NHS
Ambulatory Emergency Care Network

Ambulatory Emergency Care

Oxford brings emergency care closer to home

www.ambulatoryemergencycare.org.uk

Introduction

Back in 2007, Oxford University Hospitals (OUH) NHS Foundation Trust embarked on a journey to develop an alternative to bed-based care for frail older patients. It wanted patients with frailty syndromes to receive individualised medical, nursing and therapist treatments as close to home as possible. Oxford has a small per capita bed base compared to many other regions. There are just two admitting acute hospitals serving a population of around 800,000 – John Radcliffe in Oxford and the Horton General in Banbury. The region has seven community hospitals, and in 2010 Oxford opened its first Emergency Multidisciplinary Unit (EMU) at Abingdon Community Hospital. Since then, it has opened another community-based EMU and introduced ambulatory care to the acute hospital. This is their story…

Relying on bed-based care in an acute hospital is unsustainable for NHS trusts in the face of rising demand[1]. More importantly, it is also potentially harmful to frail older patients. Finding themselves in an unfamiliar and physically challenging environment can lead to a loss of independence and rapid deconditioning. All of the evidence points to the fact that vulnerable older people need to be treated outside of hospital if possible to avoid the risk of harm[2].

Emergency Multidisciplinary Unit

Oxford's answer to this challenge was initially to create a community-based EMU that would provide an alternative to hospital admission for frail older patients requiring urgent care. Senior Physician in Acute and Complex Medicine and Ambulatory Care Lead, Dr Dan Lasserson explained:

"The first EMU was created in 2010 and is based on the Abingdon Community Hospital site. Its aim is to rapidly assess any patient within its catchment area (11 general practices and around 140,000 people) who requires urgent medical care. GPs, community nurses, and paramedics who would normally send patients to an acute hospital can now transfer them to the EMU instead.

"The unit is staffed by nurses, healthcare assistants, physiotherapists, occupational therapists, social workers and a medical team that includes elderly care physicians and general practitioners. There is a dedicated ambulance to ensure rapid transfer to and from the unit and patients receive prompt assessment, diagnosis and treatment. The EMU helps us to meet the dual challenges of tackling system congestion and providing care closer to home."

Rapid diagnostics

The EMU relies on being able to make a rapid assessment of patients and one of the critical success factors has been access to point of care diagnostics, laboratory testing and basic imaging. Dr Lasserson said:

"Within minutes of a patient arriving on the unit, the clinical team has a full profile of the underlying biochemical parameters that can show the cause of illness, as well as a good understanding of potential risks to the patient. This enables us to make accurate decisions about the type and location of treatment the patient needs. We aim to obtain a diagnosis and begin treatment within two to four hours so the patient can go home as quickly as possible."

The EMU provides early senior medical assessment, ensuring that patients are treated in the safest and most appropriate environment. The unit is inclusive, treating anyone in the community requiring urgent care, not just frail older patients.

Short-term care beds

There is a pool of five beds available for short-term use on EMU (72 hours or less). These beds are for patients who are not suitable for ambulatory care but who require some continuity of care from the clinical team.

A 'Hospital at Home' nursing team supports the EMU, providing therapeutic interventions in patients' homes. Paramedics who are called to see a patient in crisis have a mobile number for the EMU. They can call to speak to the senior nurse or medic in charge. Any condition is considered suitable for treatment on the unit, with the exception of cardiac syndromes, acute stroke and pregnancy.

Extending the EMU approach

Within two years of launching, the Abingdon EMU extended its opening times to 8am to 8pm from Monday to Friday and 10am to 4pm at weekends. This was a pioneering move back in 2012 when the changes were implemented, but the team believed it was essential if the unit was to provide a credible alternative to hospital admission. Early indications suggested that Abingdon EMU was successfully treating approximately 80% of frail older patients who would previously have been admitted to hospital. It was integrating successfully with both acute hospital teams and teams of home-based staff. Commissioners were keen to extend the approach and Abingdon was rapidly followed by the creation of an EMU in Witney in 2012.

The Network provided a well-structured programme that would help us to maximise the opportunities for treating patients in an ambulatory way without admitting them."

Ambulatory Assessment Unit

Alongside its work to support frail older people in the community, Oxford University Hospitals established an Emergency Assessment Unit (EAU) in each of its acute hospitals, as well as separate Ambulatory Assessment Units (AAUs). In 2015, the Trust joined the Ambulatory Emergency Care (AEC) Network as a way of structuring its work on avoiding admissions and maximising the opportunities provided by ambulatory care.

Divisional Director for Medicine at OUH, James Price explained:

"We have done a lot of work over the years on changing the default from admitting emergency patients to non-admission. The EMUs were well-established by this point and we had a small ambulatory care function but we were keen to build on this. The Network provided a well-structured programme that would help us to maximise the opportunities for treating patients in an ambulatory way without admitting them."

Dr Dan Lasserson joined the team in 2015 to support the design and delivery of the new ambulatory care service at OUH. He said:

"We needed to create a more clearly marked out territory for ambulatory care with a bespoke environment, its own dedicated team and defined pathways. We identified a room adjacent to one of the elderly care wards, which soon expanded to five rooms and then an entire wing. In August 2016, we repurposed one of the medical wards as an AAU. We receive patients from GPs, the emergency department (ED) and paramedics, all of whom can call and speak to a senior decision-maker to receive clinical advice."

Based in the John Radcliffe Hospital and focussed on the frail elderly, the AAU has senior doctors at the front door and available by phone. There are no access criteria, but hyper acute patients are not seen in the unit. Patients arriving at the AAU are reviewed by the senior team, which has access to multi-professional colleagues throughout the hospital. A key difference in the AAU is that the full resource of the team is applied in a very short period.

Seven days a week

The two AAUs are staffed by a total of 20 registered nurses, eight nursing assistants, five administrative staff and three consultants, with support from other consultants to provide seven-day cover from 8am to 9pm. Nurses from ambulatory care actively 'pull' patients in from ED.

Support from radiology and diagnostics has also been key, as Dr James Price, explained:

"A flowing hospital is a healthy hospital. We depend on timely diagnostics. They are as important for keeping the hospital healthy as they are for keeping the patient healthy."

Challenges

As with any kind of change, it took some time to establish and embed these new pathways and ensure that all colleagues understood the approach being progressed by the AAU team.

"We assembled a core team who really got the vision of ambulatory care," explained James. "Once this core team was in place, we began building a broader multidisciplinary team (MDT) around them. Our focus was on embedding innovation and creating a strong evaluation framework. We integrated trainees who could share the message beyond the unit into the wider hospital. It was important to respect our colleagues in primary care. We didn't want it to be about primary care and secondary care. We wanted a new interface, with all of us working together towards the same goal."

"There was already a great deal of willingness to engage with ambulatory care among GPs after seeing the positive impact of the EMUs. GPs appreciate having access to senior physicians in the hospital and often comment on the can-do attitude of ambulatory care staff."

GP engagement

As an approach, this has succeeded in bringing GP colleagues on board. Dr Barbara Batty, a GP who works in the community and in AAU at the OUH said:

"There was already a great deal of willingness to engage with ambulatory care among GPs after seeing the positive impact of the EMUs. GPs appreciate having access to senior physicians in the hospital and often comment on the can-do attitude of ambulatory care staff."

The Oxford City GP Locality Director, Dr Chapman commented:

"There was an overwhelmingly positive response from the GPs and we have all found it very useful. Being able to speak to an experienced interface physician has been an immensely useful and a positive experience. My own experience has been very positive and all my encounters have led to good advice and prompt action from the AAU to the benefit of the patients."

"Relentlessly reasonable in the face of challenge"

Executive buy-in helped the team to overcome resistance, as did access to data:

"Having the metrics in front of you to demonstrate the impact of the work you are doing helps you to be relentlessly reasonable in the face of challenge. Combined with executive support, it provides a compelling case for change," said Dr Lasserson.

Other challenges for the AAU include finding the most accurate way to code patients coming onto the unit and ensuring that non-ambulatory patients (i.e. those with conditions that require close, intensive monitoring or that may require overnight admission) were not treated on the unit.

Impact

EMUs

Audit shows that 65% of patients seen by EMU are able to stay in their own homes during acute illness and only 17% need acute hospital admission. Other patients are cared for in emergency intermediate care beds or EMU short-stay beds.

The hospital also analysed excess bed days (days in hospital when patients are medically fit for discharge but are not functionally able to return to home due to deconditioning). These were reduced by a third in EMU areas. Qualitative research found that patients and carers tended to prefer the smaller, more personal environment of EMU compared to the acute hospital.

Ambulatory care has become the default destination for most patients coming into the hospital requiring urgent care. "It is not pathway-determined," explained Dan, "by default most urgent care patients now come to the AAU."

AAUs

The AAUs at the Horton General Hospital in Banbury and the John Radcliffe Hospitals in Oxford, deliver three main types of care, seven days per week:

1. Next day assessment: this builds on the existing day hospital function, delivering next day MDT assessment, diagnosis and treatment on an ambulatory basis following initial assessment and referral from primary/community care, outpatient attendance and EAU/ED attendance.

2. First assessment: primarily focused on Geratology Rapid Access for patients deemed as requiring urgent assessment on the same day, but not deemed as requiring emergency/blue light review. This service will concentrate, not uncommonly, on patients with complex needs.

3. Immediate streaming of patients from ED: largely older, frail patients where assessment can be done on an ambulatory basis. The very early filtering from Level 1 (ED and EAU) of this cohort of patients, helps to decongest Level 1 and prevents overcrowding of the ED.

The number of patients seen in a month at both AAUs has increased from 121 in January 2016 to over 540 in March 2017, with a step change in October 2016. These figures do not equate to the number of episodes of care as some patients return, for example the following day, for additional diagnostics or assessment.

	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
JR AAU	121	122	276	256	244	254	255	360	359	447	430	430	450	403
HGH Rowan	-	-	-	-	-	-	-	-	-	65	109	121	94	137
Total	121	122	276	256	244	254	255	360	359	512	539	551	544	540

From an average of 500 new patients seen each month, 90% are from GPs and the other 10% come through ED or direct from the ambulance service. Of the 500, approximately 66% will be seen the same day and discharged. This compares with 30% discharge from the admissions unit. Twelve per cent will be admitted and 24% will go home and come back the next day to continue their treatment on the standard AAU pathway, where treatment can continue for up to five days.

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Reconfiguration of urgent care

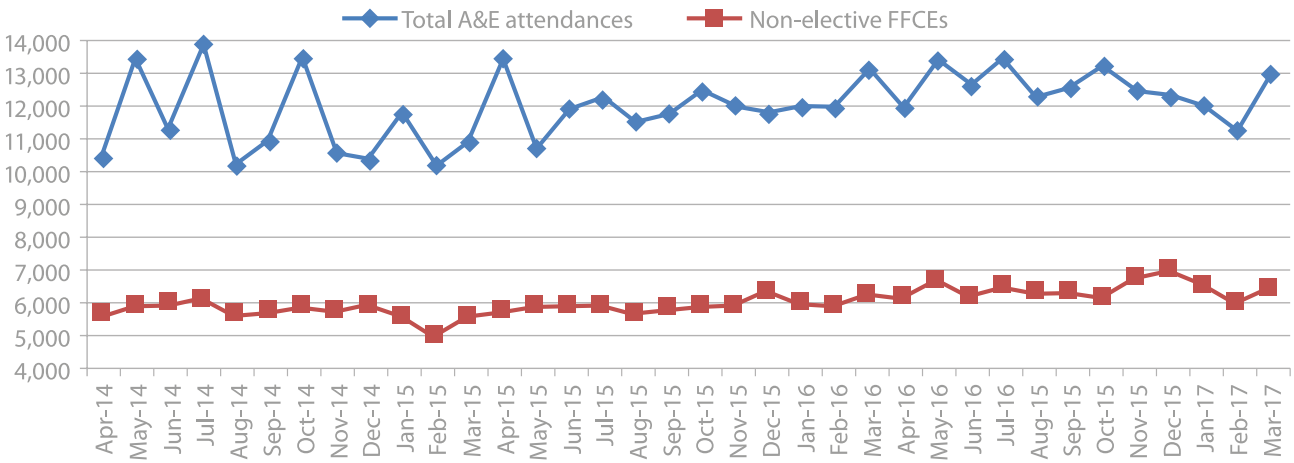
The introduction of ambulatory care was part of a wider reconfiguration of urgent care in the John Radcliffe hospital, including a new 'Hospital at Home' care team, the allocation of care home beds for post-acute care, and a reduction in the number of hospital beds.

Since bed realignment began at OUH, additional emergency admissions have been absorbed within a reduced acute bed stock and alternative services.

Dr James Price said:

"Systems of care are complex. Patients are complex. In the past, there has been a lack of co-ordination in matching resources with patient need. Over the last few years we have begun to address that more effectively and the results show that we are on track. We are successfully meeting the 5% year-on-year increase in demand for urgent care, at the same time as moving to a system that focuses less on hospital beds and more on patient-centred ways of meeting patient needs, closer to home. Patient feedback is good and our GP colleagues speak highly of the service."

A&E attendances and emergency admissions, OUH, April 2014 – March 2017



[1] Moving Healthcare Closer to Home: Financial Impacts, Monitor (September 2015)
[2] Community Services: How they can transform care, The Kings Fund (February 2014)

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Version 1.0 - November 2017