The role of Ambulatory Emergency Care (AEC) in Acute Medicine

Les Ala
Royal Glamorgan Hospital
I practice AEC as part of my ‘front door’ duties

A. Yes
B. No
C. Only on occasions
What proportion of AEC work could be undertaken in Primary Care?

A. > 80%
B. 60-80%
C. 40-60%
D. 20-40%
E. <20%
Format of talk

AEC: What and Why

AEC: How
The concept of Ambulatory Emergency Care...circa 2000

Dr Vincent Connolly
James Cook University Hospital
The concept of Ambulatory Emergency Care (WALES)

Fast-track unit ‘hope for NHS

Dr J I G Strang
The ‘Strang Principles’.
What is AEC?

The Royal College of Physicians defines AEC as:

“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.”

The Royal College of Physicians – Acute Medicine Task Force and endorsed by The Royal College of Emergency Medicine. 2012
Difference between AEC work and Day Hospital work or GP work?

- In AEC work, diagnostic support is more accessible

- AEC work is ‘Same Day Emergency Care’

- AEC work is admission avoidance (previously, these would have been admitted)
What evidence is there that AEC is a good thing....?

National ambulatory emergency care survey: current level of adoption and considerations for the future
Lynn McCallum, Derek Bell, Ian Sturgess and Kate Lawrence

with those required to deliver AEC. The benefits of AEC include improved patient experience, reduced risk of hospital-acquired infection by avoiding inpatient admission, and improved use of resources through reduced inpatient bed occupancy. It also has a key role to play in providing cost-effective approaches to improving quality of care in the NHS.10

Delivering AEC is a goal for acute medicine therefore the
Growth of AEC units (UK)

- **2010 McCallum Survey**
  - Total number of AMUs: 110
  - % with AECU: 25

- **2016 SAMBA16**
  - Total number of AMUs: 120
  - % with AECU: 30
What evidence is there that AEC is a good thing....?

“One of the clear benefits of implementing AEC for acute trusts and commissioners is that they should expect a reduction in the number of emergency bed days used”
What evidence is there that AEC is a good thing....?

https://www.ambulatoryemergencycare.org.uk

“AEC is a cost effective, high-quality, patient-focused service that delivers senior review for effective care”

Jim Mackey, CEO, NHS Improvement. 2016
What evidence is there that AEC is a good thing....?
What evidence is there that AEC is a good thing....?

“Out-of-hospital care is often better for patients and is the right aspiration for the NHS given the growing and ageing population”

Candace Imison, Director of Policy, Nuffield Trust, 2017
What evidence is there that AEC is a good thing....?

• Maintaining wellness and independence in the community prevents deterioration in conditions and therefore results in better health outcomes.

• Emergency admissions to hospital are distressing, so better management that keeps people well and out of hospital should lead to a better patient experience.

• This would result in savings of between £96 million and £238 million (Tian et al 2012).
Case 1

66 years old Female. Previously well. Non smoker

1/7 Hx severe pleuritic chest pains R sided

O/E:
Not distressed; Temp 37.4

HR 100 Reg; BP 120 / 70; HS normal

RR 22; SpO2 96%

?Dullness and scattered course crackles R base

WCC - 16; Neut – 12
CRP 109

U & Es normal

ECG: NSR 100

NEWS = 3

CURB 65 = 1
Discharged with antibiotics!

FU in AECU Day 3 and Day 7...improving

CXR after 4 weeks...Complete resolution
Case 2

• 82 F. Well controlled Hypertension. Fit & well

• For 4 days in a row, woke up in morning (?5.30 -6am ) with bilateral visual loss. Nil else.

• 8 – 10 hours to recover, initially with ‘tunnel vision’ then full recovery

• Clinical Exam NAD but ? Left subclavian bruit

• Ophthalmology review NAD

• CT head, Carotid Doppler NAD
Declined Vascular Surgery Referral

Started on Antiplatelets and discharged

FU in AECU  **Day 5, Day 10, Day 30**…no further symptoms
The ‘How’ of an AEC Unit
How to do it?  Change mind set!
Avoid automatic response ...to admit!
Avoid the ‘Pyjamas and Slippers Syndrome’...
# Location of AEC Unit

<table>
<thead>
<tr>
<th>My current set up</th>
<th>What I would like</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Separate designated area (e.g. different location, or designated area in AMU)</td>
<td>A. Separate designated area (e.g. different location, or designated area in AMU)</td>
</tr>
<tr>
<td>B. No separate area but potential AEC patients mixed with AMU patients</td>
<td>B. No separate area but potential AEC patients mixed with AMU patients</td>
</tr>
<tr>
<td>C. Co-located within ED area</td>
<td>C. Co-located within ED area</td>
</tr>
<tr>
<td>D. I do not have an AECU</td>
<td>D. I do not need AECU</td>
</tr>
</tbody>
</table>
For those who have an AEC Unit, what do you have in the unit?:

<table>
<thead>
<tr>
<th>My current set up</th>
<th>What I would like</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Beds</td>
<td>A. Beds</td>
</tr>
<tr>
<td>B. Trolleys</td>
<td>B. Trolleys</td>
</tr>
<tr>
<td>C. Chairs</td>
<td>C. Chairs</td>
</tr>
<tr>
<td>D. Mixture Chairs / Trolleys</td>
<td>D. Mixture Chairs / Trolleys</td>
</tr>
<tr>
<td>E. Mixture of everything</td>
<td>E. Mixture of everything</td>
</tr>
</tbody>
</table>
## How are my AEC patients selected?

### My current Practice

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A. <strong>Passive</strong>: Referred by ED /GP</td>
<td></td>
</tr>
<tr>
<td>B. <strong>Pull</strong>: AEC Staff pull ptns from ED</td>
<td></td>
</tr>
<tr>
<td>C. <strong>Pathways</strong> use</td>
<td></td>
</tr>
<tr>
<td>D. <strong>Process</strong>: All pass through AECU</td>
<td></td>
</tr>
<tr>
<td>E. Combination of above</td>
<td></td>
</tr>
<tr>
<td>F. I don’t <strong>have</strong> a system</td>
<td></td>
</tr>
</tbody>
</table>

### What I would like

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A. <strong>Passive</strong>: Referred by ED /GP</td>
<td></td>
</tr>
<tr>
<td>B. <strong>Pull</strong>: AEC Staff pull ptns from ED</td>
<td></td>
</tr>
<tr>
<td>C. <strong>Pathways</strong> use</td>
<td></td>
</tr>
<tr>
<td>D. <strong>Process</strong>: All pass through AECU</td>
<td></td>
</tr>
<tr>
<td>E. Combination of above</td>
<td></td>
</tr>
<tr>
<td>F. I don’t <strong>need</strong> a system</td>
<td></td>
</tr>
</tbody>
</table>
The AEC Unit Team in my hospital

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Hospital Medical Staff / GPs</td>
</tr>
<tr>
<td>B</td>
<td>Nurses / Nurse Practitioners</td>
</tr>
<tr>
<td>C</td>
<td>HCSW / MTAs</td>
</tr>
<tr>
<td>D</td>
<td>Therapists / Discharge support team</td>
</tr>
<tr>
<td>E</td>
<td>Ward Clerks / Admin support</td>
</tr>
</tbody>
</table>
DIAGNOSTIC SUPPORT:
In my AEC Unit, I have excellent support for the functioning of the AEC Unit from my diagnostic colleagues (radiologists, pathologists, physiology testing etc) and specialist colleagues

A. Totally agree
B. Partly agree
C. Neither agree or Disagree
D. Partly disagree
E. Totally disagree
My ABC of setting up an AEC Unit

**Area** – location / facilities

**Bodies** – Staff – Discipline / grades / composition

**Cases** – patient selection / flow pathways

**Diagnostics** – radiology / pathology etc

**Evaluation** – data capture / performance measures
Area – locations / facilities

Location
• RCP (ACT 10) …. “co-location with an ED or AMU is good, and may increase in throughput by 50% “
• BUT Beware – They may use AECU as overnight bed space!

Facilities
• Chairs -vs- Trolleys
• Trolleys – vs- Beds
• ‘OPD clinics’ – vs- ‘inpatient wards’
• Waiting area
• Treatment /Procedure room
Bodies – staff composition

• Team working – every member counts!

• Passion and willpower to succeed

• **Key:** Early Senior Decision Making

• On AECU days, try to avoid covering other areas
Cases – patient selection / flow

- Selecting right patients is essential
- Aim – convert traditional inpatient care into ‘same day emergency care’
Cases (Cont): Passive / Pull system for GP referrals

GP – referral to AECU

Front Door Triage

GP-referral to admit

AECU

60%

40%

97% discharge rate from AECU

AMU - admit

Rapid Assess
NEWS
Amb Score
Bloods
ECG
+-/ CXR

HOME
Diagnostic support.
Evaluation

- Robust IT system
- Data entry
- Evaluate activity
- Patient satisfactory surveys
- Feedback to staff / managers
The essentials.....

• Make the case for AEC (data!) and gain the support earlier on

• Set realistic goals then expand with demand

• Choose the right people to do it
Summary

Made the Case for AEC

Basic principles of setting up an AEC service

Thank you for listening