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Winter is coming! Developing Emergency Ambulatory Care to meet the challenge

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NHS Foundation Trust

Maximising AEC (AEC Conference) 31ST October 2018

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About EKHUFT…

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- Situated in East Kent, serving population of around 779,000 people
- Comprises of 3 sites – AEC offered at 2 main sites William Harvey Hospital at Ashford and Queen Elizabeth Queen Mother Hospital at Margate
- Geography covers the locality of 4 CCGs.
- EKHUFT A&E attendances around 19,000 a month – 3.4% growth this year

Ambulatory as an Enabl

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Work-stream Aims – 2014 AEC workshop
Improve the quality/patient experience
Increase the number of zero LOS
Reduction in LOS
Increase the number of patient through short stay
Increase the number of patients going through Ambulatory Care
To form part of the overall programme for pathway efficiencies to enable reduction of in-patient beds

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Early Journey Successes

- 6 pathways – DVT, PE, TIA, Cellulitis, COPD, Chest pain
- Successful pilot – Developed 3 Ambulatory Care Units
- Staffing allowed us to open 5 days a week 8 – 6 pm
- PCTs (at the time) happy with progress – GP forums organised to gain further support and communicate message
- Hospital at Home was utilised to support pathways
- Activity increased, zero LOS increased, LOS reduction, enabled beds to be reduced and patients liked it!

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Building on the success

- Work began on developing further 11 pathways in 2015 with AMB score as enabler
- Business case developed for increasing the capacity of the units – for staffing and size
- Engagement and communication strategies developed
- Involvement of the newly formed CCGs
- Financial and activity analysis of existing & new pathways agreed and commissioned

ACU - AMB Score as enabler

AMB score: a simple test that is sensitive in predicting discharge within 12 hours of hospital assessment & identifies patient suitable for the Ambulatory Care Pathways:

- Identifies patient suitable for AEC.
- Enable pathway efficiencies.
- Helps GP's predict the likelihood of same day discharge.
- Help Bed managers plan the daily general medical in-take.

AEC Pathways

Ambulatory Case Sensitive Pathways:	Rapid Access Chest pain pathway
Acute asthma	First Seizure
Ambulatory management of diabetes	Headache
Anaemia	Painless jaundice
Bronchiectasis	Low risk GI bleed
Cellulitis	Pulmonary Embolus
Community Acquired Pneumonia	Pleural effusion
COPD	Syncope pathway
DVT	Giant cell arteritis pathway

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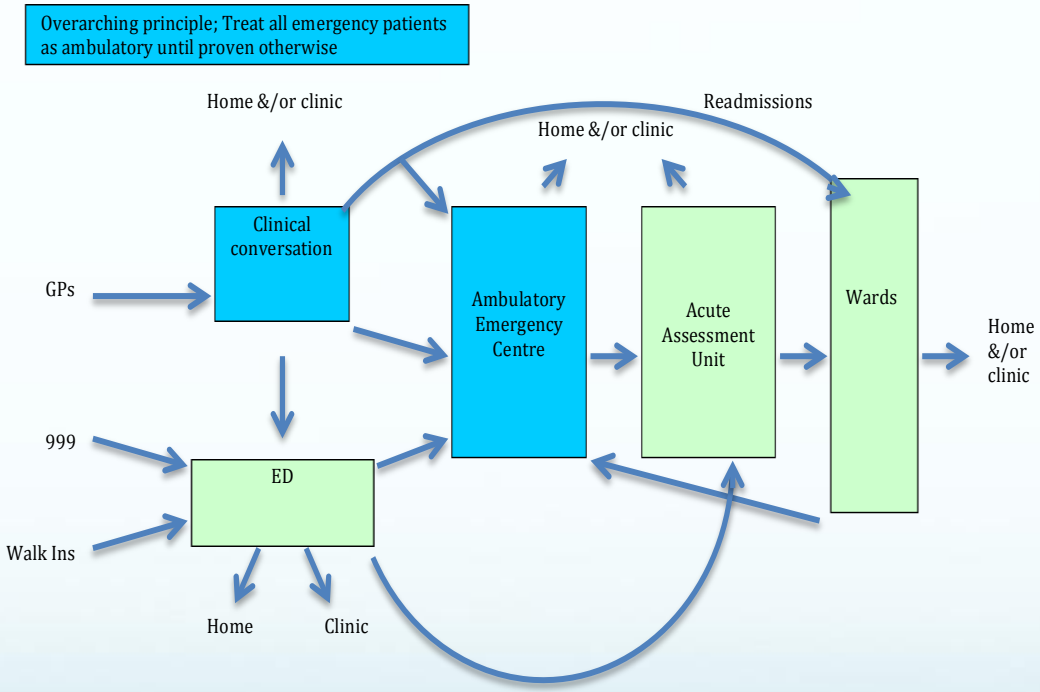
Moving forward….

- Moving away from a pathway approach and adopting a process method – RCP recommendation in 2017

- This means creating a system where all patients are considered for ambulatory care, unless clinically unstable or until proven otherwise. This approach ensures the maximum number of patients benefit from rapid access to the right treatment.

- The principles of ambulatory emergency care are transferable to any setting and can be implemented rapidly.

Process Model



Results of Pilot study: QEQM (Combined AAU +ACU)

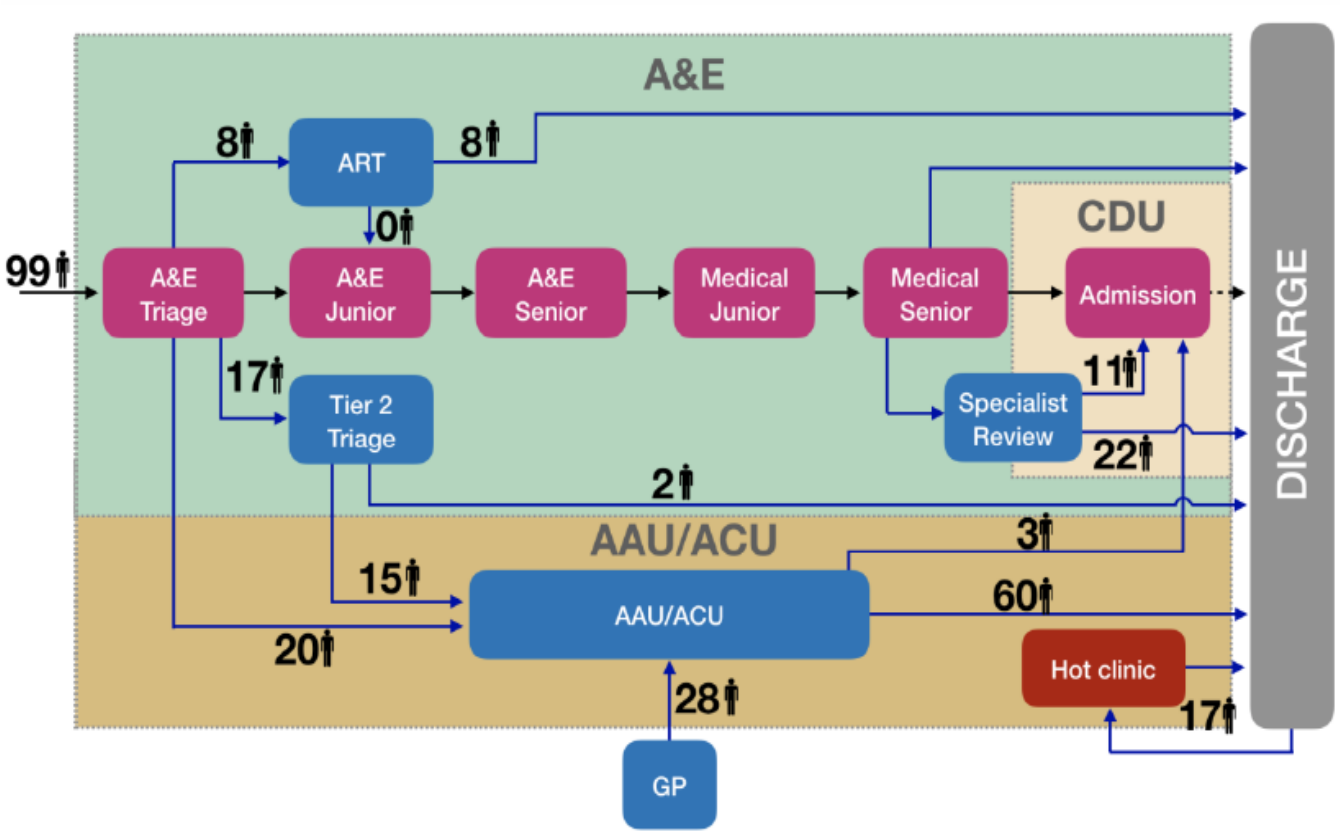


Figure 1: Flow of patients though the new front door pathways. Detailing how the new pathways (blue) the fit around the old model of medical admissions (purple). Numbers shown are the breakdown of medically referred patients throughout the trial period within 24 hours of presentation.

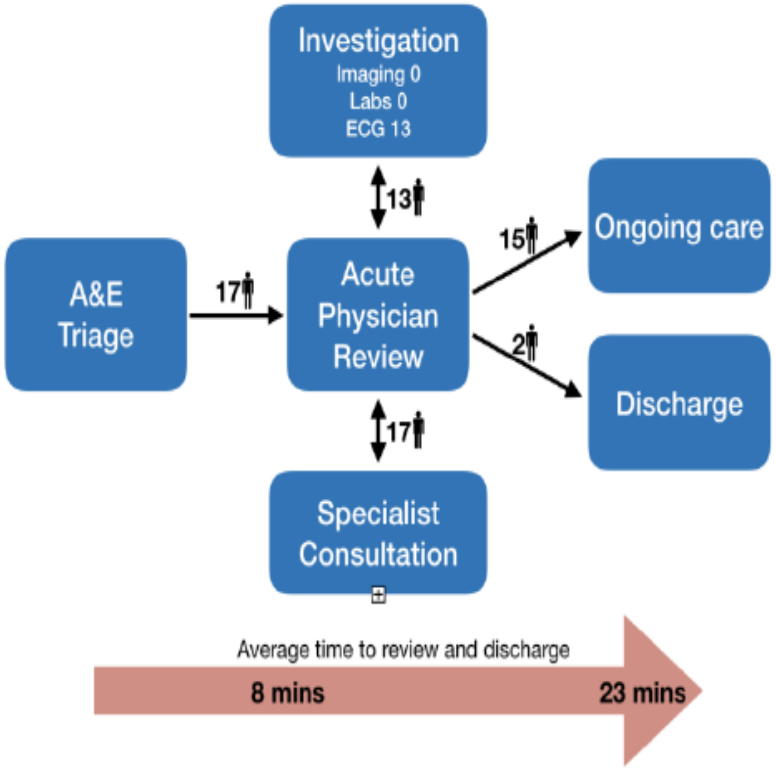


Figure 2: Patient flow through the Acute physician lead Rapid Tier 2 Triage. The overall average time from A&E triage to review was 8 minutes and patients had undergone specialist discussion or simple investigations and been moved on in an average of 23 minutes.

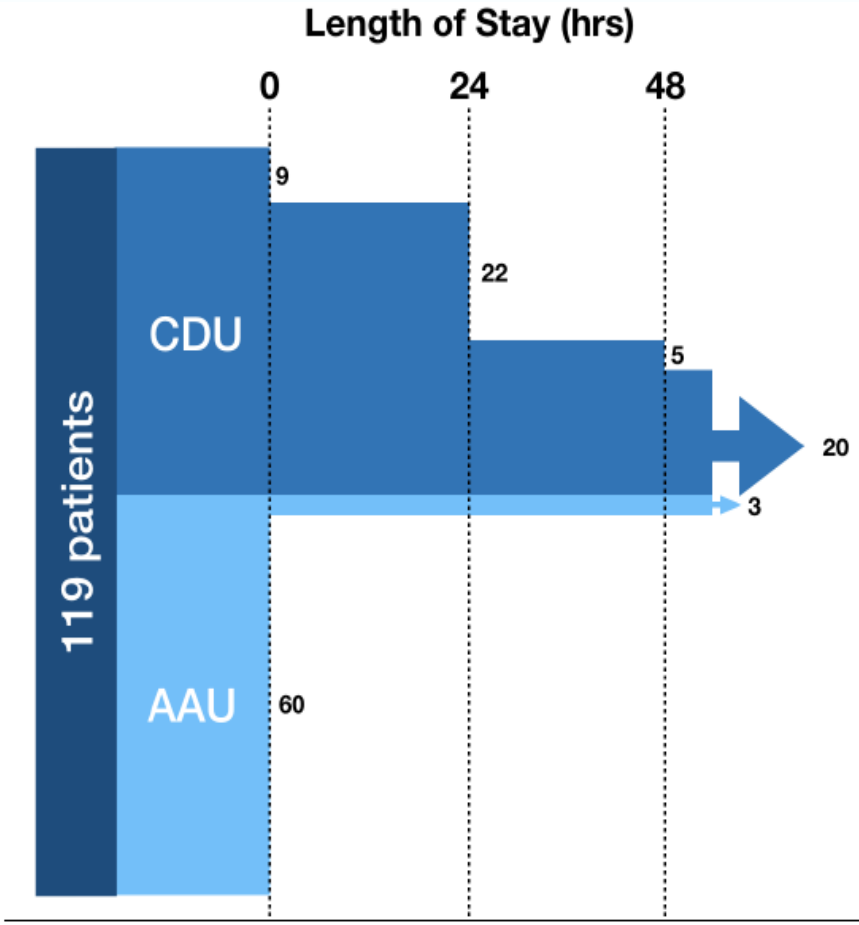


Figure 4: The Impact on Length of stay of early senior decision making. Showing the proportion of the 119 patients discharged from CDU and AAU within each time bracket.

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What we are doing…

- All clinically stable patients (EWS <3) deemed suitable for AEC
- AEC available 12 hrs/day, 7 days to receive pts. from ED / GP
- Introduction of Ambulatory Assessment Unit co-located near the Ambulatory suite
- Selection of pts maximised by AP / Senior Nurses in-reach into ED – 'pull patients'
- Display a list of common conditions with exclusion criteria – ED Triage
- Immediate access to Senior Decision maker agreeing case management plan
- Designing a process for clinical conversations between senior decision-makers at the point of referral to promote specialist In-reach
- 4 hour time frame for initial assessment & review similar to ED

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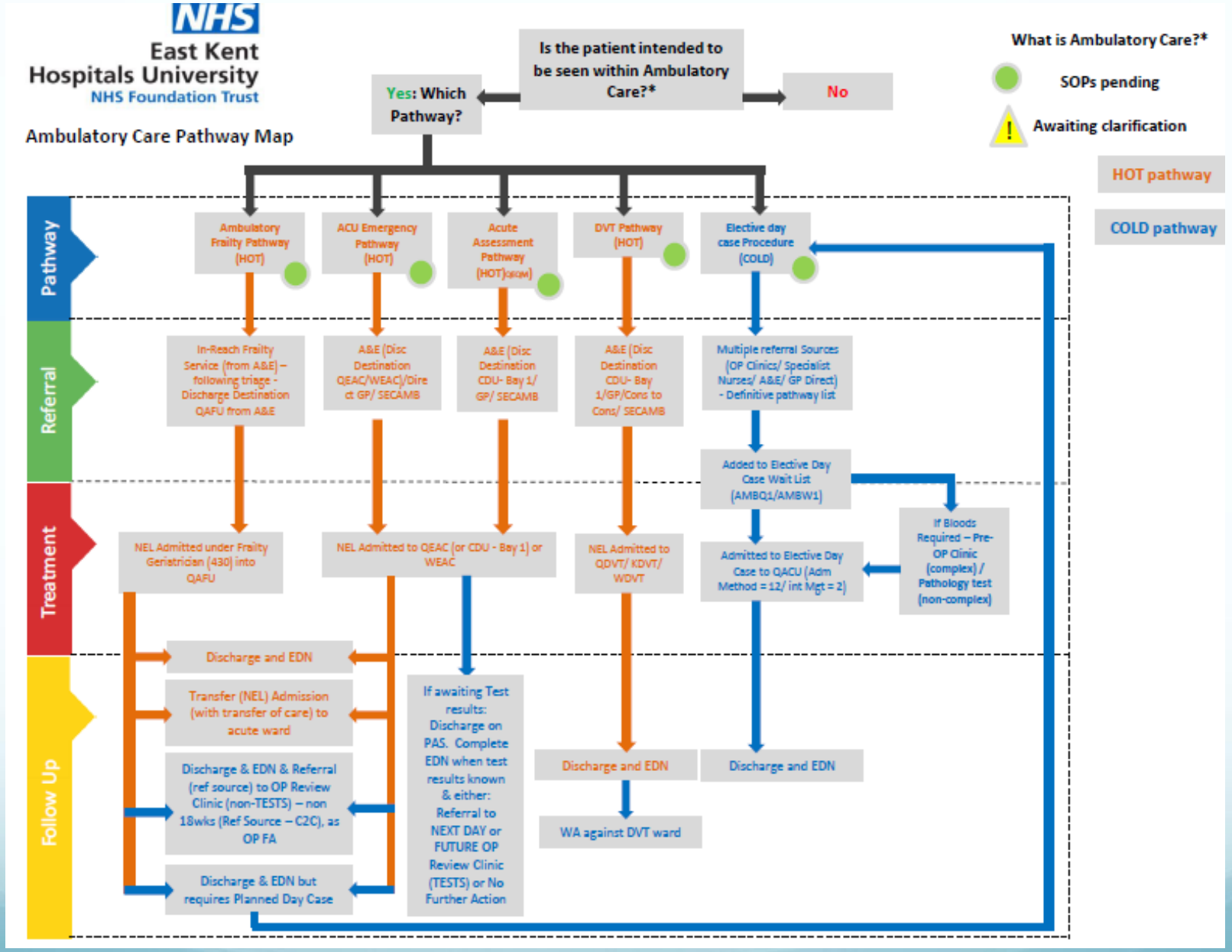
Ambulatory Acute Assessment Unit

INCLUSION CRITERIA

ACCEPTED COMPLAINTS:	INCLUSIONS
Acute Asthma	PEFR >50% & SpO_2 >92% (on air).
Anaemia	No Active Bleeding
Atrial Fibrillation / Palpitations	No hemodynamic compromise HR < 160/min
Acute Infections	Cellulitis, Rash, LRTI, UTI, Pyelonephritis.
CAP (Pneumonia)	CRB < 3 (> 3 needs admission to CDU)
COPD	SPO_2 > 85%., Not needing BiPAP
Heart Failure	No hemodynamic compromise, No STEMI
First Seizure	Non-Known Epilepsy, Not Alcohol related, No Head injury
Headache	GCS 15, No Red Flag (*as per NICE criteria)
Upper GI Bleed (Low Risk)	Only Low risk Blatchford Score 0-1 (*see criteria for Blatchford score)
Painless Jaundice	No acute abdomen, No Pregnancy, No Encephalopathy
PE	SpO2 > 92%, No hemodynamic compromise. HR < 110
Pleural Effusion	No hemodynamic compromise, Sp02> 88%
Syncope	No arrhythmia on ECG / No dynamic ST changes
Chest Pain	Cardiac sounding chest pain & hemodynamically stable ECG verifying no acute MI *HEART score applies to AAU treatment stratification
Diabetes	Only Type 2 Non-Ketotic glycaemic exacerbation. BM > 25 needs admission for Diabetes In-reach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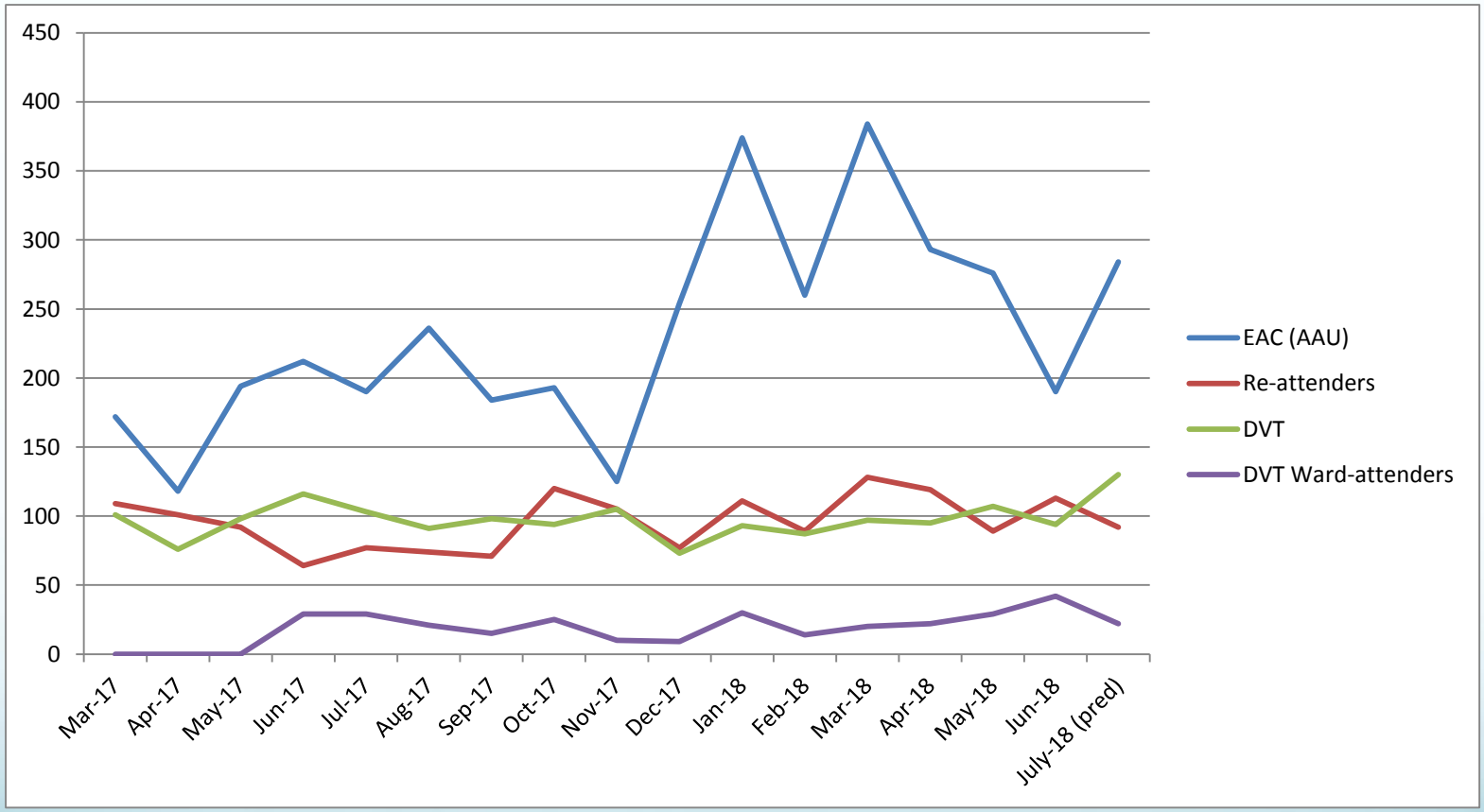
Ambulatory Care Pathway Map
Is the patient intended to be seen within Ambulatory Care?*
Yes: Which Pathway?
No
What is Ambulatory Care?*
SOPs pending
Awaiting clarification
HOT pathway
COLD pathway
Pathway
Referral
Treatment
Follow Up
Ambulatory Frailty Pathway (HOT)
ACU Emergency Pathway (HOT)
Acute Assessment Pathway (HOT)(SECAM)
DVT Pathway (HOT)
Elective day case Procedure (COLD)
In-Reach Frailty Service (from A&E) – following triage - Discharge Destination QAFU from A&E
A&E (Disc Destination QEAC/WEAC)/Direct GP/ SECAMB
A&E (Disc Destination CDU- Bay 1/ GP/ SECAMB
A&E (Disc Destination CDU- Bay 1/GP/Cons to Cons/ SECAMB
Multiple referral Sources (OP Clinics/ Specialist Nurses/ A&E/ GP Direct) - Definitive pathway list
Added to Elective Day Case Wait List (AMBQ1/AMBW1)
If Bloods Required – Pre-OP Clinic (complex) / Pathology test (non-complex)
Admitted to Elective Day Case to QACU (Adm Method = 12/ int Mgt = 2)
NEL Admitted under Frailty Geriatrician (430) into QAFU
NEL Admitted to QEAC (or CDU - Bay 1) or WEAC
NEL Admitted to QDVT/ KDVT/ WDVT
Discharge and EDN
Transfer (NEL) Admission (with transfer of care) to acute ward
Discharge & EDN & Referral (ref source) to OP Review Clinic (non-TESTS) – non 18wks (Ref Source – C2C), as OP FA
Discharge & EDN but requires Planned Day Case
If awaiting Test results: Discharge on PAS. Complete EDN when test results known & either: Referral to NEXT DAY or FUTURE OP Review Clinic (TESTS) or No Further Action
Discharge and EDN
WA against DVT ward
Discharge and EDN

AEC- activity data

Month	Total	EAC (AAU)	Review	Elective	DVT	DVT WA	TIA
Jun-17	947	212	64	200	116	29	45
Jul-17	813	190	77	183	103	29	40
Aug-17	873	236	74	158	91	21	44
Sep-17	773	184	71	126	98	15	40
Oct-17	884	193	120	138	94	25	52
Nov-17	811	125	105	150	79	10	61
Dec-17	799	254	77	137	73	9	53
Jan-18	955	374	111	108	93	30	53
Feb-18	848	260	89	113	87	14	48
Mar-18	1011	384	128	135	97	20	56
Apr-18	956	293	119	162	95	22	39
May-18	955	276	89	138	107	29	53
Jun-18	853	190	94	137	113	42	58
Jul-18	950	273	90	175	123	19	60
Aug-18	961	332	87	156	114	22	49
Sep-18	835	288	69	109	86	24	51

ACU: cumulative data 2017 - 2018



Discharge Ward	2016/17 Zero Length of Stay	2017/18 Zero Length of Stay	Change
QCDU	608	2,722	+2,114
QACU	1773	2,190	+417
WEAC	2295	4,272	+1,977

Financial Year	QEH Zero Length of Stay		WHH Zero Length of Stay	
2015-2016	3,244	Change	4,104	Change
2016-2017	3,701	+457	4,394	+290
2017-2018	6,436	+2735	6,455	+2061

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AEC impact – 0 LOS

- QEH has an estimated increase of 74% in zero length of stay since implementing the AAU model
- When comparing the six month period July – Dec 2017, there was an average nation-wide increase of about 1.72% for zero length of stay patients… EKHUFT saw an increase of 7.22% (QEH +WHH)
- 0 Los Top 5:

Royal Surrey – 52.5%
Mid Cheshire – 52.4%
North Midlands – 51.1%
UCLH – 50.6%
Royal Liverpool – 49.9%
EKHUFT (QEH + WHH) – 44.4%

Our Ideal AEC Model

- Quality standards to be developed with the CCG, to include best tariff
- Closer working with Primary Care to set up a collaborative Integrated service to enable a Frailty Day Unit within Emergency Ambulatory.
- Discussion underway with Specialists in-reach to enable Heart Failure & Arrhythmia Clinic, Monoarthritis Clinic, Pleural service, COPD/NIV Clinic & Ambulatory ILR / Syncope Unit

Realising the benefits.. What has come out of the AEC process?

- Has enabled the reduction of beds as part of the bed reduction Programme - 45 in total up to end 16/17.
- Excellent patient feedback
- Becoming business as usual with involvement of teams across the organisation – work being carried out to look at Ambulatory Frailty model
- Excellent partnership working with CCGs to enable whole system involvement and discussions – Developing Tiers of care to enable Primary care AEC pathways

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Questions?

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