Ambulatory Emergency Care

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A Compilation of "Best Practice" Case Studies

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Contents:

Ambulatory Emergency Care Catalyses Whole-System Change in East Kent

East Kent University Hospitals NHS Foundation Trust was an early pioneer of Ambulatory Care back in December 2010 when it began a pilot at William Harvey Hospital in Ashford. Three years on, the entire local health and social care system has come together to review how organisations can work in a more integrated way to make it easier for acute patients to be diagnosed, treated and discharged from hospital the same day.

Why They Introduced Ambulatory Emergency Care:

East Kent was experiencing increasing demand for emergency care. The system was overloaded and the experience of some patients was poor. The Emergency Care Intensive Support Team (ECIST) from NHS IMAS, recommended Ambulatory Emergency Care as a way of overcoming some of the patient flow issues.

What They Did:

Using the Directory of Ambulatory Emergency Care, they developed six ambulatory pathways; DVT, Pulmonary Embolism, Anaemia, COPD and TIA. The pathways were agreed with GP colleagues and through the Trust's governance processes. East Kent created an Ambulatory Care Unit at each of its three acute sites, in Ashford, Canterbury and Margate. Following the six initial pathways, a further three were introduced at the end of 2013 and two more in 2014. The new service was promoted to GPs via GP forums. A further unit is due to open in Dover in 2015.

Challenges:

Despite early successes, the Trust came up against commissioning issues in 2012. It works with four separate CCGs, each of which wanted to fully understand the impact and cost implications of Ambulatory Care. Further work on the development of additional pathways was halted to the Trust could model the activity, cost and income on the pathways it had already implemented. This provided clear evidence of impact and resulted in the Trust negotiating a block contract with the CCG in order to share the risks. It also created greater integration with community teams which helped to develop future pathways.

About East Kent's AEC Units:

East Kent's three Ambulatory Emergency Care Units are open from 8am to 8pm, Monday to Friday and Saturday from 8am to 2pm. The Trust is currently undertaking a feasibility study into Sunday opening. The units no longer simply treat pathway conditions but now consider a wider range of patients has potentially ambulatory, including those with co-morbidities. To achieve this the Trust is working to create a whole-system model of care that supports same day discharge.

Impact:

Zero length of stay has increased to 33% from 28% since the introduction of Ambulatory Care, with impacts on short stay increasing to 69.37%. Waiting times for assessment and treatment have been dramatically reduced.

Referrals from Ambulatory Care are given the same priority as A&E so treatment can begin much sooner, increasing the likelihood of same day discharge. Patients receive high quality care in a way that fits in with their day-to-day life and without the need for them to be admitted into the hospital system. This has improved patient flow and experience. The Trust is instigating closer working with GPs and developing new pathways across primary and secondary care. Progress is monitored through the dashboard, which shows the Trust activity through the units, by pathway, by emergency/elective, by GP and so on.

What East Kent is Most Proud of:

Ambulatory Care receives positive feedback, with most patients reporting an excellent experience. Having a senior decision-maker at the front of house within minutes of arrival means patients get an immediate assessment and referral for diagnostics, if necessary. The Trust is working with the community teams to create a pathway for Ambulatory Care that follows the patient back into the community. Four East Kent CCGs have had to work collaboratively to develop and streamline pathways and this closer working has led to greater integration overall. Not only has East Kent pioneered a successful federated approach, but it has also become the first hospital in the UK to create a nursing degree module for Ambulatory Emergency Care. In conjunction with Christchurch University, the Ambulatory Care Matron, developed an Ambulatory Emergency Care degree module. This has been offered in East Kent since February 2014 and there has been a lot of interest nationally from nurse managers wishing to develop a module in their areas.

Support from the Ambulatory Emergency Care Network:

East Kent found it useful to have the Network's support in getting stakeholders on board with the development of Ambulatory Care and moving away from an exclusively pathway approach. Caroline Dove, Chief Executive of NHS Elect, which runs the Network, helped to facilitate its whole-system meeting.

Critical Success Factors:

A Whole-System Approach: A system-wide monthly emergency care meeting has been effective at bringing the whole system together, in line with the national integration agenda.

A Broader Perspective: Lead Clinician in Ambulatory Care, Lobo Sunil, is driving the move towards a process approach, in recognition of the way Ambulatory Emergency Care is evolving nationally.

Communicating with Colleagues: The Trust allayed concerns from diagnostics about the fact that additional work could be created by the expansion of Ambulatory Care. By involving them in developing the pathways it became clear this was not new activity, but simply activity in ACU rather than CDU, and earlier rather than later in the pathway.

Avoiding too much focus on the financial agenda: East Kent recognises it got bogged down in discussions about the tariff and needed to allow transformation to take place without getting too fixated on financial issues.

7-day Working: You need to align your core hours to the times of peak demand. Ambulatory Care gets busy from 4pm, so you cannot close your doors at 6pm. The unit in East Kent is open six days a week from 8am to 8pm, Monday to Friday, and 8am to 2pm on Saturday. They are looking at the feasibility of Sunday opening as well.

Impact on Patient Flow

In 2013, Kettering General Hospital NHS Foundation Trust was at the bottom of the national league tables. Patients waited too long in A&E, with transit times of around 74%. The hospital was consistently failing to meet the four-hour target. Medical outliers were typically between 70 and 100.

Yet, within 12 months, the Trust had climbed to the top of the national league tables. A&E transit times were at 98% and medical outliers had reduced to between 10 and zero.

The hospital's decision to introduce Ambulatory Emergency Care played a major role in achieving this dramatic turnaround.

Why They Introduced Ambulatory Emergency Care:

Kettering General Hospital's Chief Operating Officer, Sue Watkinson, who chaired the hospital's Urgent Care Board, believed that Ambulatory Emergency Care (AEC) would help it to achieve rapid and lasting improvement.

What They Did:

They Trust provided the necessary resources to implement a new AEC Unit and gave itself just 12 weeks to do it. The new service was located in the vacated Coronary Care Unit, on the first floor between A&E and AU and staffed with personnel from the recently closed ward.

Kettering began by developing ambulatory care pathways, based on the Directory of Ambulatory Emergency Care. When the unit opened in June 2013, it had 17 pathways in place, covering some of the most common conditions. However, the hospital soon realised that this type of pathway approach could be restrictive and decided to take any patient they believed could be treated and discharged within a day, irrespective of whether there was a pathway for their condition or not. This is referred to as a process approach.

Support from the Ambulatory Emergency Care Network:

Kettering joined the Ambulatory Emergency Care Network to support its rapid implementation of AEC, so they could learn from the experience of other hospitals and get expert help and support.

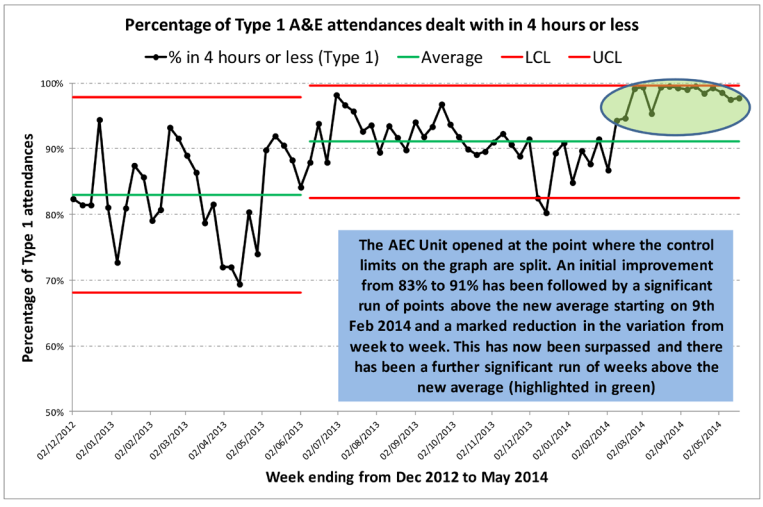
About Kettering's AEC Unit:

In its first week, the unit saw 60 patients, drawn from A&E, GP referrals, outpatient clinics, HOT clinics and wards. In less than 12 months, the number of patients per week has risen to more than 200. The Ambulatory Care Unit treats Cardiology, Respiratory and Medical patients. It also offers outpatient Cardiology, Respiratory, Neurology and Rheumatology, as well as medical HOT clinics, and day-case procedures. The unit is open seven days a week, from 8am to 8.30pm. The last referral is at 6pm. The most common conditions treated in the unit are PE, DVT, Anaemia and chest pains.

In December 2013, the unit moved from its original location to larger premises, allowing it to add a separate treatment area and waiting room.

Impact:

Kettering went from the bottom of the national A&E performance table to the top. In just over a year (from December 2012 to January 2014), the A&E four-hour target figures rose from an average of 83%, with control limits of 68-98%, to an average of 91% with far less variation



(between 83-99%). By January 2014, the worst week in Kettering was as good as the previous average. Medical outliers were down to less than 10 and, some days, zero. Most importantly, the patient experience had improved significantly.

"My GP knew about Ambulatory Care so sent me in. I was dealt with straight away and had all the tests I needed. Why would you want to go to A&E if you could be seen by the right specialist straight away in a less busy place?"

What Kettering is Most Proud of:

Kettering is the first NHS Trust in England to develop its own Ambulatory Care training programme for Advanced Clinical Practitioners and Band 4 Assistant Practitioners. The Practitioners develop a portfolio of clinical skills, including clinical examination and history taking. At advanced level, they also become qualified in prescribing.

"We have a great team. I am proud of the fact that we were able to create the ACU from scratch, within just 12 weeks. And, most importantly, the fact that we are making a definable different to patients."

Maxine White, Cardio Respiratory Service Manager

Critical Success Factors:

A number of factors that have contributed to Kettering's success in implementing Ambulatory Emergency Care are:

Just Doing It:

Working with clinicians to create the AEC pathways as a way of getting them on board. Regular communication - talking to the Urgent Care Board and visiting locality meetings, Commissioners and GPs

Getting GPs on Board:

Using a mix of different communication methods, and communicating consistently

The Right Team:

Consisting of different types of staff and attitudes, including forward-thinking consultants who can help to drive the service forward

Support from the AEC Network:

Invaluable as a way of learning from other people, maintaining momentum and boosting confidence

Measurement:

Prior to setting up the service, measurement provided a way of identifying the potential for AEC and, afterwards, it was used to monitor it's impact.

"Since June 2013 the Ambulatory Care Unit has seem more than 10,000 patients. Its use has increased from 60 patients a week to more than 200 per week now. These are all patients who would have probably been seen in our busy A&E department or been admitted to a hospital bed - when maybe all they really needed was a short spell of specialist attention."

Kettering General Hospital's Chief Operating Officer, Alan Gurney

Six Weeks to Launch a New Ambulatory Care Unit

Milton Keynes Hospital was consistently failing to meet its four-hour emergency access standard. From time to time, fewer than 70% of emergency admissions were dealt with within the target time.

The hospital's archaic admission process meant that patients who were less sick could wait for many hours in the Clinical Decision Unit (CDU) before seeing a doctor. Often, the medical intervention required by these patients ended up being minimal, but they were forced to endure a long wait in a chaotic environment and sometimes ended up being admitted due to this long wait. NHS IMAS's Emergency Care Intensive Support Team recommended Ambulatory Emergency Care to address the issue of overcrowding in the Emergency Department (ED) and convert emergency admissions to same-day care wherever possible.

What They Did:

The Acute Medical Team was charged with creating and implementing an Ambulatory Emergency Care Unit within just six weeks. An audit revealed that 65% of daily medical admissions had a zero or one-day length of stay so this 65% was the target for Ambulatory Care. The team joined the Ambulatory Emergency Care Network to learn from the experience of other Trusts. It was inspired by a visit to Middlesbrough to see an Ambulatory Emergency Care Unit working well.

About Milton Keynes Ambulatory Care Unit:

The unit is open 5 days a week, from 9am to 8pm. It is located next to the ED. All patients are considered as potential candidates for ambulatory care unless there are clear clinical indications to the contrary. The team created its own scoring system to help stream patients into the unit. Milton Keynes set up a virtual ward and patients are often discussed 'in absentia' if they were seen the day before. Telephone consultations are common. Some mildly unwell patients lie on trolleys but most sit on chairs or recliner chairs. Those who are not well enough for this go to the Medical Assessment Unit (MAU). Activity is clinically codes and Ambulatory Care receives a special tariff locally agreed by commissioners. Initially coding as an inpatient was problematic with regards to dealing with the perceived 10% of re-admissions.

Impact:

After only six weeks Milton Keynes started to notice the impact of Ambulatory Care in five key areas; safety, timeliness, efficiency, effectiveness and patient-centred care. Between 80 and 90% of patients cared for in the unit are sent home 'same-day'; having their care managed in the community, rather than in traditional hospital settings.

The patient experience is noticeably better as patients see a consultant within minutes of arriving. Faster access to senior decision-makers means that treatment can begin sooner, leading to improved clinical outcomes and far less anxiety for patients. After diagnosis, patients return to the unit at a predetermined time for their appointment, making for a less charged

atmosphere.

MAU is now a more manageable environment and it can operate as a true Medical Assessment Unit. For ED, the effect of Ambulatory Care has been to improve patient flow, releasing time to focus on the sick, unstable patients who really need care. Milton Keynes points out that it has rearranged its model of care for the convenience of patients rather than for its own convenience, to great effect. Staff and GP feedback has also been positive. The hospital is now consistently achieving its four-hour emergency access standard. Ambulatory Care is just one contributory factor in this, but the hospital acknowledges it is a big one.

Critical Success Factors:

Support from the top: Milton Keynes' Chief Executive, Jon Harrison, and the Executive Team are extremely supportive of the Ambulatory Care Unit.

Changing the mind-set of clinicians: Consultant Acute Physician, Dr Chris Lindesay, has worked hard to convey his vision to acute medicine colleagues, making the case that admitting patients to hospital is not necessarily providing the 'safe, high quality care' that it has always perceived it to be.

Keeping colleagues on board: The team talked to each department that it would be working with and agreed a standard operating procedure. This kept colleagues engaged with the process and avoided any potential alienation.

Reduce waste: Milton Keynes identified everything that happens when patients come onto the unit and looked at how these processes could be made more efficient to reduce waste.

Ambulatory Emergency Care - The Logical Way To Go

Nottingham University Hospital's Queens Medical Centre Emergency Department is one of the busiest in the country. It has two main admission wards which, prior to the introduction of Ambulatory Emergency Care, were running over capacity at busy times. Staff were working hard to maintain high standards of care and a good patient experience, but the growing pressure on beds meant that the Acute Medical Team were actively seeking alternative ways of caring for emergency patients.

The QMC was aware of discussions about the benefits of Ambulatory Emergency Care from the Department of Health and the Ambulatory Emergency Care Network. It had a well-developed Acute Medical Unit and half of the patients on the admission ward had a length of stay of just 15 hours or less. For these reasons, Ambulatory Emergency Care seemed the logical next step.

What They Did:

The QMC became part of the first cohort of Trusts to join the Ambulatory Emergency Care Network so it could learn from the experts and meet other Trusts that were adopting the ambulatory approach. They began by trailing the streaming of GP emergency admissions into an ambulatory area at the end of the short-stay ward. The area, which was adjacent to the Medical Assessment Unit (MAU), opened Monday to Friday from 9am to 10pm. It was staffed by a consultant, tow junior doctors and nursing staff. This pilot project was supported by the Trust's 'Better for You' team, which drives improvement within the hospital. The pilot enabled the Acute Medical team to measure the impact of Ambulatory Emergency Care on staff and patient experience, governance and risk. With proof of positive impact, the team took its proposal for Ambulatory Emergency Care to the Board and it was accepted.

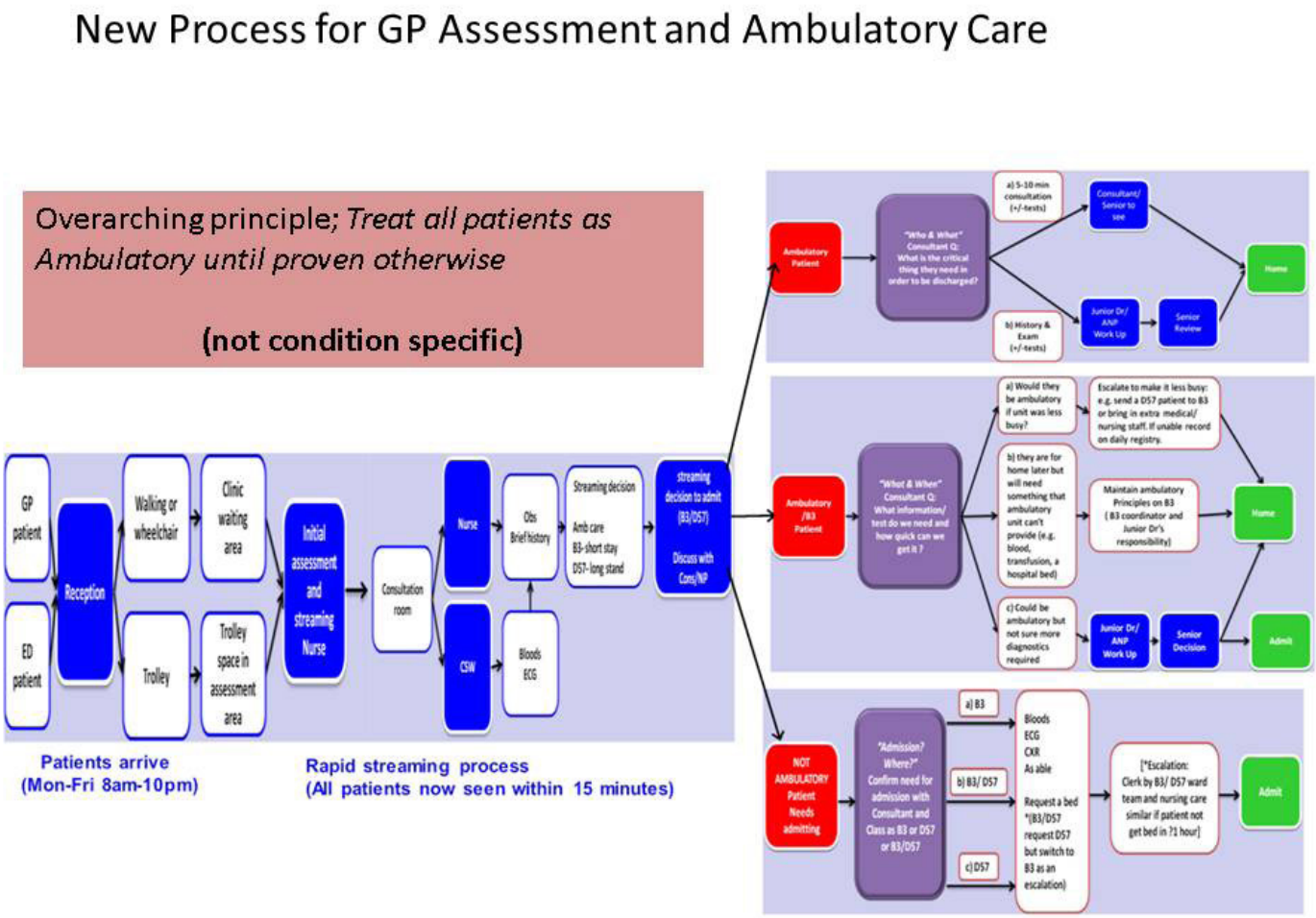
Following the pilot, the Trust created a dedicated Ambulatory Emergency Care Unit adjacent to the short-stay ward. On the unit, all GP emergency admissions are considered as having ambulatory care potential, unless there is clear evidence to the contrary. Every patient is seen by a Consultant Acute Physician and one of the nurses on arrival and the team uses the MEWS score to assess the patient's degree of illness. If patients are quite clearly sick, they are admitted to hospital but otherwise they are treated, stabilised and sent home. The mind-set in Ambulatory Care is 'No-one stays overnight if they could have gone home today'.

About Nottingham's Ambulatory Care Unit:

The unit is open from 9am to 10pm every day. It sees between 30 and 50 patients a day, with an average length of stay of five hours. The unit has a dedicated consultant from 9am to 5pm, and a shared consultant (shared with admissions) from 5pm to 10pm. There are currently two Advanced Practitioners working in Ambulatory Care and more will be appointed as the service develops. There is also a nurse, nursing auxiliary and clinical support worker. There are two junior doctors (within a flexible pool) who start at 10am until 6pm before Hospital at Night take over.

Impact:

The pilot programme proved a huge success. It calmed the emergency flow of patients and brought the situation back under control. There were no bed breaches even though the pilot took place at a very busy time. Having an area dedicated to Ambulatory Care meant the Trust could focus on getting its less sick patients diagnosed, stabilised and treated. Patients felt reassured that they could see a consultant quickly, receive treatment and go home. Because these patients were not taking up beds unnecessarily, the people who did need them could get to them faster. The pilot provided the evidence the Board needed to invest in the new service. Since opening a full-time Ambulatory Emergency Care Unit, between 60 and 88 GP emergency referrals are treated in an ambulatory way every week. That is between 30 and 40% of total referrals.



Critical Success Factors:

Support from the Board: Nottingham's Board was already favourably disposed towards Ambulatory Emergency Care, after hearing the evidence presented by the Ambulatory Emergency Care Network and Department of Health. The pilot provided the evidence they needed to invest in the new service.

Joint working between the hospital and GPs : Since the advent of the CCGs, there is a closer working relationship between the hospitals and GPs. There is also a greater understanding about the role played by the hospital in delivering emergency care, which has helped in the development of the Ambulatory Care Service.

Rapid access to diagnostics: Rather than patients waiting in a hospital bed for a scan, the radiology team now fully embraces the practice of scanning promptly to enable patients to be rapidly diagnosed, treated same day and sent home.

Clinical judgement : The fact that the Ambulatory Emergency Care Team uses its clinical judgement to decide who is suitable for Ambulatory Care and who needs to be admitted to hospital means that the QMC can consider any patient as potentially ambulatory rather than being restricted to a pathway approach.

Watford Sees Impact of Ambulatory Care Within a Fortnight

Watford General Hospital was an early pioneer of Ambulatory Emergency Care. In May 2012, keen to address the problem of ever-increasing demands on emergency care, the hospital introduced an Ambulatory Care Service located in a corner of one of the wards. It was staffed by a Lead Clinician, Dr Arif Hamda, a Senior Sister, Lynne Jeffery, and Dr Mohammed Hussein as the middle grade doctor.

Within a fortnight, it was clear that Ambulatory Care was having a significant impact on reducing the daily medical take. Divisional Manager of Emergency Medicine, Mary Richardson, presented the first business case for Ambulatory Care to the Board in August 2012. Two years on, Ambulatory Care now has its own purpose-built unit and handles around a third of the hospital's entire emergency intake (around 40 patients a day).

What They Did:

Watford started with one bed and a few chairs, in a small corner of the Acute Assessment Unit (AAU). The service began by identifying whether there were any patients in A&E that could potentially be treated and discharged same-day and bringing them into Ambulatory Care. It was a blank canvas; there were no pathways and no particular types of patients they were targeting. Within two weeks, it became clear that the flow of patients was much better, there were beds available and some of the pressure on A&E was relieved. They began to introduce ambulatory care pathways for some of the most common emergency conditions (such as cellulitis, low risk chest pain and DVT), which was useful to overcome resistance from certain clinical colleagues and bring different specialities on board. In addition, they continued to see any patient that they thought could be treated and discharged within one day.

Watford's Ambulatory Care Unit:

By August 2012, Ambulatory Care was allocated six beds in the corner of the Medical Assessment Unit (MAU) and two consulting rooms. The service was consultant-led with junior doctor support and a dedicated nursing team. From being a five-day a week service, it became a 12-hour a day, seven-day a week service.

Impact:

The on-call team began to notice a significant difference in demand, with 24-30% of the 'take' being diverted to Ambulatory Emergency Care during their opening hours. Ambulatory Care is having an impact both on the number of admissions and in-patient discharge rates. An average of 46% of medical heralded GP referrals for admission are now streamed to Ambulatory Emergency Care.

A Pragmatic Approach:

A pragmatic approach is taken to meet the demands of Ambulatory Emergency Care patients. For example, when the District Nursing Service did not have the capacity to follow-up on patients who needed IV antibiotics at home, it implemented an agreement with a private provider to provide the service. The provider assesses the patient's needs within the Ambulatory Care Unit, and then administers treatment at home whilst the patient remains under the care of the Ambulatory Care Unit. It also employs a community-based Outpatient Parenteral Antibiotics Therapy (OPAT) Nurse to work on the Cellulitis pathway.

Come A Long Way:

Ambulatory Care in Watford has come along way from the early days. Lynne Jeffrey has been Senior Sister for Ambulatory Emergency Care since the service opened. She comments: "When we started, I used to describe our approach as being like fishing. We used to go into A&E to see if we could find any suitable patients. When

we did, it felt like 'I've got one, I've got one!' There was a certain degree of suspicion from A&E staff that we were, somehow, trying to 'steal' their patients. On average, we would see three or four patients a day in Ambulatory Care, in a small, screened area in the middle of a ward. Now we are averaging around 40 patients (including new patients and returners) a day and continuing to expand. Our colleagues in A&E are incredibly supportive. If they find a suitable patient, they call us straight away and they even nominated us for Team of the Month recently. We also have a great relationship with the diagnostics teams. I am proud of the fact that our patients trust us enough to be able to pick up the phone if they have any concerns and I have the autonomy to be able to invite them to come back into the unit if needed, without having to go through a lengthy admissions process."

A Purpose Built Unit:

With some financial input from the CCG, in January 2014, Ambulatory Care finally moved into its own purpose-built unit with six examination rooms and separate male and female areas with four trolleys and one bed each. The service now employs seven consultants, one staff grade nurse, two SHO's, 13 nurses, one DVT nurse and one Cellulitis nurse. It is open from 8am to 8pm Monday to Friday and 11am to 7pm at weekends. The unit manages approximately a third of the hospital's emergency take, with around 52% of its intake from A&E and 48% from GP referrals.

Ambulatory Care continues to operate a combined process and pathway approach to identify and select suitable patients. In addition, there are a number of day case patients, who are booked in advance. These include patients attending for liver biopsies, therapeutic ascitic drains and PEG insertion. There are weekly cardiology and rheumatology HOT (rapid access) clinics. Approximately 16 patients are managed through these clinics per week, with further clinics planned for dermatology, neurology and respiratory.

Tackling the Root Cause of Waste:

Mary comments: "I had been working with the Trust for 18 months before we opened the Ambulatory Care Service. I could see that there were patients being admitted through AAU who didn't need to be. Sometimes, patients would come late in the day and simply be absorbed into that day's take. Sometimes they were admitted for 24 hours, sometimes it was longer, while they waited for diagnostics. It was a wasteful and inefficient system. Now, an average of 40 patients per day, who would previously have gone to AAU, are coming into Ambulatory Care and being discharged the same day."

Lynne adds that the Ambulatory Care Team does whatever it can to reduce waste and eliminate delays: "We take our own patients to x-ray rather than waiting for porters and we walk our bloods to the vascular lab.

They even gave us red bags to put the samples in to ensure they receive high priority. We identified, too, that waiting for TTAs (tablets to take away) was a significant cause of delay. So, we now have our own range of the most commonly prescribed drugs in ready-made TTA boxes so that we don't have to wait for pharmacy. It all adds up to streamlining the process."

Tracey Pooley, Project Manager for Urgent Care from the CCG says: "Ambulatory Emergency Care will only work well if all stakeholders are completely committed to partnership working. Through working closely with the CCG, Ambulatory Emergency Care is now linking in with health, community and primary care to work seamlessly together to ensure the patient receives an appropriate package of care upon discharge."

Continuing Expansion:

The Ambulatory Care Service is continuing to expand. In December 2013, Watford introduced Elderly Ambulatory Care to provide same-day care for older patients with co-morbidities and complex social needs. Initially, the service was only reviewing three or four patients a day, however, following the introduction of an additional member of staff to provide continuity, it is now seeing up to 11 patients a day. Patients are recruited from five streams: those from GPs and A&E who would, otherwise, have been admitted; early ward discharges; patients requiring rapid access to outpatient review and diagnostics to avoid deterioration which might lead to admission 'downstream'. Additionally, there are patients returning for review on the Delirium Recovery Programme and there are also day cases, for example, patients on Zoledronic Acid.

Dr Tammy Angel, Care of the Elderly Consultant, explains: "Ambulatory Care provides an opportunity to assess for admission, rather than admitting them to assess them. We are using a comprehensive geriatric assessment tool developed by one of my colleagues and patients are seen by the multidisciplinary team, as needed. It is extremely helpful to be able to achieve robust early follow-up, which gives confidence that the patients will be reviewed in a timely way. The registrars also get the opportunity of undergoing a training experience in a day unit setting. There is always more to be done and improved access to intermediate care beds is a key area for further development."

Watford also has plans to introduce a Surgical Ambulatory Care Unit and a Gynaecology Ambulatory Care Unit.

Dr Hamda concludes: "The new dedicated unit has enabled us to see higher numbers of patients - between 20 and 25 new patients daily and 10-15 returners - and we are already planning to expand. Without a doubt, the critical success factors for a service like ours are strong clinical leadership, a committed team, the ability to identify suitable patients, good communication and support from the diagnostic teams. With these elements in place, we have been able to grow our service rapidly and with full support of the Board and our clinical colleagues."

Integrated Care In Action

Whittington Health is an Integrated Care Organisation (ICO) formed by the joining of Islington and Haringey Community Services with Whittingon Hospital. It delivers acute and community services to around 500,000 people.

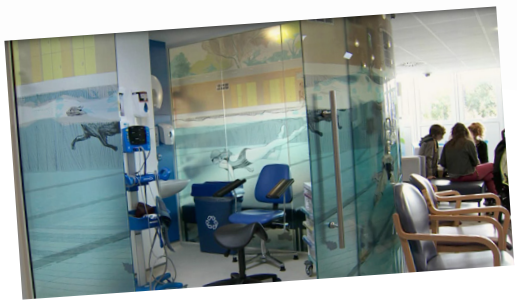
The move towards integration is more than a mere name change however. Clinicians are committed to finding new ways of delivering care that improves the experience of patients and staff and brings acute and community services closer together. In February 2012, as part of this process, Whittington Health opened an Ambulatory Care Unit co-located with the Emergency Department.

Why They Introduced Ambulatory Emergency Care:

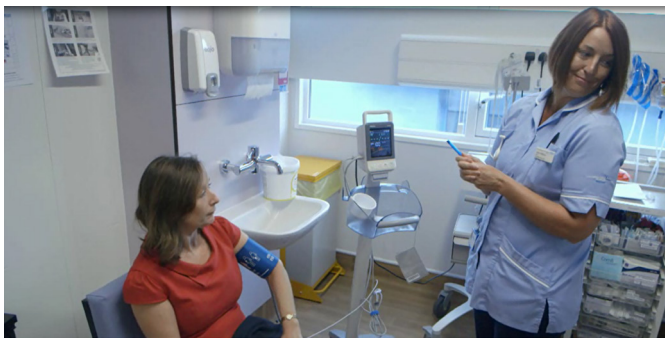
Whittington saw a clinical need for Ambulatory Care. Growing demand for acute services was leading to increased hospital admissions. Many patients were being admitted inappropriately and these admissions could lead to poor patient and staff experience. Whittington regarding Ambulatory Care as a safe alternative that would improve the experience for patients, who could receive the treatment they needed in a fast and flexible way, rather than being admitted into the hospital system. Being an ICO made it easier for Whittington Health to provide a joined-up service for patients, spanning hospital and community services.

What They Did:

Emergency and acute medical teams collaborated to devise the ambulatory care model. The unit was co-located with the Emergency Department so it could pull patients through effectively. It started small with just two rooms in ED. However, the service made such an impact that in March 2014 it moved into its own purpose-built £2.9m unit. The Ambulatory Care Centre space was co-designed with patients and clinicians. It is flexible, tailored to the model of care that the Whittington strives to provide, and addresses practical issues in traditional healthcare provision. It is also ideally located with easy access to the Emergency Department, 'hot seat' imaging and ultrasound provision, as well as the acute assessment units. The hospital has a policy of designing its services to meet the needs of the most vulnerable patients - elderly patients with complex care needs. In this way, it ensure that all of its patients are catered for. One of the priorities when it moved into its purpose-built unit was to create an integrated elderly service co-located with Ambulatory Care. Paediatric Ambulatory Care is also situated on the same site.



About Whittington's Ambulatory Care Unit:



The unit is run by a multidisciplinary team, including clinical leads, consultants in acute and emergency medicine, surgery and geriatrics, community matrons, senior nurses and therapists. GPs have direct access to the Ambulatory Care Consultant of the day via a bleep to discuss patients with the consultant and decide the most appropriate place for the patient to be seen. The

unit provides support for patients who have an acute problem, which, if left untreated, would lead to admission or prolonged length of stay. Once the acute problem is stabilised, the unit transfers the patient's care back to the appropriate clinical team.

Having community matrons as part of the core team is vital to the service as it enables patients to be seen in their own homes as part of the virtual ward; thus providing acute expertise and resources in a comfortable and familiar setting. This ensures that safe care is available to eve the most vulnerable of patients. The virtual ward team also act as a key point of contact across the hospital - for wards and the Emergency Department - in terms of case-finding appropriate patients and liaising with all appropriate care providers involved with a patient. The Enhanced Virtual Ward helps to provide a truly integrated and efficient service for patients. It has enriched links with community and voluntary teams who are crucial to ensuring continuity and joined up care for our patients.

Impact:

Ambulatory Care also helps to cut length of stay because rather than keeping patients on wards who are well enough to go home, but who may be awaiting tests or specialist opinion, these patients are discharged home and brought back to Ambulatory Care to undergo the remainder of the tests or treatment they need. Patients remain under the same clinical team, but they are seen in Ambulatory Care rather than on the ward. Ambulatory patients respond positively to the fact that they receive prompt treatment and do not have to be admitted to hospital but can fit their hospital visits around their day-to-day lives. Over 90%

rate the service as good or very good. It also means they are not exposed to the risk of hospital-aquired infections unnecessarily. GPs have also greeted the new Ambulatory Care approach with enthusiasm. They appreciate being able to arrange appropriate investigations, exclude worrying pathology and optimise patients' time in the hospital.

Critical Success Factors:

Senior clinicians as gatekeepers: While a pathway approach provides an efficient method of care for high volume attendances, such as patients with DVT or PE, Whittington believes patients with more complex care problems tend to get overlooked using a pathway model as they don't fit the pathway profile. It takes the view that anyone can be considered for ambulatory care in the Whittington and employs senior clinicians to be its gatekeepers and decision-makers, ensuring that only people who really are suitable for this method of care are admitted onto the unit.

Support from the top: Ambulatory care is central to Whittington's vision of enhanced recovery healthcare for the 21st Century.

Communication: Having a multi-disciplinary team spanning both hospital and community, seeing patients where is most appropriate for them, has meant that communication is efficient and avoids duplication where possible.

A complement for traditional care: Ambulatory care improves traditional care pathways but does not replace them.

Patient and staff experience: Using patient and staff experience to design the service helped to achieve their goals faster and more effectively.

Flexibility: Whittington has flexibility, both around their staffing model, and the way specialist input is delivered.

To find out more about Ambulatory Care please go to:

www.ambulatoryemergencycare.org.uk
Or email aec@nhselect.org.uk