



Ambulatory Emergency Care

Maximising AEC
to improve emergency
care access



Introduction

Mid Cheshire NHS Foundation Trust has been on an ambulatory emergency care journey that has taken it to the top of national league tables. Over the last three months, the Trust has consistently been in the top 10% for achieving the four-hour target. Its improvement work has been so significant it caught the attention of Jeremy Hunt, Secretary of State for Health, who described it as “a remarkable achievement.”

Although the Trust’s ambulatory care journey began approximately four years ago, it is only really in the last 12 months, since joining the Ambulatory Emergency Care Network, that Mid Cheshire has seen the full impact. This is their story...

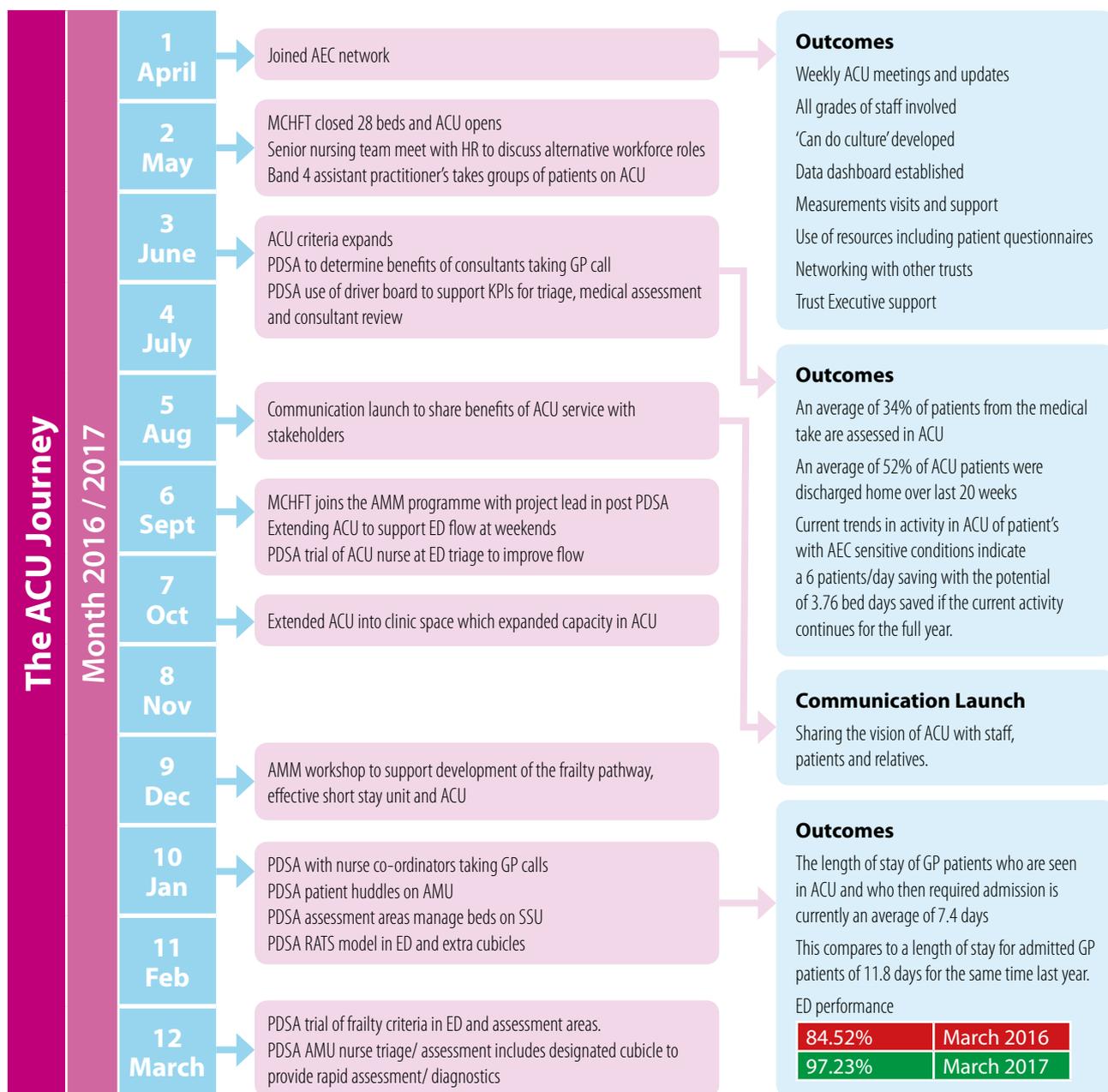
Even when something appears to be working well, there is no reason to believe it can't work better. That was the opinion of clinicians at Mid Cheshire NHS Foundation Trust in April 2016 in relation to Ambulatory Emergency Care.

Over the preceding four years, the Trust had developed a combined approach to urgent care, comprising A&E and an adjacent Primary Assessment Area which functioned as an Ambulatory Care Unit. On the face of it, the ambulatory care model was working well, however, clinicians were convinced that more could be done to maximise the impact. A visit by the CQC in October 2014 drew attention to the fact that the Primary Assessment Area was frequently fully bedded with patients despite being unsuitable for overnight stays. Not only did this provide a poor patient experience but it also hindered its ability to work as a true Ambulatory Care Unit.

"The Primary Assessment Area was deemed an inappropriate area for patients to be staying for any length of time by the CQC," explained Tony Mayer, Divisional General Manager Medical and Emergency Care, "there was no natural light and no proper ward facilities."

Director of Operations, Jonathan O'Brien added:

"In Winter 2015/16 it was clear that our assessment units were not performing as they should. A&E was blocked, patients were being bedded in an unsuitable area and we were seeing large number of patients referred by GPs who actually needed rapid diagnostics rather than A&E services. We needed to get our ambulatory care service functioning properly to improve patient flow."



Overnight bedding

In 2015 the Primary Assessment Area was moved to one half of a 32-bedded ward, with 16 flexible spaces for trolleys. The Trust introduced the concept of the “golden patient” whereby patients who were approaching 24 hours in the Primary Assessment Area were given priority discharge status. Despite these changes, many of the problems persisted. Although the area was more suitable for patients than the previous location, the fact that the Primary Assessment Area was housed in a ward environment made it easy for patients to remain overnight. This compounded the problem of overnight bedding and meant staff were forced to use adjacent day rooms and any space that could be found to provide ambulatory care services.

Joining the Ambulatory Emergency Care Network

A more radical change was needed. Associate Medical Director, Doug Robertson had been part of the Ambulatory Care Network in a previous role with another Trust. He was keen for Mid Cheshire to join the Network as he believed it would help them to tackle some of the problems they were facing and reconfigure the AEC service to make a bigger impact. In April 2016, Mid Cheshire joined the Network.

Jonathan O'Brien explained:

“We already had a team with great vision for ambulatory care. What the Network gave us was the structure we needed internally to make it happen, plus peer support, guidance and a lot of encouragement.”

A dedicated Project Lead

Doug explained:

“It has been interesting to compare and contrast the two experiences, having been involved in the Network on two separate occasions and implementing an improved ambulatory care service both times. I've noticed that certain things have worked particularly well for us in Mid Cheshire. Having the funding for a dedicated individual to drive the project forward without the pressure of their clinical responsibilities has been a particular benefit. Loraine Cornes was appointed as our Project Lead. As a clinical matron, Loraine has a background in acute care but also has received training in improvement science from the Network and at A&E improvement events. She has been instrumental in driving the project forward and keeping staff engaged and informed. Loraine met with staff on a weekly basis to build momentum and address any problems as they arose.”

Local champions

Doug also believes that having local champions has been an important contributor to success in Mid Cheshire:

“We have a very positive nursing culture which acts as a good driver for change. Rather than feeling that I had to be in the driving seat, we have taken a more distributed approach and given our nurses a lot of freedom to drive the improvements. Our Access and Flow Co-ordinator organised a visit to the Ambulatory Emergency Care Unit in Wigan so staff could see how it worked and what our service could look like. This helped to inspire and motivate us but the actual day-to-day working of the unit was self-generated by the teams involved.”

Staff reflection 'Proud to work in ACU'

“Whilst working my shift one day on ACU, we accepted a young lady who had presented to the accident and emergency department with a history of severe neck pain. The lady had received a CT scan investigation prior to being transferred to ACU and was waiting the outcome of the results. The lady and her family were very anxious. As part of my role as an assistant practitioner I have responsibility for my own group of patients and was allocated to provide care for this lady in ACU. On arrival to the unit, I welcomed the lady to ACU and helped reassure her by explaining the care we would provide in ACU. I introduced myself as Tracey explaining who I was and that I was there to help in any way, whether it was a question, advice or a cup of tea. We offered the lady a quiet room to sit in as I could see that she was distressed. The results came back of the CT scan which indicated a lymphoma which was very difficult news for the lady. We arranged for the Consultant to speak to the lady alongside the oncology nurse, who was going to speak to her afterwards to explain possible treatment. Arrangements were made for this lady to attend Christies Hospital over the weekend by the staff on ACU and a letter organised for the lady to take with her to explain the care and investigation results. Despite my patient receiving a bad diagnosis she was so appreciative of the care she had received on the Ambulatory Care Unit. On discharge from ACU there were hugs between us and my patient said it was the little extras that she would remember.

Providing care to my patient in this way makes me proud to work on ACU.”

Tracey Steele, Assistant Practitioner ACU. (Oct 2016)

A self-contained unit

In May 2016, the Primary Assessment Area moved again, this time onto a former renal unit adjacent to the Acute Medical Unit. Tony Mayer commented: "We immediately saw an improvement. The newly located Primary Assessment Area (PAA) was self-contained and not part of a ward. It was close to AMU with its own entrance, but not directly adjacent to A&E. From the outset, we sent out a clear message to colleagues that it was impossible for patients to get a bed in the PAA as it was not equipped as a ward. This meant that we no longer faced the problem of overnight bedding, which meant that we could start to operate as a proper Ambulatory Care Unit."

Broader admissions criteria

Despite this, there were still problems with GP patients being sent to A&E and with high numbers of patients being admitted from A&E. The Board was not convinced that ambulatory care was making a big enough difference and, a few weeks after the Primary Assessment Area moved for the third time, it was under threat of closure.

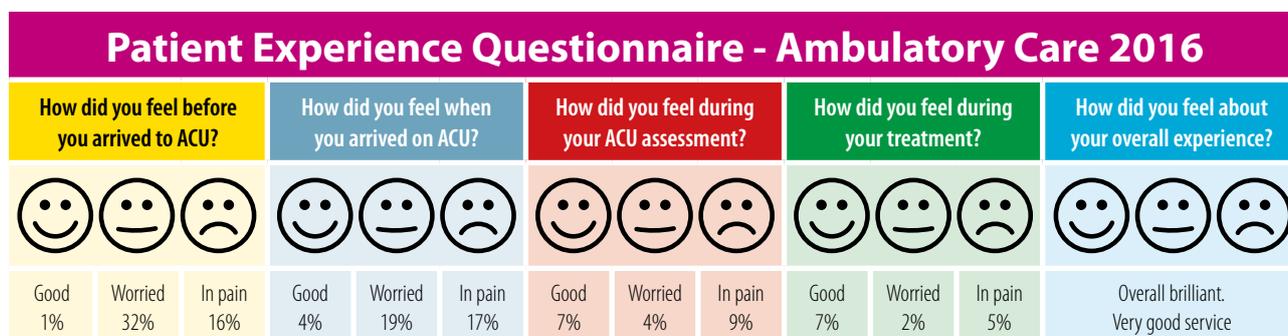
The biggest turnaround came when the team decided to broaden the admissions criteria for ambulatory care, as Loraine Cornes, Project Lead and Matron for the Primary Assessment Area explained:

"We made the decision to accept virtually all patients as ambulatory with the exception of potential stroke patients, patients with chest pain and those with active infection as we had no isolation facilities. This meant that we were immediately seeing more patients. We also worked with the Network to develop a set of key performance indicators that would help us to measure and monitor our progress."

Measurement

Measurement proved a key factor in securing executive buy-in, as Doug explained:

"Because we had had a few false starts with ambulatory care, it took a little while to convince the executive team that it was a worthwhile investment of time and resources. What really helped was Mike Holmes from the Network showing us how to present our data in a way that really meant something to people. Over time, we have been able to demonstrate a reduced length of stay and a growing percentage of the medical take being seen in Ambulatory Care. Our target was for 30% of the medical take to be seen in the unit. By 6 June 2016 we had achieved 37%. We have also been able to show that there has been no adverse impacts on patient experience, as some people had feared."



We had a vision for ambulatory care and as a team we made this happen together

Loraine Cornes,
Matron March 2017

PDSA cycles

Mid Cheshire used a PDSA (Plan Do Study Act) approach to develop its AEC services. Tony explained why:

“PDSA is a highly effective way of testing a concept prior to implementation. We look at the problem and the possible steps we could take to address it. Then we implement one of the solutions and assess the impact before deciding whether or not to accept it or reject it. Being able to work in an environment where we can learn as much from a failed test as we can from a successful one was fundamental to the development of the service”

The team used a PDSA cycle to assess whether GP calls to Ambulatory Care could be handled by nurse co-ordinators, rather than consultants as originally intended. Loraine said:

“We were keen to avoid unnecessary hospital admissions and believed that providing a direct line to the Patient Assessment Area for GPs to call would support this. In the first few weeks, consultants answered GP calls but we wanted to see if nurse co-ordinators could take on the role without any adverse impact. After the PDSA cycle we could clearly see that having nurses handling the calls had helped to increase throughput of patients onto the unit. Consultants had more time to dedicate to caring for patients and we maintained the same discharge rates, which meant that we were continuing to select the right patients for Ambulatory Care. This showed us that it was fine for nurses to answer GP calls rather than asking consultants to do it.”

“There have been a lot of small processes that have been introduced on our ambulatory care journey, which have added up to some big changes”

Staff buy-in

Tony added:

“Another benefit of using PDSA cycles is that it encourages staff to buy into the process because they are actively involved in testing it out and ensuring that it works. Rather than trying to get something perfect before it is implemented, PDSA allows us to try it out and adapt it in response to whatever we find. Utilising Experience Based Design was also a key feature as it allowed us to collect the views of the service user and implement adjustments in order to constantly improve their experience.”

Doug said:

“There have been a lot of small processes that have been introduced on our ambulatory care journey, which have added up to some big changes. For example, nurses used PDSA cycles to develop a whiteboard which provides an effective way of moving patients forward systematically. The data we gather from these cycles quickly overcomes any scepticism.”

Involving the ambulance service

The Ambulatory Care team also involved the ambulance service in re-routing patients from A&E. Once it had moved to its current site adjacent to AMU, the Ambulatory Care Unit had its own dedicated patient entrance and ambulance staff were encouraged to bring patients directly onto the unit rather than going to A&E first.

“This has been transformational,” said Doug. “Over the years we have built a really good relationship with our ambulance crews. We are good at managing turnaround times, which means we don’t keep ambulance staff waiting before admitting patients to the Emergency Department. We explained to them that we were keen to improve the patient journey and get them to the right place more quickly and they have been completely supportive of this.”

Impact

The number of patients seen within the four-hour target at Mid Cheshire has risen from 84.9% in March 2016 to 97.21% in March 2017. The hospital has 49 fewer beds occupied each day.

The Trust was the provider with best improvement in bed occupancy across the whole of England from the third quarter of 2015/6 to the third quarter of 2016/7.

Recognition

This impressive performance was recognised by Secretary of State for Health, Jeremy Hunt who wrote to the Trust saying:

“Mid Cheshire Hospitals NHS Foundation Trust is a real example to others, demonstrating how to improve performance in a short space of time and ensure your patients get the care they deserve.”

He added:

“Improvement on such a scale is very impressive and testament to the hard work and dedication of the Trust’s staff.”

Mid Cheshire's Chief Operating Officer, Denise Frodsham commented:

"It is very clear to see the impact that Ambulatory Emergency Care has made here in Mid Cheshire. It has transformed the delivery of urgent care for patients by moving us to a more planned, co-ordinated approach driven by a strong, cohesive team. It has improved patient flow and performance and enabled us to make better use of our resources.

"This is about getting it right first time for patients. Such has been the success of this approach that we are now expanding into surgical AEC. I am very proud of the work that our team has done. They have led it and owned it and it has made a real difference to patients."

The difference the Network made

Jonathan O'Brien, Director of Operations added:

"When we began our journey in 2016, we had an Ambulatory Care Unit that was more or less continually bedded and didn't have a proper home within the hospital. The executive team were supportive of our wish to join the Network and we were able to second Loraine to become our project lead, which made a big difference.

"We relocated the Ambulatory Care Unit to an area where it couldn't be bedded and, with the encouragement of the Network, we put in place robust systems and processes to get it functioning properly. I now have complete confidence in our ambulatory care offering. I know that GP referrals will be redirected from A&E unless there is a clinical need for them to be there and once patients arrive in Ambulatory Care they will be seen quickly and diagnosed within four hours or less. Fifty per cent of them will be discharged without being admitted to a hospital bed.

"We wouldn't be where we are today without the support of the AEC Network. Twelve months on, we have a unit that is functioning really well and we are receiving requests from other trusts to come and have a look at what we are doing. Our Ambulatory Care Unit got us through this winter without any major problems. We have just joined the Surgical AEC Network and hope to replicate the same success as our medical model over the next 12 months."

We have joined the new Surgical Ambulatory Emergency Care Network and recently opened a dedicated Surgical Ambulatory Care Unit."

Next steps

As Jonathan explained, Mid Cheshire is now embarking on the next step of its ambulatory care journey by developing a surgical ambulatory care service. Tony said:

"We have been very successful in pulling the medical patients out of A&E but, of course, the surgical referrals were still there. We have joined the new Surgical Ambulatory Emergency Care Network and recently opened a dedicated Surgical Ambulatory Care Unit."

Success factors

Mid Cheshire has identified a number of key factors that it believes have contributed to the huge success of AEC over the last 12 months:

- Strong clinical leadership and empowered nurses.
- PDSA cycles that have allowed them to carry out a controlled test of change prior to implementation.
- Support from the Ambulatory Emergency Care Network, particularly to secure executive buy-in.
- Developing a data dashboard that demonstrates performance in a single graph that is meaningful for staff.
- Inspiration from visiting other Ambulatory Emergency Care Units at other Trusts.
- Weekly catch-up meetings chaired by the Project Lead and attended by the Divisional General Manager, acute physicians, bed managers, staff from Ambulatory Care and ED and the wider multidisciplinary team.
- Effective data sharing so staff can see what is going well and the difference it is making.



AEC at NHS Elect
Suite 2, Adam House
7-10 Adam Street,
London, WC2N 6AA

Tel: 020 7520 9088

Email: aec@nhselect.org.uk

www.ambulatoryemergencycare.org.uk