



Ambulatory Emergency Care Position Statement

July 2017



Position Statement

This document describes the development of the clinical model of Ambulatory Emergency Care (AEC) and the key principles for successful delivery of AEC services within an acute trust.

1. Clinical definition of AEC

For the purpose of this statement, AEC is defined as *the provision of same day emergency care for patients being considered for emergency admission*. AEC services can also facilitate early supported discharge by offering the option of early clinical review, follow up diagnostics and patient reassurance. However, this should not be the main focus of the service.

2. Background

Uptake of AEC as a clinical model has rapidly accelerated in the last five to ten years, with ambulatory care now a widely recognised and respected treatment modality, delivered in the majority of acute trusts. Initially adopted within Emergency Departments (EDs) and acute medicine, the model is now spreading to surgery and some subspecialties.

The aim of AEC is to convert non-elective bedded care to same day ambulatory care at every opportunity. This will reduce emergency admissions, reduce the need for a short stay admission, whilst improving patient and staff experience. The hypothesis behind AEC is that a significant proportion of adult patients requiring emergency care can be managed safely and appropriately on the same day, either without admission to a hospital bed at all, or with admission for a minimal period not extending into an overnight stay.

Same day emergency care can be successfully achieved by:

- streamlining access to diagnostic services;
- reorganising the working patterns of clinical teams to provide early senior decision making and rapid treatment; and
- collaborative working with support services in the community to provide robust safety net systems and optimise integrated care.
- Providing an environment that supports same day emergency care

NHS England has recognised the importance of AEC within urgent and emergency care, and now requires that AEC is an integral part of local emergency care systems. The A&E Plan (2016) requires acute hospitals to deliver AEC services for 12 hours a day, seven days a week.

3. Delivery of AEC services

Working with over 100 member sites of the AEC Network through ten cohorts, the following principles have been identified as the foundation for successful delivery of AEC services:

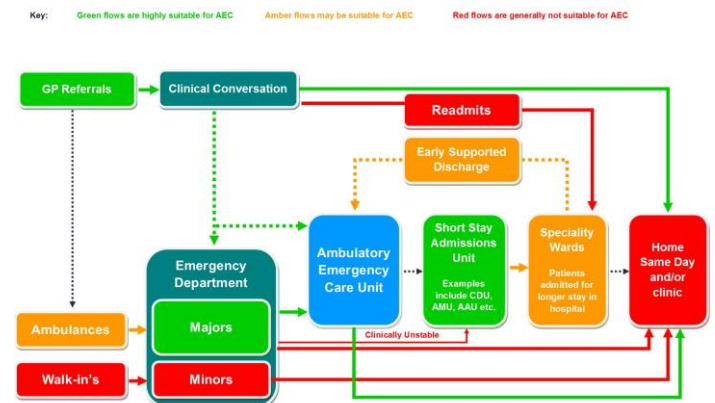
1. Senior clinical input is needed at the point of referral to redirect suitable patients to AEC.
2. Clear exclusion criteria based on the NHS early warning score (NEWS) should be developed to maximise patient flow to AEC.
3. If possible the AEC service should be closely located to ED.
4. Staffing and resources should be organised to provide rapid assessment, diagnosis and treatment on the same day.
5. The time standards in AEC should match the Clinical Quality Indicators for ED i.e. time to initial assessment: 15 minutes, time to medical assessment: 60 minutes and completion within 4 hours.
6. Patients should be informed early in their journey (ideally in 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.
8. Staff training is needed across the local healthcare system to ensure appropriate patients are streamed to AEC.
9. Comprehensive records must be kept. Discharge summaries should be given to each patient as they leave, and sent to primary care within 24 hours
10. Providers must work with commissioners to agree how AEC activity will be recorded, reported and funded
11. Clear measures must be adopted and monitored to record the activity and facilitate the assessment of the impact, quality and efficiency of AEC

It is important to note that AEC models can be embedded within almost any environment. Some systems will have a defined AEC unit, others may have AEC in multiple locations on one site, embedded within other specialties (for example, chest pain clinics or respiratory assessment). Others work well as part of an Emergency Department based Clinical Decision Unit or Acute Medical Assessment Units. The key requirements are to have clarity of pathways and processes.

The preferred model is to have a dedicated AEC unit with a focus on delivering high quality same day emergency care similar to that in a day surgery unit.

In addition, clinical champions have a significant and real impact on improving understanding, building relationships and ensuring the effectiveness of AEC care leading to better patient experience and clinical outcomes.

4. Principles of patient selection



Ensuring the correct cohort of patients are selected for ambulatory care is key to delivering a successful service. Any patient who requires admission should first be considered for care within AEC and any reasons for patients being excluded from an AEC service should be reviewed on a regular basis.

Patient selection is based upon:

- Clinical stability, established by recording a NEWS and a clinical discussion
- AEC being the best place to meet the patient's required clinical needs
- Staffing and facilities are sufficient to ensure the patient's privacy and dignity are maintained

However, ambulatory care is not suitable for all patients who present with emergency care needs. Where the 'wrong' patients are referred to AEC, this can cause blockages in capacity and limit patient flow within the hospital, and to avoid this a robust gatekeeping system is required. Examples of patients that should not be managed in an AEC service are:

- Patients needing the facilities of a discharge lounge
- Type 2 ED attenders (Minors) and Type 3 ED attenders. These patients should continue to receive their care in ED within the 4-hour A&E standard.

- Clinically unstable patients
- Patients who will breach the 4-hour A&E 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.

5. Data analysis of patient flow

Regular data analysis is highly recommended to monitor patient flow and identify whether the appropriate patients are being treated within AEC.

Some trusts use a combination of systems including their patient administration system and ED information systems. Whichever system(s) is used, it is essential that the trust can identify AEC patients through a designated location code similar to a ward code (this code needs to be separate from the assessment unit).

Once AEC patients are identified, the next step is to determine whether they were appropriate for AEC both in terms of whether they could have been discharged from ED (with or without a future clinic appointment) or whether they should have bypassed AEC and been admitted to the assessment unit/speciality ward. This can be done through undertaking a medical notes review.

This medical notes review should look at the referral source of patients attending AEC to establish if they initially came to AEC from ED, GP referral etc. In addition to this you should understand how patients were originally classified (majors or minors patient), whether they were discharged or transferred and the reasons why e.g. due to clinical need, a timing issue (e.g. the AEC unit was closing) or whether the patient should not have been transferred/accepted by

AEC in the first instance i.e. inappropriate for AEC.

Patients can then be classified using a simple 2x2 matrix as to whether they have been appropriately transferred to AEC or not, and to identify missed opportunities where patients may have been suitable for AEC but were not transferred (see figure 2 below).

	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)	

6. Further sources of support and information

- www.ambulatoryemergencycare.org.uk
- NHS Elect (2016) Directory of Ambulatory Emergency Care for Adults; 5th edition
- Royal College of Physicians (October 2014) Acute Care Toolkit 10; Ambulatory Emergency Care

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