Team from Chorley Hospital

AECU at Chorley Hospital – A Case Study

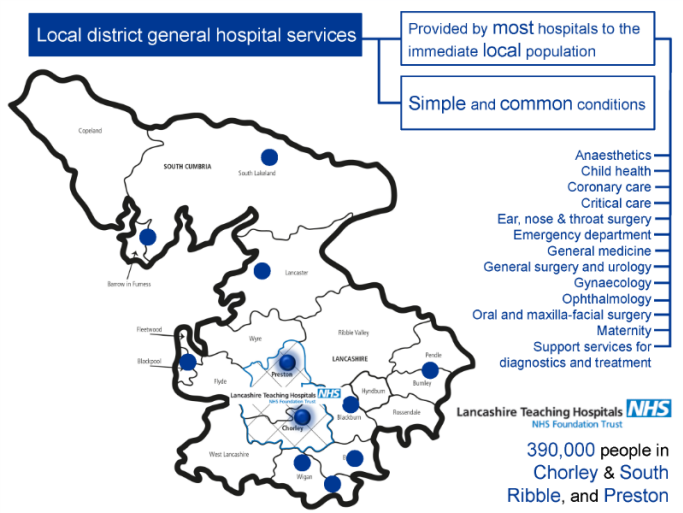
Maximising Ambulatory Care

AECU – LTHTR
October 2018

Aims and Objectives

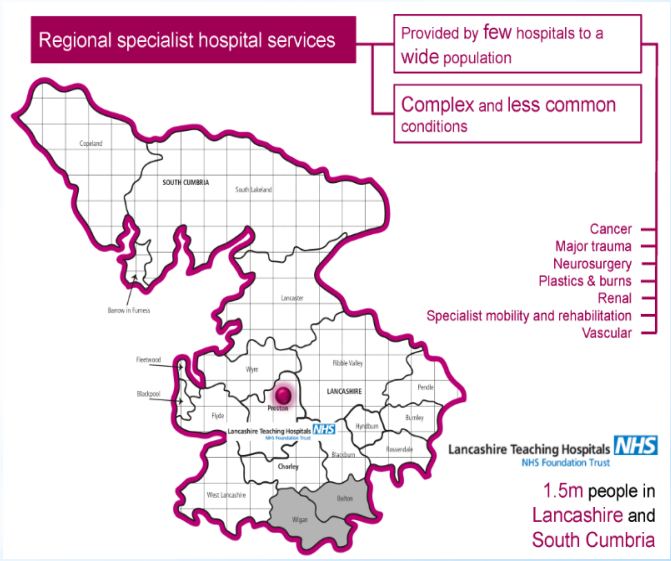
* History
* Achievements
* Maximising Ambulatory Care Units
* Future plans
* Issues/Limitations


Lancashire Teaching Hospitals
NHS
NHS Trust
Welcome to
Royal Preston Hospital
Parking Conditions Apply
Lancashire Teaching Hospitals
NHS
Chorley & South Ribble District General Hospital



We are one of the largest trusts in the country, providing district general hospital services to 370,000 people in Preston and Chorley, and specialist care to 1.5m people across Lancashire and South Cumbria.

We provide care from three facilities :
Chorley and South Ribble Hospital
Royal Preston Hospital
Specialist mobility and rehab center



Setting the scene

* A&E at CDH closed in April 2016
* GP medical take from both Chorley, South Ribble and Preston and directed to MAU at CDH
* RAU was closed
* Discussions from August 2016 about the creation of an AEC
* LTHTR joined the AEC network in 2016 as part of cohort 10.

Setting the scene

* Re opening of CDH A&E from 18 January 2017
* Unprecedented demand throughout 16/17 where the 4hr ED target was not met at all
* AECU opened on the 1st of March 2017
* AAC opened on June 2018

Key Performance Indicators

* Divert 25% of all direct medical GP referrals from MAU (within AECU opening hours)
* Improve staff and patient experience
* Increase percentage of non elective patients with a 0 LOS

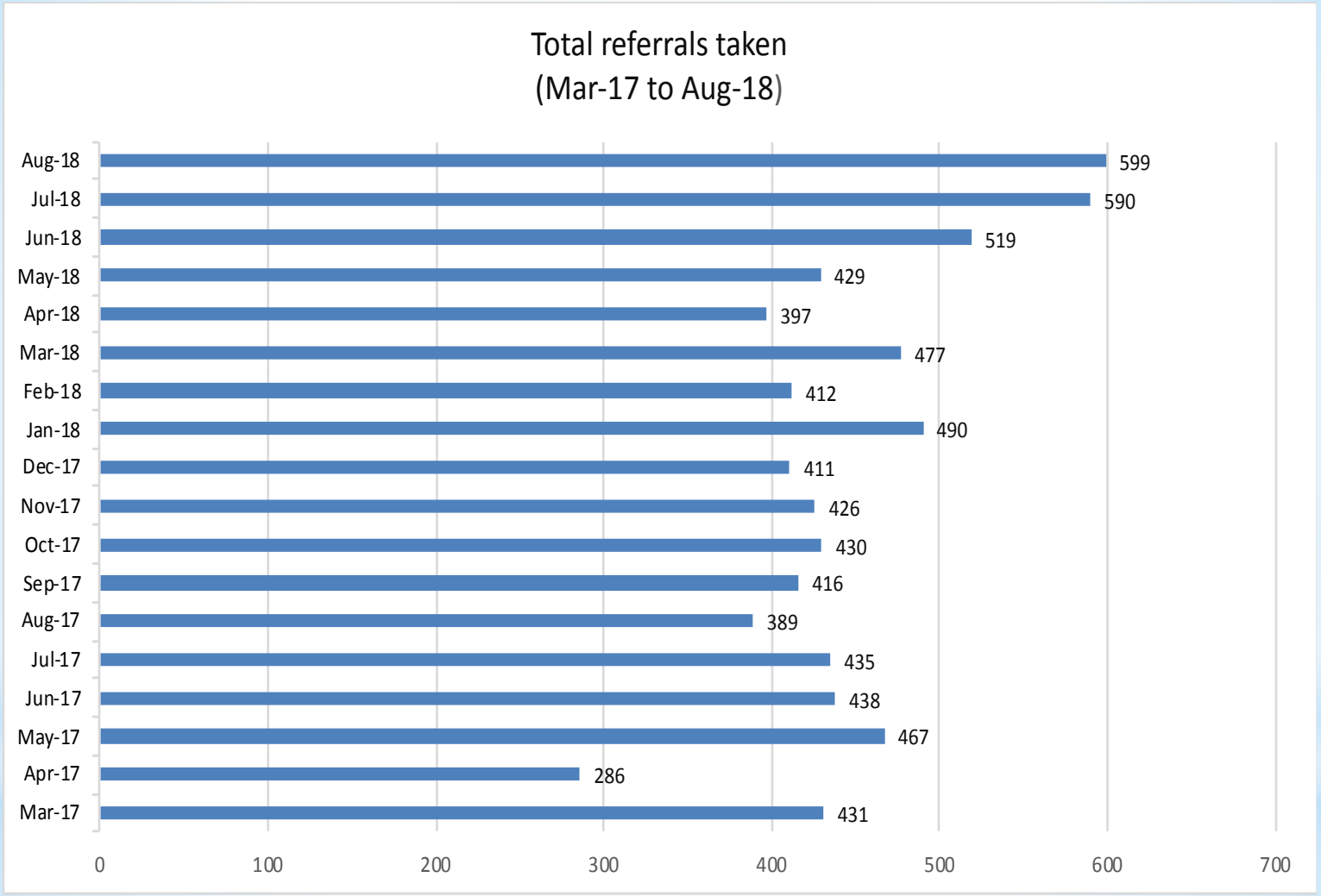
AECU

* Started with a Matron and a Medical registrar

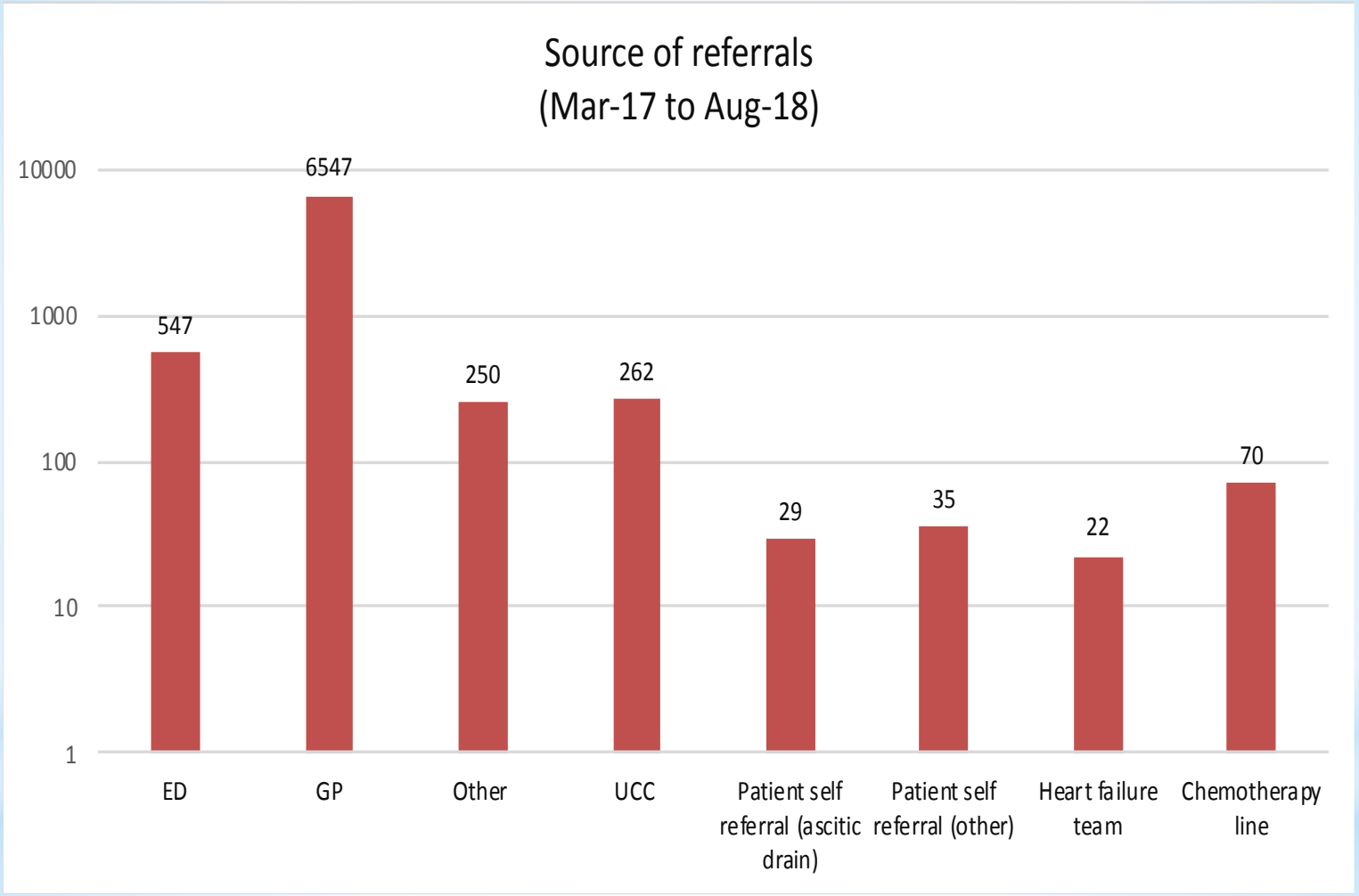
* Current staffing
  * SDM
  * GP call taker
  * 2 Clinicians
  * 1 Trained nurse
  * 1 HCA

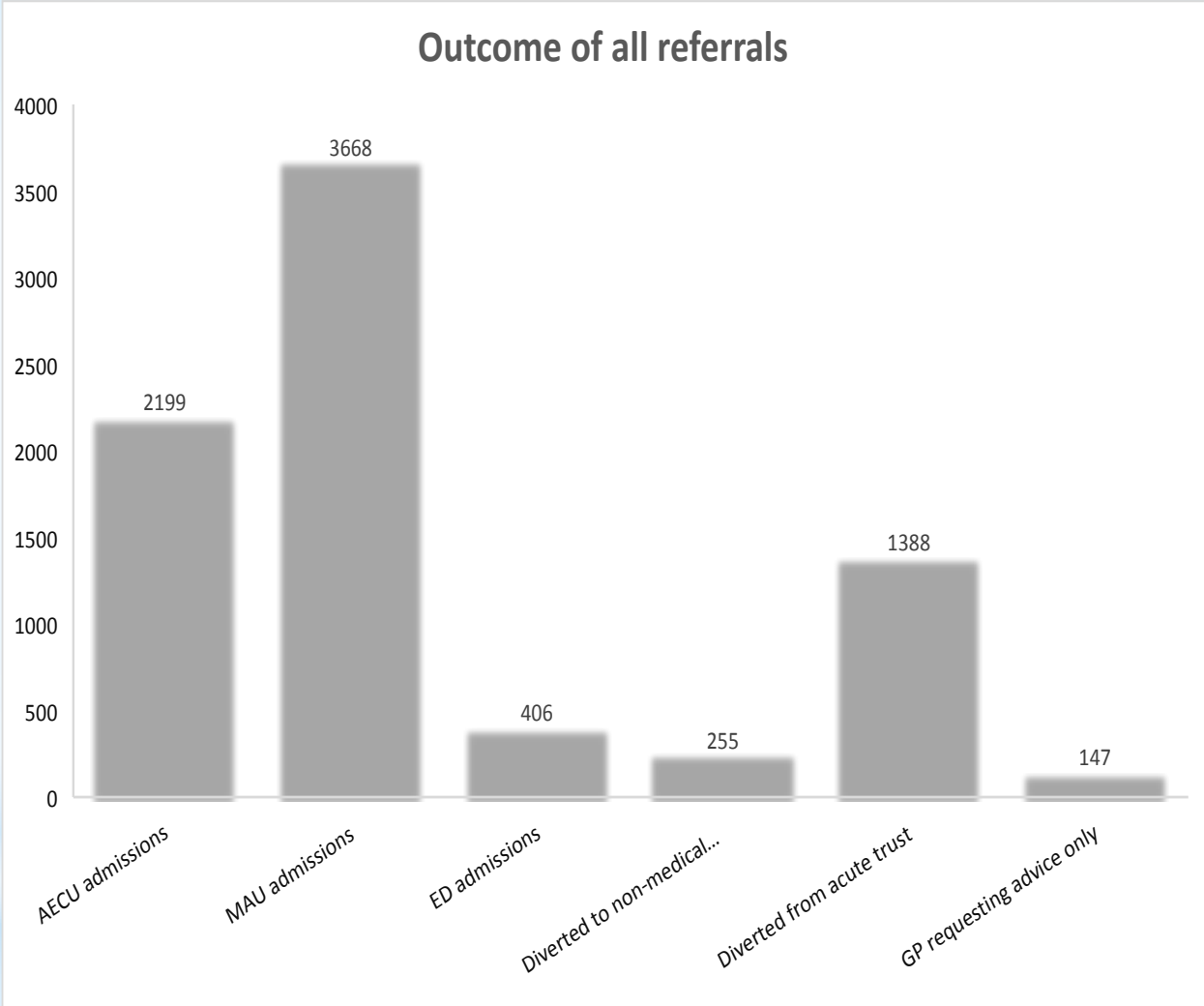
* Opening hour Mon-Fri 10 to 6pm

The AECU team



Since June-18 all referrals from ED CDH to MAU CDH have been taken by AECU (10-6pm Mon-Fri)


Source of referrals
(Mar-17 to Aug-18)
10000
1000
100
10
1
547
6547
250
262
29
35
22
70
ED
GP
Other
UCC
Patient self referral (ascitic drain)
Patient self referral (other)
Heart failure team
Chemotherapy line


Outcome of all referrals
4000
3500
3000
2500
2000
1500
1000
500
0
2199
3668
406
255
1388
147
AECU admissions
MAU admissions
ED admissions
Diverted to non-medical...
Diverted from acute trust
GP requesting advice only

Maximising Ambulatory Care

Maximising

* AECU* acting as referral hub for all medical admissions
  * Signposting referrals to appropriate assessment areas whether that be the acute setting or in the community
  * Ensuring that AECU does not replicate pre-existing services

* Driving change
  * Unique position with regards to primary and secondary care
  * Training

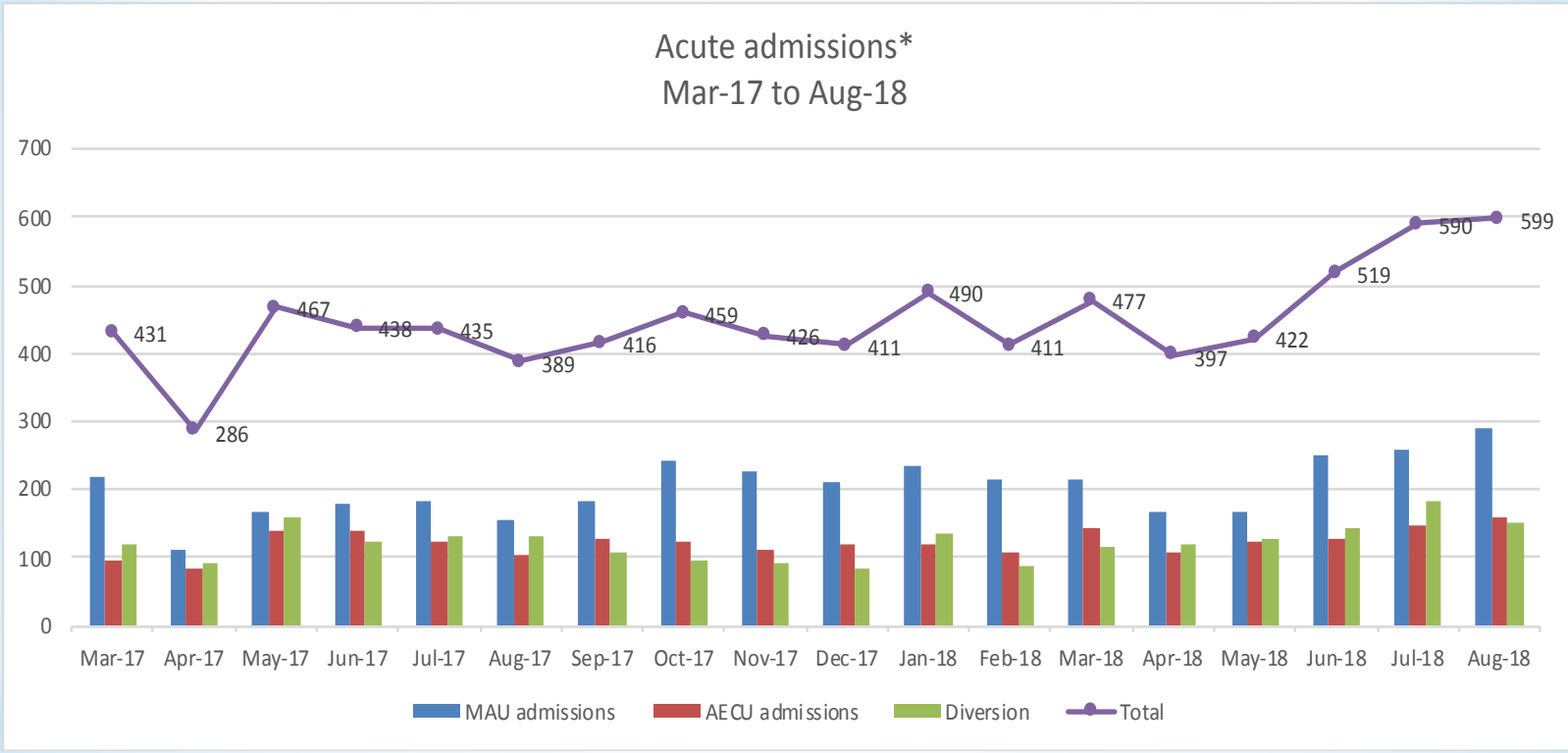
* Using data to identify service gaps and then acting as facilitators to drive change
  * Development of new acute/community pathways such as AKI, Abnormal LFT

* Hosting services
  * Ascitic drains, IV diuretics

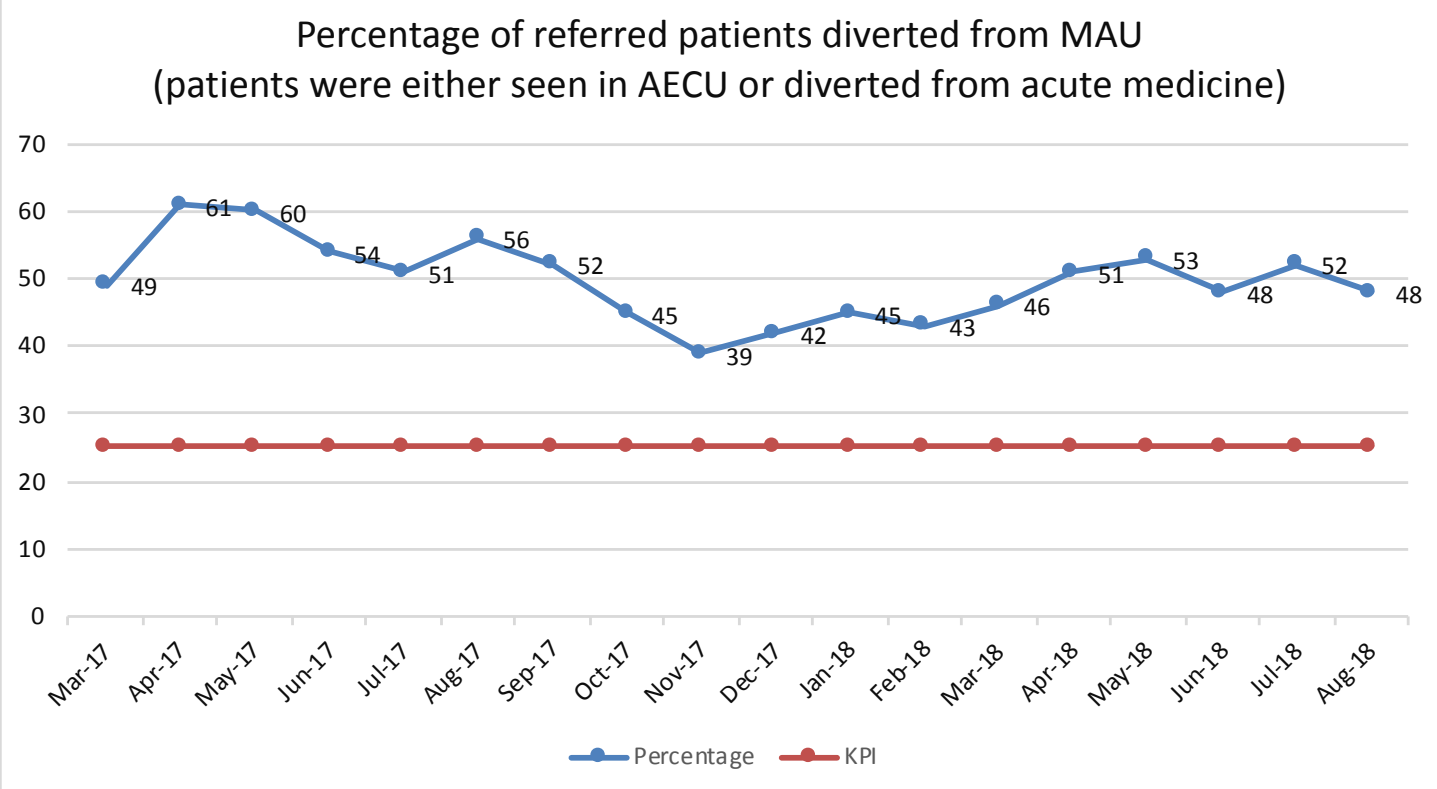
Issues/Limitations

* Quality and accessibility of data
* Tariff negotiations
* (Culture) Change management

Data from June to August 2017

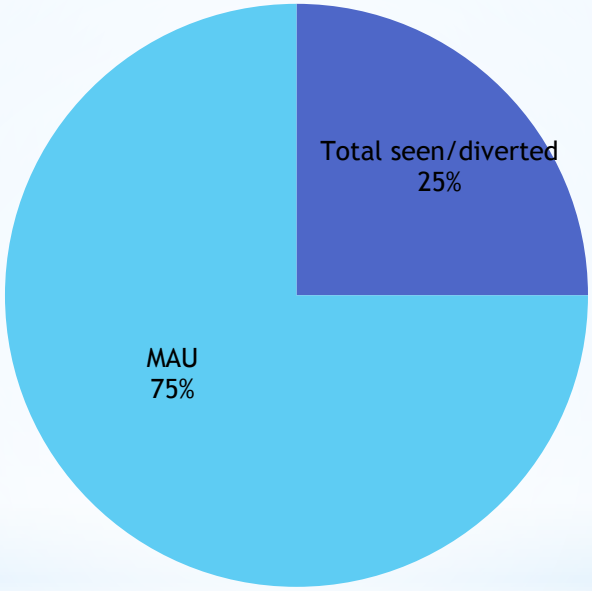


Data from BI and AMaT



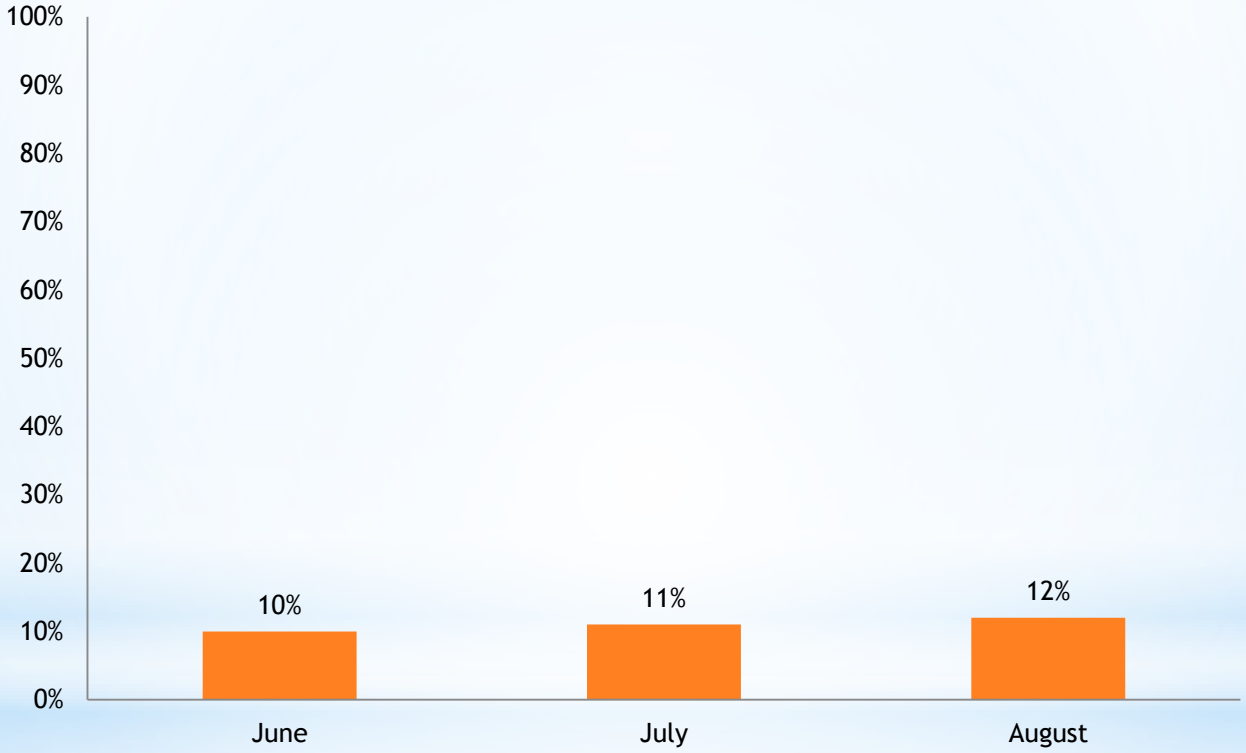
Based on calls taken by AECU 10-6 pm

Total CDH Acute Admissions (Nov-17 to Apr-18)

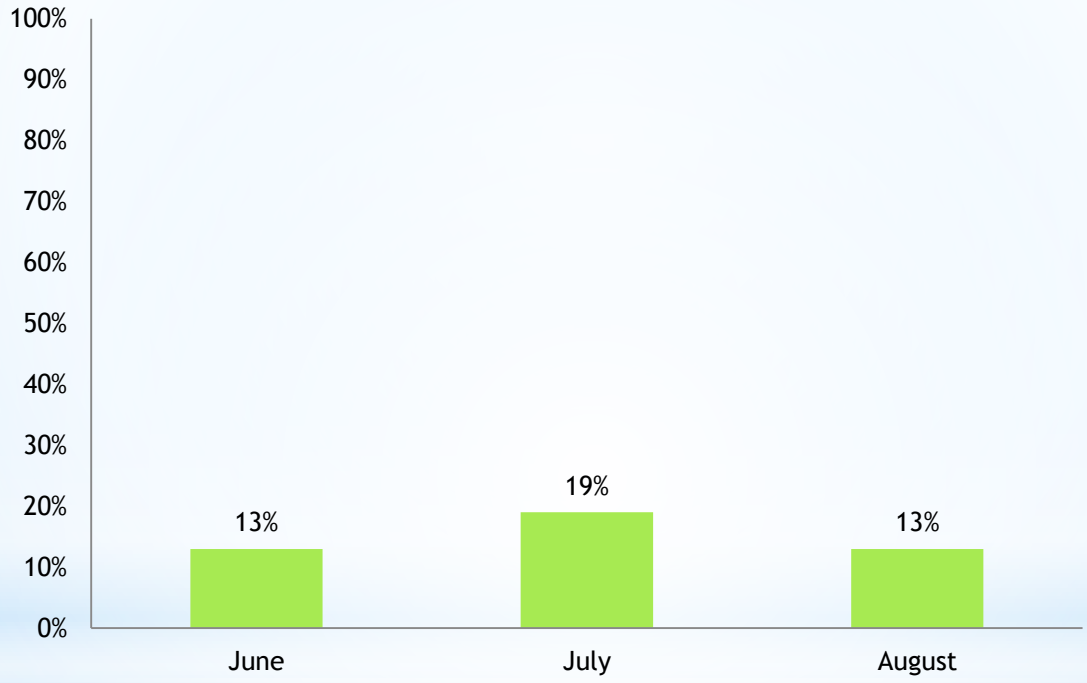


Data from BI and AMaT

Percentage of diverted patients admitted within 7 days of referral

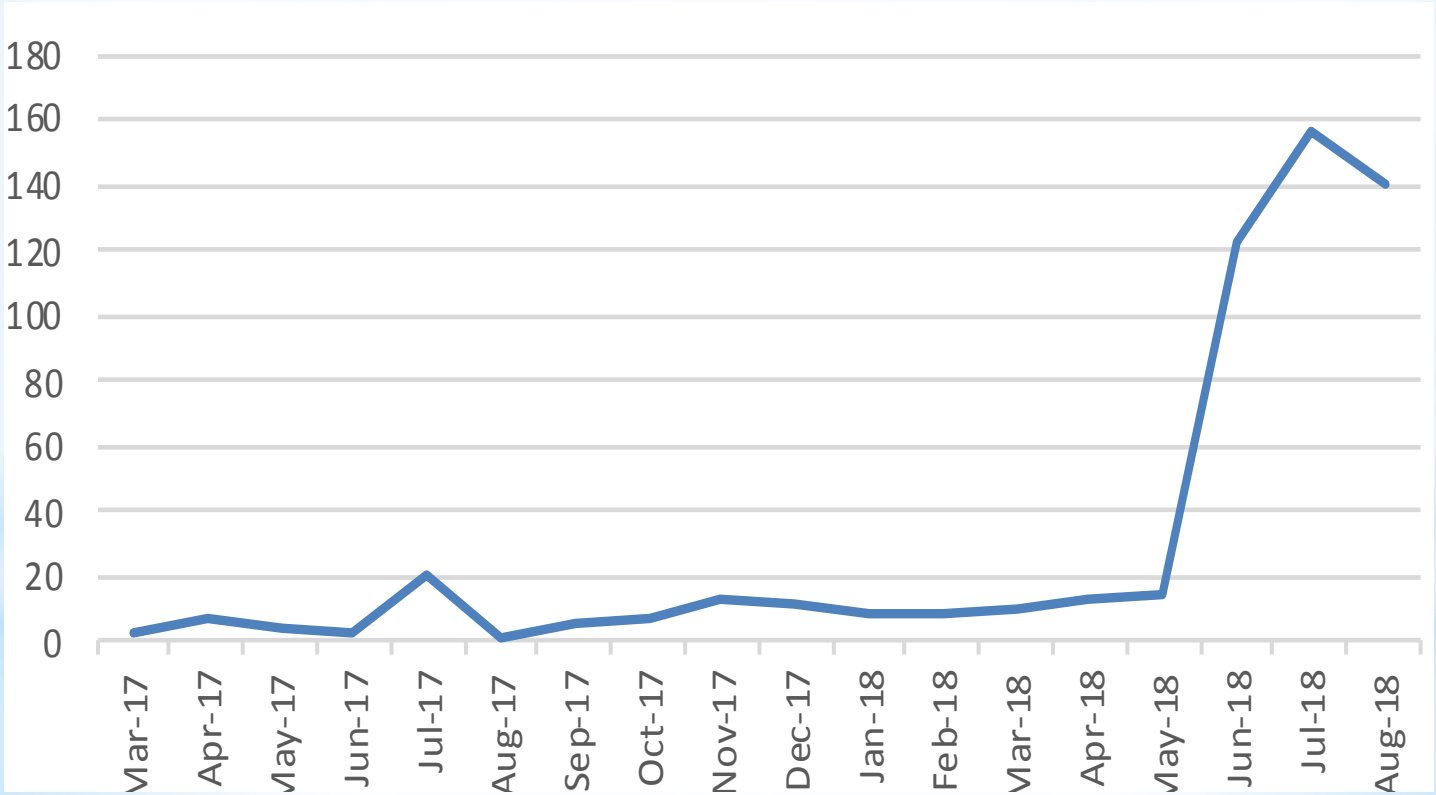


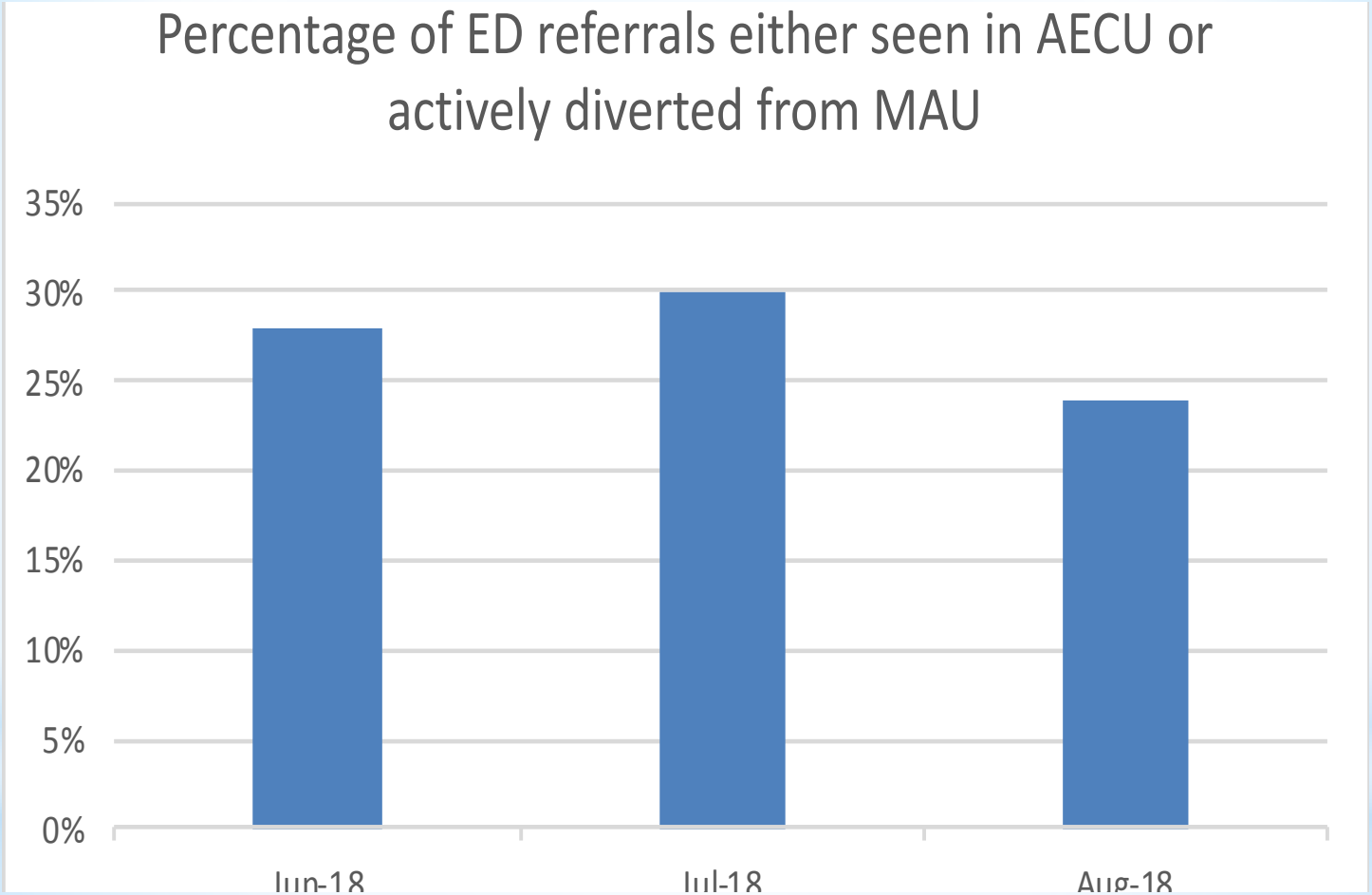
Percentage of diverted patients admitted within 30 days of referral



Maximising

* Taking ED referrals




Percentage of ED referrals either seen in AECU or actively diverted from MAU
35%
30%
25%
20%
15%
10%
5%
0%
Jun-18
Jul-18
Aug-18

Data from June to August 2017

*Ambulatory Care is a mind-set

Ambulatory Care is a transferable mind-set

Home truths

* Good referrers don't send people to an inpatient bed unnecessarily
* Most patients don't want to be in hospital for longer than they have to
* Good hospital staff do not keep people in hospital longer than the need to
* It helps the whole health economy to have a hospital that has capacity (in medicine)
* There is a difference between **urgent** and **important**

AECU's few questions

- Any patient
  - Does this patient have a(n acute) problem or not?
  - Does the problem need to solved in hospital or not?
  - Does the problem we have identified need to be sorted today or not?
- Any referral
  - What question is the referrer asking?
  - What is going to happen as an inpatient that **cannot** happen as an outpatient?

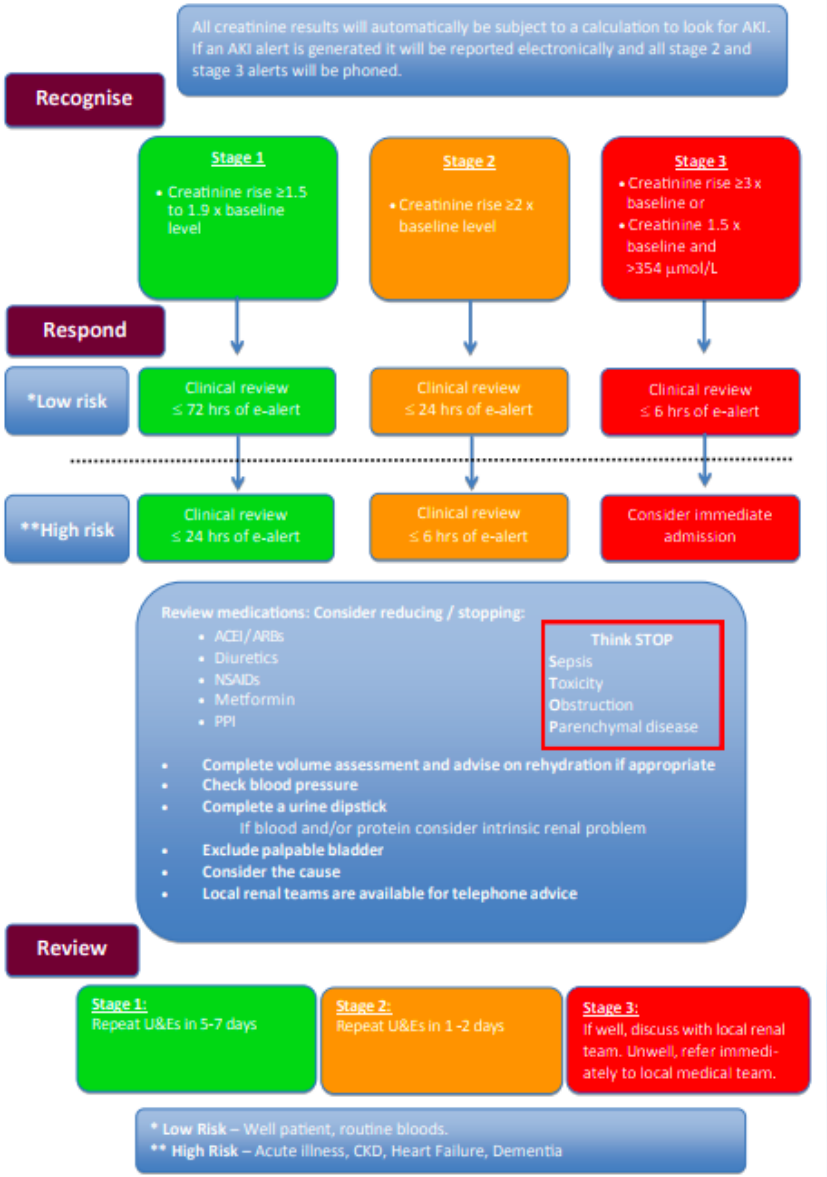
* I am going to admit you unless I can find a way to discharge you

* I am going to discharge you unless I can't

* AECU's Mind-Set

Pathways

Data from June to August 2017


All creatinine results will automatically be subject to a calculation to look for AKI. If an AKI alert is generated it will be reported electronically and all stage 2 and stage 3 alerts will be phoned.
Recognise
Stage 1
• Creatinine rise ≥1.5 to 1.9 x baseline level
Stage 2
• Creatinine rise ≥2 x baseline level
Stage 3
• Creatinine rise ≥3 x baseline or
• Creatinine 1.5 x baseline and >354 µmol/L
Respond
*Low risk
Clinical review ≤ 72 hrs of e-alert
Clinical review ≤ 24 hrs of e-alert
Clinical review ≤ 6 hrs of e-alert
**High risk
Clinical review ≤ 24 hrs of e-alert
Clinical review ≤ 6 hrs of e-alert
Consider immediate admission
Review medications: Consider reducing / stopping:
• ACEI / ARBs
• Diuretics
• NSAIDs
• Metformin
• PPI
Think STOP
Sepsis
Toxicity
Obstruction
Parenchymal disease
• Complete volume assessment and advise on rehydration if appropriate
• Check blood pressure
• Complete a urine dipstick
If blood and/or protein consider intrinsic renal problem
• Exclude palpable bladder
• Consider the cause
• Local renal teams are available for telephone advice
Review
Stage 1:
Repeat U&Es in 5-7 days
Stage 2:
Repeat U&Es in 1 -2 days
Stage 3:
If well, discuss with local renal team. Unwell, refer immediately to local medical team.
* Low Risk – Well patient, routine bloods.
** High Risk – Acute illness, CKD, Heart Failure, Dementia

Hosting services

Data from June to August 2017

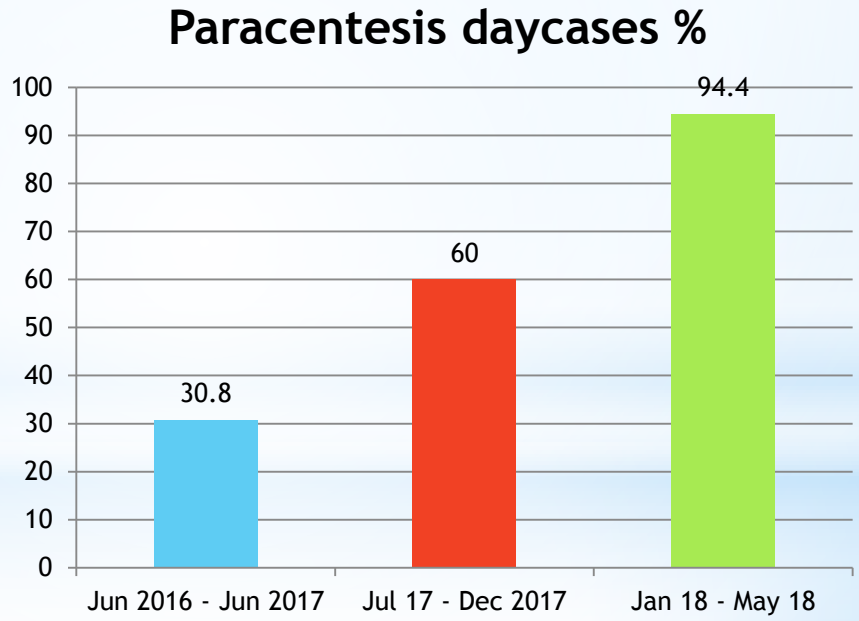
Maximising

* Hosting services
  * Ambulatory Abdominal Paracentesis Service

- Since July 2017 AECU have performed 147 elective abdominal paracentesis.
- 588 bed days saved.

"Very kind, helpful and caring. I felt safe and valued"

"Would recommend without hesitation"



*Ambulatory IV furosemide service

- Trial period July to November 2017

- 62 patients with heart failure received IV diuretics on AECU

- 186 bed days saved

- Due to commence new furosemide protocol in the next two months

"Great care, you made us feel so relaxed and cared for"

"An economic use of NHS resources, without a delay in starting treatment"

"Thank you for your kindness, efficiency and good humour"

Future

* Ambulatory services having responsibility for Day Treatment Centre/Clinical Investigations Unit
* Single culture of work over 2 sites

Thank you
Any questions?

June diverted call data – outcome