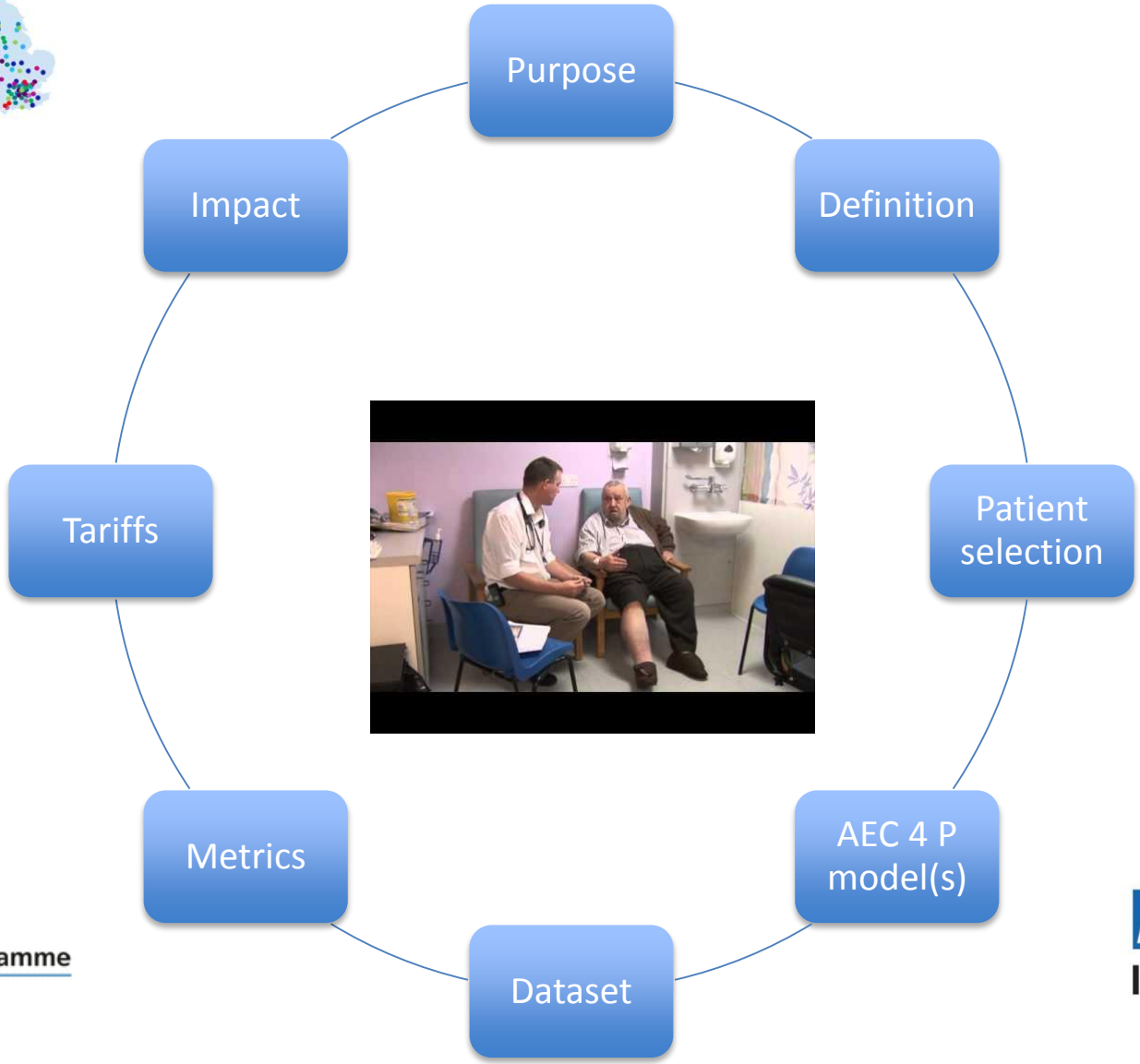
NETWORK SHARING

Our Current Network

We are supporting over 120 organisations across England

AEC

Ambulatory Emergency Care Network

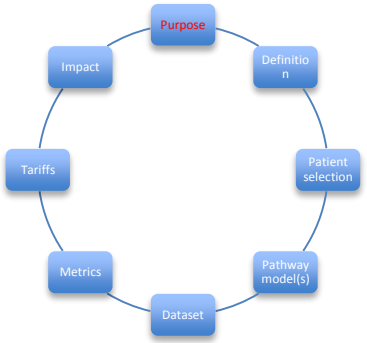


Emergency Care Improvement Programme

Safer, faster, better care for patients

NHS Improvement

Purpose



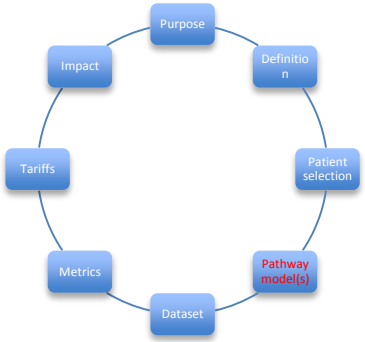
Ambulatory Emergency Care (AEC) is the provision of same day emergency care

It is a well-established model in which stable patients with acute conditions for whom inpatient admission would previously have been the default option are assessed, investigated, treated, and able to return home on the same day.

Emergency Care Improvement Programme

Safer, faster, better care for patients

NHS Improvement



Rapid Improvement Guide to:

Maximising Ambulatory Emergency Care services

NHS Ambulatory Emergency Care Network

Royal College of Physicians

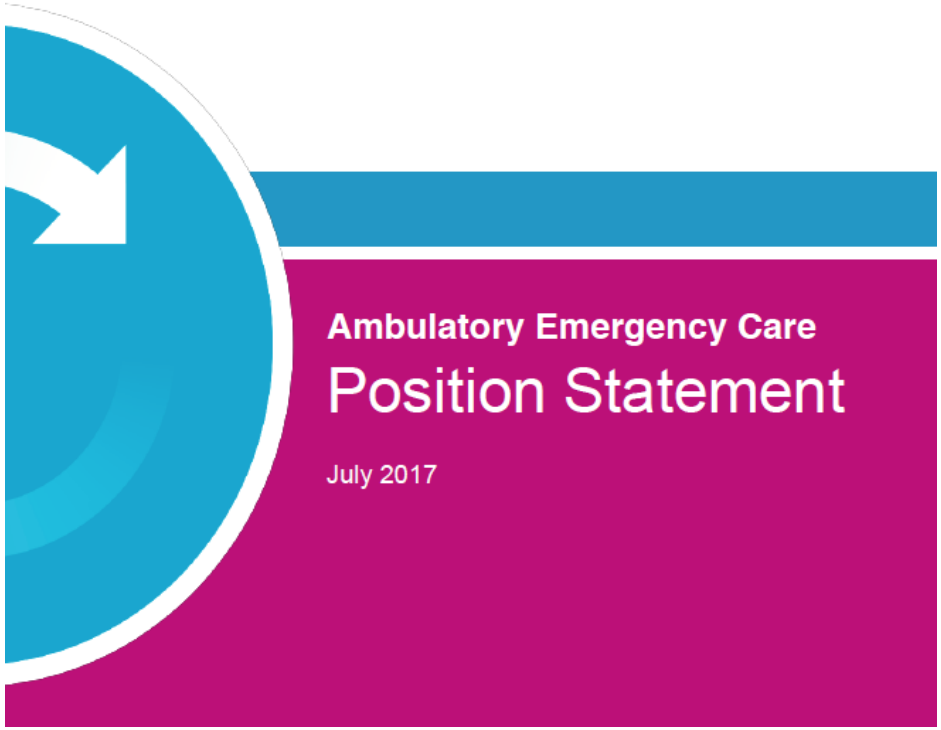
Setting higher standards

Acute care toolkit 10

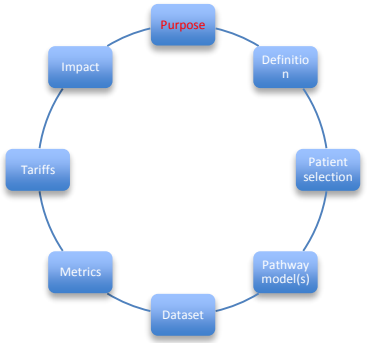
Ambulatory emergency care

October 2014

Across the UK, emergency systems are under considerable pressure, with emergency department (ED) attendances and the conversion rate to hospital admission both rising. Some clinical teams across England have recognised that a new approach is needed, and have successfully redesigned their systems to manage demand by implementing ambulatory emergency care (AEC) as part of the solution.[1,2] AEC has the potential to have a similar impact on emergency care as day surgery has had on planned care.



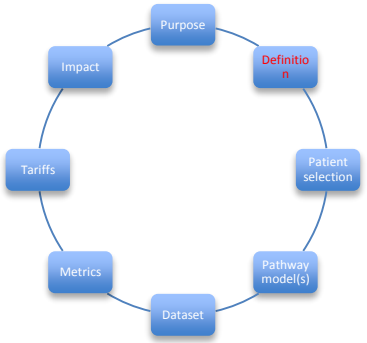
Scope



It is expected that hospitals introducing AEC could convert 30% of acute medical admissions to ambulatory care episodes[2] with further potential in other specialty groups including surgical disciplines.

NHS Improvement recommends the optimal model to be a service that is open for ‘at least’ 12 hours a day, seven days a week, considering all patients presenting acutely who are not clinically unstable[2].

Definition of NEW AEC activity

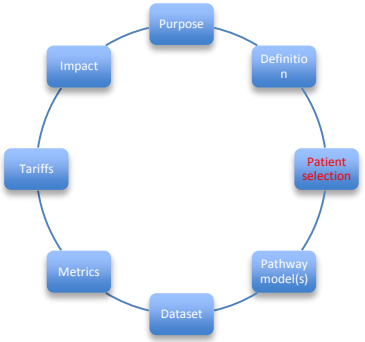


For the purpose of counting AEC activity

AEC refers to the investigation, care and treatment of patients for whom in the absence of an AEC service, admission to hospital would have been the default option.

This definition is for the purpose of identifying new AEC activity.

Patient Selection for AEC

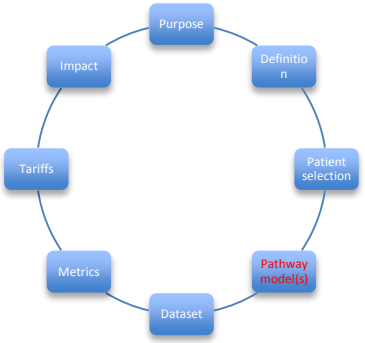


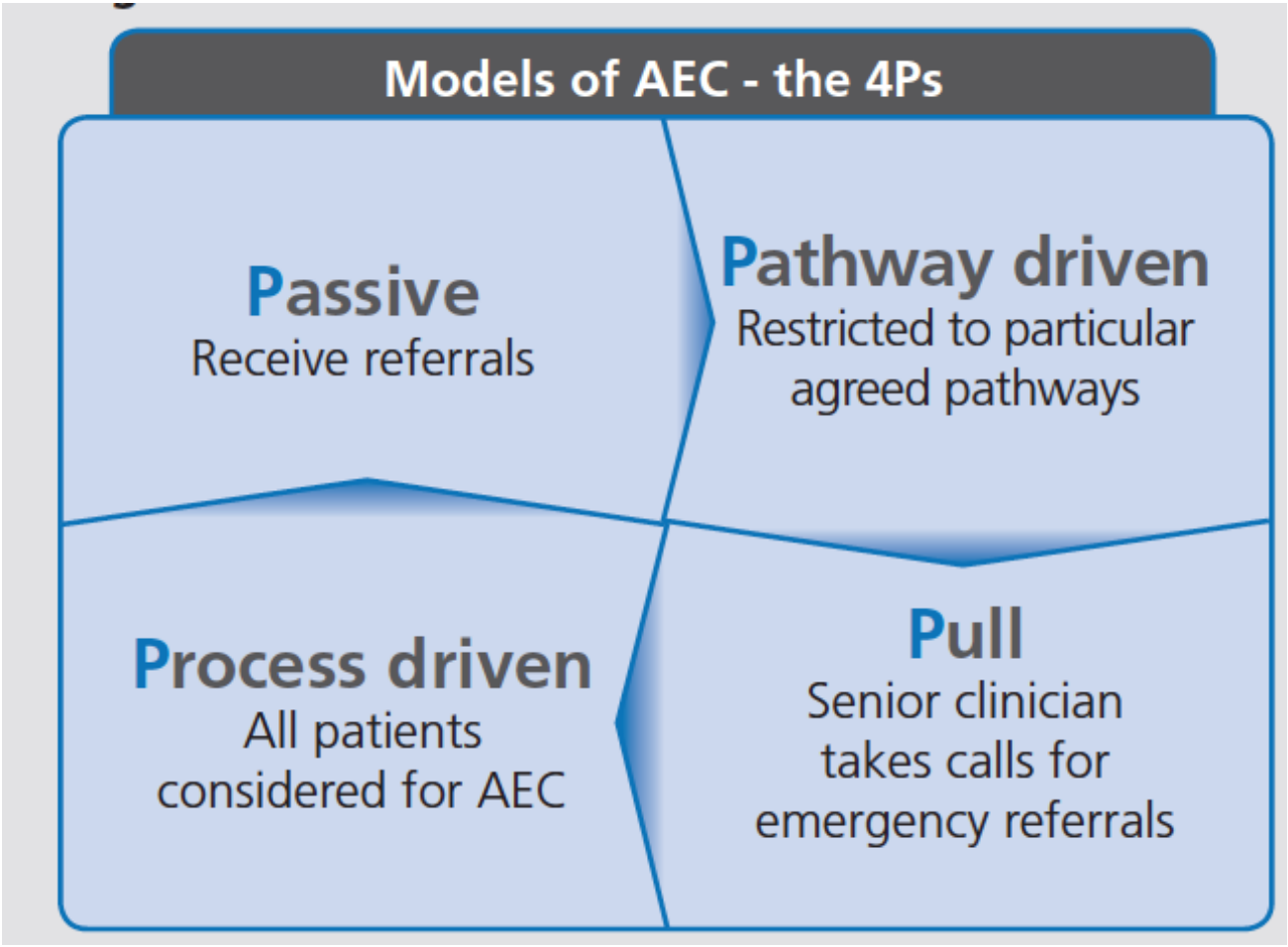
Clinical stability established by recording a NEWS and a clinical discussion

AEC being the best place to meet the patient's required clinical needs

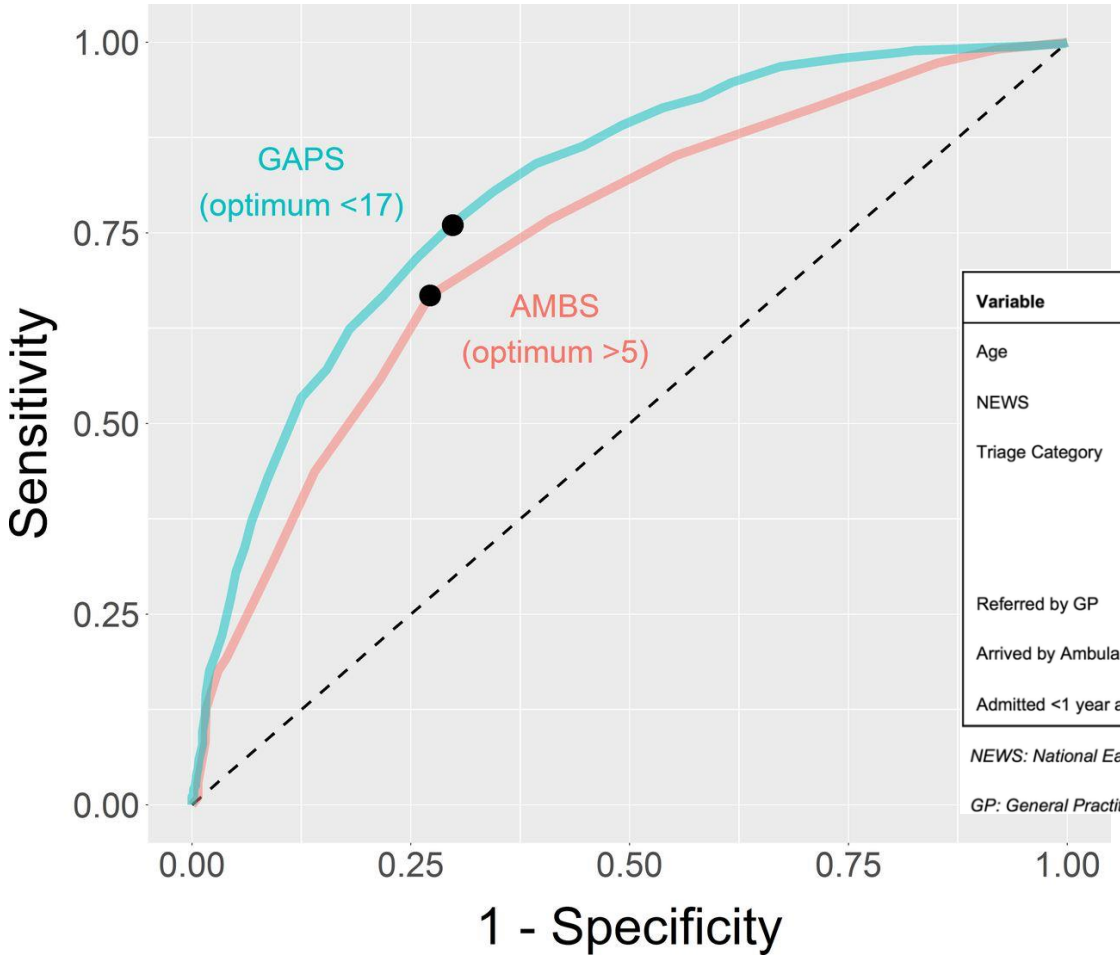
The staffing and facilities can ensure the patient's privacy and dignity are maintained

AEC admission pathways





GAPS vs AMBS

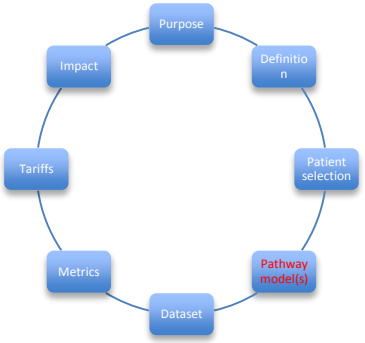


Variable		Points
Age		1 point per decade
NEWS		1 point per point on NEWS
Triage Category	3	5
	2	10
	1	20
Referred by GP		10
Arrived by Ambulance		5
Admitted <1 year ago		5

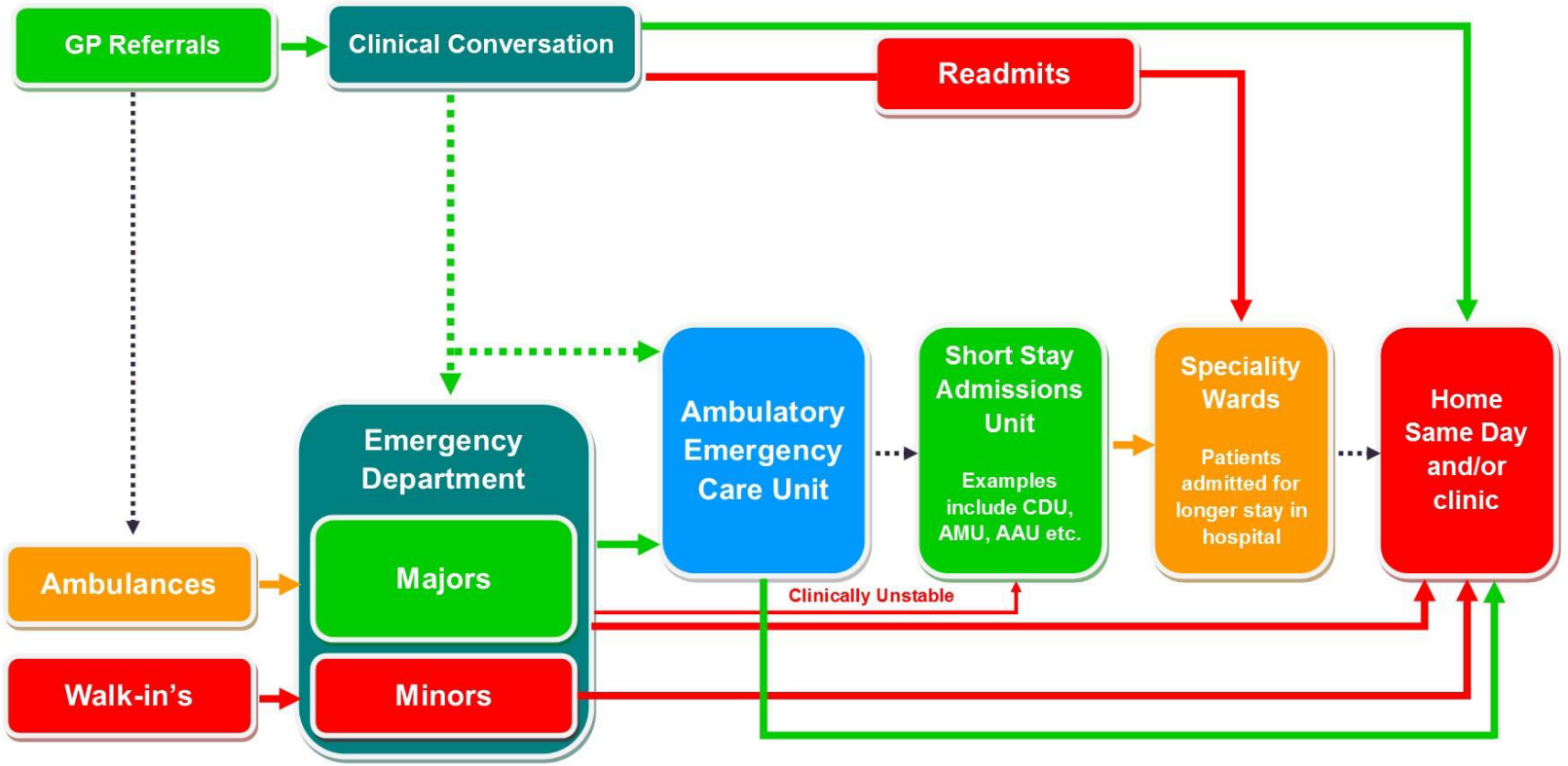
NEWS: National Early Warning Score

GP: General Practitioner

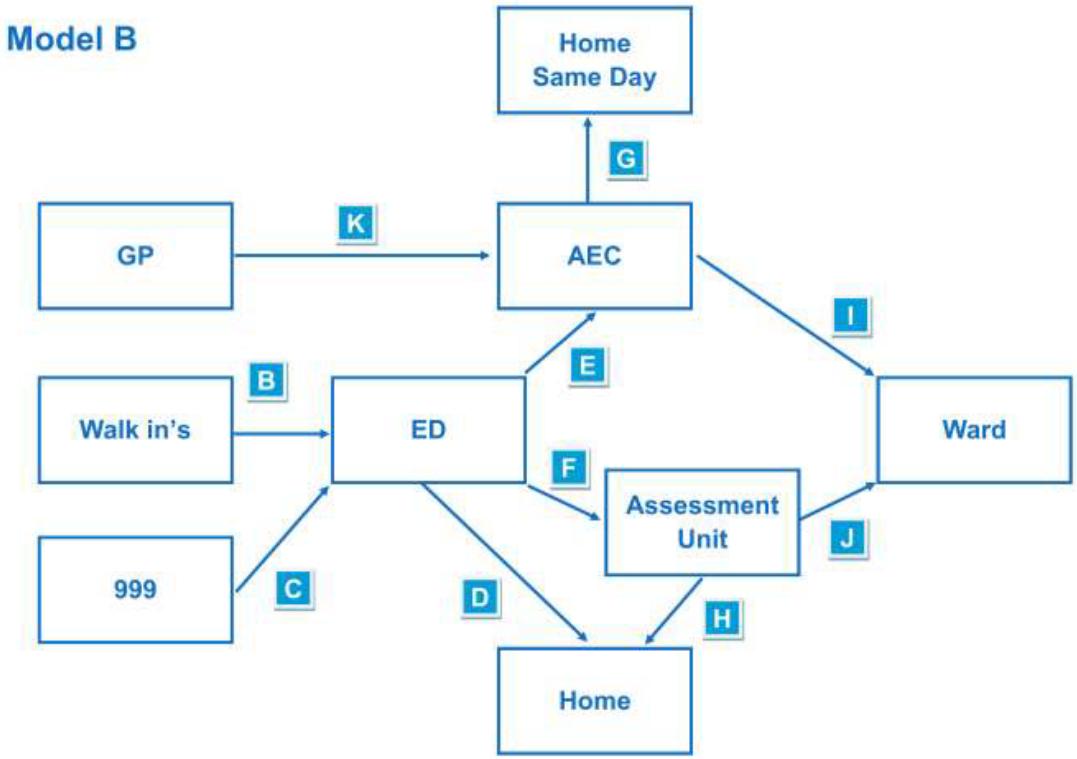
AEC relationships



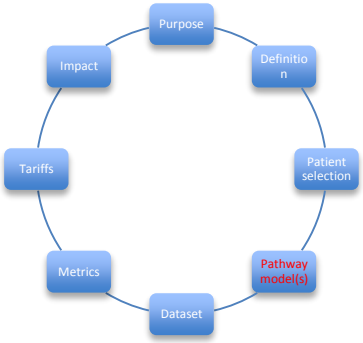
Key: Green flows are highly suitable for AEC Amber flows may be suitable for AEC Red flows are generally not suitable for AEC



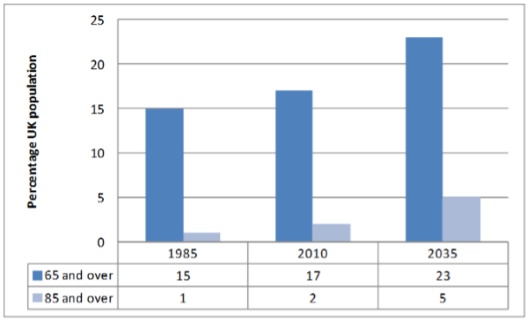
Numerators and denominators

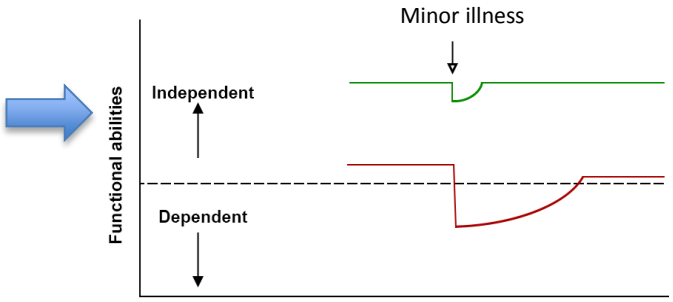


AEC efficiency



	Managed in AEC	Not managed in AEC
	Conversion	
Appropriate for AEC	**Group 1: Success** (expect about 10% conversion rate)	**Group 3: Missed opportunity**
Not appropriate for AEC	**Group 4a: Waste** (patient could be managed in another outpatient service)	**Group 2: Success** (appropriate inpatient care)
	Group 4b: Risk (patient too sick/complex at time of selection)	





CFS Grade	LoS	Readmission rate	In-patient mortality
1	4	4%	2%
2	5	7%	2%
3	7	11%	2%
4	8	13%	3%
5	10	15%	4%
6	12	15%	6%
7	13	14%	11%
8	12	10%	24%
9	10	13%	31%

NHS

Acute Frailty Network

Clinical Frailty Scale

1 Very Fit – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 Well – People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g. seasonally.

3 Managing Well – People whose medical problems are well controlled, but are not regularly active beyond routine walking.

4 Vulnerable – While not dependent on others for daily help, often symptoms limit activities. A common complaint is being "slowed up", and/or being tired during the day.

5 Mildly Frail – These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 Moderately Frail – People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.

7 Severely Frail – Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9 Terminally Ill – Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise evidently frail.

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

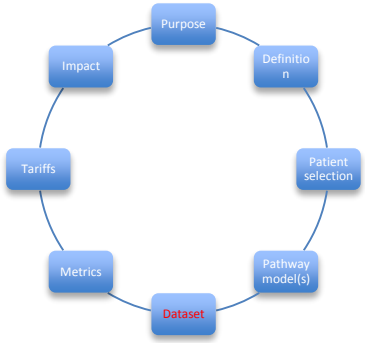
In **moderate dementia,** recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

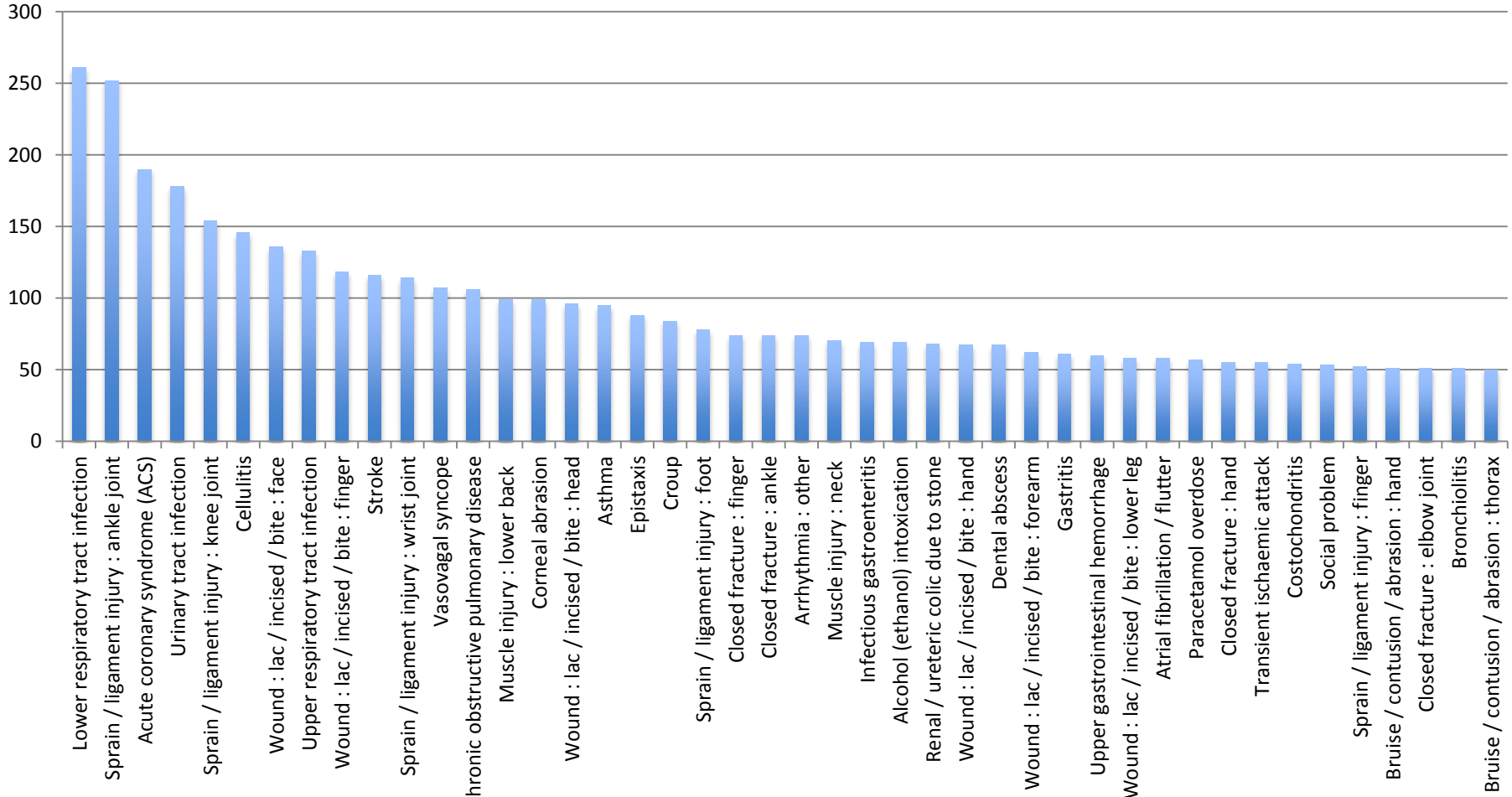
In **severe dementia,** they cannot do personal care without help.

The geriatric syndromes are especially common in moderate to severely frail older people

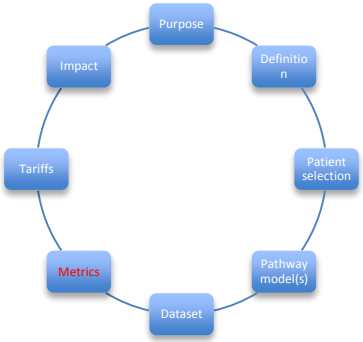
- falls/immobility
- delirium/dementia
- depression
- poly-pharmacy
- incontinence, asymptomatic bacteruria etc

AECDS (ED)


Purpose
Definitio n
Patient selection
Pathway model(s)
Dataset
Metrics
Tariffs
Impact


300
250
200
150
100
50
0
Lower respiratory tract infection
Sprain / ligament injury : ankle joint
Acute coronary syndrome (ACS)
Urinary tract infection
Sprain / ligament injury : knee joint
Cellulitis
Wound : lac / incised / bite : face
Upper respiratory tract infection
Wound : lac / incised / bite : finger
Stroke
Sprain / ligament injury : wrist joint
Vasovagal syncope
Chronic obstructive pulmonary disease
Muscle injury : lower back
Corneal abrasion
Wound : lac / incised / bite : head
Asthma
Epistaxis
Croup
Sprain / ligament injury : foot
Closed fracture : finger
Closed fracture : ankle
Arrhythmia : other
Muscle injury : neck
Infectious gastroenteritis
Alcohol (ethanol) intoxication
Renal / ureteric colic due to stone
Wound : lac / incised / bite : hand
Dental abscess
Wound : lac / incised / bite : forearm
Gastritis
Upper gastrointestinal hemorrhage
Wound : lac / incised / bite : lower leg
Atrial fibrillation / flutter
Paracetamol overdose
Closed fracture : hand
Transient ischaemic attack
Costochondritis
Social problem
Sprain / ligament injury : finger
Bruise / contusion / abrasion : hand
Closed fracture : elbow joint
Bronchiolitis
Bruise / contusion / abrasion : thorax

Metrics



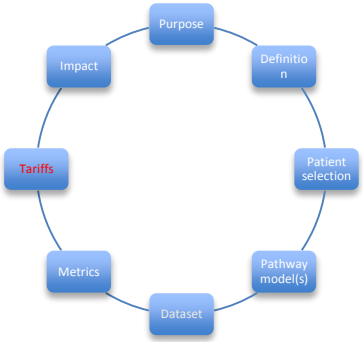
AEC

- activity must be recorded in an appropriate data set agreed with commissioners (ECDS)
- should have appropriate process and outcome metrics but NOT be subject to the ED 4 hour standard regarding discharge, transfer or admission.
- The key metric to understand the impact of AEC is the **reduction** in the number of non-elective admitted patients with a LOS greater than zero.
- core activity is not the same and not conflated with non AEC work e.g. ‘hot clinics’, ED diverts and day hospital work

Same Day Emergency Care Rates

Clinical scenario	75th percentile rate	Current national average rate
Abdominal pain	40%	35%
Anaemia	16%	12%
Bladder outflow obstruction	30%	23%
Chronic obstructive pulmonary disease (COPD)	2.1%	1.6%
Community acquired pneumonia	12%	10%
Low risk pubic rami	13%	10%
Minor head injury	64%	56%
Supraventricular tachycardias (SVT) including atrial fibrillation (AF)	34%	29%
Transient ischaemic attack (TIA)	30%	26%

Tariffs



Tariff discussion re the marginal tariff, the 48hr threshold and AEC reimbursement.

Marginal rates

- Re-baselining the marginal tariff from 2008/9 to 2017/18
- Re-balancing from 70/30 to 80/20 or 90/10

Creating a national AEC tariff

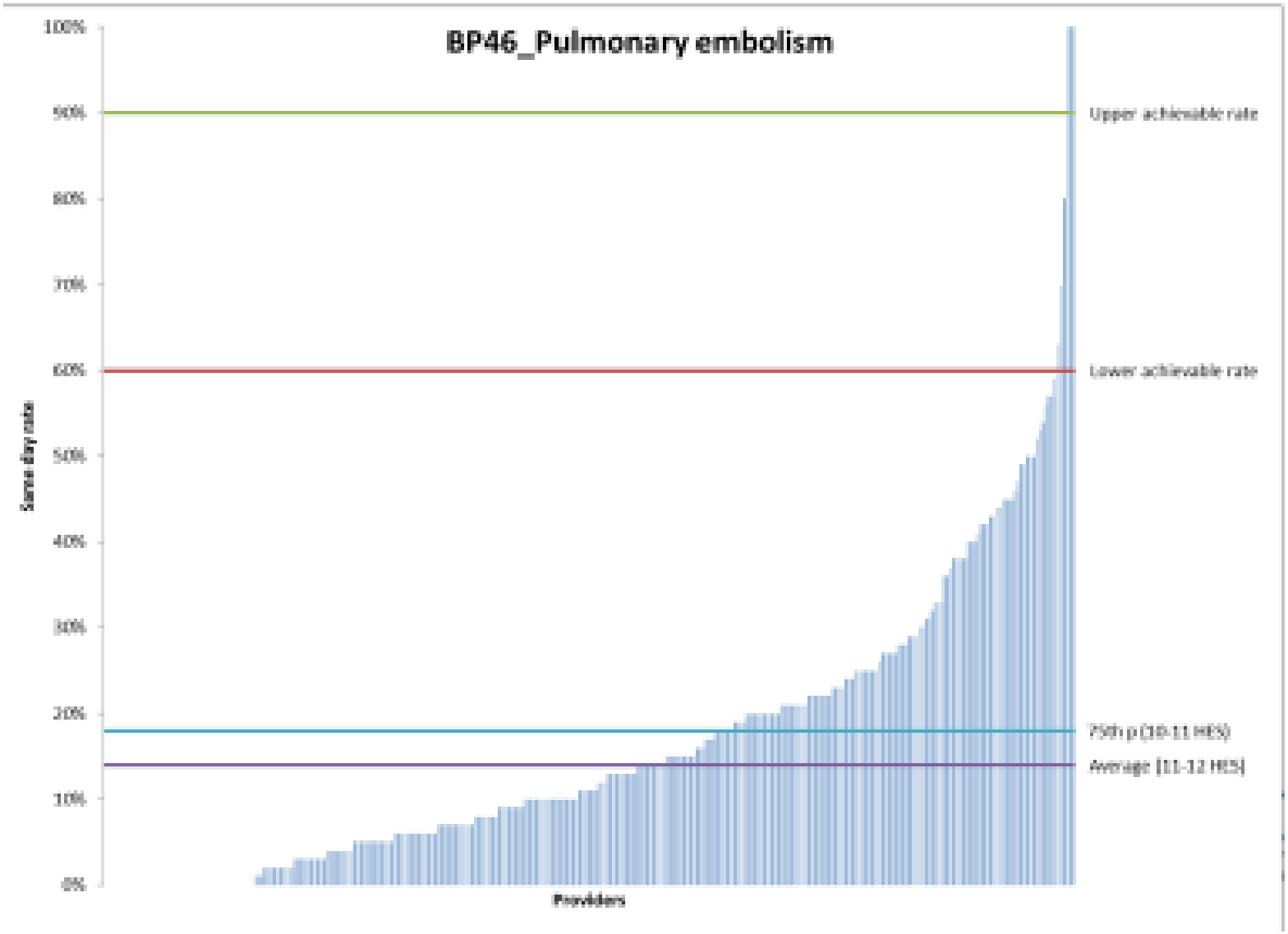
- AEC tariff - set a level of payment somewhere between an A&E attendance and a non-elective admission
- As AECDS comes into widespread use, we may have access to richer data on:
  - Patient demographics
  - Episode information
  - Clinical information
  - Disposition

It is madness that the tariff for admission is reduced if the LoS is < 48hrs. Every time we make care more efficient and effective we lose money!

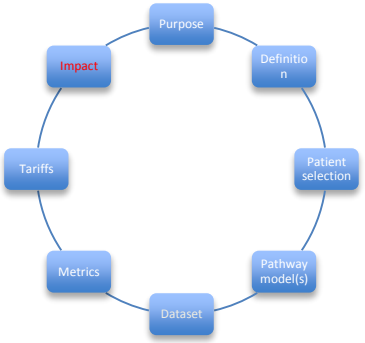
A 3 part non-linear payment model for U&E care

- Fixed fee – the cost of running the service 24/7 taking into account current volumes and casemix
- Increased activity fee – a proportional uplift to reflect increased activity paid at a rate that recognizes costs increase in a stepwise manner (e.g. wte) whereas patient numbers do not
- Quality/Incentive payment – to promote best practice e.g. front door senior decision making to reduce admission rates and LoS

The (R)evolution of Suspected PE Management – There is still enormous potential



Impact per month



30% = 161100

(900 per hospital)

Total = 537,016

(non-elective admissions in Dec 2017)