Care
The Consultant’s View
Dr Richard Darling,  
GP Riverbank Medical Centre

Dr Darling is former Chair of the North Somerset Urgent Care network and is a local GP who has been actively involved in the setting up of the Ambulatory Care unit. He says:

“The idea for an Assessment and Treatment Centre (now renamed Ambulatory Care) came about following discussions with local GPs in Weston who identified the need for a service for patients who needed urgent assessment but who, probably, didn’t need to be admitted to hospital (and, by this, I mean in their pyjamas and in a hospital bed overnight). Initially, the idea was for local GPs to run the unit, but we couldn’t find enough GPs willing to take it on, so the hospital agreed to manage the unit.

“Ambulatory Care has suffered from being shifted around the hospital over the years, but now that it is co-located with A&E, it is able to deliver fully on its goal of providing acute ambulatory care for patients who, previously, would have been admitted to hospital. There are a number of reasons why this is better for patients: often the clinical outcomes are the same whether people are treated in hospital or at home, and most patients would prefer to be treated at home. Also, the sort of patients we are talking about are often elderly. There is a danger of them becoming “sucked into the system” once they are admitted to hospital. They can quickly become institutionalised and their support networks can break down. It can then take a huge amount of effort to get them back home and their stay in hospital can become lengthy.

“The benefit of the unit for us as GPs is that we can phone up and have the reassurance of knowing that our patient will be seen immediately, without any interruption to their home support arrangements. GPs receive a discharge summary extremely promptly – often the same day – so we can see exactly what treatment the patient has received, helping us to provide continuity of care.

“The main thing we have learned from our experiences here in Weston is that there has to be something in this for everyone. Historically, staff in the NHS have referred to elderly people with complex but not serious conditions as “bed blockers” so there is clearly an advantage to them to avoid admissions, and it is in the patients’ interests, too. However, there has to be a multi-disciplinary team in place to take over the care of these patients at home. The Collaborative Care Team (CCT) in Weston fulfils a vital role in providing rapid response care at home for patients who have been treated in Ambulatory Care or the Emergency Department. If patients receiving treatment from the CCT run into medical problems, the team refers the patient back to the hospital, as they remain under the care of hospital doctors while they are being seen by Collaborative Care.

“To make ambulatory care work, hospitals need to develop a new mindset. The traditional secondary care approach
to treating a patient is to assess the illness, to develop a plan to treat it and then to search for a hospital bed where treatment can begin safely. Now, we are asking hospitals to assess the illness and stabilise patients, but to manage their treatment in a completely different way and to get people back home quickly, where they want to be. This means assessing risks in a new way and developing the confidence of consultants and community teams to allow patients to be treated outside hospital.

“GP commissioners need to realise that hospital beds are expensive and that ambulatory care is the way to go. They need to work together with hospitals to make this happen. If hospital doctors are trying to protect their admission rates, there will be a problem. Similarly, if community services are not well-established, there will be a problem.

“Making a financial case for ambulatory care can be quite difficult, however, the best healthcare systems in the world have worked out that it is far cheaper to manage people outside a hospital setting.

“Patient feedback for the Ambulatory Care unit in Weston is almost universally positive. Our experience here has taught us that you need to keep elective and emergency treatments separate as it is difficult to manage one alongside the other. Also, to work effectively, the Ambulatory Care unit really needs to be close to A&E, in an urgent care environment. Working relationships are crucial, too. Hospital doctors need to be given the confidence to discharge patients on the same day and they need to be assured that there is a strong community support team who can care for the patient at home. This approach is hugely beneficial for all concerned, but don’t underestimate how long it will take.”
Julie Thomas is a Discharge Manager at Weston Hospital. She manages the Collaborative Care Team and, here, explains the team’s crucial role in avoiding hospital admissions, expediting discharge and ensuring patients receive the right support in the right environment.

“I joined Weston Area Health NHS Trust in May 2011,” says Julie. “The PCT is actively involved in trying to prevent hospital admissions and, for some time, a team of four primary care discharge liaison nurses were based in the Emergency Department to provide a Meet and Greet service that would identify individuals who might be able to receive care from the community services team and avoid admission to hospital. This service had some success, but it was not enough. A case was made to expand the team and integrate all elements of the team to be managed by the hospital.
“In June 2011, the new team was formed and became the Collaborative Care Team, commissioned as a pilot for 2011/12. The aim of the expanded team is to provide up to five days’ of home-based care for patients who have been seen in the Emergency Department or Ambulatory Care. During this time, patients remain under the care of hospital physicians and can be brought back into Ambulatory Care for further treatment at any time. At the end of five days, patients who require ongoing care can be transferred to the relevant community services teams.”

Prior to the introduction of the Collaborative Care Team, patients who needed home-based support were referred directly to Community Services by the Hospital Discharge Team. The benefit of the Collaborative Care Team is that it bridges the gap between hospital-based and home-based care. Staff from the team can assess patients while they are in hospital and then visit them at home to provide intensive treatment in the crucial first few days. This consistency of care gives patients confidence and offers them a familiar face who can answer questions about their ongoing care. The Community Care Team is well-informed about the range of support service available from Community and Social Services and can refer patients on to the most appropriate teams, if necessary.

In August 2011, the Collaborative Care Team was relocated so that it is now adjacent to the Emergency Department and co-located with Ambulatory Care. The aim was to improve communication and collaboration between the three departments. Julie explains: “We take patients from the busy ED environment and bring them into our assessment area where we can assess their clinical requirements and home environment to determine how we can best support them. We then devise a care plan. We have access to five nursing home beds if we need them, and our multi-disciplinary team includes OTs and Physiotherapists who can provide ongoing support. We also have care managers who work with social care teams and can fast-track referrals. Our urgent care remit allows us to circumnavigate some of the lengthy social care processes that our Community Services colleagues have to follow and get referrals underway quickly, which is beneficial to patients.”

The Collaborative Care Team and Community Services work closely together to provide a seamless service for patients. To facilitate this, members of the Collaborative Care Team shadowed their Community Services colleagues when the team was first established to give them a good understanding of the services on offer and how the Community Service team works. Collaborative Care Team staff have joint appraisals with Julie Thomas and Jane Haros, Head of Community Services. Julie explains why it is important for the two services to work closely together: “The majority of patients that we work with are elderly, some of whom are frequent fallers and some who have social issues. Our aim is to get them back into familiar surroundings as quickly as possible to speed their recovery. Once elderly people develop an in-patient mindset, it can be quite difficult to rebuild their confidence and they can become prone to infections and complications, so it’s important to get them home as soon as possible.

“Once home, together with Community Services, we help to maintain their independence and keep them out of hospital. This might mean providing equipment to help them or supporting them through rehabilitation after fractures. As well as offering support to patients, we provide reassurance for carers by demonstrating that we are on hand to assess the home environment and ensure it is safe for the person to return to.”
Sometimes, the work of the Collaborative Care Team can be as simple as providing reassurance to patients and organising practical support, such as someone to care for pets while they are in hospital, or someone to bring a bed downstairs for people with mobility problems, working with a Home from Hospital team and charities such as Age Concern who provide this type of practical help.

Julie summarises the benefits of the Collaborative Care Team to other hospital staff: “The team has a good reputation. Ward staff and staff on ED find us approachable and there are no onerous referrals processes to follow. They simply call us and, later the same day, a member of the team visits to assess the patient. We are proactive in helping to avoid admissions and reduce length of stay. We attend the daily 8.30am meeting in the Emergency Department to find out about the patients they have in that day. It may be that some are already known to us or that we might be able to provide support to new patients. We also walk to wards to see if there are patients that we could help with and we attend daily bed meetings and discharge meetings.”

Julie is proud of the fact that the Collaborative Care Team, most of whom originated from an acute care background and were facing redeployment when their ward closed, have seized this opportunity with both hands. “Despite the fact this is a pilot project, the team has not held back. It is really good to hear comments from patients like “They’re good, old-fashioned nurses.” Without a doubt, there have been challenges. The overlap with Community Services has been one of the biggest challenges and so, too, has the fact that most of the policies and processes we follow are designed for an acute care setting rather than a home environment. However, we are working to overcome these challenges through open and honest communication.

“My advice to anyone setting up a similar service would be to make sure you get engagement from the Community Services team at the outset by networking and asking for their input and ideas. They are the experts after all. In the future, we hope to become even more closely integrated with Community Services. I would also like to blur the boundaries between acute and community care, so that there is a shared team delivering Collaborative Care services. Also, I would advise organisations to be very clear on what data they need to capture and the reporting processes they will use. You need to think about how you will measure the success of the service from the very beginning – we developed measures as we went along so we don’t have a complete picture of the service impacts.

“We have found that being part of the Ambulatory Emergency Care Delivery Network has heightened our enthusiasm for the Collaborative Care Team service. After a while, you tend to take it for granted but when other Trusts don’t have a service like this and they ask you all about it, it makes you realise just how good it is.”
10 Top Tips from Weston

1. Co-locating Ambulatory Care with the Emergency Department and the Collaborative Care Team helps to improve communication and patient flows.

2. Avoid being too specific about which conditions are appropriate for ambulatory emergency care otherwise staff may avoid referring other kinds of patients. It may be better to specify which conditions/types of patients are not suitable for ambulatory care.

3. It can be difficult to make a financial case for ambulatory care at the outset as it focuses on avoiding hospital admissions, which has the potential to reduce income. It may be better to explain the patient benefits (quicker recovery and improved experience) and the long-term financial gains for the system as a whole (e.g. reducing bed days).

4. Get as many people in the organisation engaged at the outset by networking, explaining your objectives and asking for input and ideas. Frame your explanation of the service differently for different groups of people so everyone can see how they will benefit.

5. Be aware that the service may become a victim of its own success and be clear about your treatment criteria.

6. Learning from the experience of other organisations, such as becoming involved in the Ambulatory Emergency Care Delivery Network can help to galvanise the service and speed its development.

7. Encourage the team to work closely with Community Services – a team such as Weston’s Collaborative Care Team can provide an important bridge between hospital-based and home-based care for sicker patients.

8. You may need to adapt policies and processes to cover both acute-based and community-based care provision.

9. Staff and patients need a different mindset to make ambulatory care work effectively. Consultants need support to develop the confidence to discharge patients same-day and patients need support to understand that treatment can be just as effective outside hospital.

10. Design your service according to the needs of your patients. There is no one, correct way to do it.