



# Commissioners Guide to Ambulatory Emergency Care (AEC)



# Introduction

This brief paper is intended as a resource for commissioners to help understand the elements of an AEC service that should be commissioned to improve outcomes for patients and reduce reliance on overnight hospital admission in emergency care.

In December 2014, NHS England published planning guidance for CCG's and healthcare staff identifying models of care that will apply in 2018 and the steps needed to achieve the vision. Many of the steps described apply to AEC such as:

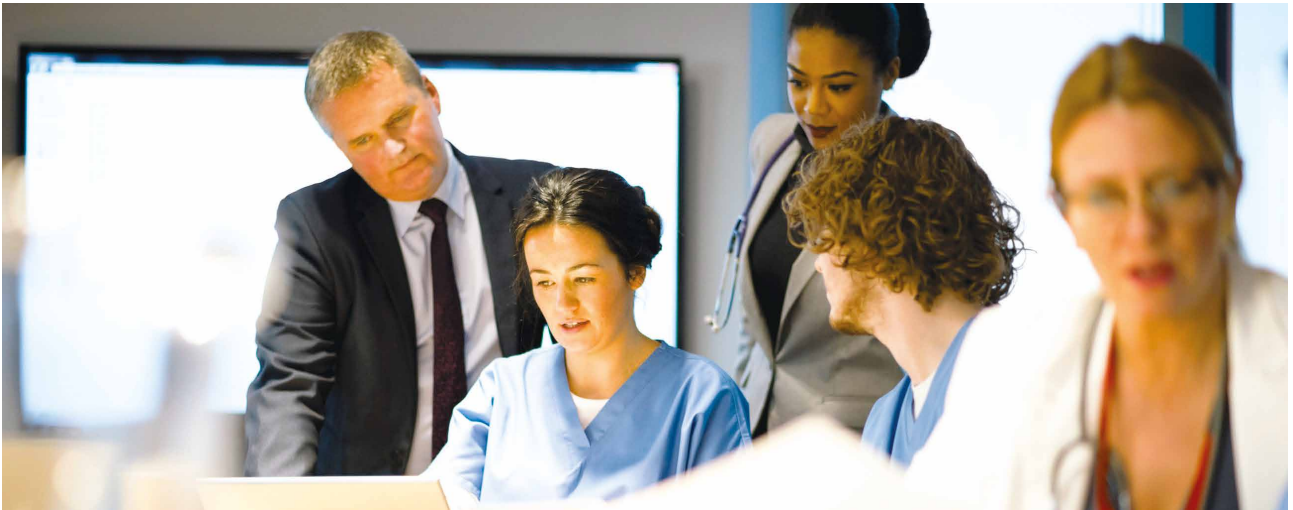
'Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital!'

'Increasing the number of people with mental and physical health conditions having a positive experience of hospital care.'

## **The report shares examples of patient feedback and states:**

'Our patients have consistently told us how important it is that they don't have to wait for treatment. They tell us that waiting can be the most distressing part of their illness. And we know that waiting can make clinical outcomes worse and can even make services unsafe. We also know that our services can only improve outcomes for patients if they are available to them and they receive those services quickly, when they need them, and in a way which is convenient for them and fits with their daily lives.'

We know through sites that measure patient experience, that patients report a very positive experience whilst in AEC and that this model of care has many of the elements needed to meet the ambitions set out in the NHS planning guidance.



## What is Ambulatory Emergency Care (AEC)?

AEC is defined as the provision of same day emergency care for patients being considered for emergency admission, .

This is achieved by reorganising the working patterns of clinicians to be able to provide early decision-making and treatment, and streamlining access to diagnostic services to support rapid decision making. There is also a need for immediate access to support services in the community to provide robust safety net systems and optimise integrated care. This is particularly important for managing frail older people within AEC.

Once the core service is established AEC can be expanded to provide an 'early supported discharge' stream to inpatient wards. Providing early senior review will often allow clinicians to discharge complex patients much earlier as they are reassured their episode will continue within acute care. This activity should be monitored and tariff agreed as needed.

Over recent years AEC has become an accepted and recognised treatment modality and has led to the Royal College of Physicians producing the "Acute care toolkit 10: Ambulatory Emergency Care" (2014) which lists the principles needed within a system to maximise AEC. NHS England recognises the need to make AEC services an integral part of emergency care, and acute hospitals were required through the A&E Improvement Plan to have AEC services in place by November 2016.

## Expected outcomes

AEC is known good practice to improve patient flow, speed up decision-making and access to treatment, improving clinical outcomes.

The impact of AEC on the urgent and emergency care system has been explained by NHS England in the document Safer, faster, better: good practice in delivering urgent and emergency care (2015), where AEC is seen as a key component of a well-resourced system. Included in the recommendations is that:

"Each acute site should consider establishing an AEC facility that is resourced to offer emergency care to patients in a non-bedded setting" (NHS England, 2015). Evidence from this review highlights areas where AEC can impact and makes the case for implementation compelling. These are:

- Preventing crowding in emergency departments improves patient outcomes and experience and reduces inpatient length of stay.
- Getting patients into the right ward first time reduces mortality, harm and length of stay.
- Patients on the urgent and emergency care pathway should be seen by a senior clinical decision maker as soon as possible, whether this is in the setting of primary or secondary care. This improves outcomes and reduces length of stay, hospitalisation rates and cost.
- Frail and vulnerable patients, including those with disabilities and mental health problems of all ages, should be managed assertively but holistically (to cover medical, psychological, social and functional domains) and their care transferred back into the community as soon as they are medically fit, to avoid them losing their ability to self-care.
- Ambulatory emergency care is clinically safe, reduces unnecessary overnight hospital stays and hospital inpatient bed days (NHS England, 2015)

# Processes and structures

## 4 P's

There are different ways of structuring AEC services, which are described in the RCP's document "Acute care toolkit 10: Ambulatory Emergency Care" (2014) and NHS Elect's Directory of Ambulatory Emergency Care (2016). To maximise the impact of AEC a combination of the 'Process' and 'Pull' approach are recommended. Senior clinical decision at the earliest point in the patient journey is key; enabling sicker patients to be safely treated in AEC and actively 'pulling' from ED and primary care into AEC before any decision to admit is made. (See Figure 1)

## Tariff and payment

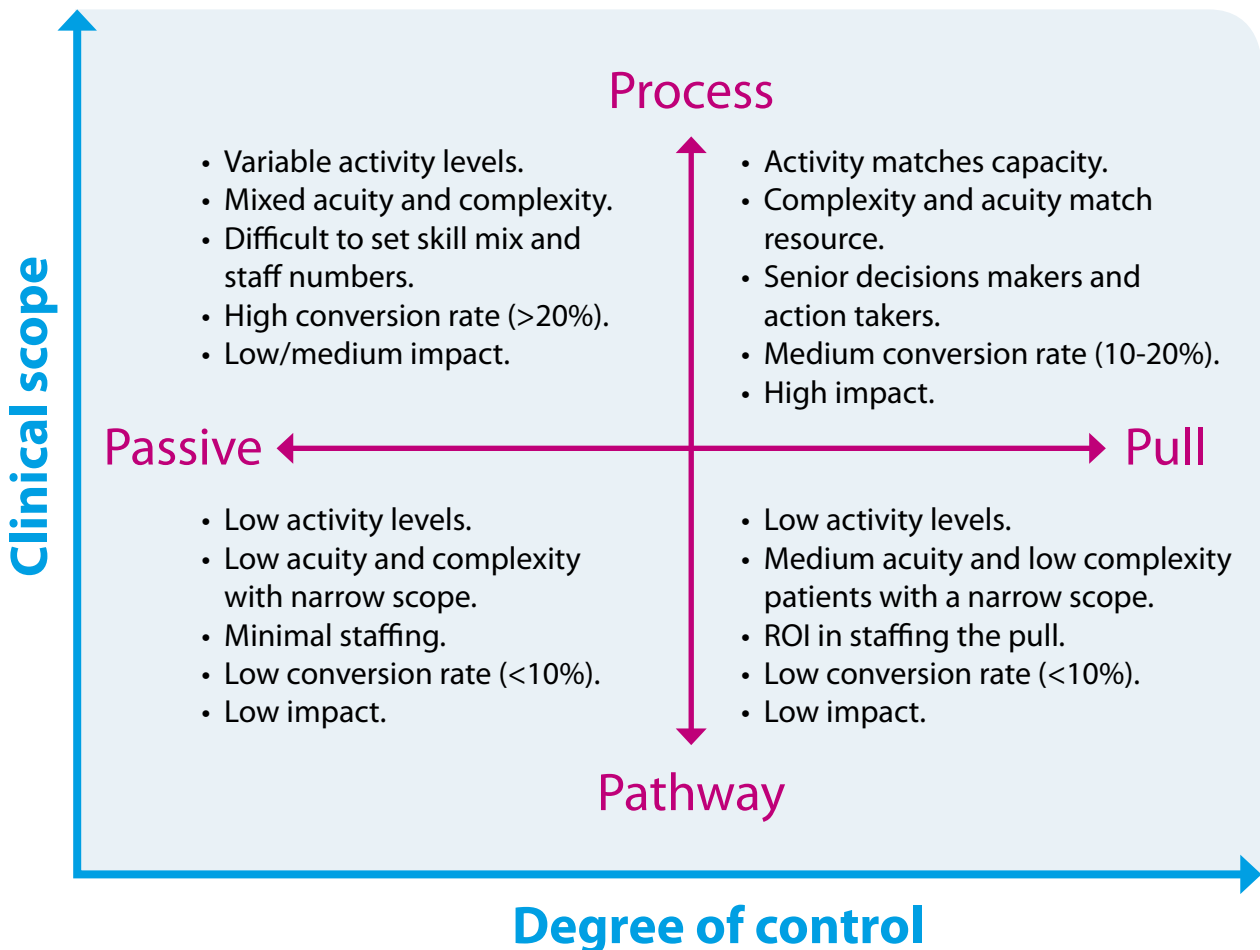
Effective AEC services should provide a 'same day' service, reducing unplanned non-elective admissions.

The philosophy of AEC is that without the service, the patient would be admitted for emergency care. The care package delivered to the patients is not reduced in an AEC

setting, just delivered more rapidly. If the right patients are being managed in the AEC service, the costs of care will be similar to short stay inpatient care. This means patients continue to receive all elements of the care needed, e.g. Consultant assessment, diagnostics, procedures and further review within one day rather than being spread over 1-2 days. One way to describe this is that the care episode remains the same but is "microwaved" into one day as delays are removed from the patient journey.

It is important that commissioners are assured that the right patients receive the right care in the right place. This is illustrated in the 2x2 matrix below (Figure 2). Simply counting the number of patients who receive AEC is not sufficient to demonstrate the service is operating in the way that it was commissioned.

Figure 1



**Figure 2**

	Managed in AEC	Not managed in AEC
Appropriate for AEC	<p><b>Success</b> Expect around 10-15% conversion</p>	<p><b>Missed opportunity</b></p>
Not appropriate for AEC	<p><b>Wasted capacity</b> Non-urgent case</p>	<p><b>Appropriate</b> inpatient / outpatient care</p>
	<p><b>Potential clinical risk</b> Patient too acute ± too complex</p>	

An important component of streaming the right patients to AEC is the ability for GPs and paramedics to send patients directly in to the service through contacting the senior medic on duty and discussing clinical management / appropriate referral. This will avoid A&E and associated tariff costs. This component of the service may need to be included in commissioning plans with performance metrics. To ensure consistency and optimal patient flow for those patients who walk into the local ED/A&E service. ED/A&E needs to follow the exact streaming process/guidance as GPs and Paramedics. Streaming pathways both into and within the trust need to be considered and streamlined.

### Tariff and payment

Across England, health economies use a variety of approaches to establish payment of AEC services. This includes local tariffs, block contracts, and national tariff for non-elective admission. In rare cases the outpatient tariff is used, and in some instances, there is a mixed approach.

### Best practice tariff and national inpatient tariffs

Best practice tariffs have been designed for a number of common AEC clinical scenarios and are designed as a lever to promote the management of these conditions on a same- day basis using an ambulatory emergency care model. There is more information about the same day emergency care best practice tariff in the best practice tariff leaflet available from the AEC website. An underlying assumption for best practice tariff and short stay tariff is that all patients that receive AEC would ordinarily have been admitted. This assumption can and should be actively monitored.

If the assumption that all care (the whole patient journey) would otherwise have been received as an inpatient, any follow-up AEC appointments will be included in the costings for inpatient tariffs. Often AEC follow up can be provided safely within primary care supported by community services. Commissioners need to ensure consideration is given to this area of AEC pathways so that patients don't default to AEC unit follow ups when other alternatives are available and already contracted.



### Local tariff and value of block contracts

If patients would otherwise have been admitted, then local tariff agreement can be set accordingly – based on national inpatient reference costs adjusted to take into account that the patient does not need a bed / overnight stay.

Some local health economies develop bottom up costs and apply locally developed financial models (for example using patient level costing models). Others calculate the cost of running the service and anticipated patient numbers to calculate the local tariff. Others use relevant national reference costs. Some health economies look at all three approaches to inform their approach. These principles can also be used to inform block contracts.

How necessary follow-up appointments are costed can be locally agreed – either included or excluded in the core local AEC tariff.

Local tariffs should be calculated to cover the costs of all elements of the patient journey described above.

Some services use a combination of 'local tariff' and 'best practice' tariff where it applies.

### Outpatient tariff

Generally speaking, outpatient tariffs are too low to cover the costs involved with the complexity of clinical care provided in an AEC service. Acute care, which has short turnaround times compared to regular outpatient care tends to have a higher unit cost associated with faster turnaround times and early senior decision making. The inpatient tariff also includes tests and diagnostics costs that are not routinely costed in an outpatient tariff.

An outpatient tariff will not include costs of necessary follow-up appointments to complete treatment in AEC, so the expectation with this tariff is that each episode of activity will need to receive tariff.

Where there is a stream of 'follow up' activity being managed in the AEC service this can be set up and costed as a clinic.

Historically, health economies have used the marginal rate rules to offset the impact. As patients are counted as "not admitted" then fewer inpatient will receive a marginal rate applied to the tariff income. The national marginal rate is important to understand as changes to emergency patient flows and inpatient coding does influence financial flow.

### Telephone activity

As indicated above, clinical discussions that jointly agree the most appropriate place for care will enable AEC to manage the right patients, at the right time and also avoid unnecessary attendance to A&E. In order to protect and promote this aspect of the service, it may be necessary to include this activity into the commissioning plan as a strong "win-win" for acute and community.



## Commissioners Approach

To ensure commissioned plans for AEC meet the needs of the local population and to help health economies develop a joint approach, the following principles should be applied:

- ensure there is a clear shared purpose for AEC between commissioners and providers
- develop a joint understanding that both providers and commissioners benefit from the right patients receiving care in AEC and this underpins the shared purpose
- ensure both commissioners and providers work together to understand the cost of service provision compared to traditional inpatient care
- reach agreement to measure and discuss the anticipated impact of change in patient flows and how this in turn may influence financial flows
- work together to understand of all costs to develop AEC service
- be conscious of both internal and external pathways into AEC. The ED relationship with the unit/s as well as external clinicians needs to receive the same examination
- using transformational tools and techniques supports the development of AEC services and how they are contracted thereafter 'bottom up'
- explore the use of 'Hybrid' contracts and tariffs. One contract or tariff can't be defined for such a complex service. CCG Vanguard sites to consider possible inclusion within MCPs going forward.

Using and working with these principles will facilitate change and maximise AEC, allowing the focus to remain on the best model of care for patients, that is affordable for the health economy.

## Summary

All these approaches assume patients receiving care in AEC would otherwise be admitted. This is a central philosophy of care. The label "outpatient tariff" may indicate a different philosophy of care. The label "inpatient tariff" may also indicate a different philosophy of care. In the future, it is hoped that there will be a data definition and coding established for AEC. When this is established, it will make commissioning of AEC much clearer but due to the nature of the service being in-between outpatient and inpatient care, transparency and monitoring of how the service is seeing the right patients will be important to establish, regardless of the coding approach.

To find out more about Ambulatory Emergency Care or to ask for help with your service development go to [www.ambulatoryemergencycare.org.uk](http://www.ambulatoryemergencycare.org.uk)



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