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and Value**

Ambulatory Emergency Care.

**What is it, why do we need it
and how to do it.**



Ambulatory Emergency Care

What is it?

- **Primary Care?**
- **Community Care?**
- **Simplistic shift?**
- **Or a new way of integrated working?**
- **Akin to the development of Day Case Surgery**



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Acute medical care

The right person,
in the right setting – first time

Report of the Acute Medicine Task Force

October 2011



What is Ambulatory Emergency Care?



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RCP (L) Acute medicine taskforce:-

Ambulatory care is clinical care which may include diagnosis, observation, treatment, and rehabilitation, not provided within the traditional hospital bed base or within the traditional out-patient services that can be provided across the primary/secondary care interface.

Delivering Quality and Value
**Directory of Ambulatory
Emergency Care for Adults**



Categories of Ambulatory Emergency Care

1. Diagnostic exclusion group

- Eg chest pain rule outs etc (many already in place)

2. Low risk stratification group

- Eg low Rockall score GI bleed

3. Specific procedural group

- Eg effusion drainage

4. Infra-structural group

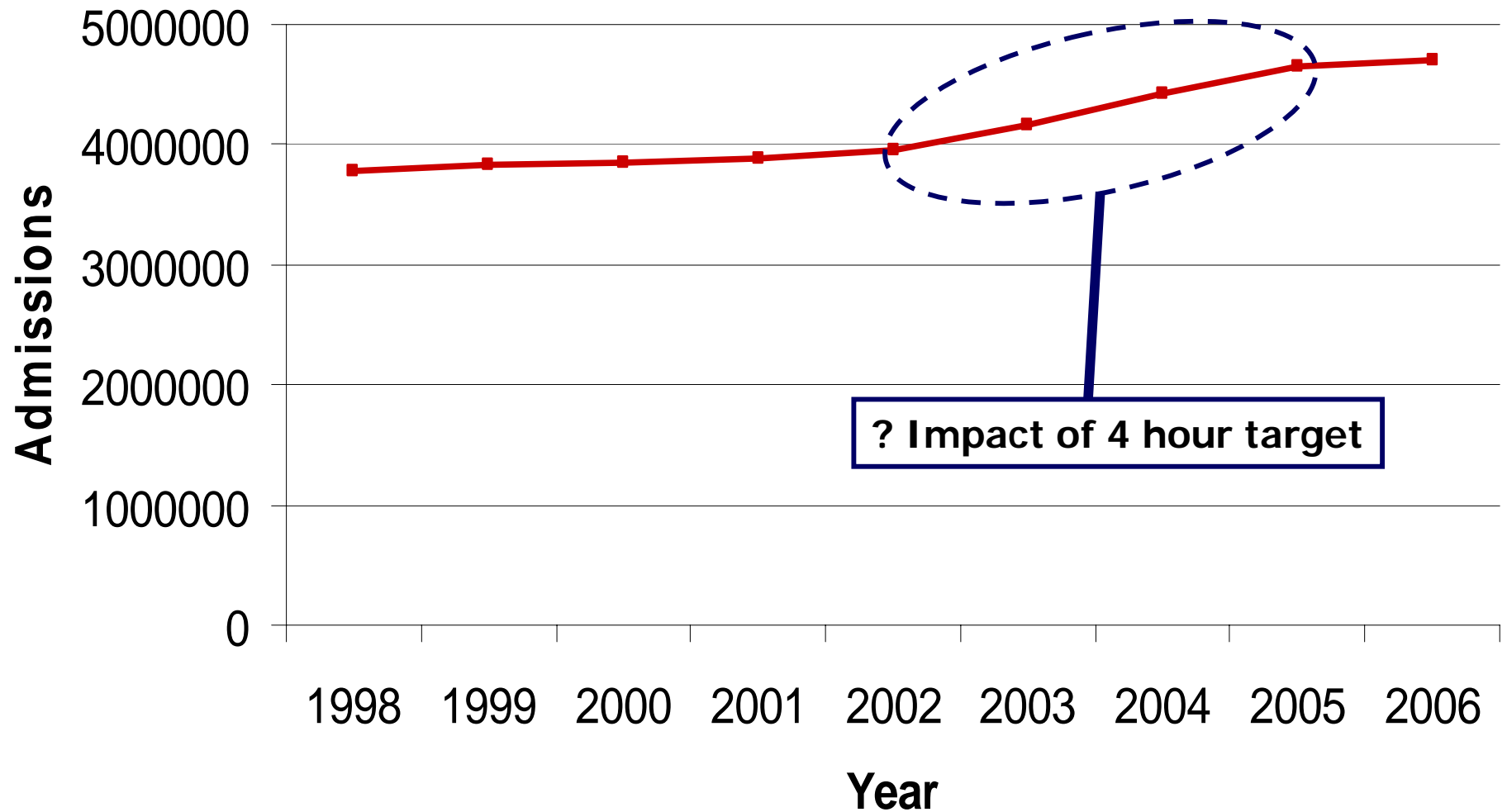
- Eg care home admissions

Ambulatory Emergency Care

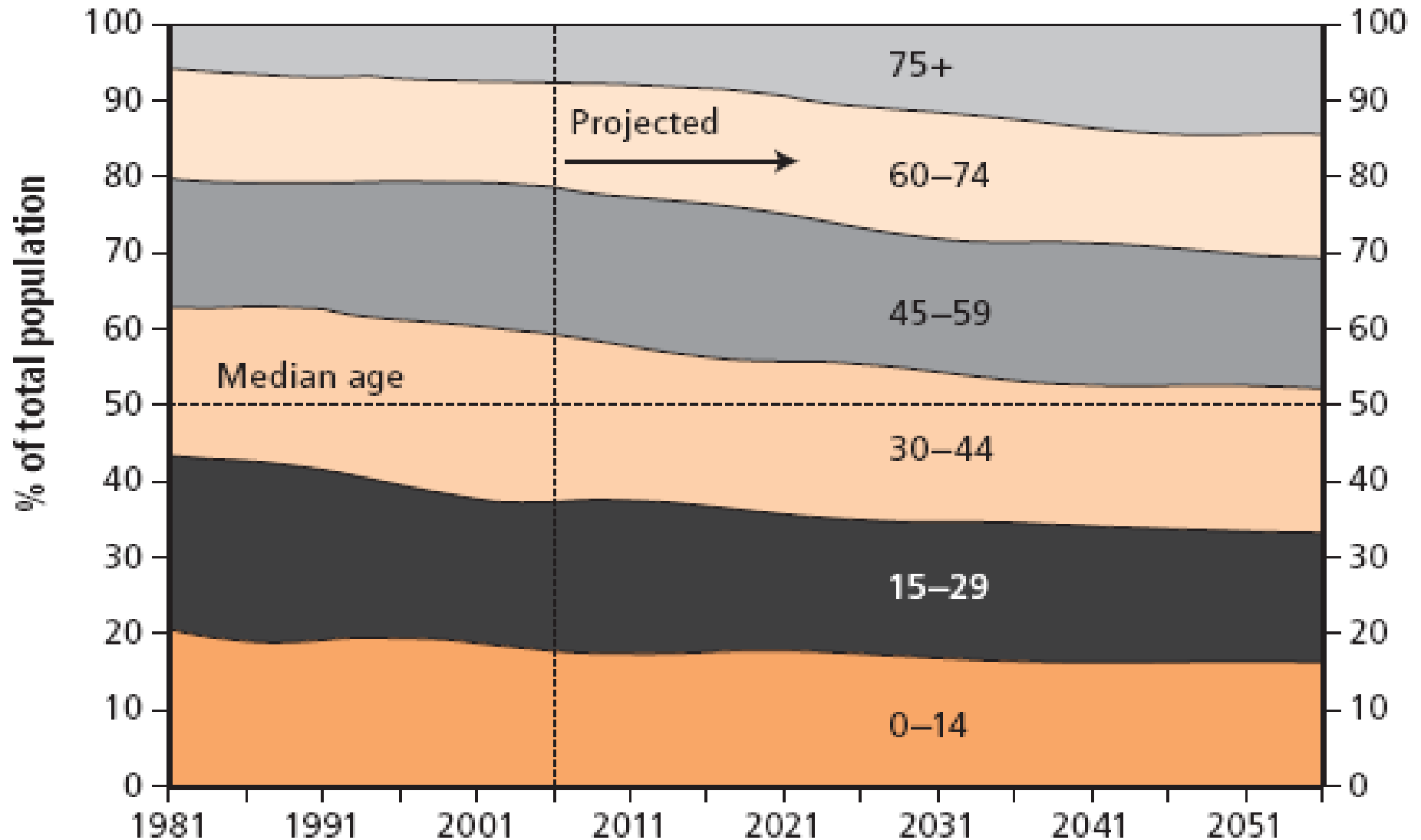
Why do we need it?

- Acute care activity
- Demographic shift
- Changing capacity
- Understanding bed swings

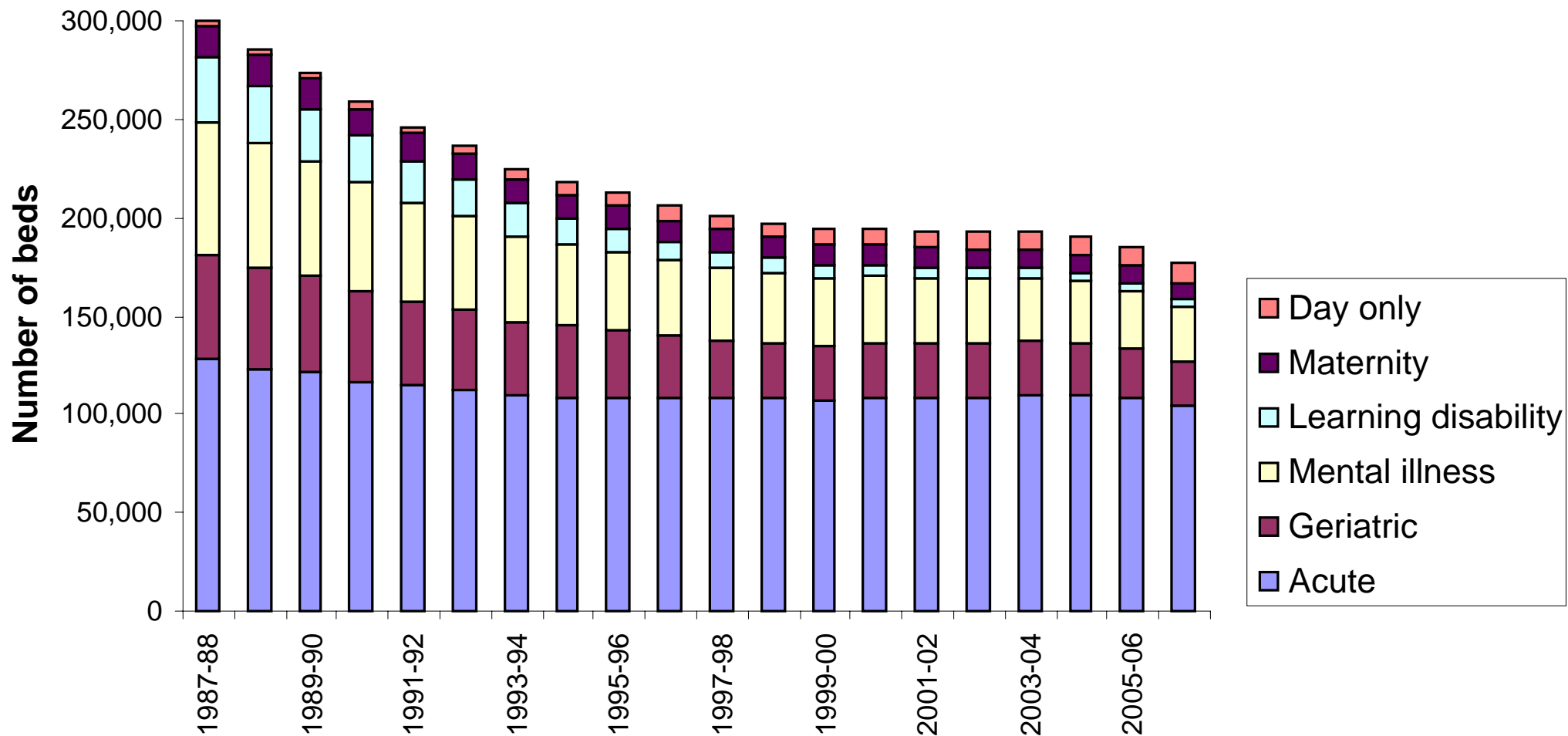
Emergency Admissions England 1998 to 2006



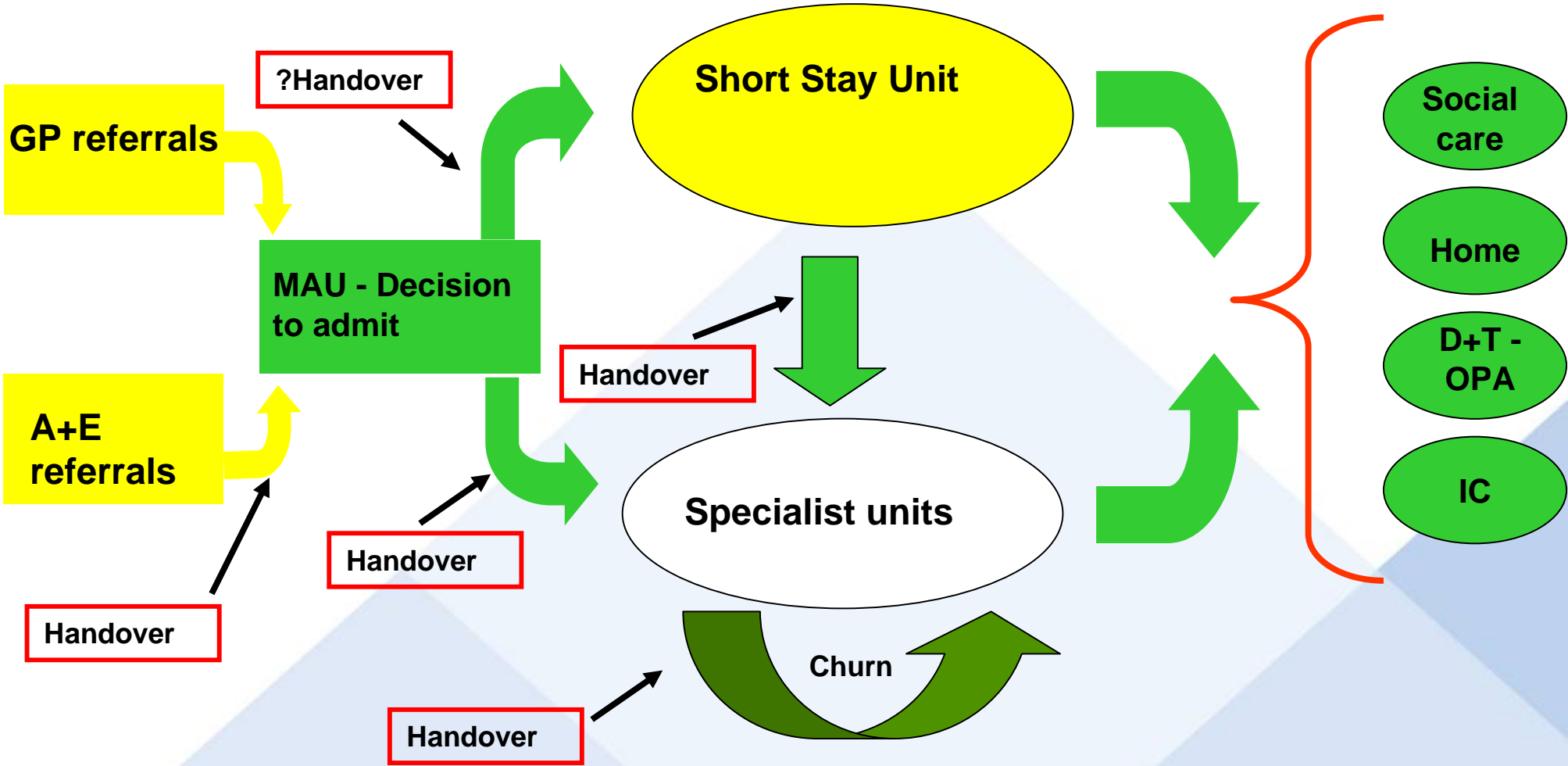
Actual and Predicted Age Distribution UK, 1981 to 2056



Average daily number of available beds England, 1987-88 to 2006-07

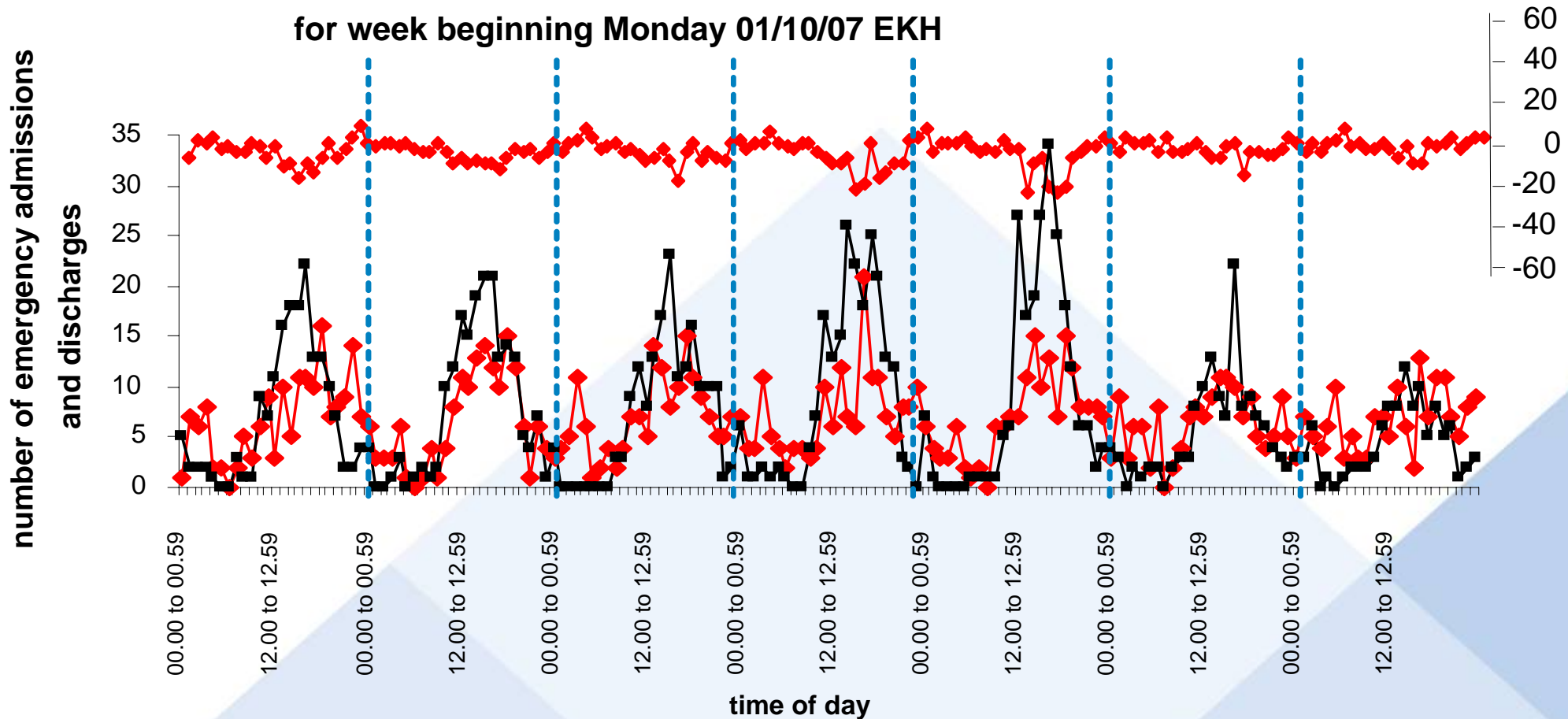


Traditional Model for Acute Medicine



In-day variation mismatch admissions & discharges

Emergency admissions and discharges by hour of day
for week beginning Monday 01/10/07 EKH

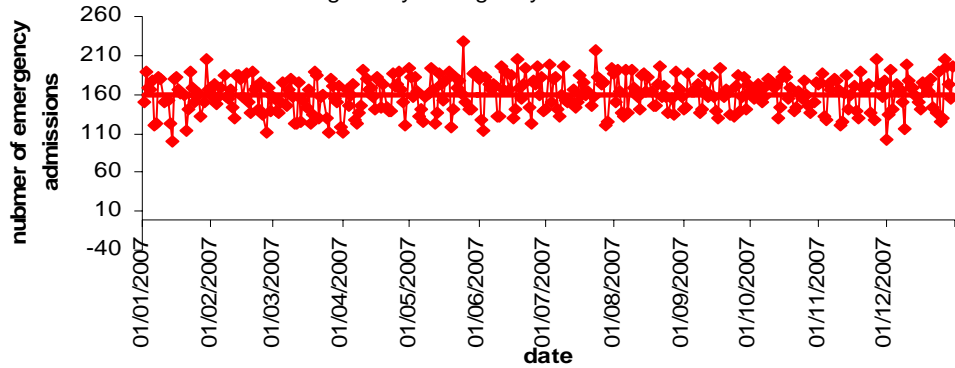


In-day Emergency bed swing = 33

Day to day emergency bed swing

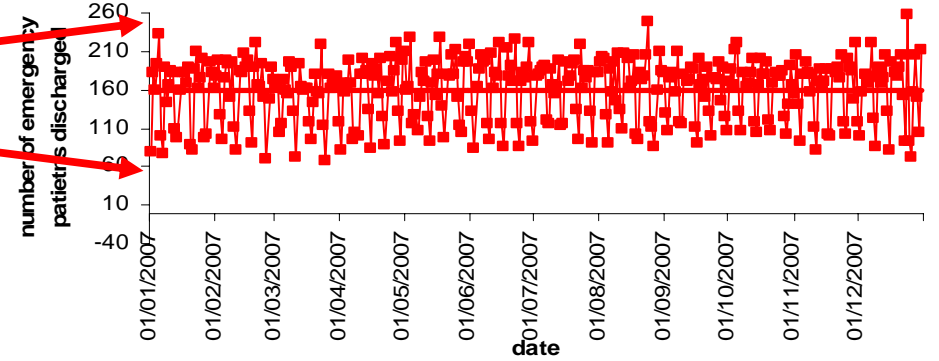
No of emergency admissions
EKH 2007

Average daily emergency admissions = 160



Number of emergency discharges
EKH 2007

Average emergency discharges 160

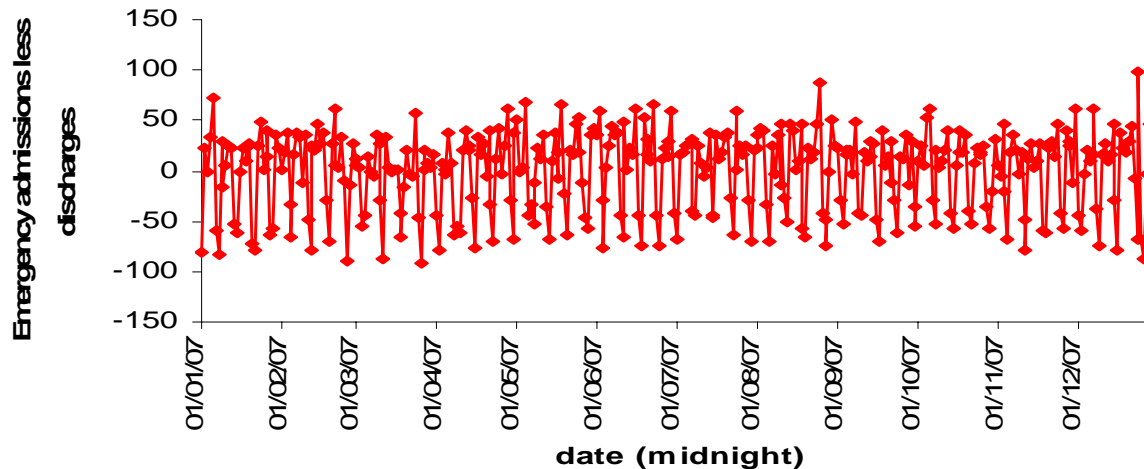


Average daily emergency admissions = 160

Average daily emergency discharges = 160

||

Day to Day Emergency bed swing



190 bed swing

Consequences of admissions & discharges variation mismatch

Backlog guaranteed:

- Patients stored in ‘Assessment Units’
- A&E flow compromised
- Patients to the wrong wards
 - **Outliers**

Additional Cost:

- Overtime, locum, agency and opening wards

Quality

- HSMR and harm events
- Patient and staff experience

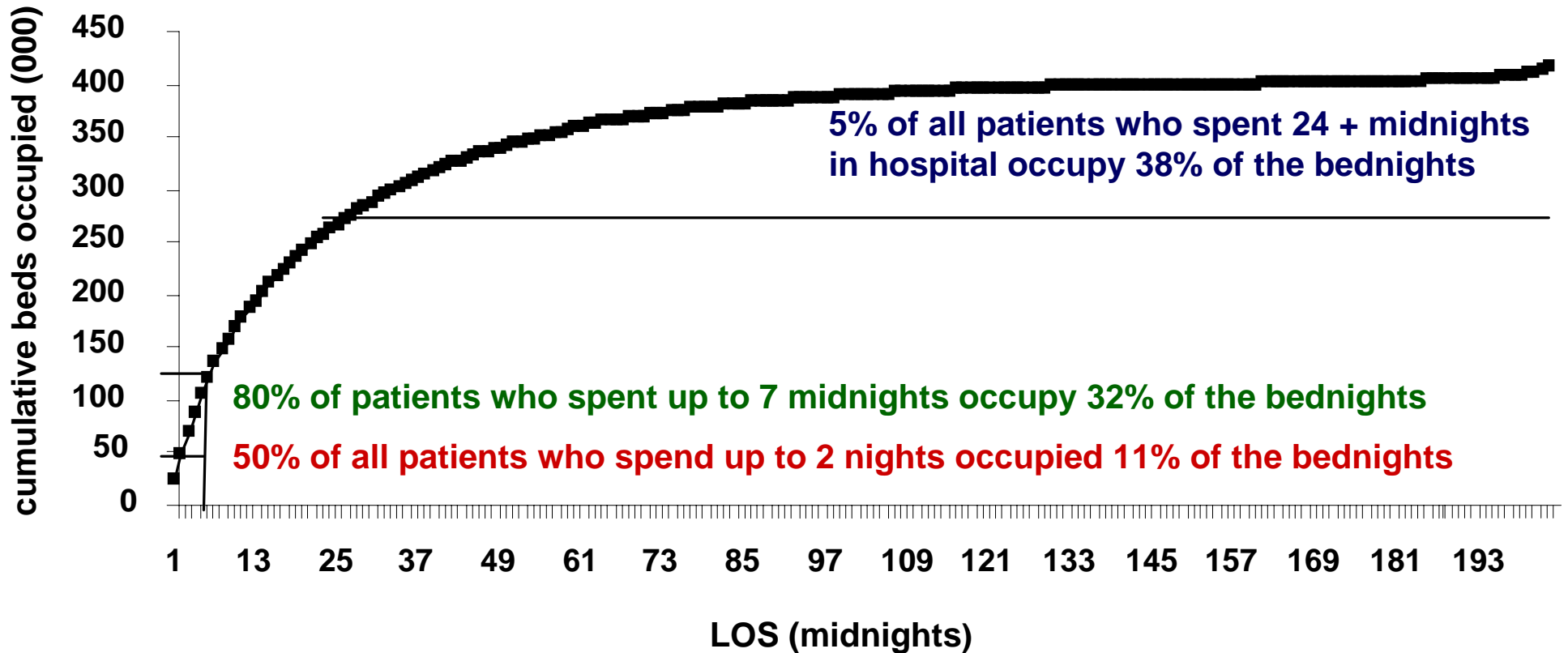
Total In-patients

Pareto: cumulative beds occupied by LOS



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Cumulative beds occupied by all in-patients EKH 2007



Ambulatory Emergency Care

How to do it:

- Opportunities
- Implementation
 - Structure – physical and organisational
 - People and behaviours
 - Processes – bundles + safety
- Measurement
 - Process metrics
 - Outcome metrics
 - Balancing metrics

Critical Success Factors

- **Engaging clinicians**
- **Focus on quality and safety**
- **Whole system planning**
- **Horizontal integration**
- **Joint clinical, managerial and financial governance framework**
- **Aligning financial incentives**

South East Coast Strategic Health Authority Opportunities Assessment



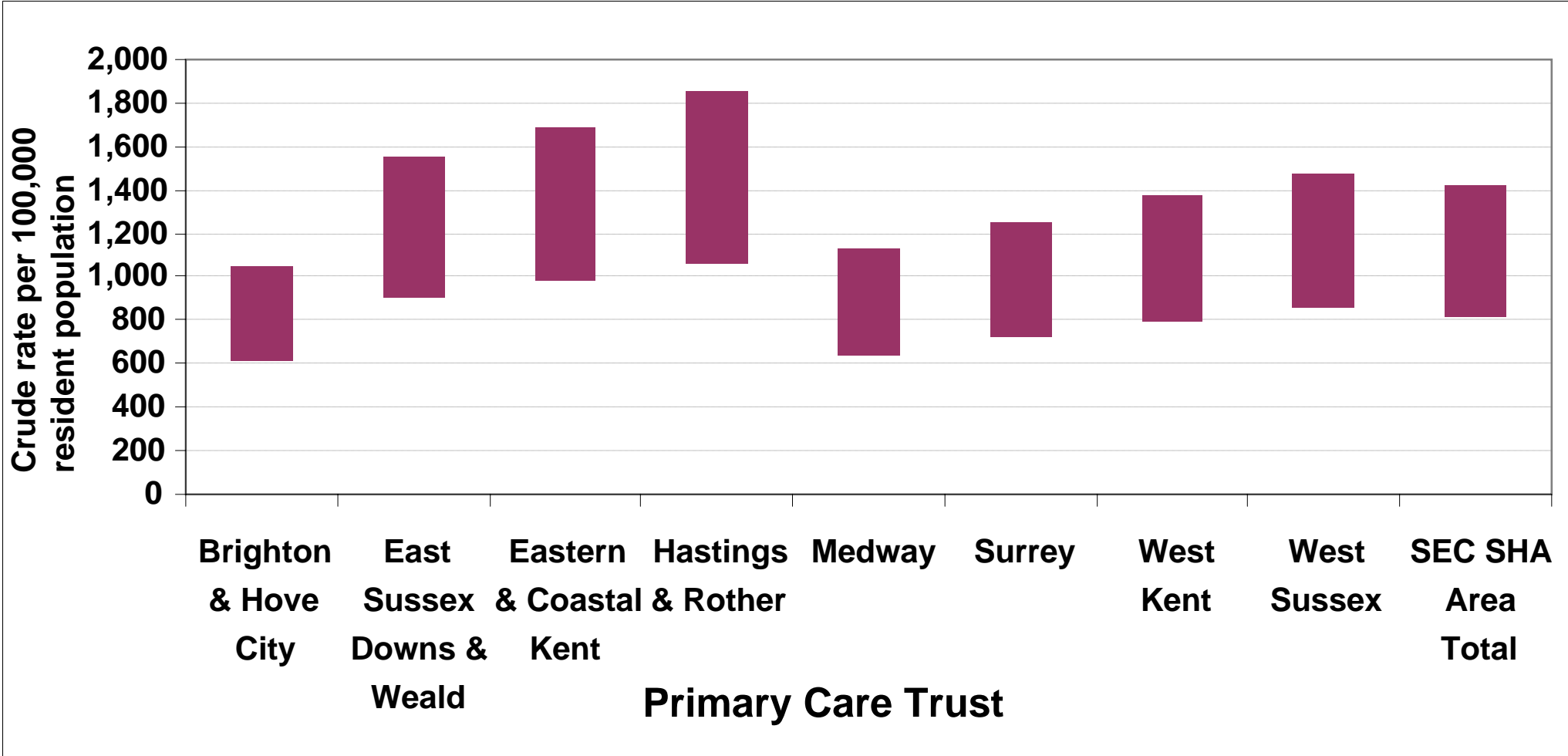
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Clinical Scenario	No. of Adj. Ad. - Low	No. of Ad. Ad. - Upper	% of total admissions (low)	% of total admissions (upper)
Total admissions	267,712	267,712		
GM11 Chest Pain	3,146	6,292	1.2%	2.4%
GS01 Acute abdominal pain not requiring operative intervention	2,894	5,787	1.1%	2.2%
TO02 Appendicular fractures not requiring immediate internal fixation	2,739	4,109	1.0%	1.5%
GM31 Falls including syncope or collapse	2,274	3,411	0.8%	1.3%
GM24 Cellulitis	1,865	2,798	0.7%	1.0%
GM29 Deliberate self harm	1,731	2,597	0.6%	1.0%
GM08 Lower respiratory tract infections without COPD	1,527	3,055	0.6%	1.1%
GM10 Supraventricular tachycardias	1,518	3,037	0.6%	1.1%
GM15 Seizure in known epileptic	1,375	2,063	0.5%	0.8%
GM14 First seizure	1,361	2,041	0.5%	0.8%
Etc etc				
Total Emergency Care Admissions	34,469	59,423	12.9%	22.2%

South East Coast Strategic Health Authority Opportunities Assessment



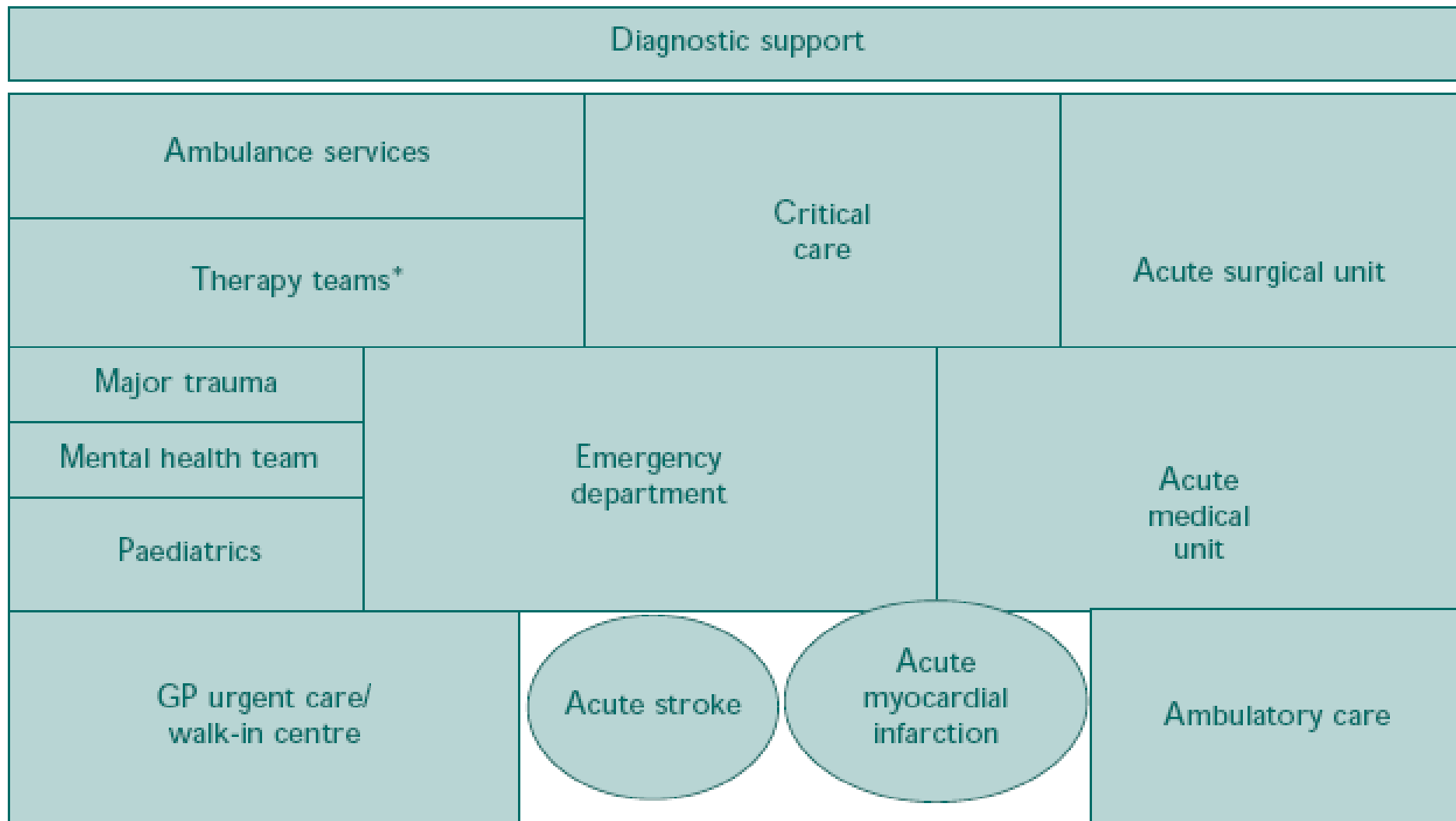
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RCP Acute Medical Care 'Emergency Floor'



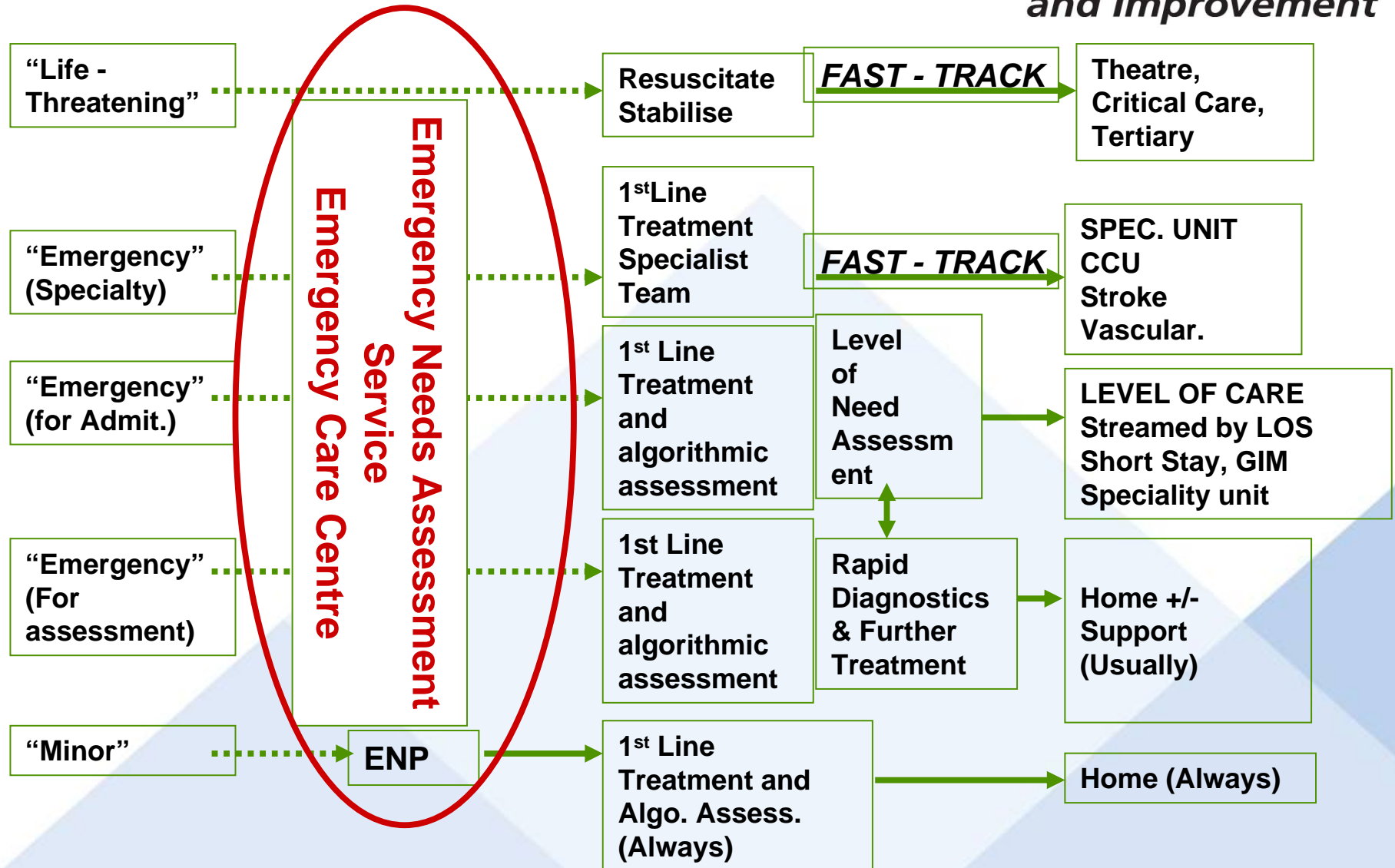
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Kent and Canterbury Hospital – Emergency Care Centre



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Effective clinical decision at point of entry - competency and seniority – being there!:

1° Diagnosis (or differential)

Co-morbidity diagnoses + functional/social problems

Case management plan:

- ZLOS - 1° care/IC/SC/OPA/Joint care (Teams & walls)
- Non ZLOS:
 - Why 'admission' required – monitoring/interventions
 - Investigations/interventions – not just what but when and make it happen!
 - Clinical criteria for discharge + Expected LOS – date and time
 - Stream by LOS
 - What to expect post-discharge – recovery + follow up

Remove redundant steps

- Point of entry – decision making team at front of house
- Handover = delayed decisions = increased LOS

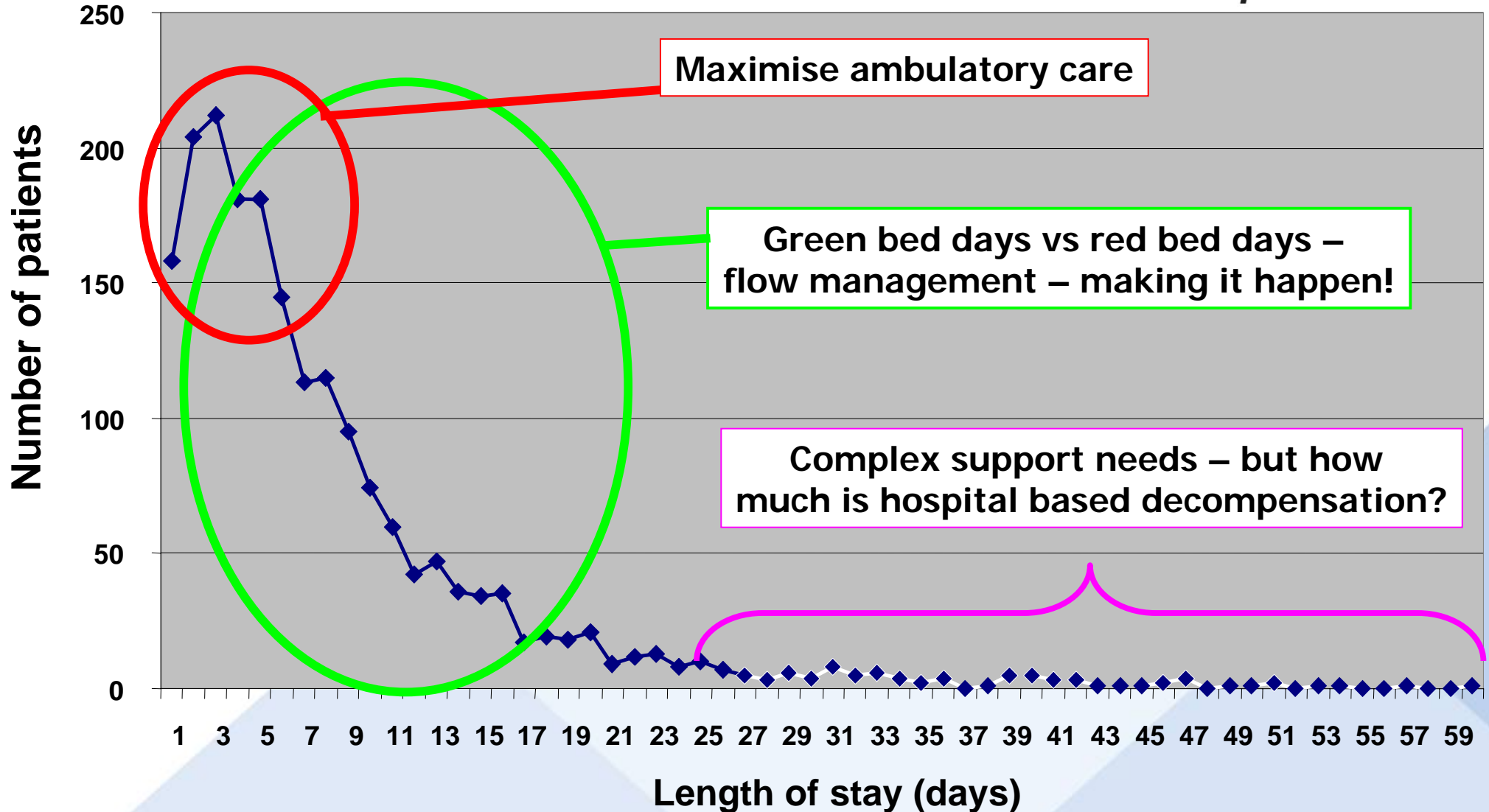
Reduce variation in emergency discharges

- Reduce internal batching and carve-out
 - Eg Batch ward rounds on-call
 - Eg Twice weekly Ward rounds
 - 24/7 + 7/7 demand and 7.5/24 + 5/7 capacity
 - Standardisation of processes

Segmentation of patient by LOS

- Principle of lanes on a motorway
 - Different process speed and variation
 - Standardise case management processes where possible

Managing Length of Stay



Segmentation by LOS - 1



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Short Stay - Locus of control = Internal:

- **Zero LOS and Short Stay (2 days or less) – up to 65% of all admissions - never hand over – EDD to the minute/hour!**
- **Left shift to ambulatory care**
- **Big impact on within day and day to day variation in demand – hourly drum beat**
- **Generalist skills + standardisation (decision making and case management)**
 - **Senior decision making and diagnostics available 8 a.m. to 10 p.m.**

Ambulatory Bundles

- **Common assessments**
- **Linked diagnostics**
- **‘Shared’ pathways of care**
- **Provide ‘bite sizes’ of the elephant!**

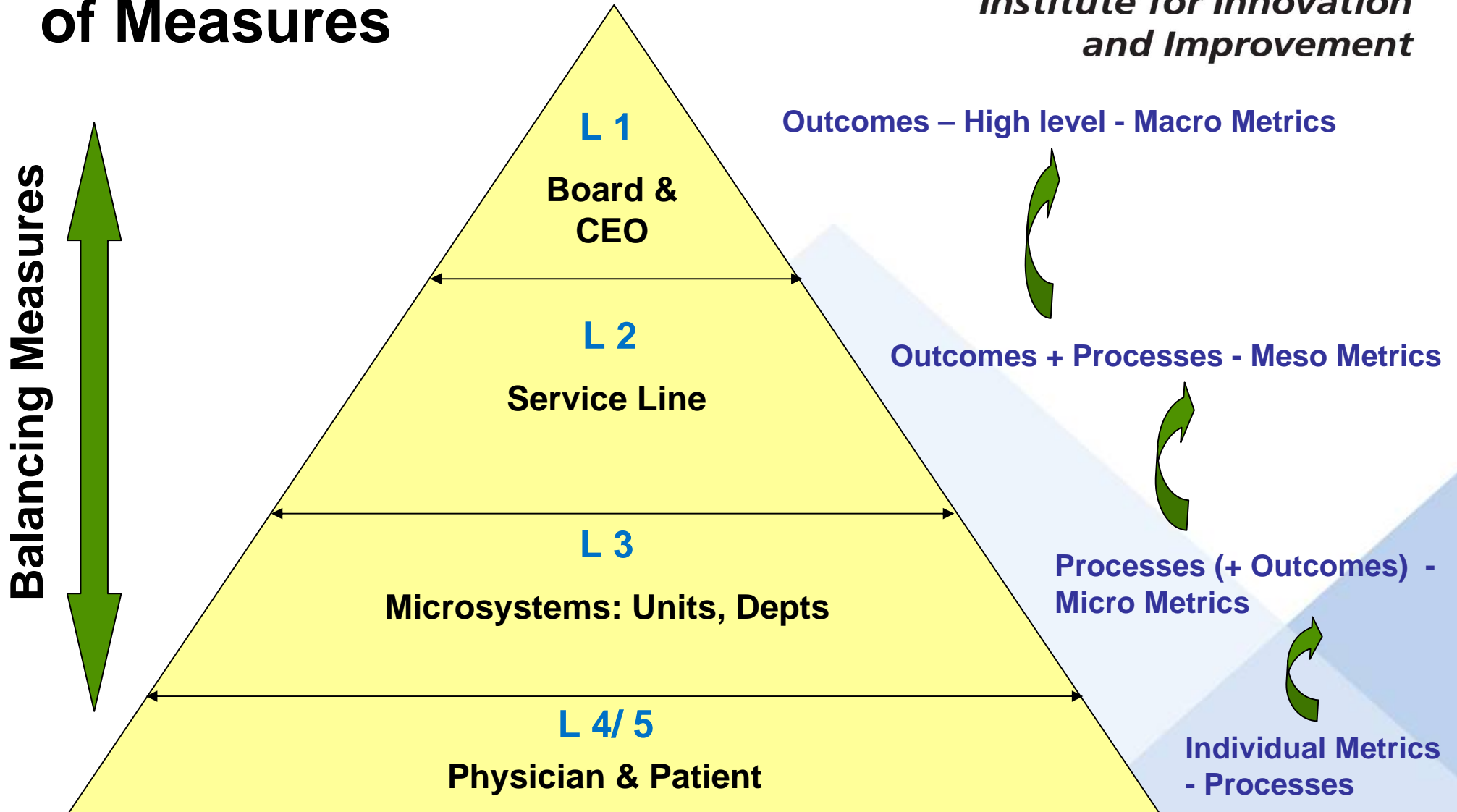
Ambulatory Bundles

- **‘Respiratory/leg bundle’**
 - **DVT**
 - **Cellulitis**
 - **Pulmonary embolism**
 - **Pleural effusion**
 - **Pneumothorax**
 - **Community acquired pneumonia**
 - **COPD**

Ambulatory Bundles

- **Frail Older People Bundle**
 - UTI in older people
 - Fractures not requiring surgery
 - Falls
 - Care Home Admissions
 - End of life care

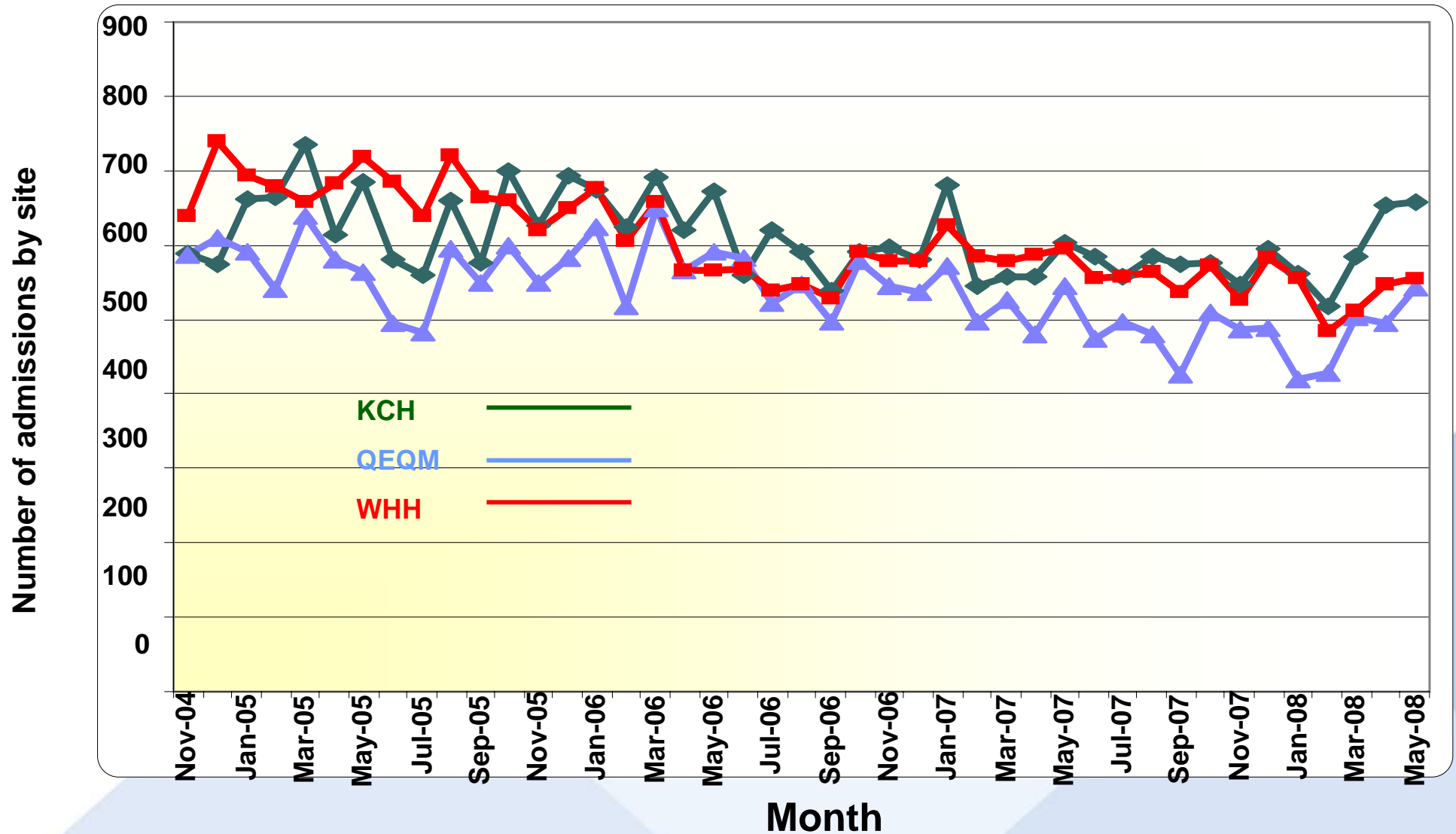
Building a Cascading System of Measures



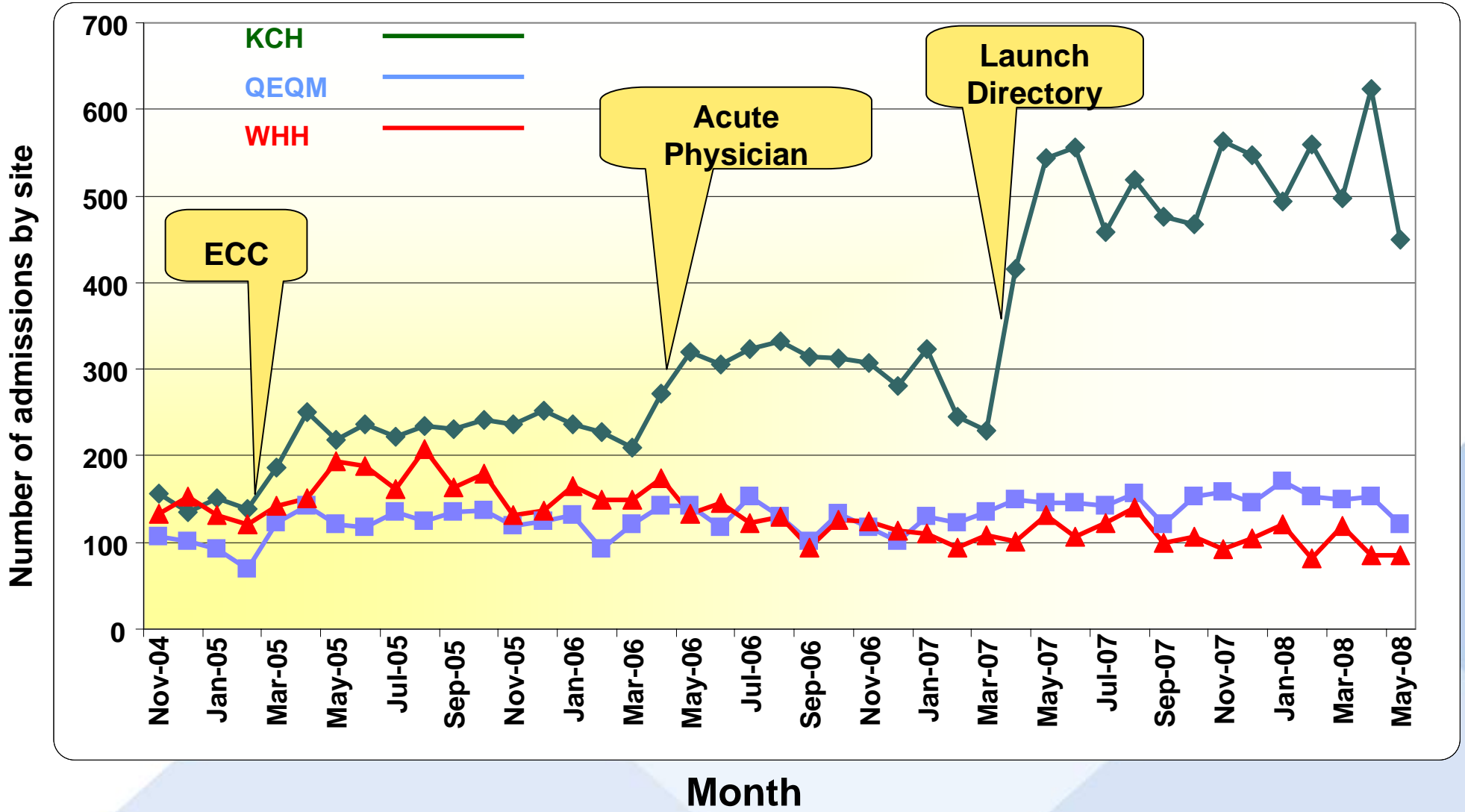
Combined Medicine Admissions (Excl ZLOS)



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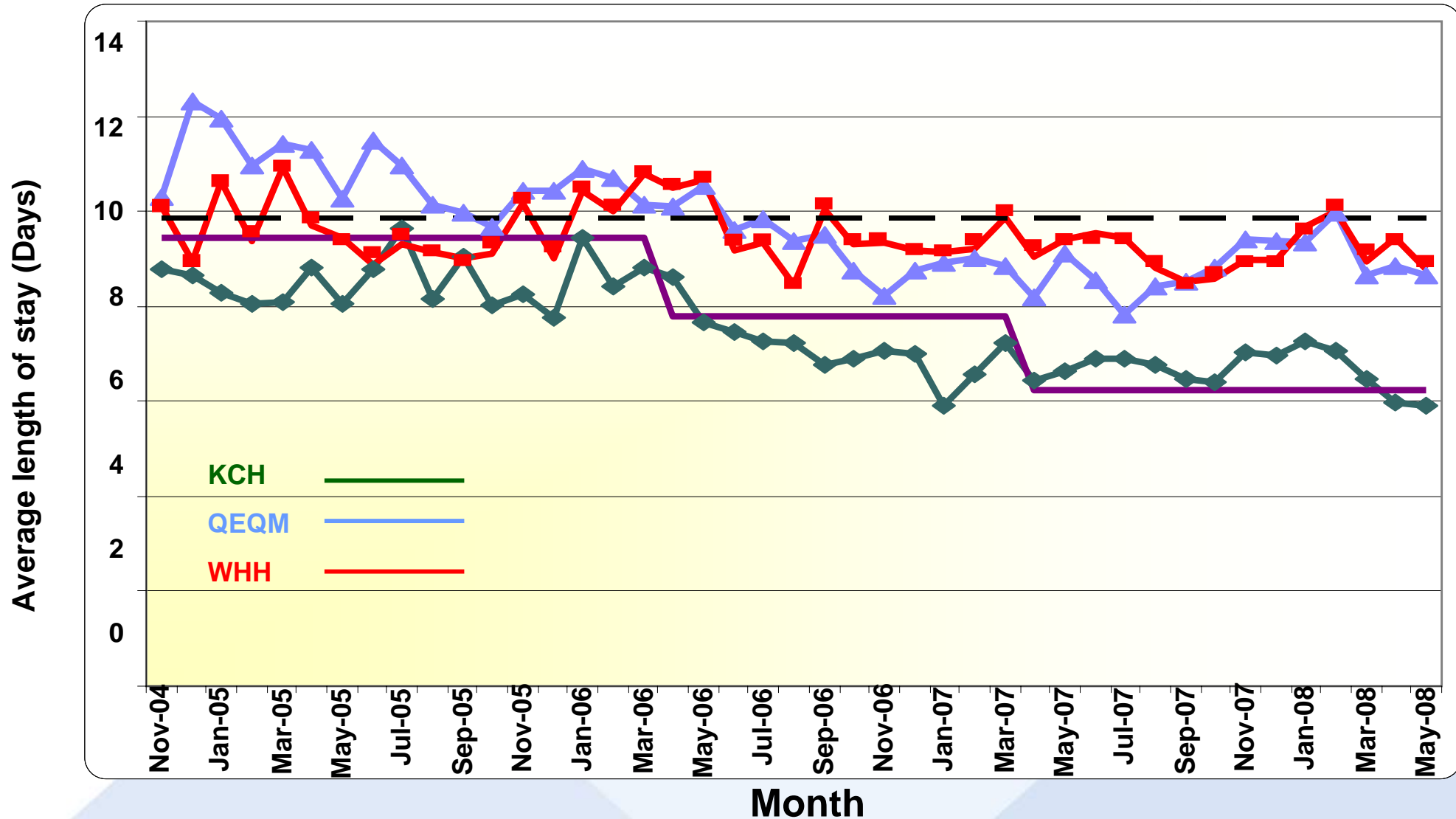
Zero LOS Admissions



Combined Medicine LOS (Excl zero LOS)



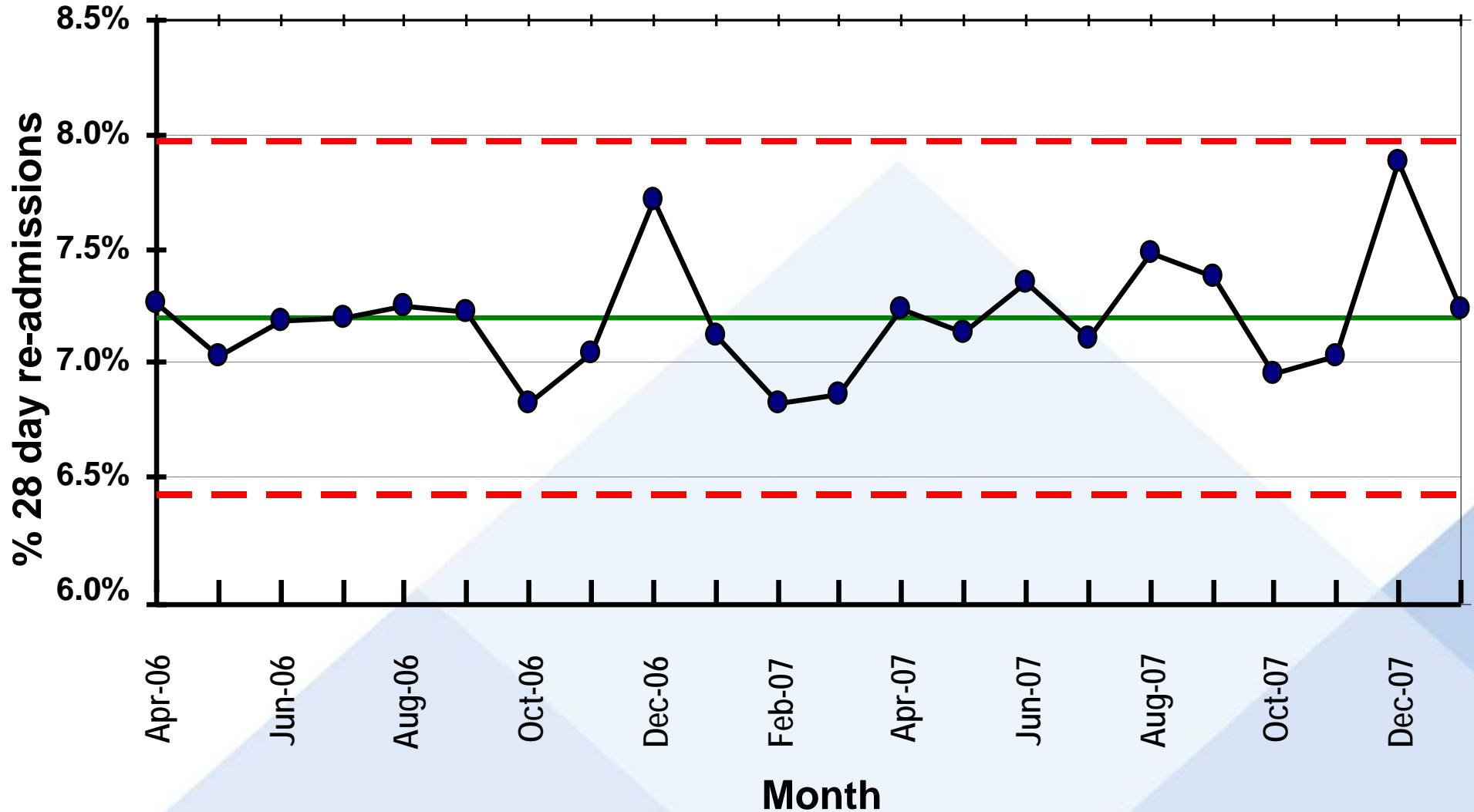
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Emergency Re-Admission Rates



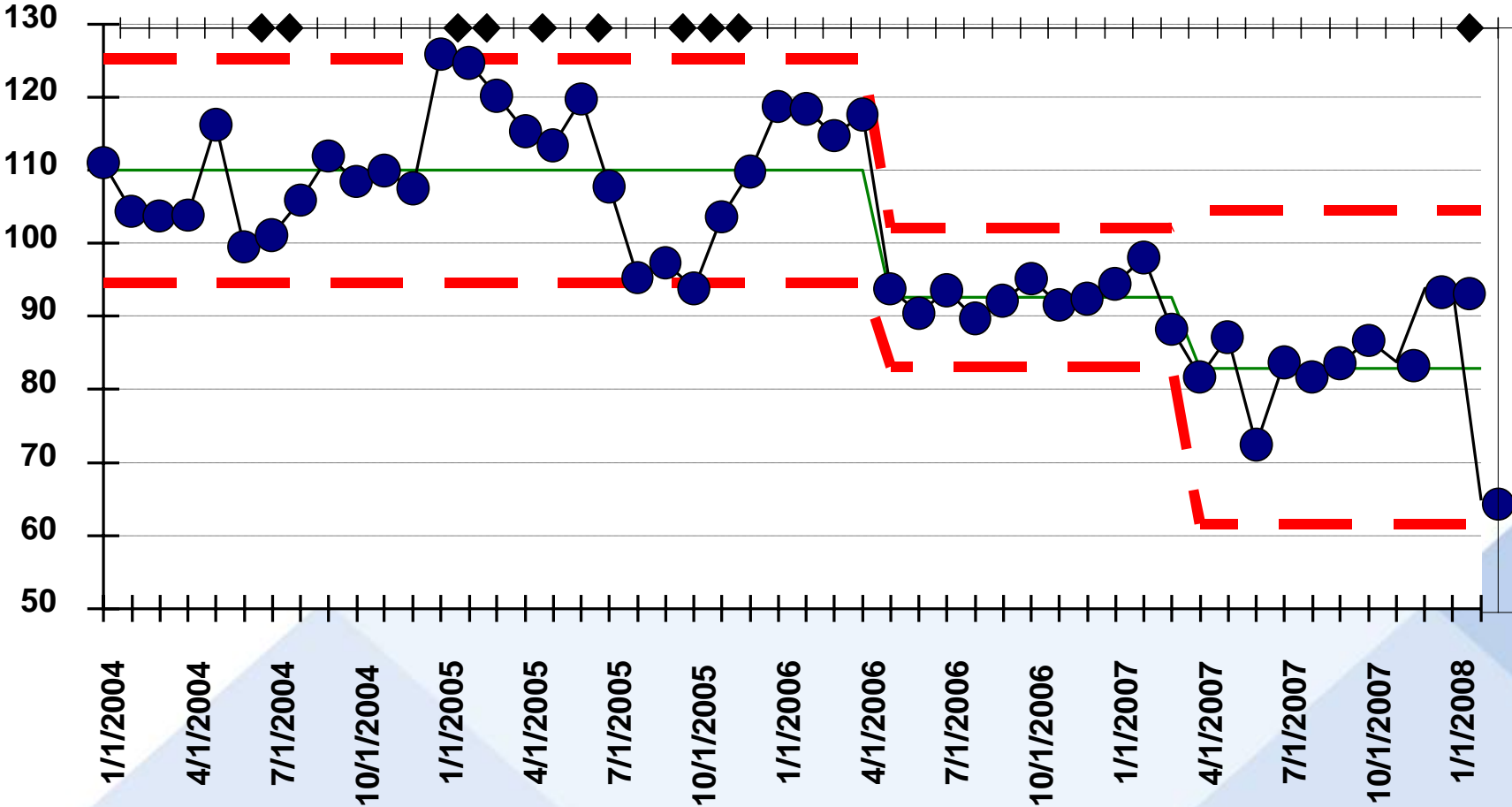
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HSMR - non-elective

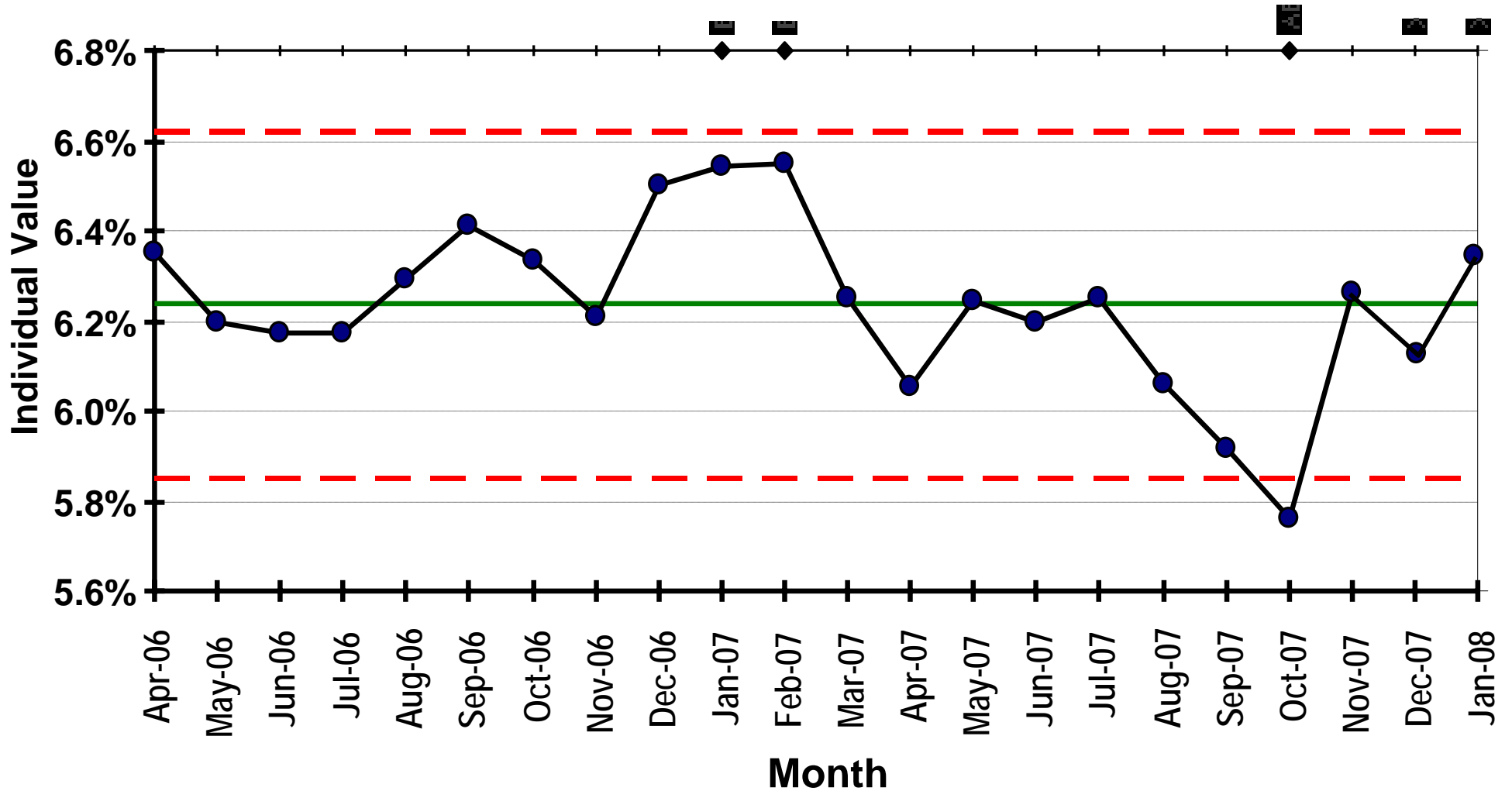


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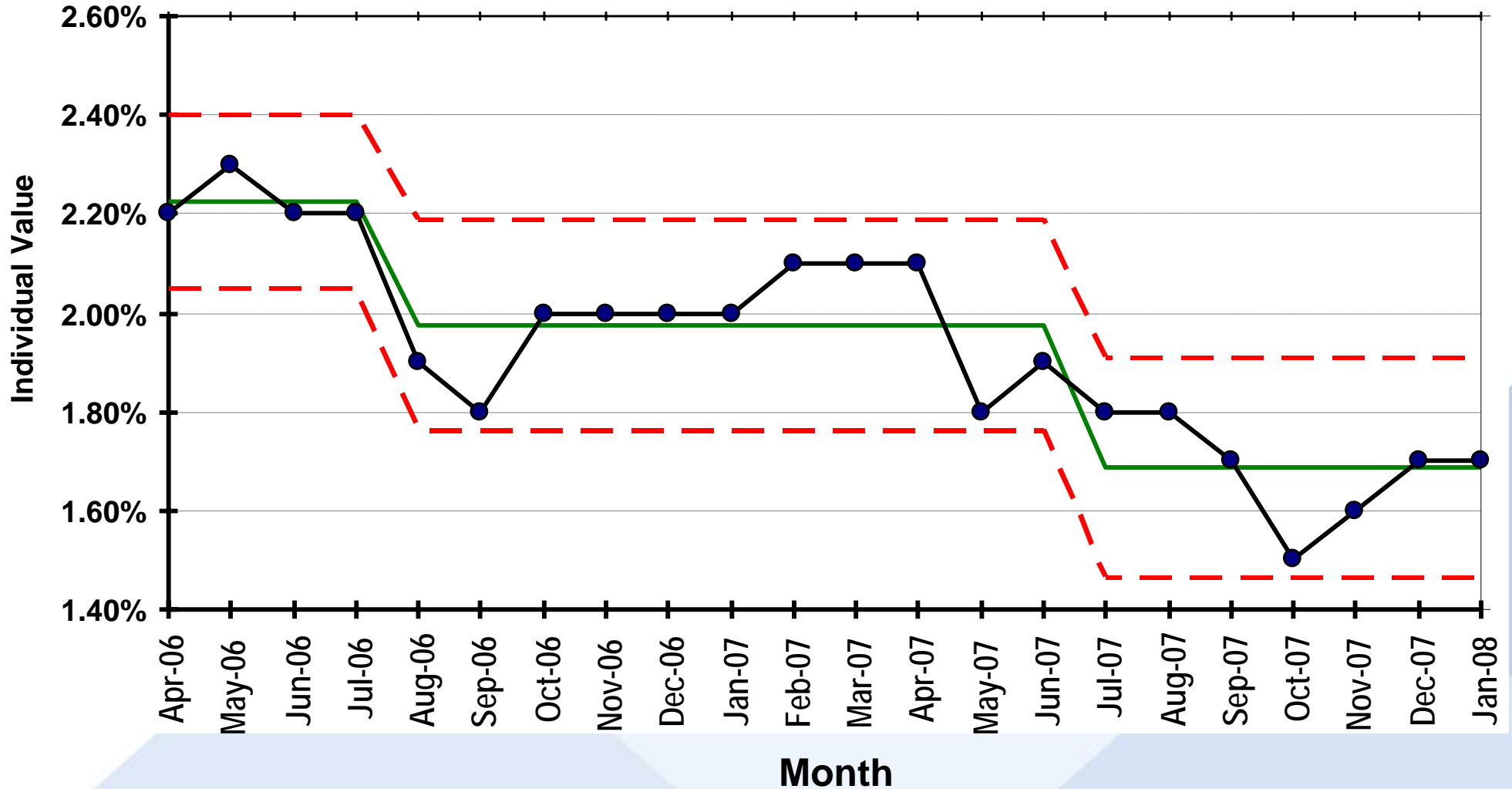


28 Day Mortality Rate

In or out of hospital



Acute Care Institutionalisation Rate



Directory of Ambulatory Emergency Care for Adults



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Summary

- An enabling document
- Focussing on the patient's outcome, safety and experience
- Evaluate current opportunities
- Select a small 'set' and build on success
- Horizontal integration – true joint working
- Joint clinical, managerial and financial governance

- NOT – a demand management tool
- NOT – a performance management tool
- NOT – a simplistic shift tool

And finally:



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We hereby acknowledge significant contributions from the following organisations to the development of the directory:

Royal College of Physicians – Acute Medicine Task Force

College of Emergency Medicine

Academy of the Royal Medical Colleges

Society for Acute Medicine

British Association of Day Surgery

Urgent Care Team – Department of Health

Care Services Improvement Partnership – Department of Health

Emergency Access Team – Department of Health

South Tees Hospitals NHS Trust

Milton Keynes General NHS Trust

Homerton University Hospital NHS Foundation Trust

North Tees and Hartlepool NHS Trust

Ealing Hospital NHS Trust

East Kent Hospitals NHS Trust

Improvement Foundation

