

A large decorative graphic on the left side of the slide, featuring a blue circle with a white arrow pointing right, and a white curved line separating the blue and purple background sections.

Ambulatory Emergency Care

# Themes across the accelerator programme

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## Accelerator collaborative aim

- Maximise the provision of same day emergency care for patients being considered for emergency admission.
  - Release pressurised bed/day capacity in admission wards
  - Improve emergency flow
  - Avoid risks associated with hospital admission
  - More effective use of resources

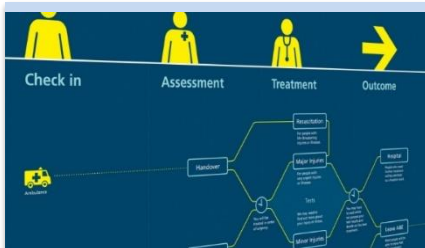


# Methods



## Current service and plans

Face to face meeting - current service and plans; walk patient pathway



## Activity data

National data

local data



## Casefile review

Clinically led casefile review





	Managed in AEC	Not managed in AEC
Appropriate for AEC	<p><b>Box 1: Success</b></p> <p>Patient appropriately seen in AEC (expect around 10-15% conversion)</p>	<p><b>Box 2: Missed opportunity</b></p> <p>(clinically conservative / AEC capacity)</p>
Not appropriate for AEC	<p><b>Box 3: Wasted capacity</b></p> <p>Patient could/should have been managed outside of AEC</p>	<p><b>Box 4: Success</b></p> <p><b>Appropriate</b> inpatient / outpatient care</p>

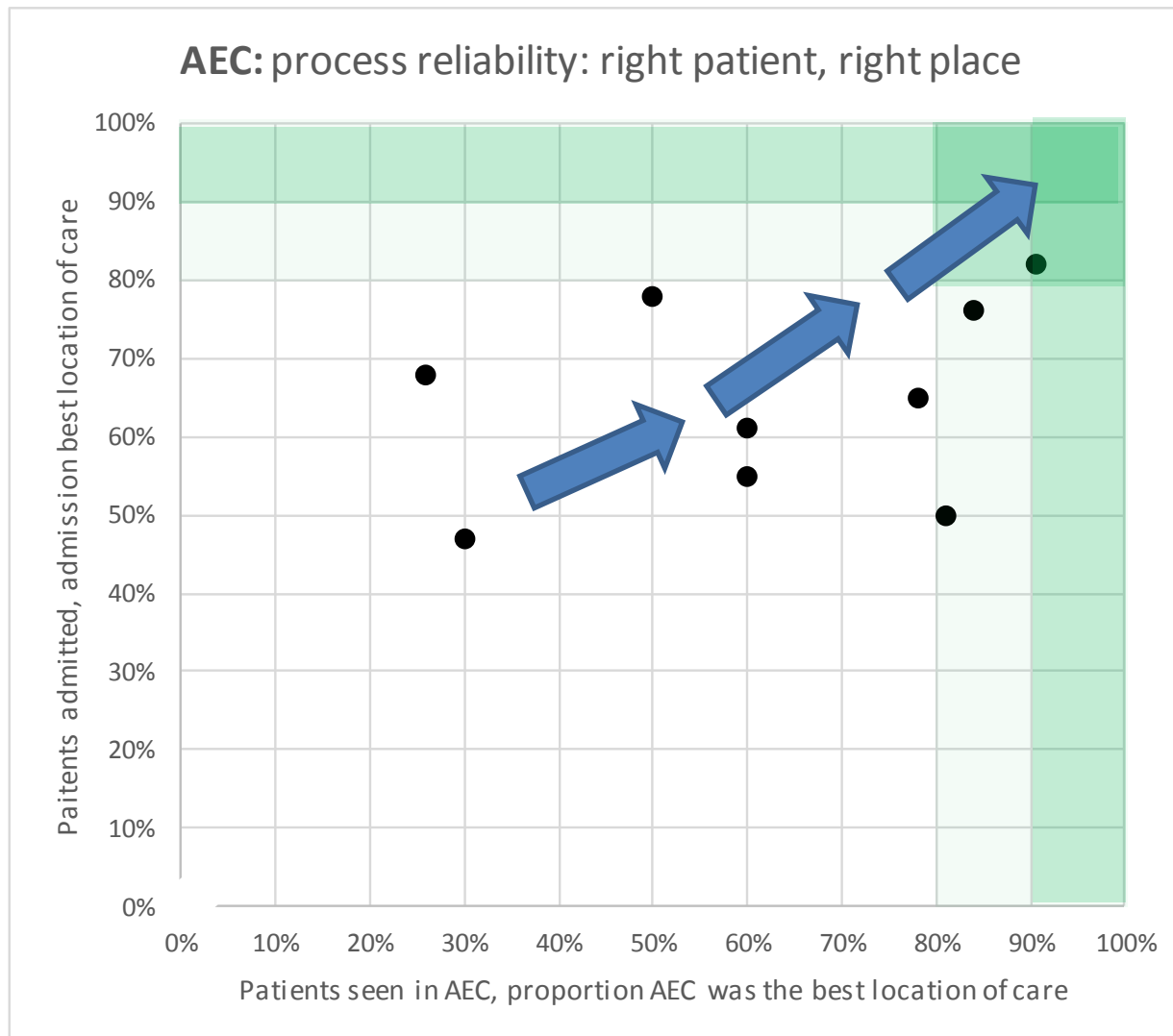


## Findings across the collaborative

- Are patients in the right place of care? What is the potential to further expand the service?  
Effectiveness of the service
- Clarity of model for AEC
- Service oversight, evaluation and operational measurement



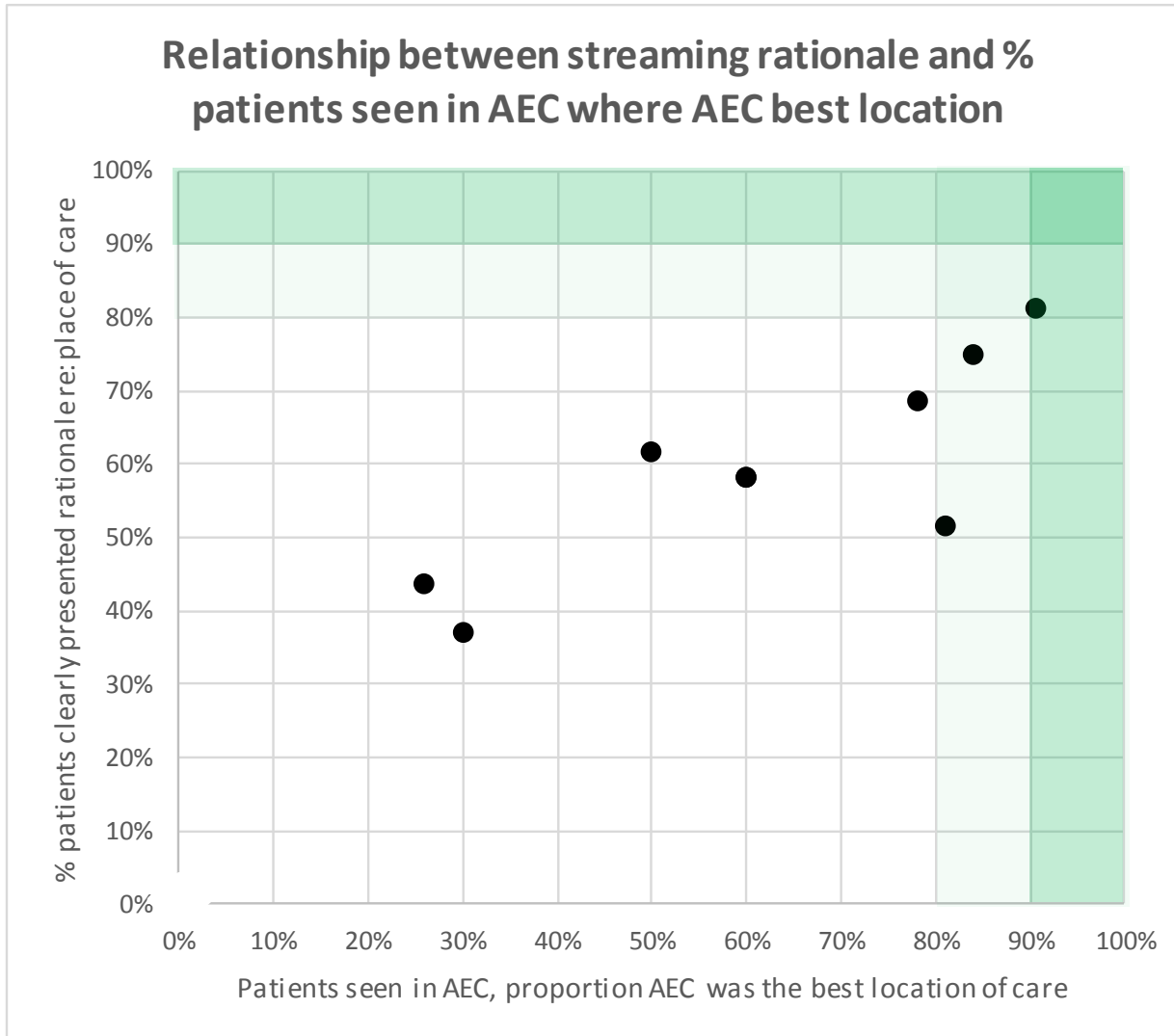
# Patient in right place of care?



n=337

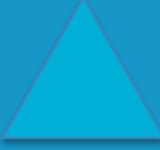


# Streaming patients to the best place of care



Clarity of streaming decision making is a foundation for right patients being managed in AEC.

n=337



- With better streaming across the collaborative  
**34%** patients could have avoided an admission releasing bed days at peak times.
- 37% of these patients had 0 LOS
- On average these patients use **1.15** bed days.

Assumes 6 hour LOS for 0 LOS patients

N=27

35% average across 9 hospitals





# How to stream patients to AEC

- Clear and shared aim for AEC
- Clinical criteria that work in practice

# Basis for patient selection ...

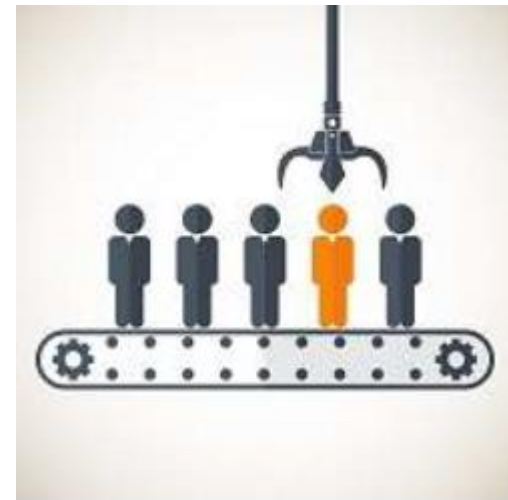
AEC is defined as the provision of same day emergency care for patients being considered for emergency admission.

- Clinical stability, this is established by recording a NEWS and a clinical discussion
- AEC being the best place to meet the patient's required clinical needs
- AEC staffing and facilities can ensure the patient's privacy and dignity are maintained

Obvious patients generally managed in AEC

Risk service is path of least resistance – being all things to all services results in poor use of AEC capacity. Can be a result of deferral of decision making or culture of 'helping' rather than 'advising' referrers.

Risk aversion and confidence to manage patients outside of a bed base.





# Impact of a clear service aim

- Clear aim supports appropriate GP referrals and care for patients that would otherwise be admitted

GP referred patient to AEC.

65 year old with generalised oedema. Breathlessness. NEWS score was aggregate 1-4.

**History:** Gynae mdt for ?ovarian cancer - no evidence, repeat CT.

Tests and assessment in AEC: Echo, ECG, bloods. Examined fluid overload.  
Medication.

Diagnosis: heart failure, changed medications, arranged next day OPA cardiology appointment.

Further follow-up with GP.



## Impact of a clear service aim ... core services simply delivered

- Few high volume pathways or simple criteria
- Appropriate

65 year old. Swelling of L calf for a week, breathlessness. Seen in AEC at 17:40.  
? DVT. NEWS 1-4.

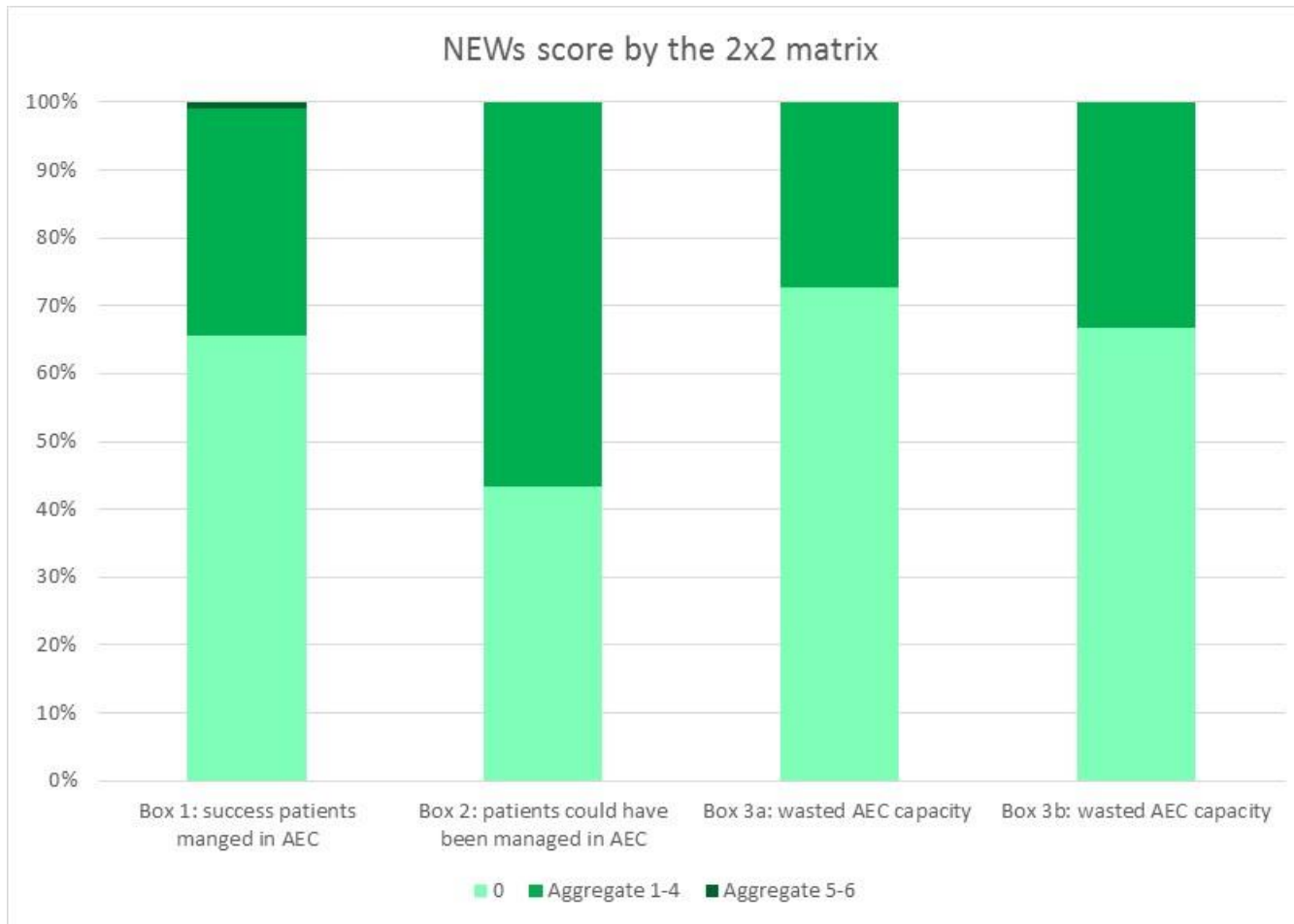
Tests: Bloods, ECG, chest xray

Diagnosis: No evidence DVT. Exacerbation of COPD – discharged with steroids.

No further follow-up.

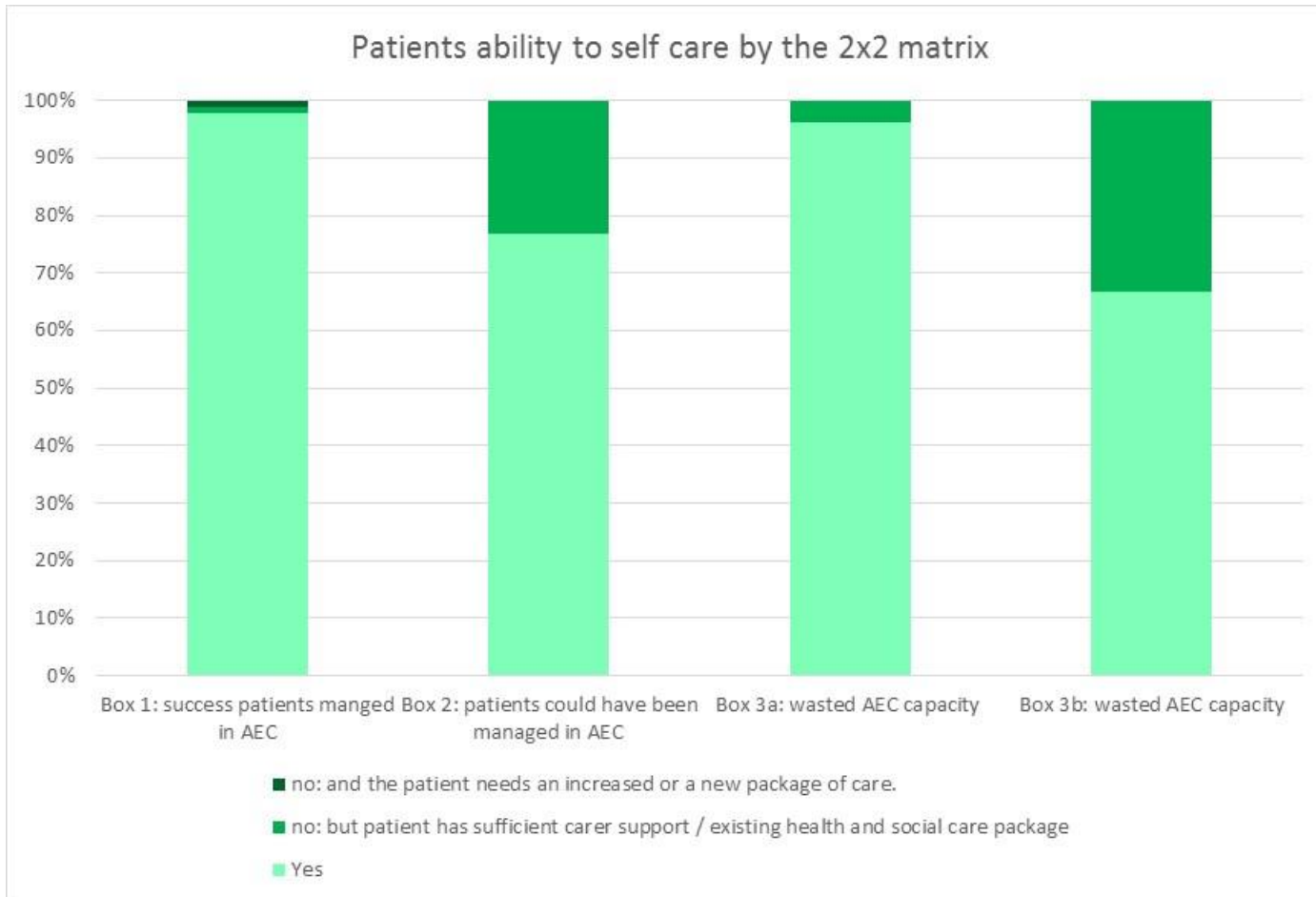


# NEWS score across the collaborative





# Patients ability to self-care across the collaborative





## Clinical conversations ... ensure these take place and are robust

- Patient referred as “ ....” but clinical indicators not present

30yr lady with 1 week history cough and some chest pain; referred as ?sepsis; no signs present.

In AEC tests were:  
bloods; ecg; cxray; ddimer; sputum sample;

Treatment: oral antibiotics

?would clinical conversation focusing on presenting signs and management options avoided a patient needing to attend the hospital?



There are a number of clinical risk stratification tools that can be used to support clinical decision making. These have largely been developed in the context of research studies. They should be seen as adjuncts to the clinical decision making process. Currently the following are available:

- DVT – Well's
- PE – Wells, Hestia, PERC
- Chest pain – TIMI risk score, HEART risk score
- Pneumonia – CURB65
- Acute upper GI Bleed – Glasgow-Blatchford
- Syncope - San Francisco risk score





# Frailty score

- Enable patients with low scores to be appropriately managed in AEC

## Clinical Vignette

Male 92 yrs. Lives with wife. Few co-morbidities. Attended A&E at 12:08 by ambulance.

Presented feeling dizzy and not himself. ?electrolyte ?pneumonia. X-ray. Oral antibiotics referred to AMU. Normal obs (NEWS=0). Consultant saw at 4pm. Expected day of discharge 2-3 days. Went home next day.

The patient was old, not frail. Frailty score -> AEC would have been a better option to avoid risk of decompensation. +/- follow-up in community

[#32 – 2017-11]

# Clinical frailty score and AEC + medical presentation

- CFS based on how the patient was **TWO** weeks ago
- Ask them, families or carers
- Can the ambulance service help?

## 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.

\* 1. Canadian Study on Health & Aging, Revised 2008.

2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

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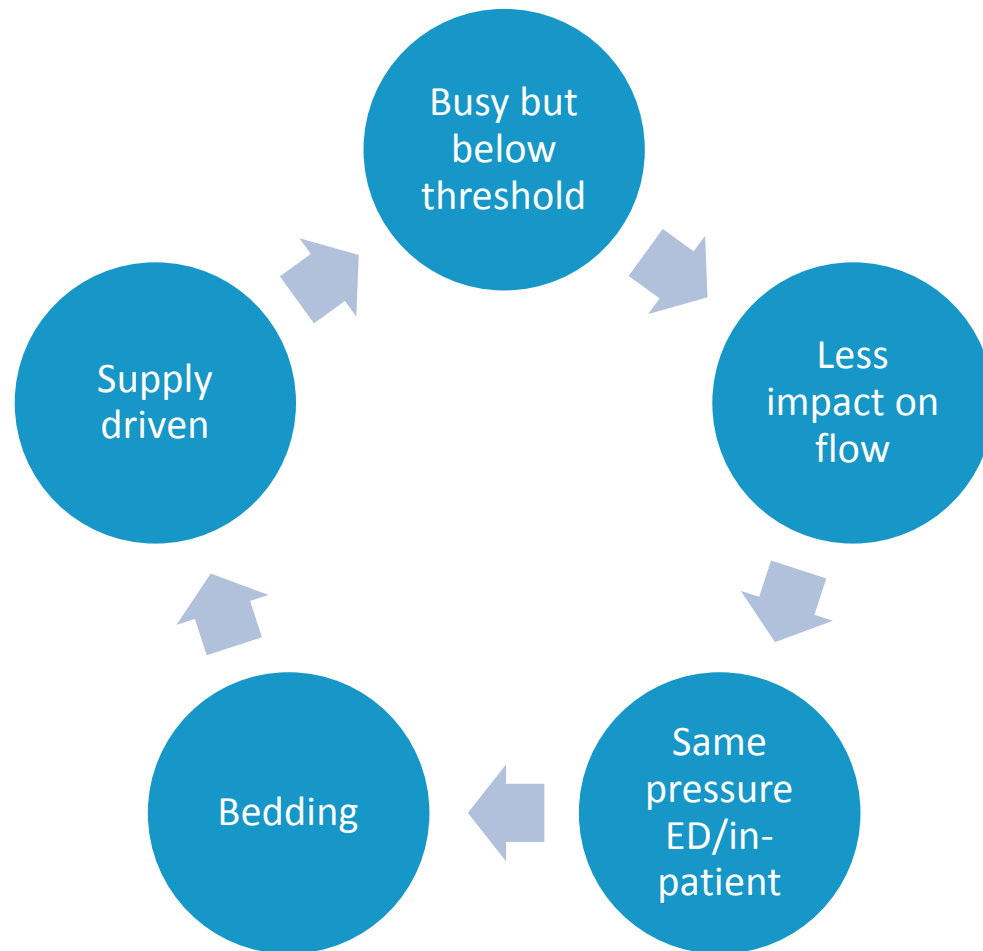


Ambulate if patient meets clinical criteria

Acute frailty model / service with comprehensive geriatric assessment

# Breaking the cycle of lower impact ...

“We are busy and help other services”



*“Deferral of decision making can take place along the whole patient journey – poor use of precious time”*



Other services mainly a combined model

AEC is part of an assessment unit (3)

process

pull

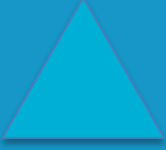
passive



## Model: illustration

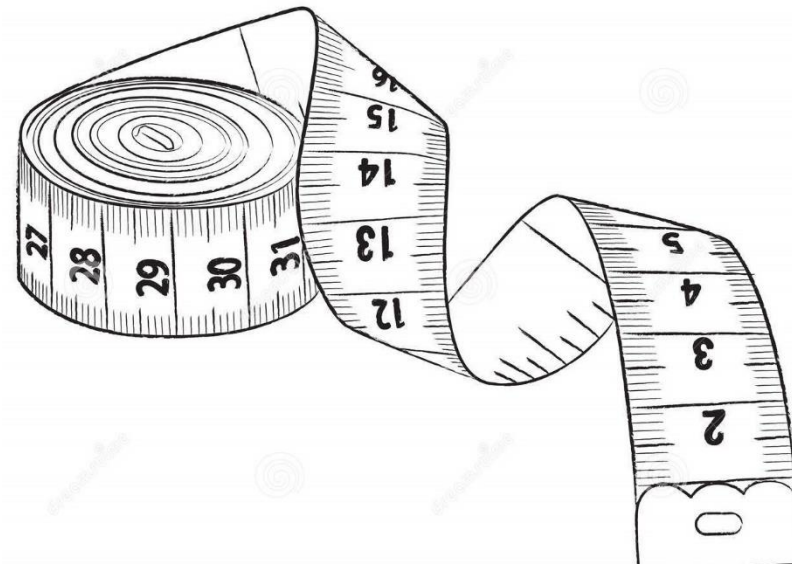
- Current position:
  - We cover multiple types of models within the unit.
  - We are passive due to capacity, but also are pathway driven in multiple specialities.
  - The aim would be a Pull unit at all times but this is only intermittent at present.
- *The long term goal is that every patient is reviewed as a potential AEC patient.*

[focus on those being considered for admission]



“some measures in place but not routinely reviewed or discussed”

Pre-site visit questionnaire





## Operational measures: effectiveness

- AEC activity – new patients / follow-up patients (majority) and source of referral/or in-reach
- % medical take, %conversion
- One trust had an elegant dashboard of other activity specialty referrals, orders, ie AEC workflow
- Friends and family test (1 trust)



## Impact

- A&E performance most cited for flow
- Reflection of activity and impact on medical take
- However, highlighted this is difficult ..



# Tip 1: keep an eye on supply led demand

- Has total emergency activity increased, decreased or stayed the same? With service development.
  - Monitor 0 LOS + AEC
  - Monitor 1+ day LOS activity
  - Total – should be the same



Focusing on medical take maybe more sensitive BUT keep an eye on the whole picture.



## Tip 2: monitor measures and impact on flow

### **Are admissions being avoided?**

- Challenge? Simple ongoing casefile review
- Reduced 1+ LOS or emergency beddays with any improvements?

### **Journey: do patients avoid A&E?**

- How long do patients stay in A&E before being seen in AEC?
- Impact seen with any improvements?



## Tip 2: monitor measures and impact on flow

### Are admissions being avoided?

- Challenge? Simple ongoing casefile review
- Reduced 1+ LOS or emergency beddays with any improvements?

### Journey: do patients avoid A&E?

**38-72%** patients attend via A&E

- How long do patients stay in A&E before being seen in AEC? - **184** minutes on average
- Adjusted to take into account some patients don't go via AEC **79** minutes per "AEC patient"



## Tip 3: operational measures

- Is the service optimised?
  - (rapid diagnostics, senior decision making, rapid specialty review, readmission, conversion)
- Patient experience good?
- Casemix / complexity appropriate



## Tip 3: operational measures

- Is the service optimised?
  - (rapid diagnostics, senior decision making, rapid specialty review, readmission, conversion)

Reattendance **4%**

Conversion **7-14%**

- Patient experience good?
- Casemix / complexity appropriate
  - NEWs score etc



# Themes

- Patient Selection
- Service Aim/Purpose
- Early Streaming
- Clinical Conversation
- AEC Processes