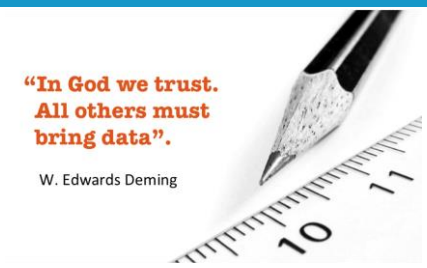
Ambulatory Emergency Care Network

Measurement Factsheets

#2 – Recording AEC Activity



What is the purpose of this factsheet?

A common question amongst people starting out on their AEC Journey is 'how should we record AEC activity?

Background and context to this fact sheet

AEC does not fit neatly into the current guidance on how to record patient activity. The current NHS data model sees patients treated in secondary care only in one of three ways: as an inpatient, as an outpatient or as an A&E attender. None of these descriptions completely covers what AEC units are providing. However we are left with a choice of these three existing datasets until the Data Standards that govern practice provides us with a way of identifying ambulatory emergency care patients.

Option 1: A&E Attender

To qualify as an A&E attender, the treatment has to take place within the department (link): We cannot therefore recommend recording AEC activity as an A&E attender because commonly the activity does not take place within the A&E department.

Option 2: Inpatient

To be correctly classified as an inpatient, patients must require and make use of a bed as a result of their condition. Historically guidance has been given to enable a distinction between elective day cases and outpatient attendances (link). This makes it clear that if a patient is using a hospital bed because of the active intervention rather than because of the patient's condition this activity is not counted as an admission but as an outpatient attendance—consultant. There is also similar guidance within the PbR material (link). AEC patients are therefore not officially inpatients and if the decision is made to record them in this way to ensure that clinical coding takes place, they should be removed from reports of inpatient activity so as not to mislead.

Option 3: Outpatient

AEC patients are not a traditional outpatient either because they are not planned in advance. The definition of what constitutes an outpatient appointment is not absolutely specific on this point but the inference is clear (link). However this is an alternative option where doctors are involved in the care of the AEC patient. If the AEC unit is run by nurses alone, the guidance on how to record the activity is less clear. The reference above refers to an appointment with a care professional and the list of approved professionals includes nurses. However the PbR guidance referenced under option 2 when referring to attendances on a ward states that those patients seen by a nurse should be recorded as ward attenders. However the same guidance does also support the use of the outpatient route for emergency cases.

On balance therefore this option is acceptable. The issues here are twofold: (a) is clinical coding willing to code what is being recorded an outpatient activity and (b) BPT assumes inpatient activity. It is important therefore to have discussions with your commissioners about reimbursing AEC activity.

Recording follow up activity

The recording of patients who come back to the AEC unit for a second or further visit also needs some consideration. Should they be a follow-up outpatient attendance, a ward-attender or a re-admission? The guidance given above applies equally to subsequent attendances as it does to the first. Thus there is a case for any of these options.

If you have chosen to record first attendances as an inpatient, you have a choice that is determined by why you chose the inpatient recording route. If your AEC patients don't meet the inpatient criteria (the most common situation) but it is convenient for you to record them as such, then the follow-up patients are not inpatients either. These should be recorded as either a follow-up outpatient attendance or ward attender. The majority of sites capture their data like this.

However, if your AEC patients **do** meet the inpatient criteria and if the re-attendance also qualifies as an inpatient, they should be a re-admission. If the re-attendance does not require a bed then they should be recorded as a follow-up outpatient attendance or a ward attender.

If you have chosen to record the first attendance as an outpatient, then you have a choice of a follow-up attendance (for doctor led units) or ward attender (for nurse led ones).

Issues to consider—the impact on national KPIs

When AEC new activity is recorded as an inpatient emergency admission

The number of emergency admissions will remain the same. To avoid attracting new activity and experiencing an increase you must have strong 'gatekeeping' rules.

The number of emergency admissions with a 0 day length of stay increases which is not only the result of a shift from a 1 day length of stay to a 0 day length of stay but from all along the length of stay distribution. This would result in a shift to the left of the length of stay profile and therefore a reduction in average length of stay and occupied bed days.

The 2008/09 emergency admission ceiling, where beyond this providers only receive 30% tariff for each emergency admission, will be activated as before that there will be no saving for providers here.

The number of emergency readmissions and mortality rate within 30 days of an admission remains the same.

ED waiting times decrease as patients are put on the correct pathway (turnaround and discharge, AEC, short stay, base ward) but this is dependent of the efficient streaming as soon as the patient enters the system.

The conversion rate from ED attendance to emergency admission remains consistent.

If patients who would have traditionally been seen and treated in ED are admitted to AEC as an inpatient then we would recommend conversion rates are monitored as a balancing measure.

All the above predicated on AEC activity remaining within the inpatient activity for external reporting. If AEC activity is removed/excluded then impact will be described for outpatient below.

When AEC new activity is recorded as an outpatient

The number of emergency admissions decreased which could potentially bring emergency admissions under the 2008/09 emergency admission ceiling.

The number of emergency admissions with a 0 day length of stay (and potentially 1 and 2 days length of stay too) potentially decreased and therefore there could be an increase in average length of stay but there will be a reduction in occupied bed days overall. The occupied bed day reduction will be underestimated as the same day discharges are treated as occupying 0 beds. In reality those patients occupy a bed for several hours.

The number of emergency readmissions and mortality rate within 30 days of an admission potentially decreases as the new activity is recorded at non-admitted.

ED waiting times decrease as patients are put on the correct pathway (turnaround and discharge, AEC, short stay, base ward) sooner but this does depend on where in the process the patient is triaged and by whom. The conversion rate from ED attendance to emergency admission decreases.

The number of outpatient new attendances increase which will have an impact on the new to follow-up ratio which might be monitored by the CCG on QIPP/CQUIN schemes. The ratio is likely to decrease but numbers are small compared to overall outpatient volume thus the impact may well be negligible.

The outpatient DNA rate for new attendances will decrease as it is not an appointment the patient needs to come in to attend. Again the small volumes involved could mean that the impact is negligible.

When AEC returners are captured as an outpatient follow-up then this will increase the new to follow-up ratio but the overall impact is unlikely to be noticed.

Recommendation

There is no right answer and therefore no recommendation. What we advise is that you consider the above and do what fits best with your organisation and its priorities.