NHS
Ambulatory Emergency Care Network

Clinical Definition and the Principles of Ambulatory Emergency Care

Definition of Ambulatory Emergency Care (AEC)

For this statement, AEC and Same Day Emergency Care (SDEC) are interchangeable terms.

AEC/SDEC is defined as: *the provision of same day emergency care for patients being considered for emergency admission.*

AEC/SDEC is: *the investigation, care, and treatment of patients on the same day who otherwise would have been admitted to hospital for one night or more.*

Principles of Same Day Emergency Care

1. Senior clinical input is needed at the point of referral to SDEC services to ensure accurate identification of patients and rapid streaming direct to the SDEC unit.
2. Clear inclusion criteria including NEWS2 should be agreed to maximise patient flow and avoid duplication of services. Some high-volume presentations may be pathway based but ownership must be clearly understood and consistently applied within the system.
3. The SDEC service should be located close to the Emergency Department (ED) and assessment units to facilitate collaborative working and simplify the transfer of patient care.
4. Staffing and resources should be organised to provide rapid assessment, diagnosis and treatment on the same day.
5. The time standards in SDEC should match the clinical quality indicators for ED to ensure care is delivered at an appropriate pace to support same day discharge i.e., time to initial assessment – 15 minutes; time to medical assessment – 60 minutes.
6. Patients should be informed early in their journey (ideally in the ED or by the GP) that they are likely to receive treatment that day and are unlikely to be admitted overnight, to manage their expectations and those of their family.
7. Secondary and primary care services should be geared around patient needs and work together to provide ongoing care outside of hospital to avoid a full admission. This could be supported by a virtual ward.
8. Ongoing staff education and training is needed across the local healthcare system to ensure that appropriate patients are streamed to SDEC.
9. A clear clinical plan as part of a comprehensive record must be in place to enable same day discharge, including a discharge summary provided to the patient and sent to primary care within 24 hours.
10. Providers must work with commissioners to agree how SDEC will be recorded, reported and funded and clear measures must be adopted and monitored to access the impact, quality and efficiency of SDEC services

Let's look at each of the principles in more detail….

1. Senior clinical input is needed at the point of referral to SDEC services to ensure accurate identification of patients and rapid streaming direct to the SDEC unit.

Patient identification and selection is a key step to ensure that those patients most likely to benefit can access SDEC services.

Patient selection should be based on:

- Clinical stability that is established through a clinical discussion and physiological measures including NEWS2.
- SDEC being the best place to meet the patient's required clinical needs.
- The staffing and facilities can ensure the patient's privacy and dignity are maintained.

Examples of this principle can be found in the Surgical AEC case study from Antrim Area Hospital, Northern Ireland here.

2. Clear inclusion criteria including NEWS2 should be agreed to maximise patient flow and avoid duplication of services. Some high-volume presentations may be pathway based but ownership must be clearly understood and consistently applied within the system.

It is important to work with all teams across the patient journey to agree clear processes to stream appropriate patients to SDEC.

Where there is an SDEC service, any patient who needs an admission should be considered for care within that service. Teams must regularly review reasons for patients being excluded from the SDEC service and consider changes necessary to give these groups access to same day emergency care.

It is equally important to ensure the 'wrong' patients are not referred to SDEC as this will block capacity and deny access to the service for patients who would most benefit. This will limit patient flow within the hospital. The types of patients who should NOT be managed in an SDEC service are:

- Patients needing the facilities of a discharge lounge.
- Type 2 ED attenders (Minors). These patients should continue to receive their care in ED within the four-hour standard.
- Type 3 ED attenders. These patients should continue to receive their care in the ED within the four-hour standard.
- Clinically unstable patients
- Patients who will breach the four-hour standard but whose clinical care does not require a move to another team.
- Patients overflowing from other services that do not have the capacity to manage their care.
- Patients who are more appropriately managed on outpatient pathways e.g. two week waits

Sending the wrong patients to SDEC will have a negative impact on the system. Robust gatekeeping processes are needed to ensure the right patients are streamed to the service. A simple way of achieving this rigour is to judge all referrals against the question 'Would this patient have been admitted to a bed in the hospital if SDEC didn't exist?'

Examples of this principle can be found in the Surgical AEC vignette from University Hospitals of Wales, Cardiff here and in the AEC Accelerator Programme case study from Royal Devon and Exeter here.

3. The SDEC service should be located close to the Emergency Department (ED) and assessment units to facilitate collaborative working and simplify the transfer of patient care.

Where SDEC services are located close to ED and inpatient assessment units transfer times are reduced and the disruption of sending staff with patients can be minimised. An additional benefit is the ability for teams to have vision across urgent care areas in order that resources and flow can be optimised. Clinical conversations between teams are easier and protective behaviours can be avoided.

Health Building Note (HBN) 15-02 gives guidance on the planning and design of an SDEC department and can be found here.

4. Staffing and resources should be organised to provide rapid assessment, diagnosis and treatment on the same day

SDEC provides the opportunity and benefits of a flexible multi-skilled workforce. Staffing should be organised to reflect the skills needed to respond to the patient acuity, complexity and volume. It is difficult to give a simple answer as to at staff ratio etc. due to the wide variation in current SDEC services and local availability of different staff types. However, analysis of potential activity and case mix will aid in developing the staffing model. There is huge opportunity for advanced non-medical roles within SDEC in order to increase senior decision-maker capacity.

When communicating with stakeholders, it will be vital that there is a shared understanding of SDEC providing an alternative to admission and getting the priority for diagnostic and other response that facilitates this. SDEC activity does not represent "new work" in the system (in fact many organisations see a reduction in diagnostic requesting and onward referral) and so no new capacity should be required. However, how the existing capacity is structured will likely need review.

"A day in the life of a pharmacist advanced clinical practitioner" *The Pharmaceutical Journal February 2020*, can be found here.

5. The time standards in SDEC should match the clinical quality indicators for ED to ensure care is delivered at an appropriate pace to support same day discharge i.e. time to initial assessment – 15 minutes; time to medical assessment – 60 minutes.

SDEC should never be seen as a method of managing ED performance metrics and should be used when it is the best place of care for an individual patient. Ensuring a similar pace and rigour to time standards as ED is helpful in ensuring this is the case. Monitoring and improvement of bottlenecks in the system, and potential conflicts in ED/SDEC/acute

assessment flows, is vital to ensure a cohesive urgent and emergency care (UEC) approach across the organisation and wider system.

6. Patients should be informed early in their journey (ideally in the ED or by the GP) that they are likely to receive treatment that day and are unlikely to be admitted overnight, to manage their expectations and those of their family

Engagement of patients and their significant others as partners in care is vital in achieving same day care. There needs to be a focus on self-care and home monitoring where this is possible, and for patients to feel sufficiently informed and supported to be concordant with this approach. Clear timelines for treatment plans with planned follow up where needed along with safety netting is essential including instruction for help seeking outside of normal operating hours.

7. Secondary and primary care services should be geared around patient needs and work together to provide ongoing care outside of hospital to avoid a full admission. This could be supported by a virtual ward.

A significant proportion of UEC patients are suitable for management without admission provided there is coordination of services across primary and secondary care. There needs to be clear understanding and formalised agreements in place to ensure this is delivered safely and consistently and so that the clinical record is available at all points it may be required.

A virtual ward approach can be particularly helpful in achieving this. Many follow up encounters that are currently delivered face to face in secondary care could be completed by telephone or via a virtual platform and many organisations have invested in such provision and practitioner capabilities during the COVID-19 crisis. This approach will preserve capacity within the SDEC service for those that need face to face admission avoidance contact.

Colleagues from the Whittington have recorded on webinar on their SDEC service and the use of virtual wards which can be accessed here.

Dr Vince Connolly, Professor Dan Lasserson and Professor Simon Conroy have recorded a podcast on virtual wards ““*Creating Virtual Wards on the Shoulders of Giants*” which can be accessed here.

8. Ongoing staff education and training is needed across the local healthcare system to ensure that appropriate patients are streamed to SDEC

Shared understanding across the system of SDEC as a treatment modality is essential for effective utilisation. As new treatment and diagnostic options become available the opportunity to move inpatient care to SDEC and SDEC care to community providers will increase and an ongoing process of review should be in place to maximise this opportunity. Joint learning is invaluable as a part of this process so that different services across the UEC system can identify their interdependencies and work together to improve the patient experience, optimise capacity, operating hours and access.

There is a great opportunity for the team (direct members and wider stakeholders) to learn from both positive and negative outcomes. The team should have a formal meeting to discuss incidents, serious incident, complaints, morbidity and mortality, and also positive feedback and examples of good outcomes.

9. A clear clinical plan as part of a comprehensive record must be in place to enable same day discharge, including a discharge summary provided to the patient and sent to primary care within 24 hours.

Moving admitted care to same day and home-based care safely and in a way which adds value to patients is dependent on communication across the system centred around the patient. Challenges still remain in terms of interoperability of NHS information systems. However, the landscape is much improved within recent years. As a minimum all providers must be able to provide a paper discharge summary on the day of discharge that can be held by the patient in case they need further healthcare contacts prior to receipt of this information by other services.

10. Providers must work with commissioners to agree how SDEC will be recorded, reported and funded and clear measures must be adopted and monitored to access the impact, quality and efficiency of SDEC services

You might need to use a combination of data systems including your patient administration system and emergency department information system to analyse patient flows through the service. It is essential that you can identify your SDEC patients through a designated area code such as a ward code; this code needs to be separate from your assessment unit.

We recommend you create a functional flow map to examine flows similar to the example illustrated in Diagram One.

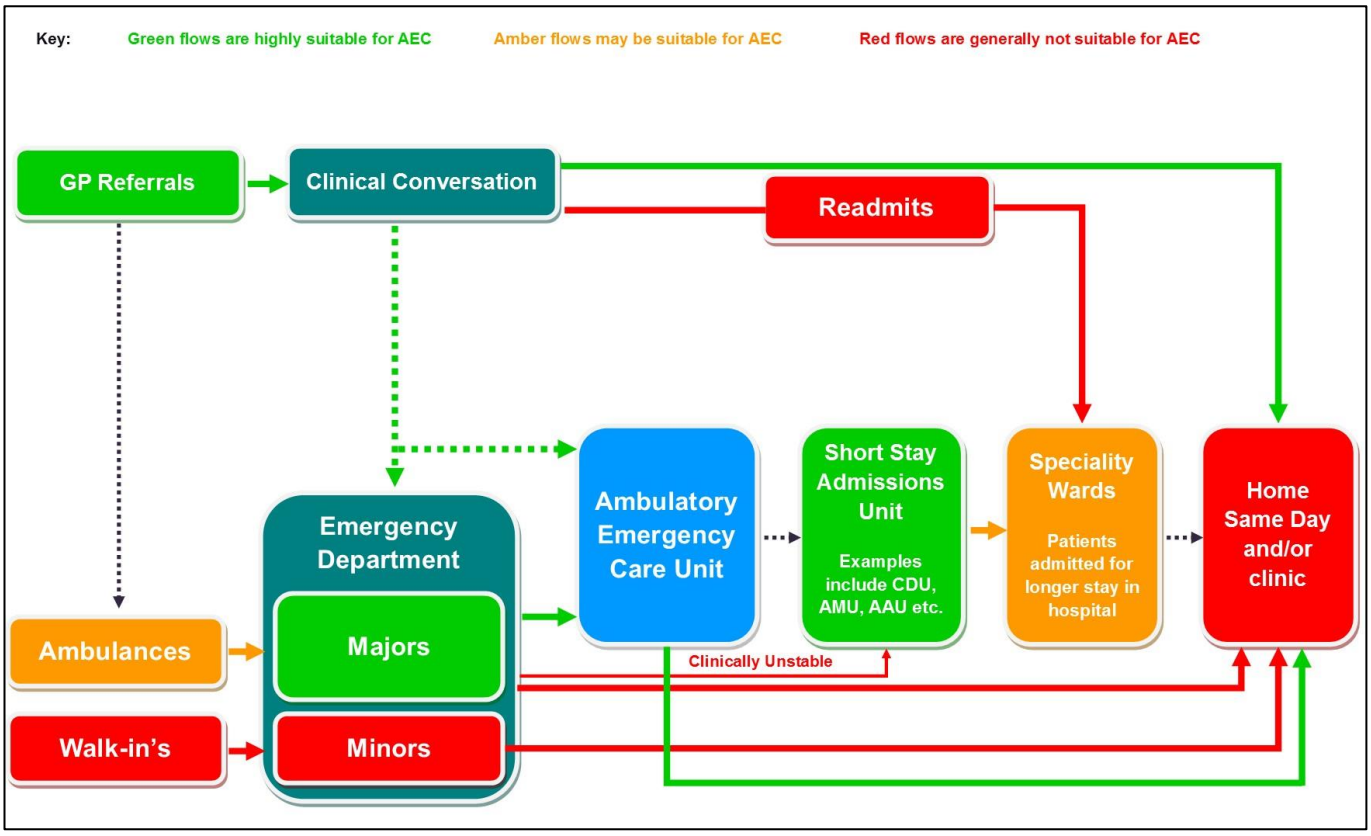

Diagram One: Functional Flow Map

Once you can identify your SDEC patients, the next step is to determine whether they were appropriate for SDEC both in terms of whether they could have been discharged from the ED (with or without a future clinic appointment) or whether they should have bypassed SDEC and been admitted to the assessment unit/specialty ward direct. You may also identify some 'below threshold' patients that should have been managed in primary care. It is important to work with primary care to create a process to divert these patients to the right service.

To determine if the right patients are using the service you can start by reviewing whether the SDEC patient was discharged or transferred. If the patient was transferred, a case file review would help to determine whether it was for clinical reasons or if it was a timing issue.

We recommend you use a 2x2 matrix as a checklist for the case file review to ensure you have the correct data to assess the appropriate/inappropriate balance of activity.

	Managed in AEC	Not managed in AEC
Appropriate for AEC	**Success** (expect around 10-15% conversion)	**Missed opportunity**
Not appropriate for AEC	**Wasted capacity** (Non-urgent case)	**Appropriate** inpatient / outpatient care
	Potential clinical risk (Patient too acute ± too complex)	

Other routes into SDEC may include GP admissions where following a clinical discussion SDEC is decided as the appropriate destination.

Examples of this principle can be found in the AEC Accelerator Programme case study from United Lincolnshire here.

Points to note are:

- SDEC activity must be recorded in an appropriate data set agreed with commissioners.
- To understand the efficiency and effectiveness of the SDEC service, process, outcome and balancing metrics should be monitored regarding length of stay, time to first assessment, transfer and admission or reattendance.
- The key metric to understand the impact of SDEC is the number of non-elective admitted patients with a LOS greater than or equal to one night. When SDEC is operating effectively this number will reduce. If this does not reduce, corrective action is needed to avoid a 'supply side driver' being created. It is important that core SDEC activity is not the same and not conflated with non SDEC work e.g. 'hot clinics', ED diverts and day hospital work.

You can access more information on the development of the SDEC model at

www.ambulatoryemergencycare.org.uk

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