NHS
Ambulatory Emergency Care Network

Ambulatory Emergency Care

How Sunderland quadrupled its Ambulatory Care intake

www.ambulatoryemergencycare.org.uk

Introduction

In 2013/14, City Hospital Sunderland was treating an average of 43 emergency patients a week as ambulatory. By 2015/16, that had risen to an average of 186 patients – up by more than 400%. This extraordinary performance is due to a whole-system approach to Ambulatory Emergency Care, which has been led by NHS Sunderland CCG. This is their story…

Work to develop a whole-system Ambulatory Emergency Care (AEC) service in Sunderland began as a small eight-bedded unit at City Hospital. By 2015, the hospital had identified that the unit was insufficient to meet growing demand. With the support of NHS Sunderland CCG, City Hospital joined the AEC Network as part of its plans to grow the service. Around the same time, the CCG began to look in earnest at how AEC could become not simply a hospital-based service, but a whole-system service.

Tracey Lucas, Urgent and Ambulatory Care Clinical Lead for NHS Sunderland CCG explained:

"AEC has always been too tough a nut for us to crack. Avoiding hospital admissions has tended to be seen as the hospital's problem but we believe the only way to really address the problem is to develop a whole-system approach and for admission avoidance to be a priority for all health and social care organisations.

"We recognise, however, that we can only avoid admitting patients if viable alternatives to admission actually exist. So, alongside changing the perception that AEC is a problem for acute care only, we needed to ensure that robust systems were in place to support the provision of effective emergency ambulatory care."

Whole-System Approach

To kick start the AEC improvement work, Sunderland brought together representatives from across the health and social care system – including GPs, nurses, consultants, paramedics, pharmacists and community services - for an initial brainstorming event to discuss and plan what an AEC work program would look like for Sunderland. They agreed that avoiding hospital admission is a collective concern rather than simply a problem for the acute trust and began creating a vision for a whole-system approach.

A working group was created, with representatives from across all of the different stakeholder organisations, all of whom had the seniority to make strategic decisions. The working group's vision was to have:

"Clinical discussion between key partners to ensure the right patients benefit from AEC, in the right place, time and by the right professional thus providing a simple and seamless pathway to patients across different sectors – AEC is not a location but a philosophy of care"

The group, led by the CCG, developed a five-strand AEC programme of work, the aim of which was both to address the philosophy of AEC and to target specific processes or pathways. The programme comprised:

- An acute medicine decision-makers pilot, to provide GPs with immediate access to telephone-based advice from local hospital consultants to support the uptake of alternative pathways (Consultant Connect)
- Ambulatory care pathways for core conditions such as cellulitis and DVT
- Direct access to the Ambulatory Care Unit for the ambulance service (Paramedic Pathfinder)
- Engaging the public, staff and patients in the change process
- Developing a communication strategy to keep all partners and patients fully informed, consisting of a dedicated website and videos explaining AEC.

Engaging with GPs

Sunderland CCG holds bi-monthly Time In/Time Out sessions for General Practice to provide clinical training and update them on the CCG's organisational responsibilities and their progress against operational plans. On these days, practices close at 1pm so that GPs, practice managers and nurses can attend the events, which are held in a local sports stadium. These sessions provided an ideal showcase to share progress on the AEC programme, enabling the CCG to reach a vast audience quickly and to invite regular GP feedback and questions.

A collaborative approach

The AEC programme is supported by senior clinical and managerial staff from each of the key organisations, who meet regularly to review the work. Debbie Burnicle, Deputy Chief Officer of Sunderland CCG is one of two commissioner sponsors. She explained:

"As a sponsor, my role was to help to create the vision for the project, to set the aims and agree objectives. While frontline staff, usually clinical staff, worked through the day-to-day issues and challenges and identified how things could be improved, the sponsors supported them to make these necessary changes. In particular, we helped to engage senior clinicians, remove barriers and provide a joined-up perspective. Clinical time is precious so we needed to ensure that our clinicians felt fully-supported to do what they needed to do and their time was used effectively."

Debbie added:

"Collaboration is key for us here in Sunderland. It is important for us to understand the providers' issues and for everyone to be on board with what we are trying to achieve. This is one of the reasons we were chosen to be a national vanguard for developing a new care model for out of hospital care and a pathway approach to AEC. This work enables more people to be supported at home or a reduced length of stay in hospital. We saw this as a challenge for the whole system to tackle and asked for everyone's input into designing an approach that would work."

Think 'Home First'

Service Reform Manager and Ambulatory Care Programme Lead for NHS Sunderland CCG, Natalie McClary said:

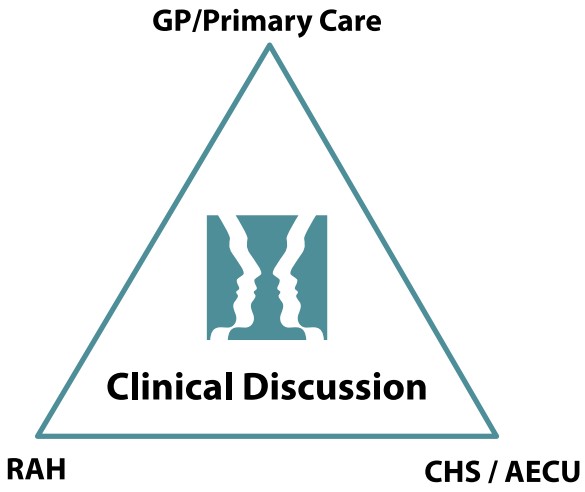
"Sunderland CCG is one of the 50 NHS England Vanguard sites tasked with developing new care models to act as blueprints for the NHS moving forward. Our vanguard community care model has enabled us not only to focus on the top 2-5% of our vulnerable population, i.e. multidisciplinary hubs, but has also supported the development of a strong, integrated community service infrastructure, housing together community nursing, equipment, social care and out of hour GP services within the same building. The community service hub is called Recovery at Home (RAH). It is a big enabler to delivering our AEC work programme as it means patients don't get admitted to hospital when they don't need to be and can be kept at home with the support of our community hub. No one wants to be in a hospital bed unless they absolutely need to be. Our aim is to change the culture and behaviour from assess to admit to assess and discharge – Think Home First!"

"No one wants to be in a hospital bed unless they absolutely need to be."

A philosophy of care

Tracey explained:

"We wanted to embed the idea that ambulatory care is not a location but a philosophy of care. One of the strands of work is called the Decision-Maker Project. It looks at how we can get patients to the right place first time by supporting clinical decision-makers, primarily GPs. We believe this is one of the keys to providing a seamless service."



Consultant Connect

One of the initiatives piloted as part of the Decision-Maker Project was Consultant Connect, a telephone helpline that GPs can call for general medicine advice about patients who previously may have been sent straight to ED or the local GP admission suite. The majority of calls are taken by a consultant, or if not then by a registrar or nurse practitioner. The telephony system enables any unanswered call to be routed to the next clinician, reducing the need for the GP to keep trying to get the call answered. The idea is to facilitate clinical conversations between senior decision-makers and also to be able to signpost possible alternatives to hospital admission that GPs might not be aware of. There are multiple benefits:

- **Better patient experience** – speeds up the care pathway, avoids unnecessary patient visits to hospital, reduces follow-up visits to GPs.
- **Better GP experience** – more patient episodes conclude with no follow-up work, case-based learning, reconnecting with consultants.
- **Better consultant experience** – reduction in inappropriate referrals, reduction in the number of written requests for advice that require responses, reconnecting with GP.
- **Better for the hospital and CCG** – full tracking of advice and guidance activity, greater 'whole system' efficiency, with savings available to support other hospital and community initiatives.

All calls are recorded and a selection of them are reviewed by the AEC project multidisciplinary team, consisting of hospital and primary care colleagues.

"Listening to the calls enables us to see how effectively GP enquiries are being dealt with and also shows us quite clearly where there are gaps in our provision," said Tracey. "It quickly becomes apparent, for example, if a new pathway is needed. We feed this information back at our regular GP events and act upon it."

Natalie added: "At first some clinicians were sceptical about Consultant Connect, especially it's connection rates, but now there is wide scale appreciation of the service. It allows GPs to have quick clinical conversations with consultants, with the patient present in the room, about whether or not a patient needs to be admitted and enables consultants to advise on alternative courses of action, if necessary. 90% of practices are now using the service and we have just extended the pilot for a further six months. We are currently scoping additional planned and unplanned specialties to come on-line, for example, general surgery AEC."

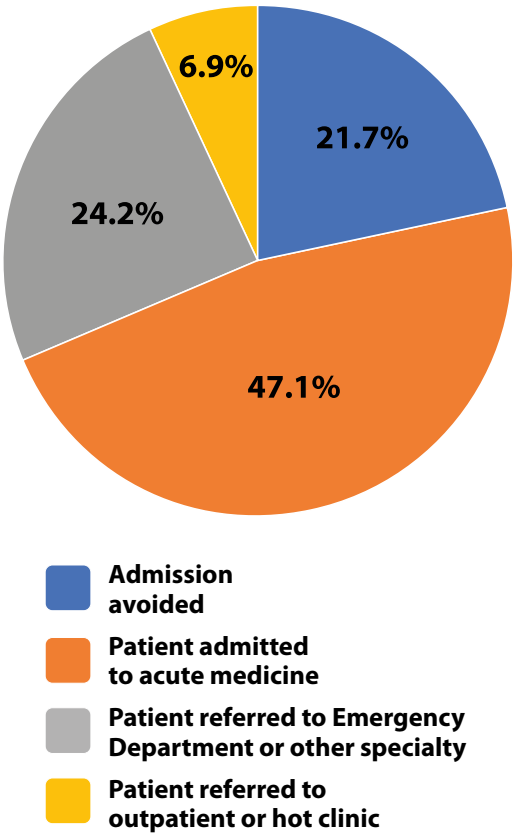
Initially, the GP medicine admission bleep was staffed by nurse practitioners. The idea of piloting a 'quick and direct' telephone advice line was introduced to replace the bleep system with medical consultants or registrars - the most senior decision-maker available - answering the calls. "Our previous audits had shown that we were more likely to avoid admissions if GPs could have a senior level clinical discussion with a consultant," explained Natalie. "That is not to underestimate our Nurse Practitioners, they still play a key role in admission avoidance both on the rota of the Consultant Connect line as well as common condition pathways."

Impact of Consultant Connect

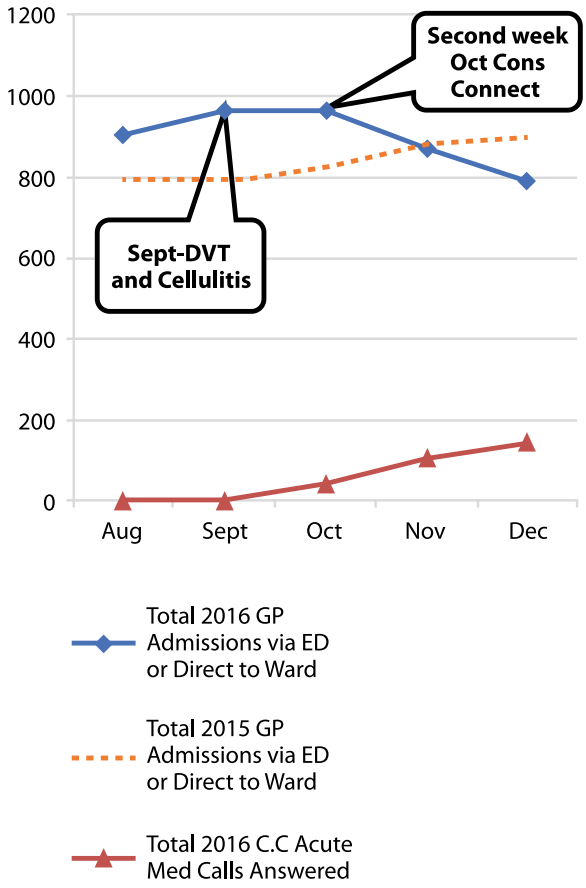
The CCG developed robust metrics to monitor the impact of Consultant Connect, as well as other projects in the AEC programme.

At the end of the initial six-month pilot (October – March 2017), the metrics show:

- **96%** of local practices have used or regularly use the system
- **934** calls have been made to the system with **682** calls being answered **(73%)**
- Average call to connect time is one minute with a call length average of four minutes
- Average admission avoidance is **22%**. The remaining **79%** of patients were sent to the right place first time and, if they were admitted, experienced a quicker admission process



Since the introduction of the system a clear reduction in GP referrals to the local ED has occurred. However, this reduction can also be attributed to a combination of other projects within the AEC program launched within a similar timeframe i.e. DVT and Cellulitis pathways, as well as the local Paramedic Pathfinder initiative. The graph identifies the correlation between all of the work taking place.



Further data analysis following December is currently in progress.

Ambulatory care pathways

Certain conditions including Cellulitis and DVT present frequently in ED. The CCG set out to create ambulatory care pathways for five of the most common conditions – DVT, Cellulitis, Lower Respiratory Tract Infection, COPD and PE - with a view to managing them in the community hub wherever possible and diverting patients to Ambulatory Care rather than ED if they need to go into hospital.

In the case of DVT for example, GPs are now provided with point of care tests in collaboration with a WELLS score that allow them to identify if the patient requires a scan and are given rapid access to scan slots, which can be booked direct with the hospital.

Sunderland has introduced a software programme within GP practices called Map of Medicine which alerts GPs to the ambulatory care pathways and alternative services they can refer patients onto rather than sending them to ED or for admission. Its aim is to support effective decision-making.

The metrics show clear evidence of a reduction in admissions, particularly in relation to the DVT and Cellulitis pathways.

Direct access to Ambulatory Care for NEAS

The CCG believed that not only GPs but also paramedics and ambulance technicians should be empowered to make choices about diverting patients from ED to Ambulatory Care wherever possible. The Paramedic Pathfinder Project developed a governance process that gave decision-making capabilities to North East Ambulance Service staff.

Natalie commented:

"In the past, ambulances have been queued outside ED waiting to hand-over patients. Now, paramedics or technicians can ring ahead to the Ambulatory Care Unit and arrange to take appropriate patients direct to there rather than going via ED. It is another way that we are taking pressure off ED"

Patient, staff and public engagement

Patient and staff engagement is key to all projects within the AEC programme. As a way of bringing professionals across the system together to build relationships and enable people to put faces to names, the AEC programme has developed a clinical engagement group with clinicians from across the system.

Natalie said:

"We have engaged with patients across GP practices (using television adverts and leaflets) to introduce the philosophy of AEC as well as explain our new pathways, especially the Consultant Connect project, where we are currently analysing feedback from more than 100 patients to date."

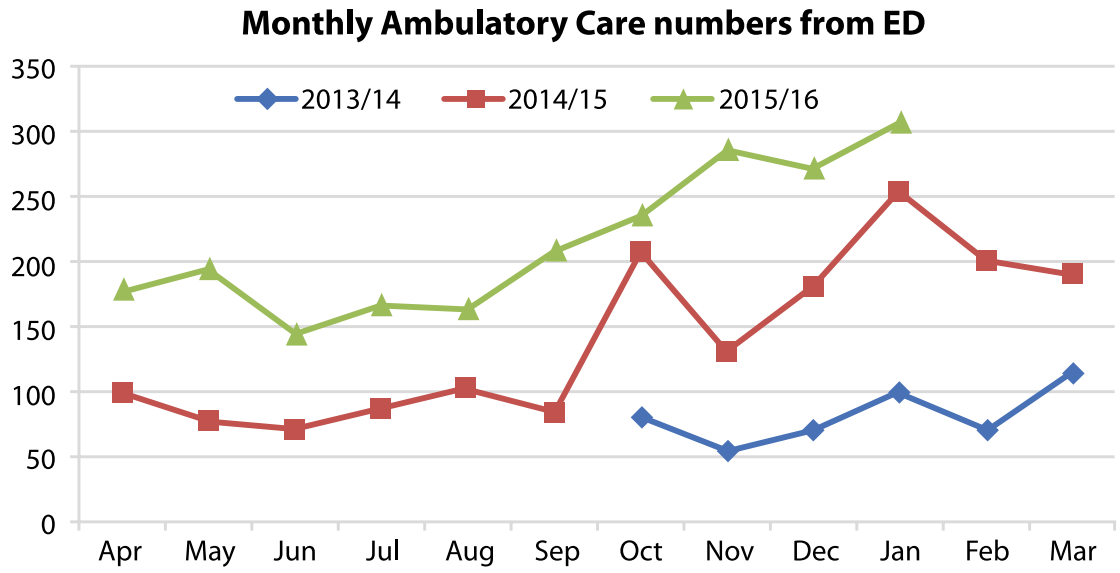
Improvement work in City Hospital

In conjunction with the system-wide development work, City Hospital has been involved in its own improvement project in relation to AEC.

The hospital has 735 beds, serving a population of 340,000. The ED sees on average 375 patients per day, with an average take of 83. It is preparing to move to a new £20 million footprint which includes ED, the Integrated Assessment Unit and a co-located Ambulatory Emergency Care Unit.

In April 2015, City Hospital Sunderland joined the Ambulatory Emergency Care Network as part of its plans to support the growth of ambulatory care in medicine. At the time, ambulatory care was housed in an eight-bedded unit and saw an average of 43 patients per week. It quickly became apparent that this was insufficient to meet growing demand and the unit was co-located with the Integrated Assessment Unit in a space that included a rapid assessment area, 12 assessment chairs, 12 beds and an ultrasound scan room.

Other specialties within the hospital are now keen to develop AEC and are looking at how standard AEC ways of working can be developed. General surgery joined the national surgical AEC network in 2017 to develop its service in a similar way to medicine.



Access criteria

Back in 2015, City Hospital was particularly keen to address the high numbers of short-stay patients (those admitted for less than 24 hours), as it believed these patients were potentially ambulatory. Project Lead for Emergency Care, Anthony Watson explained:

"We decided that our approach would be that all patients should be regarded as ambulatory unless there were clinical indicators to the contrary. Providing they have a NEWS score of five or less, with no single parameter scoring three, patients are treated on the Ambulatory Care Unit. The ambulatory team attends the daily ED board round so they can actively pull patients into the unit."

Impact

There has been a dramatic increase in the number of patients being treated as ambulatory in City Hospital. Historically the average was 43 patients a week. This has now risen to an average of 186 patients.

Previously, all GP-referred patients would have been admitted to the Integrated Assessment Unit. Now, staff from Ambulatory Care filter the referrals and are able to convert 67% to an ambulatory pathway.

The Ambulatory Care Unit operates seven days a week from 8am to 10pm Monday to Friday and from 7.30am to 8.30pm at weekends. A newly-created rapid assessment area provides immediate assessment by a staff nurse for all new referrals. Patients typically stay on the unit for an average of five hours.

The unit is staffed by a consultant, a registrar, four Nurse Practitioners, three staff nurses and two Healthcare Assistants. There is also a unit manager who supervises care delivery and is involved in the strategic direction of the unit.

The hospital's Chief Operating Officer, Sean Fenwick said:

"Delivery of AEC is central and indeed pivotal to ensure we can provide 24/7 urgent and emergency care services."

Challenge

Between October and December 2016, following the introduction of Consultant Connect, the hospital believes approximately 175 patients, at a conservative estimate, avoided admission. Natalie added:

"This is an astonishing amount, given that this reduction occurred during winter. The figure is potentially higher when reviewing the DVT and Cellulitis pathway. This data is currently under analysis. The challenge is to ensure that any additional capacity created within the system as a result of our programme is utilised appropriately to meet the needs of our population."

Next steps

The next key steps for AEC across the system in Sunderland are to:

- Continue to develop the principles and practices of the decision maker project as well as patient pathways
- Further develop and standardise AEC areas within the Trust – standard interface for general practice and community services, as well as the local ambulance trust
- Develop a whole system AEC tariff/contract
- Continue to engage patients, public and staff.

Across the system, work on both the Sunderland Vanguard and AEC programme is continuing.

"We don't underestimate the challenge of our AEC programme and are very much about changing the hearts and minds of everyone involved," said Natalie. "We have a key group of stakeholders working together who were the catalyst for this work in Sunderland. They are crucial to its delivery and we couldn't do it without them! Although in some areas of work we are starting to move from transformational to transactional I feel we have the relationships to help us weather the storm. Though we have achieved so much so far, there is still plenty of work to be done."

"It starts with a willingness to see that this is not just a hospital-based problem but a problem that we all face"

Key success factors

Stakeholder relationships

One of the things that makes this such an extraordinary project is the fact that it crosses boundaries and is a true whole-system approach. Natalie said:

"The relationships between stakeholders have been the key to this. We have had buy-in from all of the senior staff of all of the different health and social care organisations. Each of them has sponsored the programme and identified the people within their organisation who would make it work. Clinical staff have also engaged with the programme and we ensured that everyone felt safe to challenge one another and ask questions."

Willingness to engage

Commissioning sponsor Debbie Burnicle believes it is the willingness of clinicians and managers across the board to engage in the process and try something new that has made this such a successful project. She points to the rapid take-up of Consultant Connect as an illustration of how rapidly clinicians took on board new approaches. Debbie commented:

"It starts with a willingness to see that this is not just a hospital-based problem but a problem that we all face and that we all have a part to play in changing things. A collaborative approach has always been our first position as a CCG and local provider organisations have been willing to respond and engage.. It is the foundation of a more mature system that can become fully joined-up for the future, which can only benefit local people as well as help the system be sustainable for the long-term.

A clear vision

Having a clear, agreed and consistent vision is also vital. "As we get into discussions about money things can get more challenging," commented Natalie, "but, we are all agreed that this work needs to happen so we need to keep bringing ourselves back to the understanding of what we have to do to make things work for the patient."

Clinical leadership

Strong clinical leadership has helped to engage clinicians and keep them engaged. "Tracey played a key role in bringing GPs on board and continues to keep clinical colleagues informed," said Natalie. "Anthony and the clinical leads within the hospital have also played a pivotal part in leading this work, building a seamless interface between hospital AEC and other partners in the system.

"There was undoubtedly scepticism at first, especially as this area of work has been on the 'too hard to do pile' for a while – in fact in one case, everyone in the room laughed when we first suggested the idea of Consultant Connect and the call connection times it could potentially deliver. But, we continued having those conversations, being visual and kept everyone informed about the difference this work would and could make in the future. When they could see the impact, and when they had experienced Consultant Connect for themselves, even some of the most vociferous critics were won over."

AEC in commissioning

Going forward, all commissioners will have Sustainability and Transformation Plans (STPs) at the heart of their local planning. The work taking place in Sunderland illustrates the important role that AEC can play in reducing demand for inpatient beds. The Ambulatory Emergency Care Network points out that ambulatory care:

- Can be provided on sites where there is an UCC or no ED
- Can cover medical, surgical, urology, gynae
- Can link in with specialist teams in centres
- Can use telemedicine
- Can work with point of care testing so is not dependent on having pathology services on site

The Network is developing a guide to ambulatory care for commissioners.

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