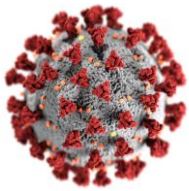
NHS
Ambulatory Emergency Care Network

Ambulatory Emergency Care (AEC)/Same Day Emergency Care (SDEC) considerations in Covid-19 and general surge scenarios.

COVID-19 is likely to be a significant consideration for patients and health care planning for some time to come. The effective application of the principles of AEC/SDEC should help to mitigate the risks to patients and staff allowing for the continuation of excellent acute medical care



The aim of this guide is to compliment the Directory of Ambulatory Emergency Care for Adults and enable AEC/SDEC services to consider the delivery of the service during the pandemic period and other forms of surge.

It is important to note that the epidemiological patterns of COVID-19 are changing rapidly, this may lead to changes in national guidance on the management of NHS services which should be followed.

Principle One: Senior clinical input is needed at the point of referral to redirect suitable patients to ambulatory care

Ideally, AEC/SDEC should be led and delivered by a Consultant and other senior decision-makers. There is evidence that initiatives led by senior clinicians are more likely to succeed and the more senior the clinician the more likely they are to take clinical risk and manage patients effectively on same day pathways.

During COVID-19 and other forms of surge this becomes even more important so that the case mix within AEC/SDEC can be maximised for increased acuity and complexity in a safe and effective manner. This in turn will lead to a greater shift in admission avoidance freeing up inpatient beds to accommodate surge patients, facilitate cohorting for infection control, and expedite appropriate admissions to the bed base from ED.

Frontloaded senior clinical management also allows for a more streamlined journey through AEC/SDEC reducing unnecessary investigations and interventions. Decision making for diagnostics and referrals can be more complex when the risk of Covid-19 needs to be considered. It is also an enabler to offering advice and guidance to referrers that can avert a transfer to the non-elective component of Secondary Care.

Telephone triage by senior decision makers can ensure patients are directed to the most appropriate service for their needs.

Principle Two: Clear exclusion criteria based on the NHS early warning score (NEWS2) should be developed to maximise patient flow to ambulatory care

The system default should be same day emergency care unless the patient is clinically unstable. Processes need to be developed to quickly stream patients through to SDEC for assessment.

Most providers will find that they do not have the estate required to deliver an AEC/SDEC that is cohorted into COVID and Non-COVID streams, so in addition to the usual exclusion considerations there needs to be a clear assessment of infection risk. This may mean that high risk patients who would otherwise have been managed in AEC/SDEC are managed in a RED AMU or RED ED. This does not mean however that they cannot benefit from the same day emergency care.

Care home residents are often frail with multiple co-morbidities and may present with atypical coronavirus features. Those displaying features of infection or sepsis should not attend the AEC/SDEC service. Local knowledge can be invaluable in increasing awareness of care homes with coronavirus infection, residents from such care homes should not attend AEC/SDEC. These patients should be directed for assessment of potential coronavirus infection in the appropriate COVID receiving area. Awareness of the local COVID incidence rate is important in judging the likelihood of COVID-19 for patients with atypical presentations. High incidence rates will be associated with more atypical presentations compared to low incidence rates.

A key part of AEC/SDEC exclusion criteria and the senior clinical conversation at referral is to screen out those patients who are below the clinical threshold for AEC/SDEC i.e. those that are not at risk of admission and who can be appropriately managed in another service. This approach will preserve AEC/SDEC capacity for those patients who will derive the most benefit from an AEC/SDEC modality and give the clinical team the capacity to manage a higher acuity/complexity cohort of patients. Most AEC/SDEC units are physically small for the patient volumes they deal with and so reducing the number of patients in the unit at any given time will also facilitate social distancing.

Alongside the screening out of new referrals there is a need to ensure that follow up and any early supported discharge activity is minimised to only that which is essential and avoids an emergency admission. Wherever possible, referral back to Primary Care or outpatient services should be the preferred route in order to preserve AEC/SDEC capacity for “New” patients who would otherwise have been admitted. For follow up activity that is necessary in AEC/SDEC consideration should be given to providing this via a virtual consultation rather than face to face as this is very time efficient and will allow for reduced traffic through the department that might increase risk of exposure to infection.

Principle Three: Where possible the ambulatory emergency care service should be closely located to ED and acute assessment units

Physical proximity to upstream and downstream services clearly provides efficiency in terms of time taken to transfer but it also aids in communication between teams and the ability to share risk across the organisation.

Providers should already have put in place traffic routes through their estate to avoid patients and staff crowding or passing through unnecessary clinical areas. Transfer between ED/AEC/SDEC/AMU will be high traffic and close proximity makes this task easier and where providers are considering/have needed to move/expand services this should be considered. Signage should reflect the new location of any moved services to avoid patients getting lost and spending longer than required on hospital premises

Some providers have collocated AEC/SDEC with GREEN ED or GREEN AMU. This has been successful during the period of low AEC/SDEC activity that was seen during the early pandemic however with activity level returning to normal for many services now considerations must be given to the sustainability of these models as part of the Recovery and Restoration plan. An inability to support a return to normal AEC/SDEC demand will put additional pressure on inpatient beds and consequent backflow into ED which will hamper the response to any second wave or infection.

Wherever possible the AEC/SDEC environment should not be used as inpatient escalation that would severely limit the physical and staff capacity to deliver admission avoidance. If this is not possible there must be a clear departmental and Trust escalation and service continuity plan that avoids the potential of AEC/SDEC shutting down and consequent effects on admission and ED.

Principle Four: Staffing and resources should be organised to provide rapid assessment, diagnosis and treatment on the same day

Maximising AEC/SDEC in order to minimise unnecessary admissions is key at any time but particularly during any type of surge. For units that have historically functioned with a very lean staffing model and/or have tended to focus on a very low acuity/complexity patient case mix this is likely to mean providing additional resource in terms of number of staff and skills. The temptation to rely on high temporary staff usage should be resisted so that AEC/SEC staff are kept consistent, and familiar with systems, processes and capabilities. This will ensure that there is less unwarranted variation in care and delays in processing.

As volumes of patients increase you may have to review and refine your staffing model. For example, you may introduce more junior staff to undertake basic tasks and act as an assistant working to a plan of care prescribed and overseen by a senior nurse or ACP.

Most providers have had to redeploy staff during the pandemic and consideration needs to be given to the impact of redeploying AEC/SDEC staff and denuding the service of capacity. Staff redeployment should also avoid excessive movement of staff between patients and increased risk of infection spread.

AEC/SDEC is highly diagnostic dependant as a service and where service hours are modified and/or increase this must be accompanied by diagnostics and other support services. If this is not in place queues will build making a same day outcome and social distancing increasing difficult to deliver. Near patient testing has been used successfully in some units for high volume tests.

Many AEC/SDEC units have had success with increasing the amount of work they schedule rather than process ad hoc and this has enabled them to smooth their activity curve throughout the day as well as minimise time in department for patients. There are many referrals, especially those later in the day, that lend themselves to being scheduled to attend at a time where a particular diagnostic or specialist opinion is known to be available. There is also a large proportion of patients who present overnight in ED that can safely receive initial management and then return to AEC/SDEC the next day for definitive care. For these patients a very successful approach has been for their details to be given to the AEC/SDEC team for discussion in a morning huddle, the patient is then contacted by the AEC/SDEC team to close their encounter virtually, schedule face to face assessment, or refer on to another service. This avoids a morning rush of patients that then wait for a protracted period making social distancing and capacity difficult to manage.

A key priority is to keep staff safe by ensuring the availability and use of PPE. Transmission risks from staff movement should be minimised to avoid exposure to Covid-19.

Principle Five: The time standards in AEC/SDEC should match the Clinical Quality Indicators for ED i.e. time to initial assessment: 15 minutes, time to medical assessment; 60 minutes

Ensuring the pace of patient care is essential at all times, but especially in the context of pandemic or surge. This will minimise time in department to assist with social distancing as well as ensuring maximal throughput and admission avoidance.

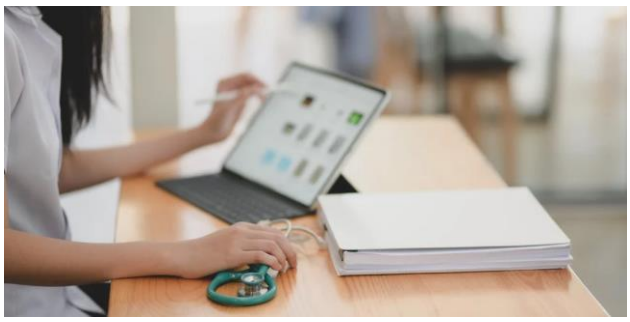
There will necessarily be periods of waiting involved in AEC/SDEC management eg. Diagnostics. Consideration should be given to how this can be managed without the patient occupying a treatment or waiting space wherever possible. For some patients awaiting a diagnostic that is expected to exclude the diagnosis in question it may be appropriate for them to go home and be rung with their result when it is available. Other patients will need to wait on premises for the next stage of their care and these can be managed with a pager system or mobile phone call to allow them to leave the department. For all of these and similar approaches there should be clarity about how risk is managed.

Experience suggests patients want to spend the minimum amount of time on a hospital site if possible.

Principle Six: 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

Nationally, a significant reduction in unscheduled Primary and Secondary care has been seen as patients avoid contact with health services either through fear or altruism. There is concern that for some of these people there will be negative outcomes as a consequence of delaying or missing a genuine health event. Communicating realistic expectations about the AEC/SDEC process may be useful in reducing inappropriate healthcare avoidance. This can be communicated by the senior decision maker who is undertaking telephone triage.

Principle Seven: 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



During the pandemic there have been many examples of Primary Care increasing the threshold for referral to Secondary Care, as well as being much quicker to accept patients back for follow up and review. This risk needs to be shared equitably across the system and reflect the capacity available in each area. As activity levels return to normal all parts of the system need to be mindful of the sustainability of some of the great initiatives that have been put in place and ensure that those yielding high impact are supported to continue.

Principle Eight: Staff training is needed across the local healthcare system to ensure appropriate patients are streamed to ambulatory care

Response to COVID-19 has required a huge amount of change in an unprecedently short period. It is essential that there is up to date knowledge across the system regarding the current systems and processes for accessing AEC/SDEC and the capabilities of each different service that contribute to its delivery. This will need to be updated on a regular basis as things return to a new normal. Telephone triage can help to manage the changes in service provision and delivery as it would not be expected for referrers to be aware of all the changes taking place within a hospital to manage the pandemic.

Principle Nine: Comprehensive records must be kept, and discharge summaries sent to primary care within 24 hours

With a higher acuity/complexity case mix and a push to transfer out of secondary care rapidly the risk of inadequate or inaccurate communication increases. For

Primary Care to successfully support AEC/SDEC it is essential that expectations are clearly set out along with a management plan. Electronic discharges with connected GP practices are ideal for timely communication but the quality of the information contained within these can be variable so AEC/SDEC units should review what is auto populated and what needs manual entry so the clinical team can ensure the GP has all the information they need. Consideration should be given to a patient held record for those who will be having multiple visits or formal continuation of a care plan via the GP, this can be especially helpful for those providers who are reliant on postal services for discharge summaries.

Principle Ten: Providers must work with commissioners to agree how AEC/SDEC activity will be recorded, reported and funded

The latest guidance from NHSE/I regarding recording of AEC/SDEC activity is that it should be recorded in the ECDS system or as a zero length non-elective admission in the non-elective admitted patient data set . Those providers still using outpatient or ward attender methods should have a plan in place for moving to one of the recommended methods. The big advantage of these is that there will be greater vision of case mix in order to guide teams in ensuring they are seeing true admission avoidance patients.

As we enter Recovery and Restoration it is important to take stock of any changes that may have taken place to the business model used to deliver AEC/SDEC locally and understand if any of these changes are temporary or permanent

Principle Eleven: Clear measures must be adopted and monitored to assess the impact, quality and efficiency of AEC/SDEC

With so many changes to services in a short space of time it can be difficult to assess which changes were effective and which were not. As things return to normal it is essential that lessons are learned wherever possible to create resilient systems in the future. Working closely with the business analysts for the service is essential to analyse date to understand when changes were made, what they were and whether AEC/SDEC data was recorded accurately during this period; this will help to draw out these key pieces of learning.

For any further information on the document or the Surgical AEC Network generally, please get in touch via email at aec@nhselect.org.uk