NHS
Ambulatory Emergency Care Network

Ambulatory Emergency Care

What Happens Now?

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UK Acute Surgical Unit Survey

- 14 units
- 110 patients per week (range 42-200 patients/week)
- Average reduction LOS by 1.1 days (range 0.9-1.6 days)
- 12% admission avoidance
- Savings £0.45-1.34 million/year
- Many common themes
- 3 units dedicated ambulatory care

Richards S, Anderson I, 2014

Acute Surgical Units- "*Horses for Courses*"

- Ambulator
- Urgent l e lists
- Incr nsultant input- theatre and f
- sed frequency of ward rounds
- uty Consultant" rather than "on call Consultant"
- Peri-operative physicians
- Emergency General Surgeons

NO TRUST HAS IT PERFECT

The Journey Ahead

Interactive session

- Chatham House Rules. *("Information disclosed during meeting may be reported by those present, but the source may not be explicitly or implicitly identified")*
- My problems
- Your problems
- Common themes

Control the Front Door- Blackburn/Watson Model

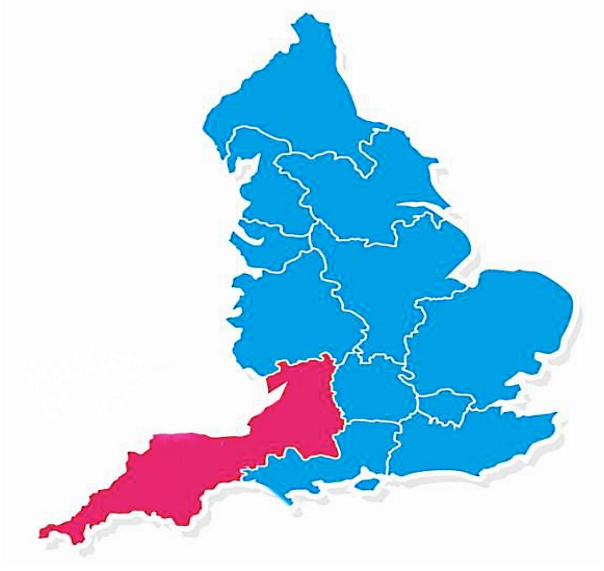
- Surgical triage/assessment unit:

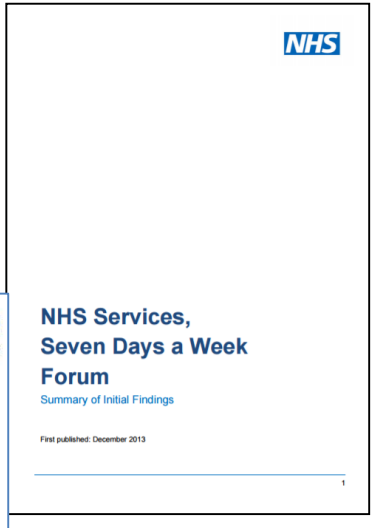
  Reduce admissions by 25%

  Rapid senior decision making

  - Separate area from A&E with trolleys
  - Senior staff front door

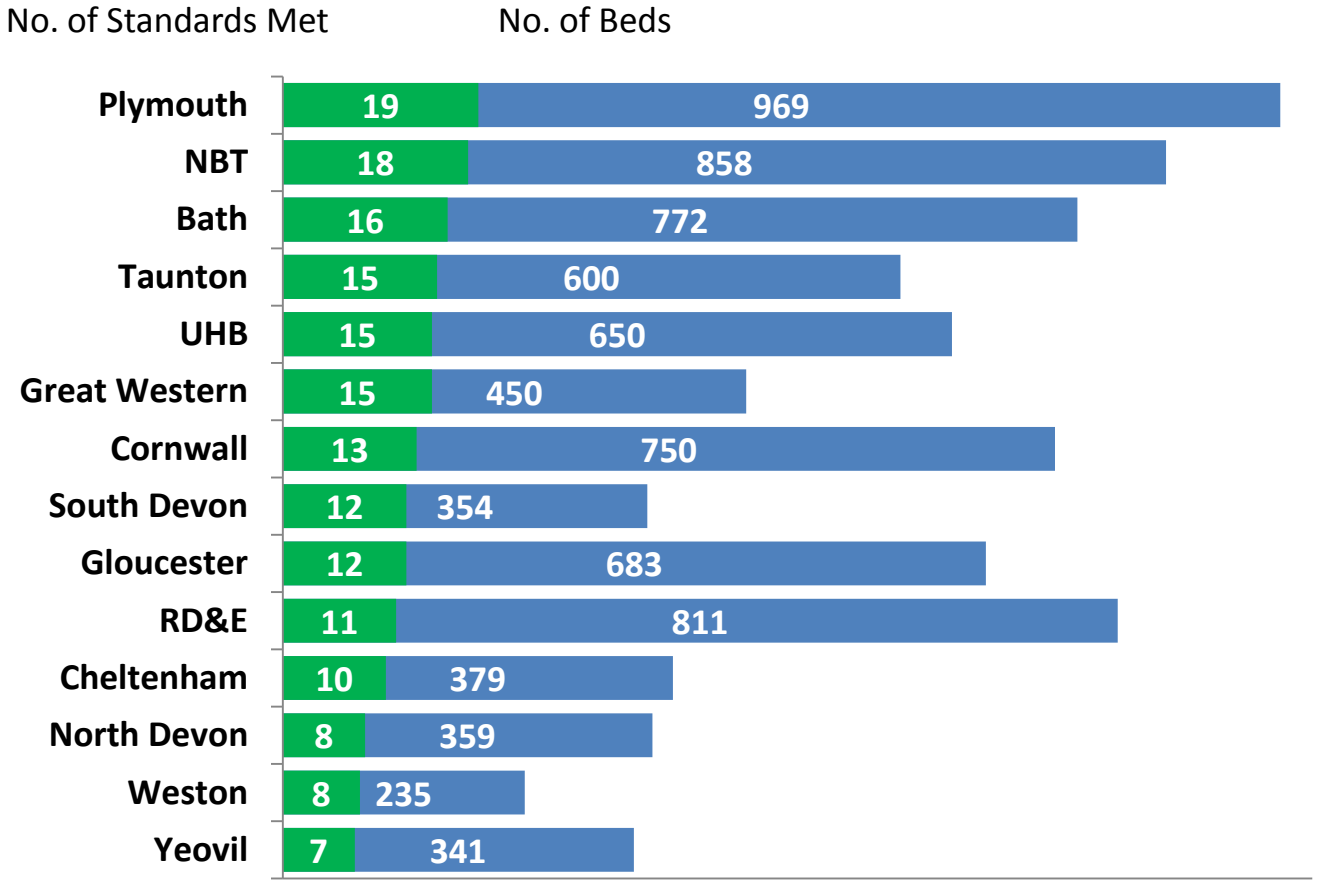
Emergency General Surgery:
A Review of Acute Trusts in the South West





- 23 separate standards audited

No. of standards met vs. hospital size (no. of beds)



Six key recommendations

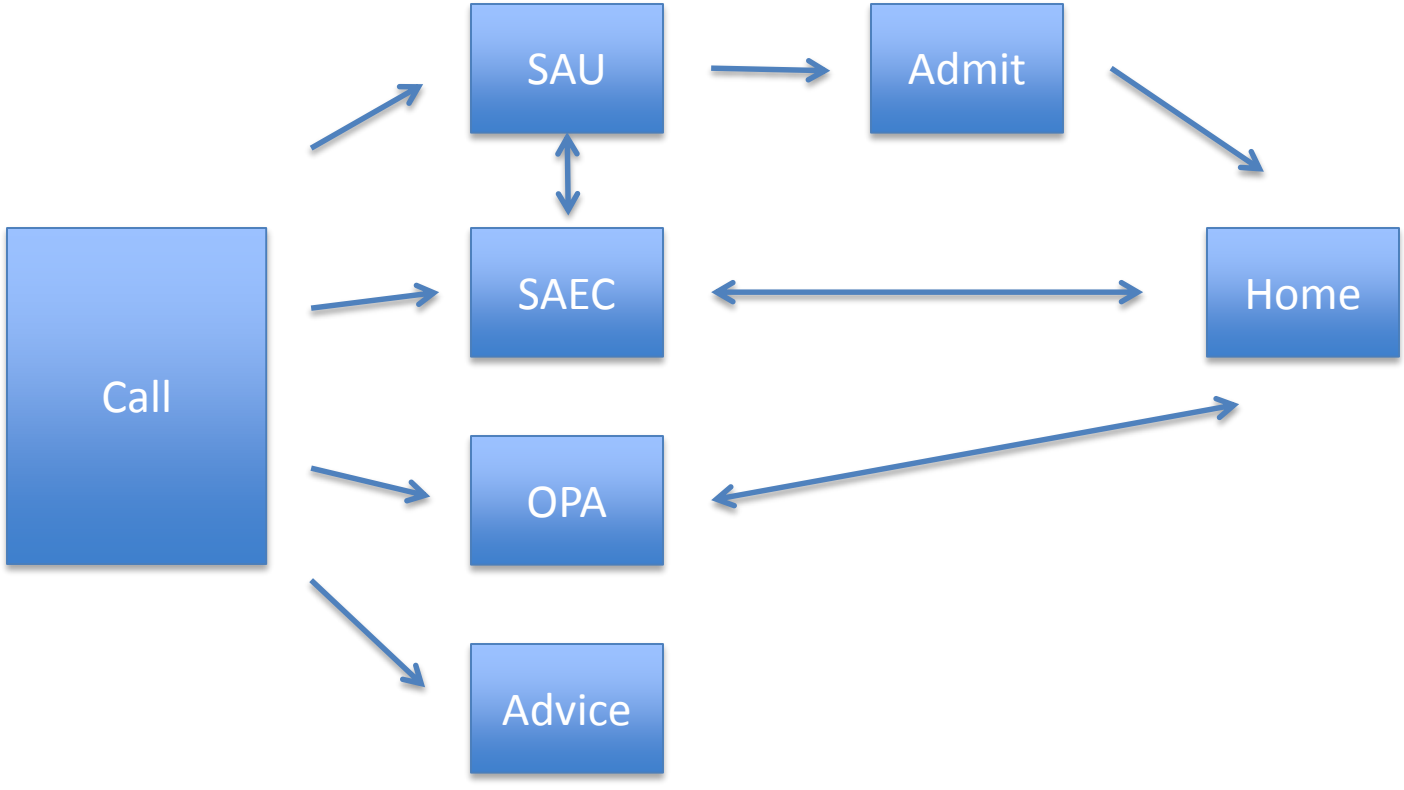
The recommendations can be summarised as:

1. The provision of a protected Surgical Assessment Unit.
2. The provision of 24/7 CEPOD or Emergency Theatre.
3. Development of a fully integrated ambulatory EGS service.
4. A standardised, rolling audit of EGS.
5. Delivery of 2 consultant led ward rounds per day of EGS patients.
6. The appointment of an EGS lead and an Emergency Nurse lead in each Trust.

SAEC vs SAU

- Two distinct entities
- Does this involve two teams?
- Rapid triage assessment is different from ambulatory care.
- Resource, personnel and diagnostic heavy

Theoretical Pathway- Process Driven



So…..

- Who should hold the phone?

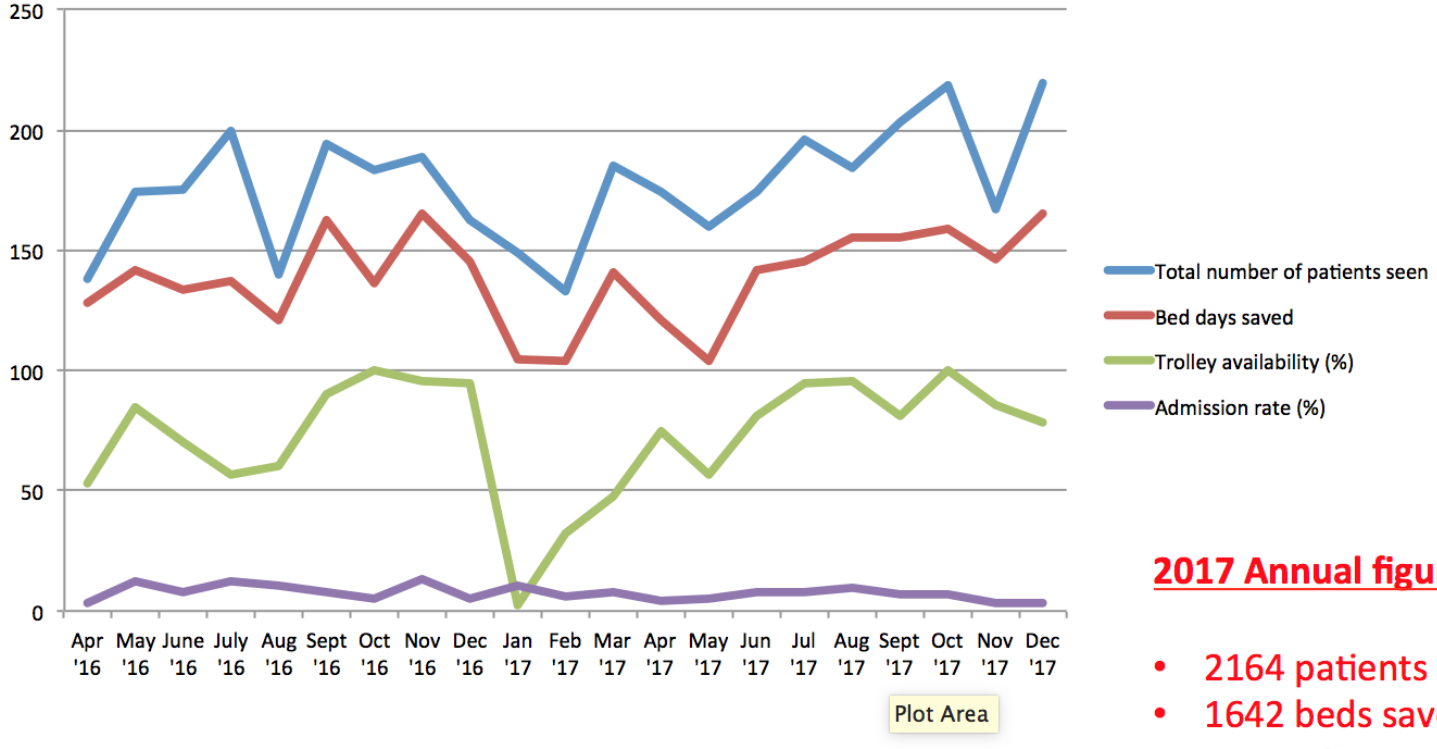
- Who are the referrers?

SAEC vs “Hot Clinic”

- Is there a difference?
- Does it drive abuse?
- How do you not drive unnecessary demand?
- Is tariff key?
- 48 hour bookings only?

Bedding the Unit

ESAC Annual Bed Savings



2017 Annual figures

- 2164 patients
- 1642 beds saved
- 6.7% admission rate

Driving Demand

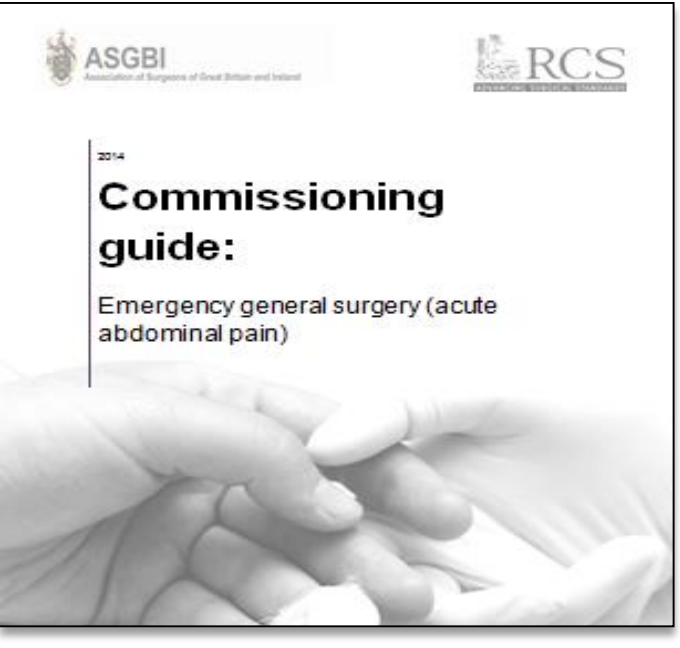
Medicine and Surgery

Combined Ambulatory Care

- Does this work?
- Is it the only way?
- Very different specialties.
- Does it make overnight bedding harder?

Royal United Hospitals Bath NHS
NHS Foundation Trust

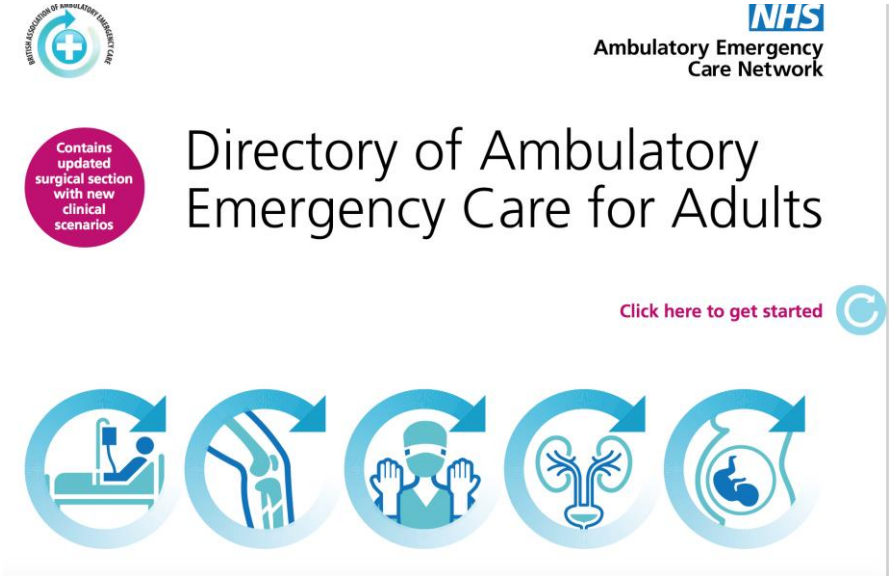
Conditions Suitable for ESAC



Conditions requiring admission	Conditions suitable for ESAC
Peritonitis	Non specific abdo pain
Intestinal obstruction	Biliary colic
Appendicitis	Mild cholecystitis
Pancreatitis	Some Abscesses
Intestinal ischaemia	Stable PR bleeding
Severe cholecystitis	Chronic conditions without acute exacerbation
Trauma	Simple Diverticulitis

Royal United Hospitals Bath NHS
NHS Foundation Trust

AEC Directory



February 2018

Potential Conversion to SAEC

CONDITION	% SAEC	CONVERSION
Acute abdo pain not requiring operative intervention	30-60%	Moderate
Cutaneous abscess requiring drainage	60-90%	High
RUQ pain	60-90%	High
Non-obstructed hernia	60-90%	High
Haemorrhoids	>90%	Very High
RIF pain	30-60%	Moderate
LIF pain	30-60%	Moderate
Anorectal issues	60-90%	High

Volume Data (Irish)

Rank by volume	Diagnosis	Number of patients	Average length of stay (days)	Percentage same day discharges
1	Pain localised to other parts of the lower abdomen	3871	1.9901	21.77%
2	Other and unspecified abdominal pain	2817	2.044	20.55%
3	Cellulitis of lower limb	1974	6.0506	3.75%
4	Pain localised to upper abdomen	1437	2.325	21.09%
5	Unspecified injury of head	982	1.2434	30.24%
6	Haemorrhage and haematoma complicating procedure not otherwise specified	940	2.4968	7.021%
7	Urinary tract infection (site not specified)	885	3.5322	11.75%
8	Diverticulosis of large intestine without perforation or haemorrhage	880	4.1261	3.64%
9	Gastrointestinal haemorrhage unspecified	866	5.254	10.83%
10	Wound infection following a procedure	853	6.3998	9.14%
11	Constipation	797	3.5175	13.05%
12	Diverticulitis of large intestine without perforation or haemorrhage	760	4.0132	1.97%
13	Acute cholecystitis	755	5.0146	2.65%
14	Other and unspecified ovarian cysts	751	1.8229	14.65%
15	Other and unspecified intestinal obstruction	735	6.2531	3.13%
16	Other specified injuries of head	734	1.4591	31.16%
17	Acute pancreatitis, unspecified	723	6.8645	2.21%
18	Acute tonsillitis unspecified	718	2.0682	4.60%

Non-Perineal Abscesses

- Push to LA techniques
- Nurse Practitioners
- Training
- Exclusions- breast, children, ?diabetics

Biliary conditions

- RUQ pain very successfully managed
- US, analgesia, OP antibiotics, MRCP etc
- Good access to theatre with acute cholecystitis and gallstone pancreatitis

Mrs RJ

- 35 years old
- Recruitment consultant
- Normally fit and well
- 3 admissions with biliary colic
- 4 ED attendances
- Unable to work
- Small child at home
- Religiously sticking to fat free diet

"I can not tell you how miserable my life has become, it has come to a complete stop"

RIF pain and Appendicitis

- Red (no intervention)/green hours (intervention move forward)
- 2016- confirmed appendicitis, average LOS 78h27mins
- Admission to surgery- average 24h14mins
- Senior review (SpR and above) to surgery- average 9h 20mins

Ambulatory care a safe alternative in the majority!

NSAP

- Very resource heavy
- “It’s a waste of my time”
- FODMAP diet, reassurance, Mindfulness etc
- Is this really what I wanted to do?
- RISK!!

Mother-of-four, 33, died after doctors missed her cancer THIRTY TIMES - blaming her symptoms on 'nerve pain and anxiety'

Rectal Bleeds

Admit or virtual ward/ESAC with paper triage for appropriate follow up:

- Hb> 12g/dL males, >11g/dL females
- No anticoagulants other than aspirin
- Systolic BP >110mmHg
- ASA= or <II
- Telephone at home
- Lives with another adult

Dealing with the Unexpected

- High number of unexpected cancers
- Breaking bad news

Mum diagnosed with terminal cancer two weeks after giving birth tries to raise money for her girls' future

Lisa Wells, 31, thought she had a water infection but doctors found a tumour on her bowel which has spread to her liver - and has been given less than a year to live

- Shoe leather!

PRINCIPLES

1. Referrals should be process driven
2. Consultant-led and delivered
3. Rapid access to diagnostics
4. Rapid access to theatre
5. Early supported discharges
6. The Virtual Ward
7. The SAEC should be run from a designated, protected area
8. Nurse Practitioners and other Health Care Professionals
9. Robust documentation and safety-netting
10. Avoid unnecessary referrals to SAEC

What do you need?

- Enthusiastic core SAEC team
- Management and administrative support
- Involve stakeholders across the pathway
- Clinical leadership (medical and nursing)
- Active Executive involvement and support
- Commissioning involvement and support
- Clear project aim and plan
- Clear operational plan understood by all
- Everything else will follow……..

…….DO NOT FOCUS ON THEATRE PROVISION

The Headlines- Dec 2017

Surgeons are needed in A&E to prevent winter crisis

News

Surgeons to guard hospital doors this winter in bid to stop overcrowding

In trusts such as Bath, Derby and Blackburn,

. . . the times they are a-changin’

Contact Details

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or want to access work shared by other organisations go to:

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