Case Study: Swindon

AEC- getting it right- slowly!!

Sarah Fallon ,Matron
Claire Adlam, Head Of Service
October 2018

History

- Started October 2011, Mon-Friday (initially 10am – 8pm)
- Process driven v Pathway driven
  - Based upon 49 ACU conditions Directory
  - “Are they well enough to sit in a chair?”, “Is there a single definitive test that would enable discharge?”
- Close links with the Emergency Department
  - Initially co-located
  - Moved to 3rd floor Dec 2012
  - Senior Decision Makers - Consultants
- Good access to radiology / investigations
  - ETT/ECHO bay – same day access

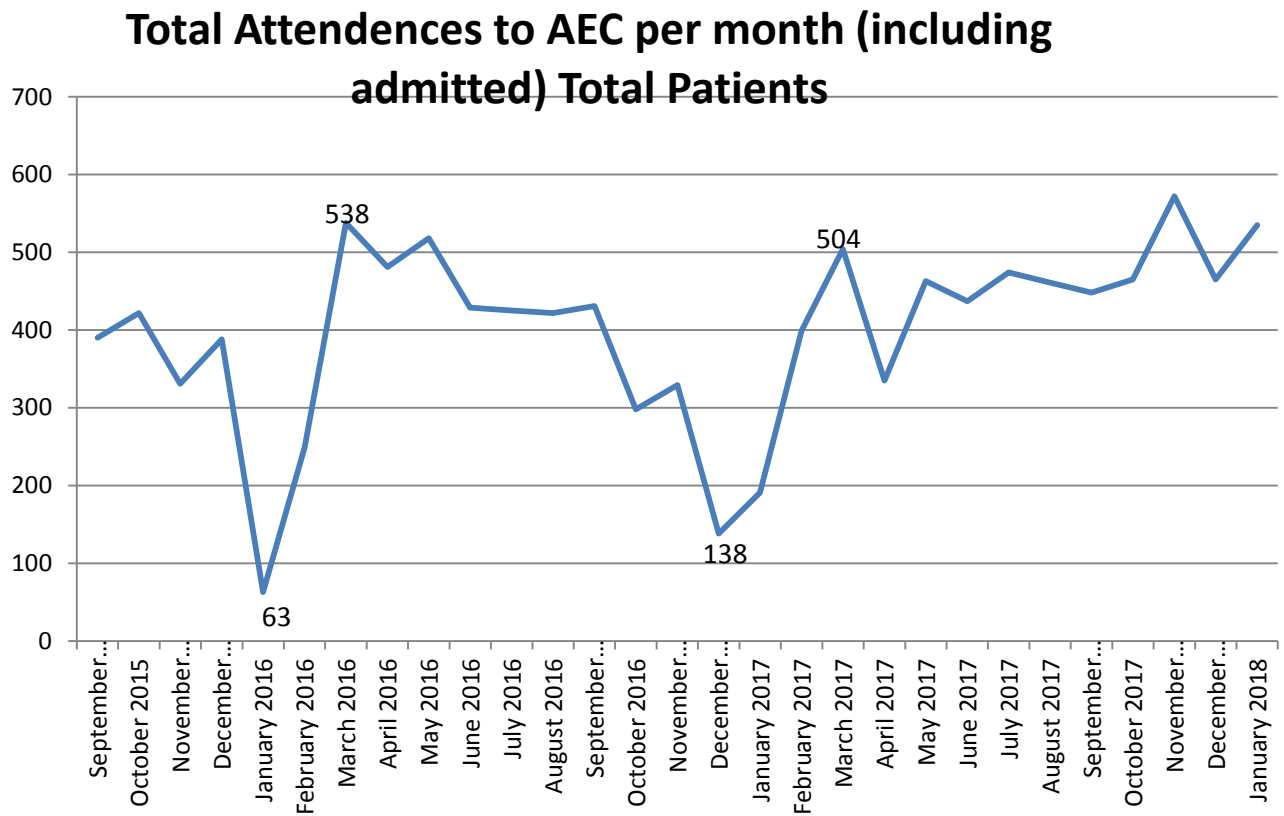
ACU High Volume Conditions

- Chest pain awaiting troponin/ETT
- Chest pain ?PE
- Cellulitis needing IVABx
- Headache ?SAH ?migraine ?temporal arteritis
- Severe Hypertension
- Heart Failure
- Mild CAP
- (Pseudo-)Hyperkalaemia
- Anaemia/low risk GI bleed
- SVT/AF
- Ascites/Pleural Effusions

What was wrong?

- The unit was incorporated on the 3rd floor alongside the AMU and SSU - distant from ED and diagnostics
- Previously a ward environment -provided space and ease to bed overnight at times of escalation- inpatients
- Review of data showed a zero length of stay of ~33% on AMU
- Frustration from clinical team
- Poor patient experience

What the data showed



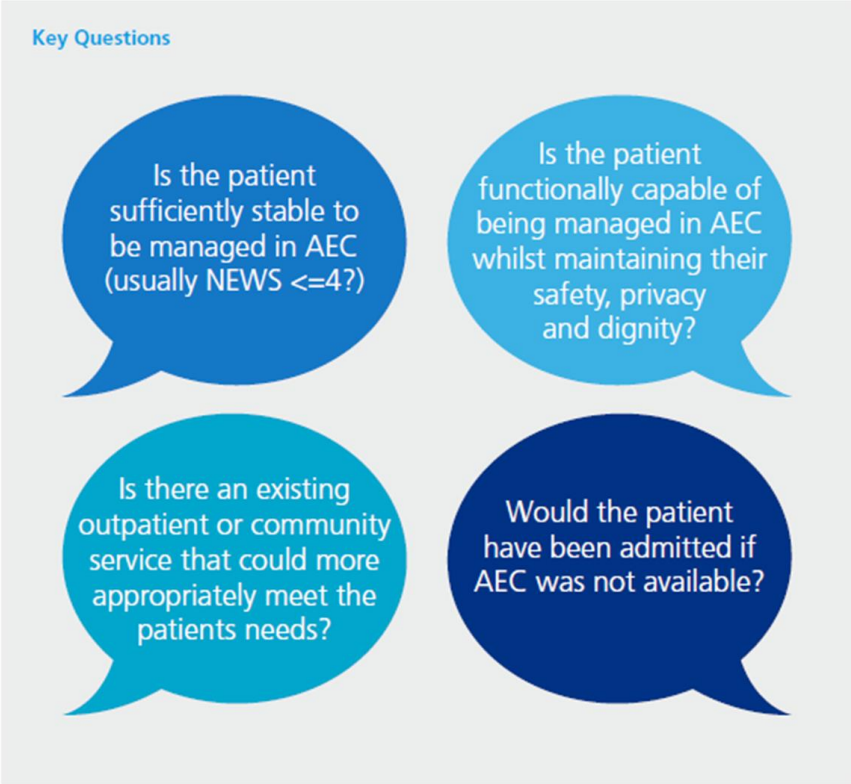
So what did we do….

- Business case to move the AEC to location on the ground floor, close but not adjacent to the ED.
- We acknowledged loss 3 single side rooms/consulting rooms but gained a waiting room with 26 chairs, 4 trolleys/couches
- Assessment area for ECG, bloods obs
- Use of consulting rooms in the adjacent UCC if required.
- Protected area that could not be bedded
- Increased staffing model
- Buy in from execs
- Expectation to deliver on KPI's ~ improve standards for patients and internal professional standards.
- Deliver 30% of medical take daily through AEC = better flow and 4 hour performance

We did it….

- Business case successful and funding approved and build went ahead
- Opened in Jan 2017
- ANP team increased by 2 WTE
- GP Triage Phone calls taken by the whole team not just nursing team- consultants included
- Consultant Advice line established
- Opened an MEU on AMU to accept triaged GP calls from AEC to AMU if criteria met.
- We saw approximately 4% improvement in our 4 hour performance as a Trust-
- Daily Staffing on AEC now included –
- 1 Consultant
- 3 SHOs
  - Clinical Fellow, GP Trainee, Acute medicine SHO
- 2 Advanced Nurse Practitioners
- 1 RN Band 6
- 1 Assistant Practitioner
- 1 Patient Coordinator/Admin

Is the patient suitable for AEC?



Unsuitable.. at present

Great Western Hospitals NHS
NHS Foundation Trust

Ambulatory Care: Unsuitable Referrals

• Suspected cardiac chest pain	➢ **ED**
• Suspected CVA or acute ICH	➢ **ED**
• Non-ambulatory patients	➢ **Acute Medical Unit**
• Confused patients/mental health patients	➢ **Acute Medical Unit**
• Those with oxygen requirements	➢ **Acute Medical Unit**
• Those needing isolation • i.e. D&V, Flu, Meningitis, TB or Neutropenic infection	➢ **Acute Medical Unit**

Great Western Hospitals NHS
NHS Foundation Trust

Ambulatory Care: Unsuitable Referrals

• Under 18-year olds	➢ **Paediatrics**
• Suspected giant cell arteritis	➢ **Rheumatology or Ophthalmology**
• Suspected idiopathic intracranial hypertension	➢ **Neurology**
• Upper limb cellulitis	➢ **T&O**
• Facial/orbital cellulitis	➢ **Maxillofacial**
• Cholecystitis or appendicitis	➢ **General Surgery**

Great Western Hospitals NHS
NHS Foundation Trust

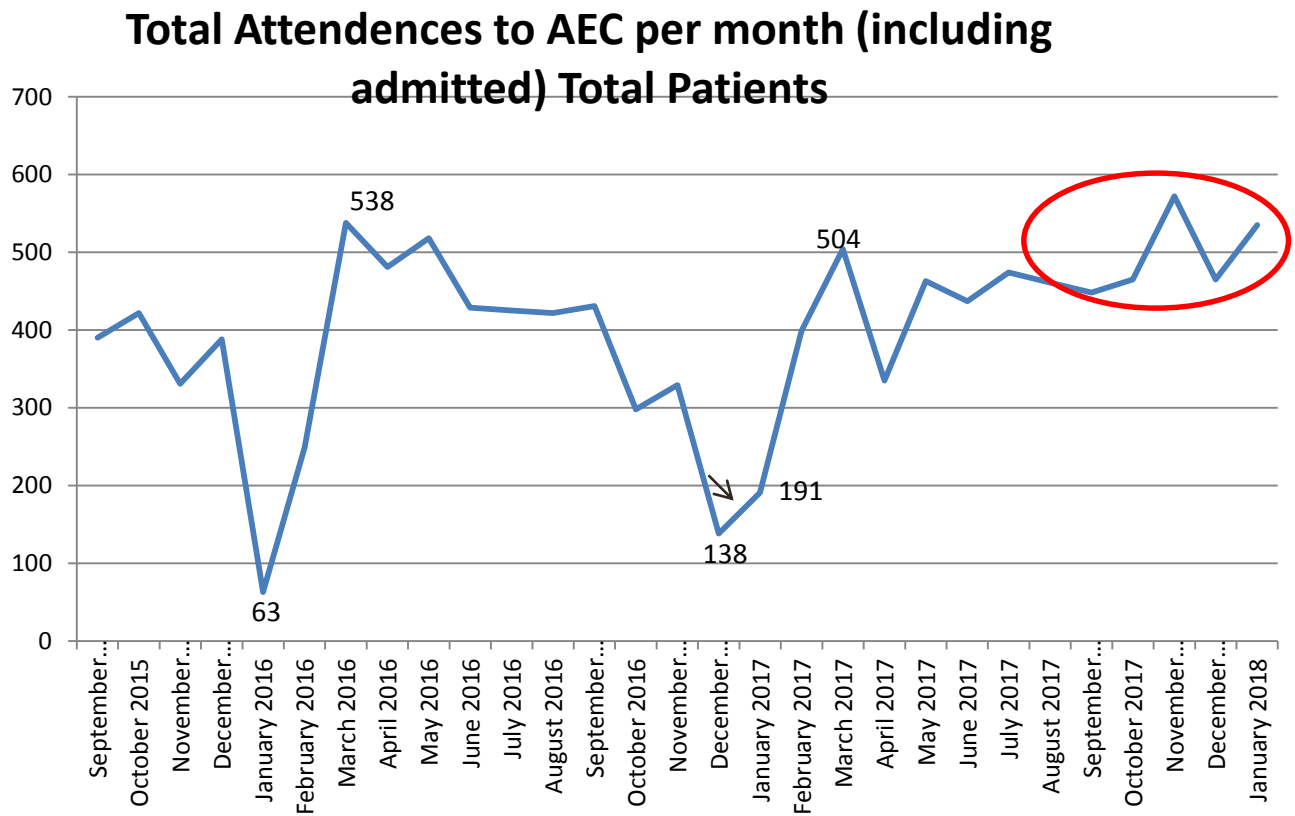
Access to Hospital Outpatient Treatment: HOT Clinics

- **Neurology HOT Clinics**
  - 5 days per week
  - Not a TIA service
  - Screened through AMU/ACU first

- **Cardiology Chest Pain HOT Clinics**
  - 5 days per week
  - Referrals from AMU/ACU and ED

- Plans to expand to respiratory/pleural

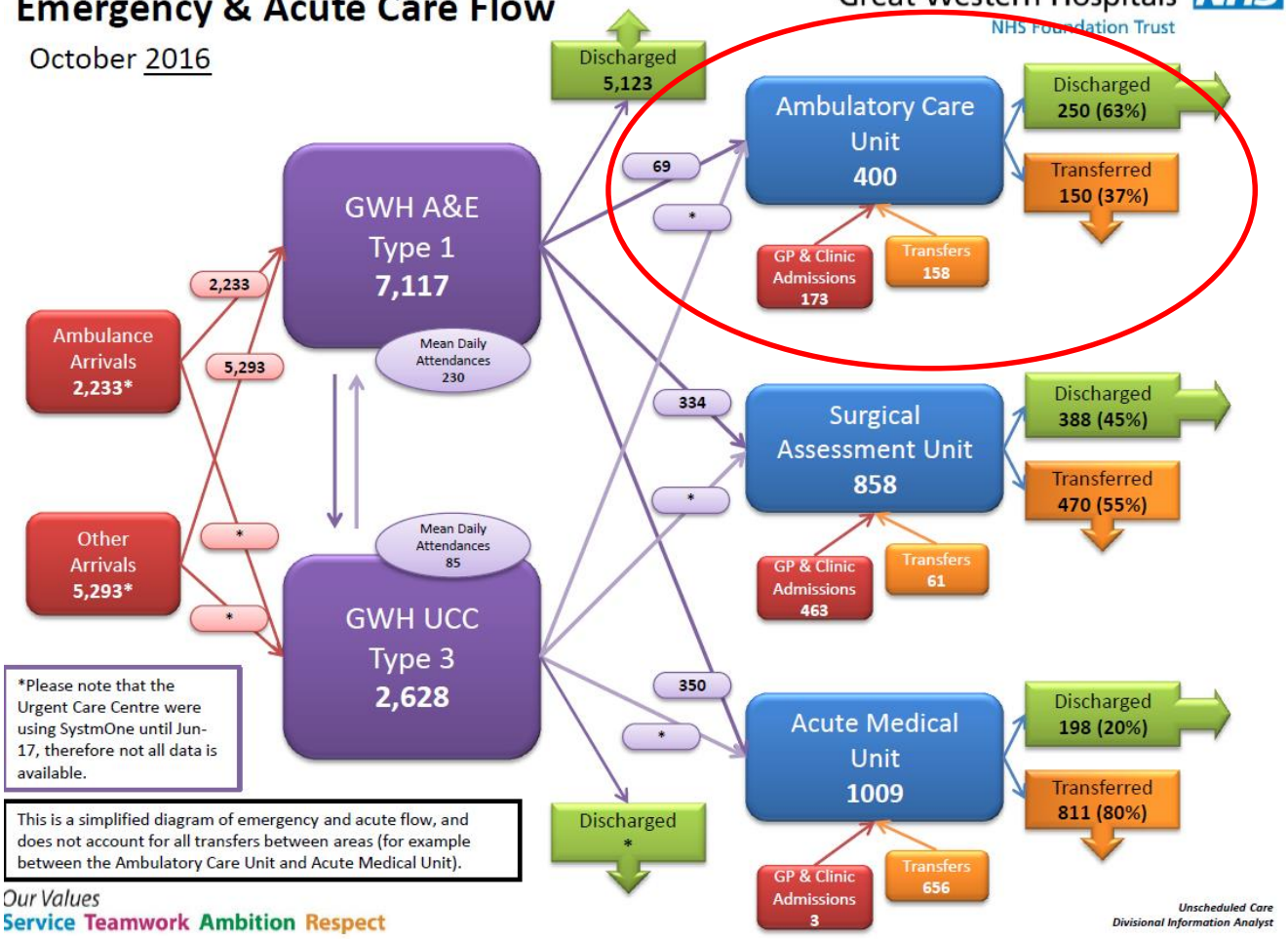
What the data showed



Emergency & Acute Care Flow

October 2016

Great Western Hospitals NHS
NHS Foundation Trust

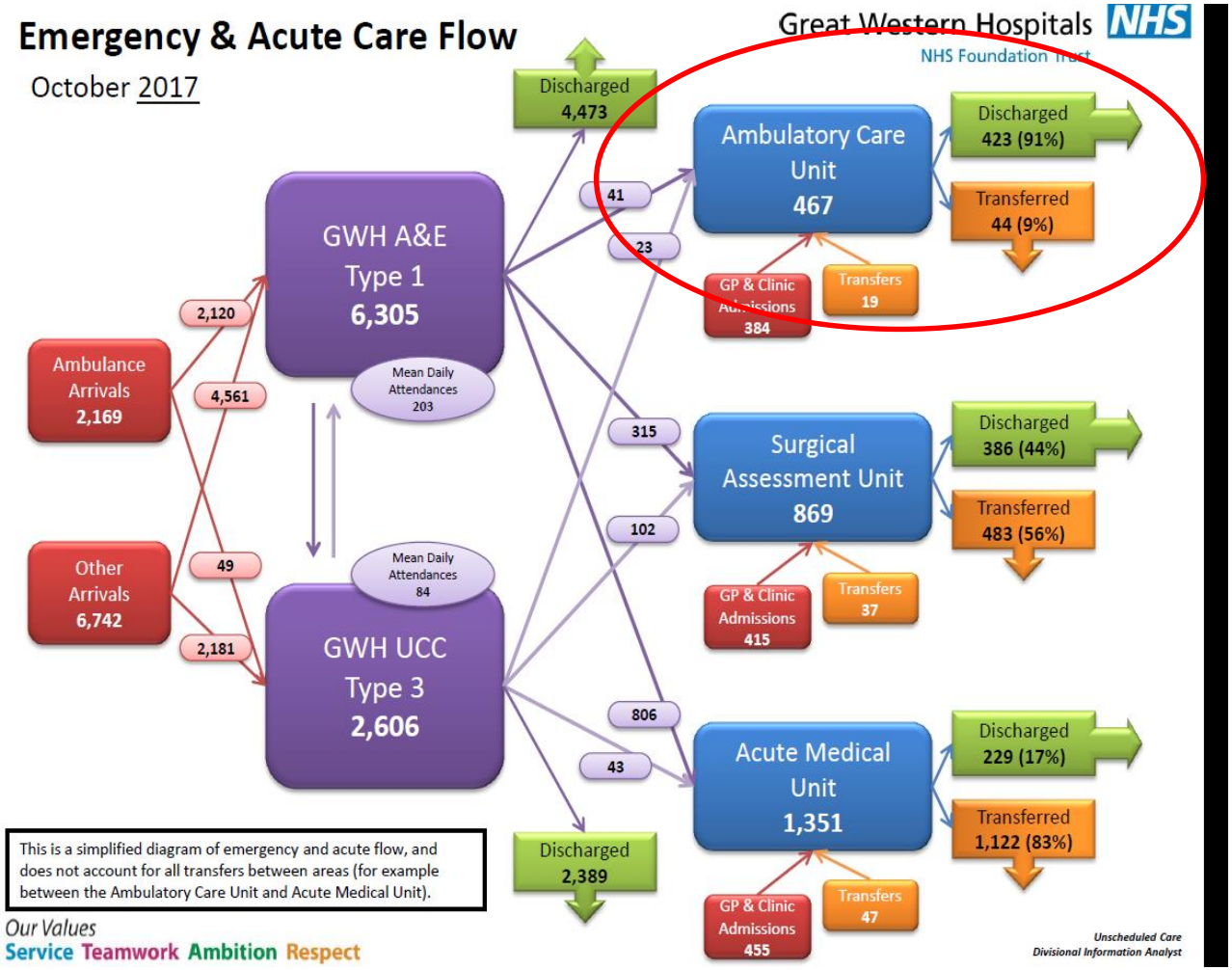


*Please note that the Urgent Care Centre were using SystmOne until Jun-17, therefore not all data is available.

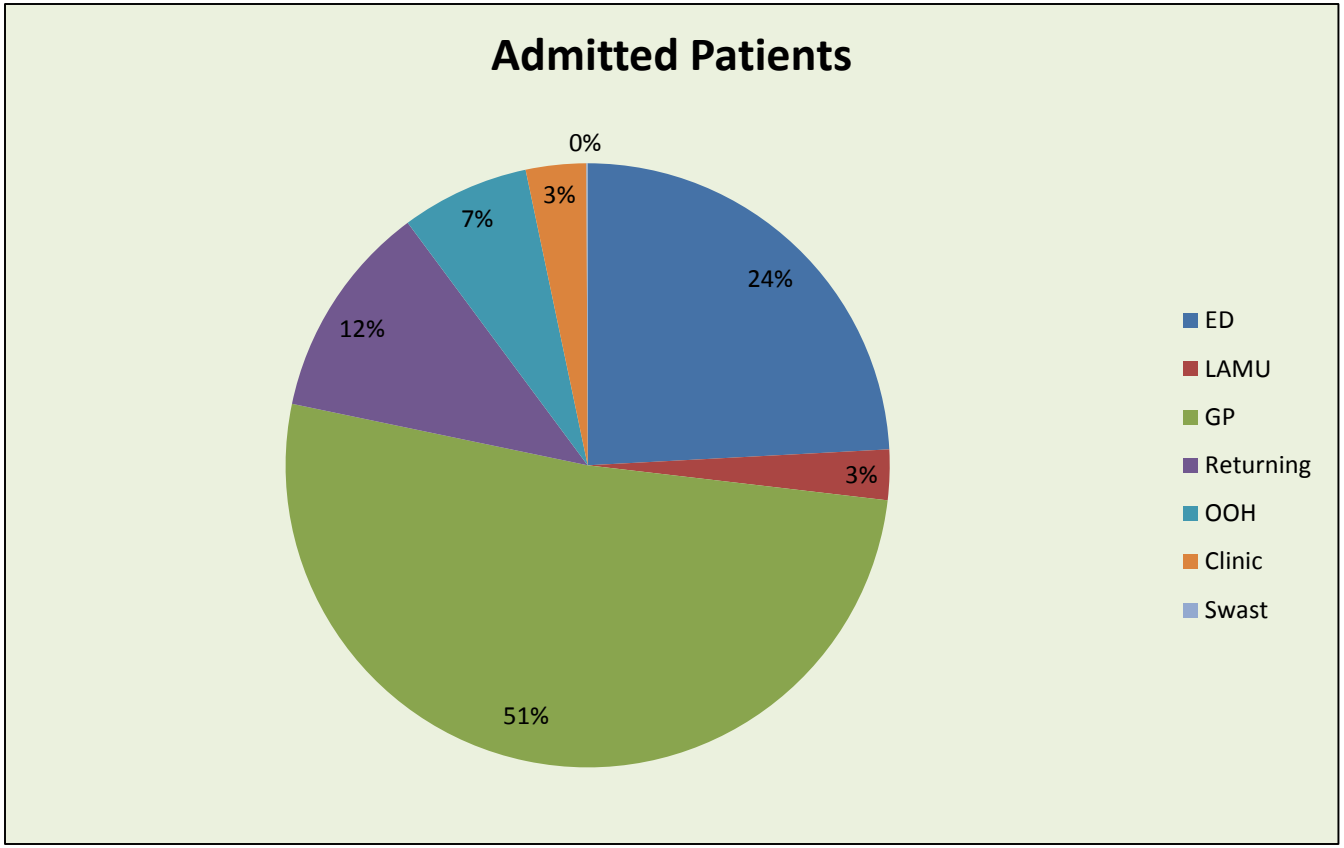
This is a simplified diagram of emergency and acute flow, and does not account for all transfers between areas (for example between the Ambulatory Care Unit and Acute Medical Unit).

Our Values
Service Teamwork Ambition Respect

Unscheduled Care
Divisional Information Analyst


Emergency & Acute Care Flow
October 2017
Great Western Hospitals NHS
NHS Foundation Trust
Discharged 4,473
GWH A&E Type 1 6,305
Mean Daily Attendances 203
Ambulance Arrivals 2,169
Other Arrivals 6,742
2,120
4,561
49
2,181
GWH UCC Type 3 2,606
Mean Daily Attendances 84
41
23
315
102
806
43
Ambulatory Care Unit 467
Surgical Assessment Unit 869
Acute Medical Unit 1,351
GP & Clinic Admissions 384
Transfers 19
GP & Clinic Admissions 415
Transfers 37
GP & Clinic Admissions 455
Transfers 47
Discharged 423 (91%)
Transferred 44 (9%)
Discharged 386 (44%)
Transferred 483 (56%)
Discharged 229 (17%)
Transferred 1,122 (83%)
Discharged 2,389
This is a simplified diagram of emergency and acute flow, and does not account for all transfers between areas (for example between the Ambulatory Care Unit and Acute Medical Unit).
Our Values
Service Teamwork Ambition Respect
Unscheduled Care
Divisional Information Analyst

Where did they come from..



Challenges

- We had no isolations rooms
- Capacity for ECHO could match our demand at times
- DVT pathway in community collapsed and came into secondary care
- AEC was separate from the rest of Acute Medical team
- As confidence grew we began to take ‘outpatient’pathways for other department that lacked capacity or own pathways.
- Team have to ‘pull’ from ED rather than active referral
- Inpatient referrals to support early discharge constant challenge.

Successes

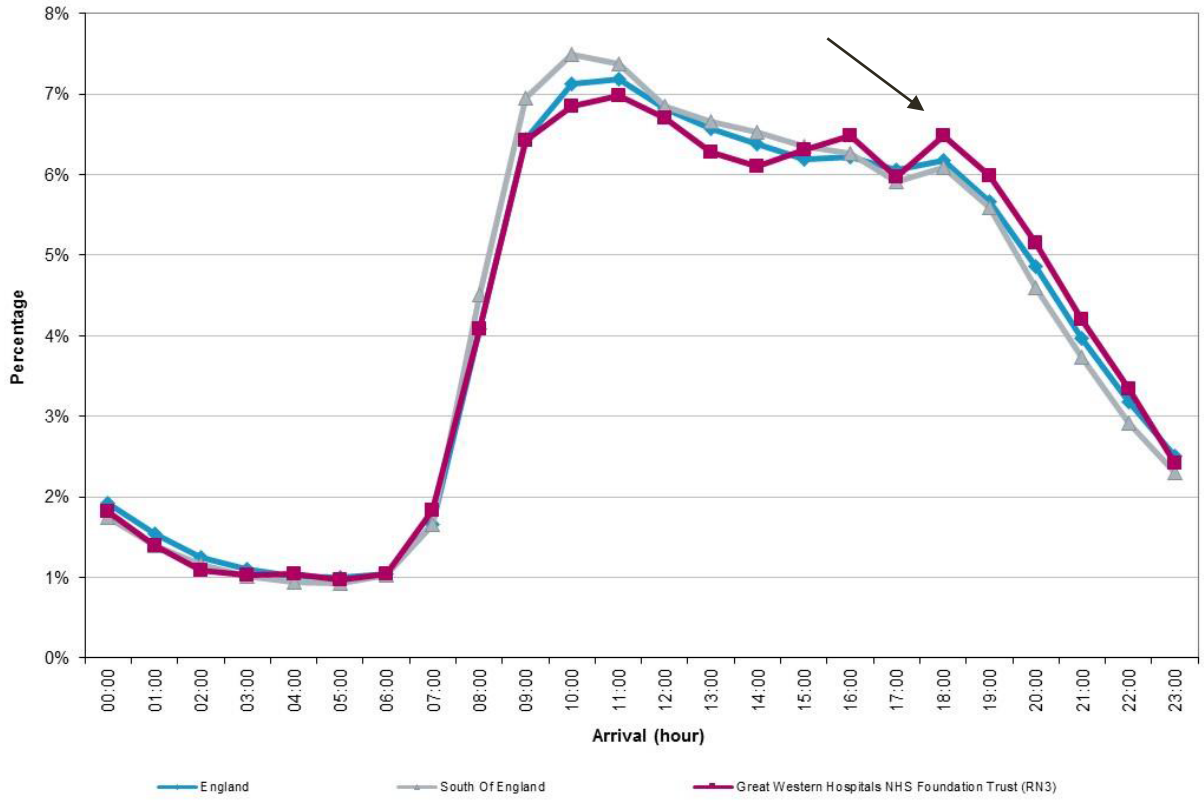
- We consistently see 25-35% of the daily medical take in AEC
- We have built a robust service that has reduced our zero length of stay on AMU
- Developed new pathways and continue to do so
- Introduced point of care testing for D-dimer – DVT

So what next

- We had our AEC review and rated ‘Excellent standard’
- Currently building larger unit where ALL GP patients arrive and are RAT’ed ensuring optimisation of pathways into AEC
- 4 trolley bay, 7 consulting rooms and 2 monitored trollies waiting/treatment area of 26 chairs
- USS clinic room and discussion re training ACP to undertake USS of lower limb for ACP led DVT pathway
- Extended POCT
- Frailty pathways identified with DOME consultants and Older persons short stay unit
- Combining AEC and MEU means speciality consultants will provide more robust in-reach services.
- All patients sent to MEU will have been triages, blood radiology etc.
- Extended hours until 2200
- Improved advice and guidance

Extending Hours

To meet demand of take pressures



Future dreams….

- Co locate front door!!
- Work on active referral from ED
- Promote use of AEC for early discharge from Inpatient wards
- Have one combined unit
- Develop further ACP pathways with consultant oversight