NHS
Ambulatory Emergency Care Network

# United Lincolnshire Hospitals NHS Trust

The United Lincolnshire Hospitals NHS Trust was one of the first tranche of hospitals to join the Accelerator Programme in 2019. This is their story…

# Introduction

In recent years, same day emergency care (SDEC) has been one of the NHS' success stories, helping to ease pressure on overloaded Emergency Departments (EDs) but also to prevent unnecessary admissions. The Ambulatory Emergency Care (AEC) Network has worked with more than 120 healthcare teams across England and Wales, supporting them to establish or expand ambulatory care within their organisations. There have been many excellent results.

However, even when an ambulatory care service begins well, it can plateau. Initial enthusiasm may start to wane, the original mission may lose some of the original pace and impacts can begin to lessen. This is why the AEC Accelerator Programme was established. The AEC Network, which runs the programme, aims to support organisations to re-energise their AEC service. The Network works alongside organisations to help maximise AEC as an alternative to admission, improving patient flow and reducing pressure on hospital beds.

United Lincolnshire Hospitals NHS Trust (ULHT) is one of the biggest acute hospital trusts in England, serving a population of more than 720,000 people. It includes Lincoln County Hospital, Grantham and District Hospital, Pilgrim Hospital Boston and County Hospital Louth.

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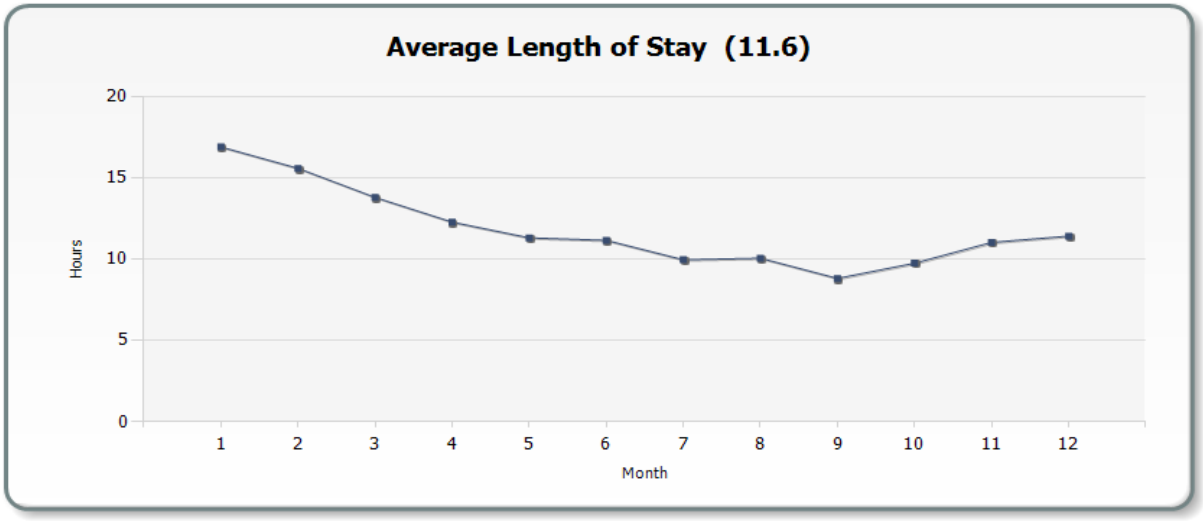
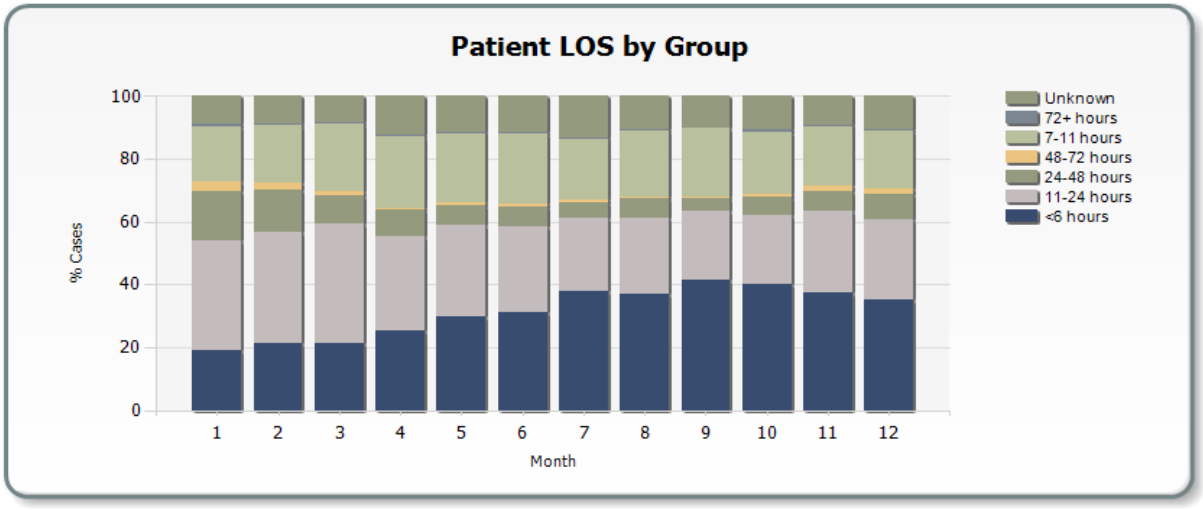
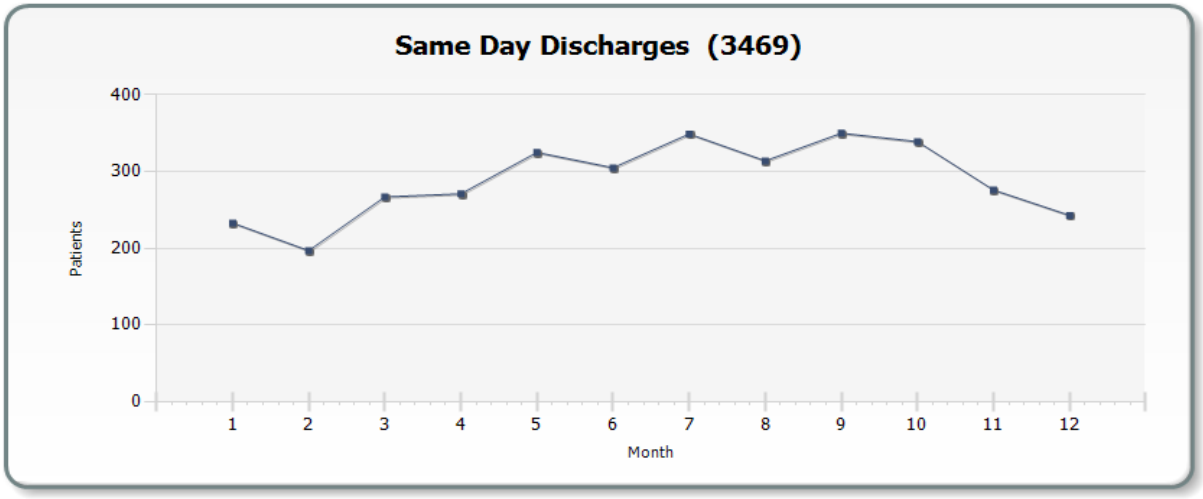
## ULHT's Same Day Emergency Care journey

ULHT began its SDEC journey in April 2019. Its dedicated transformation team established SDEC across three sites - Lincoln, Boston and Grantham – with a slightly different model in each location. ULHT used the AEC model as the basis for its Ambulatory SDEC service.

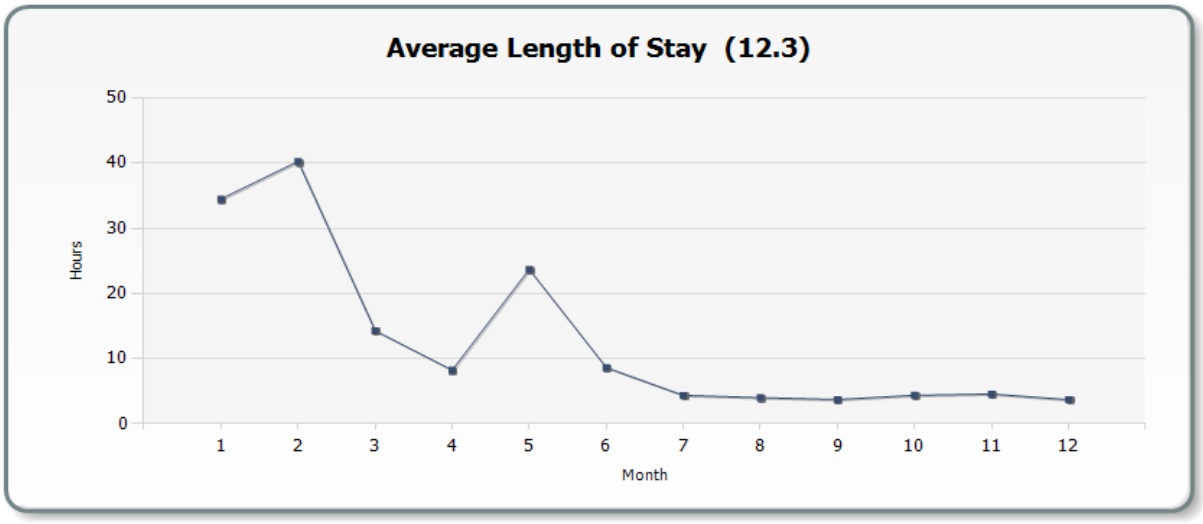
**Pilgrim Hospital Boston:** Boston has a 24-bed integrated assessment Centre (IAC). The IAC combines the Surgical Assessment Unit (SAU), the AEC and acute medical admissions. It is located on the Urgent Care floor, close to ED and serves as the main assessment centre for all patients coming into urgent care. There was a maximum length of stay of 11 hours. This innovative model, combining SAU and AEC, helped to improve patient flow and avoid hospital admissions.

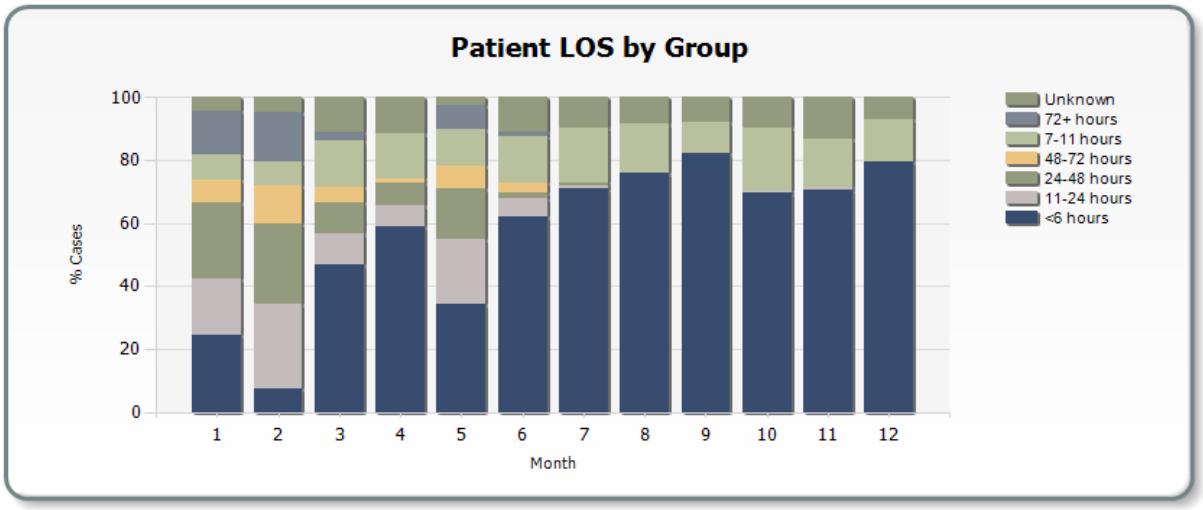


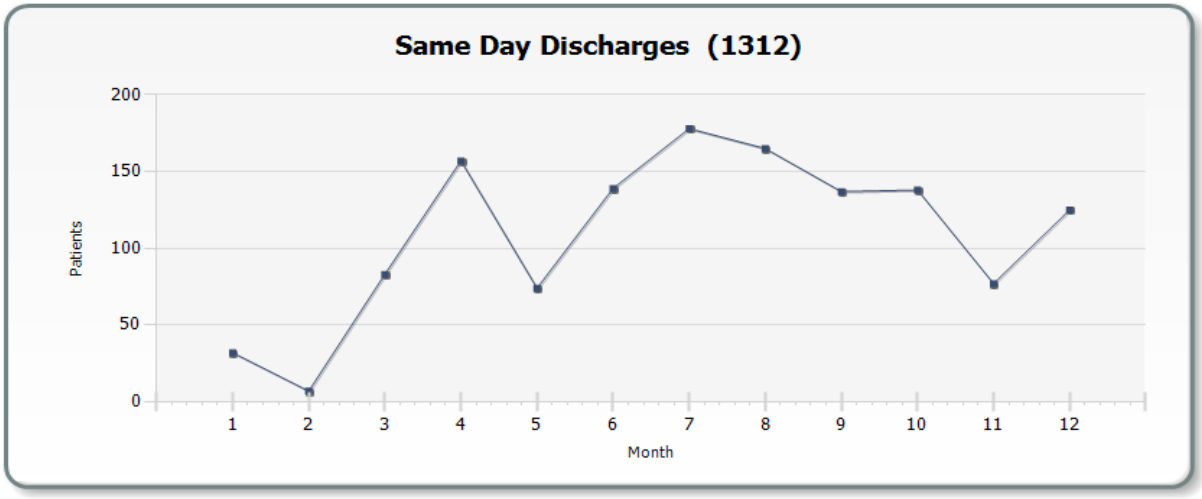





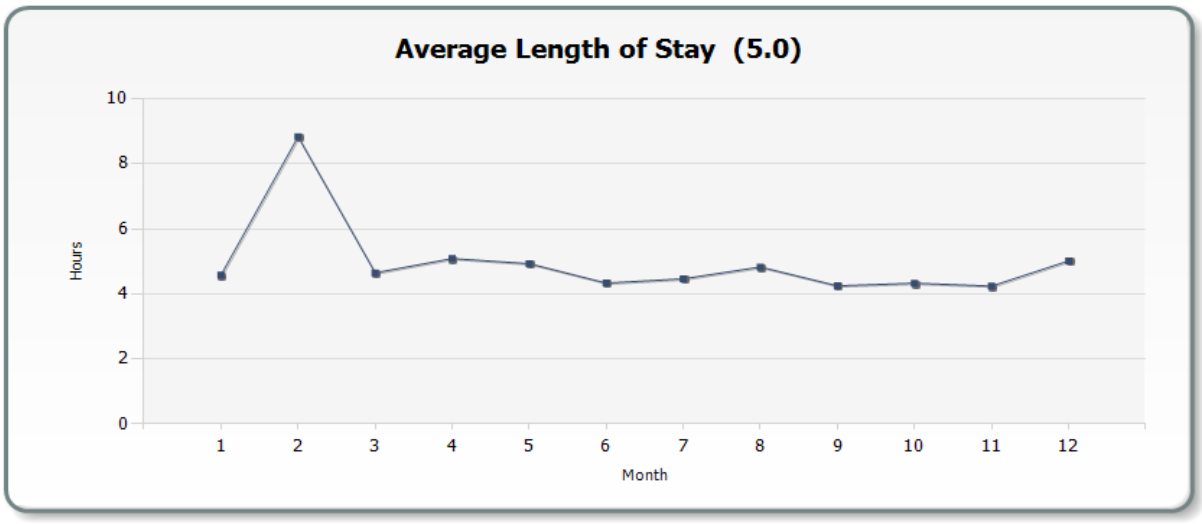

**Lincoln County Hospital:** In Lincoln, there was a well-established SAU with a SDEC service adjacent to ED. SDEC had a length of stay of 24 hours or less.

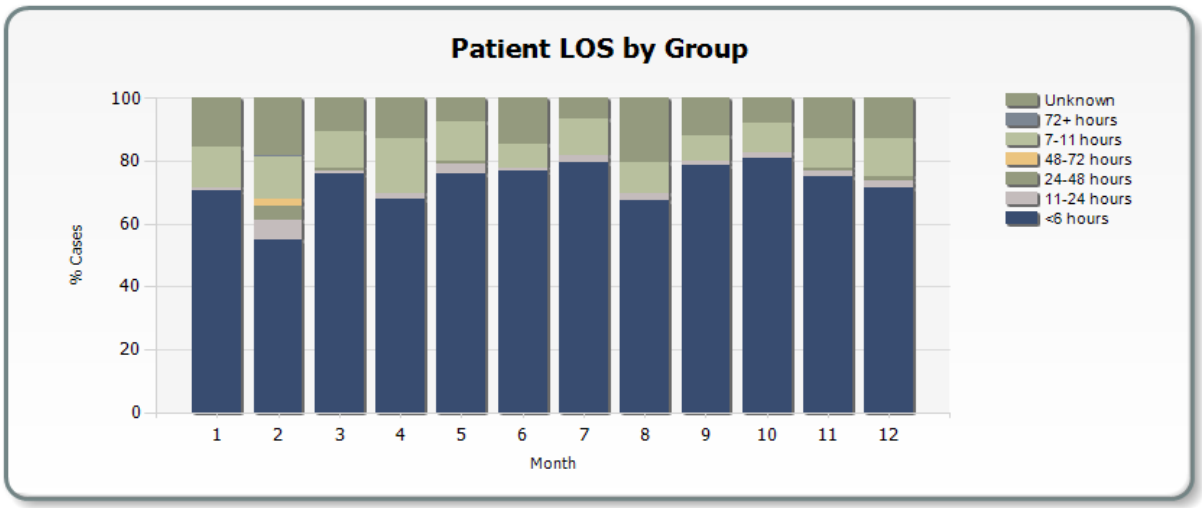


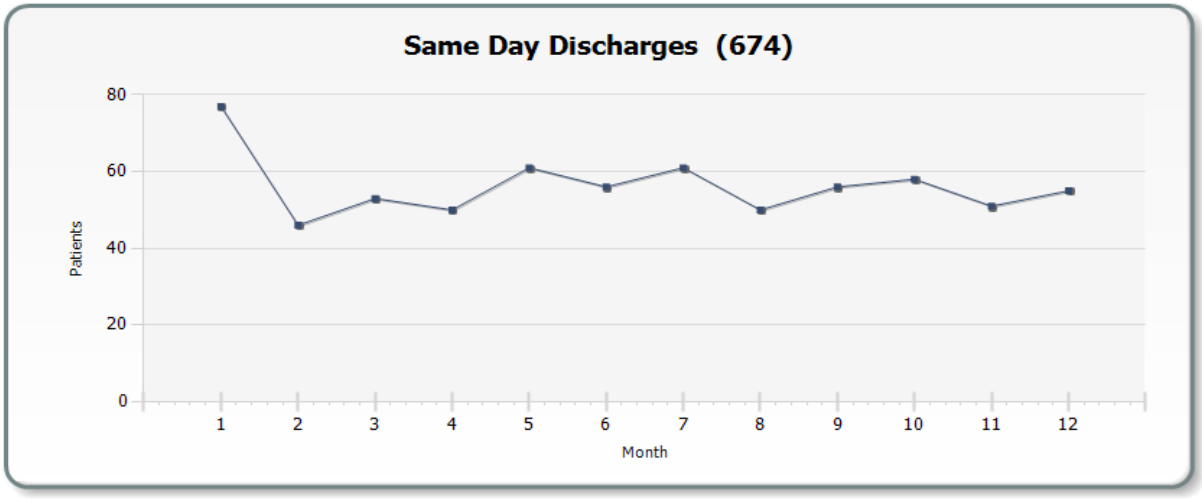






**Grantham and District Hospital:** In Grantham, there was also a SDEC. Grantham was considered to be the most immature of the 3 sites. The Ambulatory Care Unit was situated adjacent to the ED, and it operated 8am to 6.30pm. After 6.30pm, Ambulatory Care was managed through the Emergency Assessment Unit (EAU), which also catered for all emergency medical admissions. Activity through this unit was not recorded separately and the pathways in place were not as robust as those at Lincoln County Hospital or Pilgrim Hospital Boston.






## What was the challenge for ULHT?

Although the Trust had established SDEC and had been building its service for several months before joining the AEC Accelerator Programme, it had run into problems.

Alistair Nelson, Transformation Lead for Reconfiguration SDEC and Frailty (Boston and Lincoln), explained:

"*The main problem was that SDEC was constantly being escalated into across the Trust. In Boston, we quickly realised that the ambulatory care element of the IAC was too small to cope with demand. Although we had all of the pathways in place, once winter pressures set in, the area was quickly escalated into and could no longer operate effectively. There were similar problems in Lincoln. There were also issues with staffing. If we hadn't been invited to join the AEC Accelerator Programme we would have been really struggling to deliver SDEC.*

*As an organisation, we were risk averse and through this programme, we challenged the pathway criteria and access. The webinars were "thought provoking" and in turn, equipped us to use national examples where certain pathways were exploited to the maximum potential. By doing this, we increased the number of patients that could and should access these pathways – not always successfully though. This needs further work during both restore and recovery*."

## Joining the AEC Accelerator Programme

The Trust joined the AEC Accelerator Programme in Autumn 2019. Members of the Accelerator Programme team visited the site and carried out an analysis of around 15,900 patients who were admitted between 1 April and 30 September 2019. The vast majority (93.6%) were not seen in AEC. An average of 39 patients each week - 6.4% of the total - were seen in AEC but this number was highly variable. The analysis identified significant growth potential for AEC, with 44.1% of patients matching a scenario in the AEC Directory. The team made a range of recommendations to help the Trust improve the rapid identification and streaming of patients from ED and to increase the number of patients referred to AEC directly from their GP.

Alistair said:

*"This report from the AEC Accelerator team was invaluable. It gave the team what we needed to make our case for transforming SDEC."*

## What steps did ULHT take?

### Established a project team

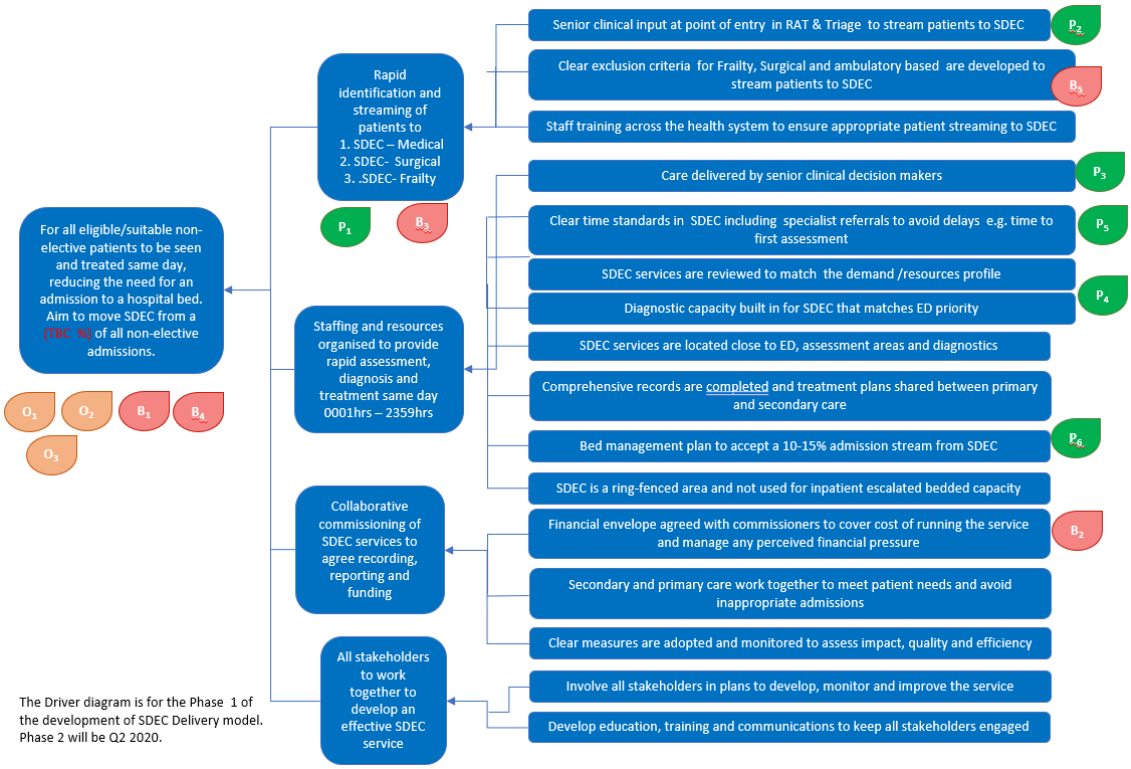
Lincoln established a project team to lead its SDEC transformation work, led by Alistair Nelson. SDEC became part of the Trust's Urgent and Emergency Care (UEC) Improvement Programme, led by Sarah Hall, Programme Manager. Executive Support was provided by Simon Evans, Director of Operations and the Programme Director for the UEC Improvement Programme. The SRO (Senior Responsible Officer) for SDEC was Michelle Harris, Deputy Director of Operations, Urgent Care.

As SDEC transformation Lead, Alistair was supported by Pavlos Zefeiris, Clinical Lead for Acute Medicine, Anne Dobbs, Senior Advanced Clinical Practitioner, Acute Medicine and Michael Bland, Clinical Service Manager. Data collection and analysis was provided by Amardeep Johal, Improvement Programme Data Analyst.

## Created a driver diagram

The team began by creating a driver diagram and setting out the project's overall objectives. Across the Trust, the aim was for all eligible/suitable non-elective patients to be seen and treated same day, with zero-day length of stay. This would reduce the need for admission to a hospital bed. To achieve this, they would need to rapidly identify and stream patients to a SDEC service covering medical, surgical and frailty. SDEC would need to be ring-fenced and not used for inpatient escalated bedded capacity. Staffing and resources would have to be organised to provide rapid same day assessment, diagnosis and treatment.

The driver diagram also specified the importance of commissioner involvement to agree recording, reporting and funding of the new service. The team wanted all stakeholders to get behind the new service, particularly primary and community care who would be required to meet patient needs and avoid inappropriate referrals, attendances and admissions. The majority of aims set out in the driver diagram were achieved during the six-month project.




## Agreed the definition and scope of SDEC

Across the NHS, there is some variation in the definitions of SDEC and AEC. ULHT defined SDEC as "everything with a length of stay of less than 24 hours". Its primary aim was admission avoidance and all types of patients, including medical, surgical and those with frailty, were to be included in the scope of the project. Surgical patients who would previously have been admitted awaiting tests and scans were to be sent home and brought back onto the unit the following day. SDEC staff would in-reach into ED to identify patients who could be treated and discharged on the unit rather than be admitted.

## Established a new dedicated SDEC in Lincoln

The team identified an area in Lincoln County Hospital that could be used to create a new dedicated SDEC unit. By moving the Urgent Treatment Centre to a larger area next door, it was possible to fit the new SDEC in beside it, adjacent to the ED waiting room. Pathways and processes from medical, surgical and frailty were used to manage admission of patients onto the unit.

By December 2019, the new SDEC was fully operational and open seven days a week. Acute medicine was located at the front door and surgery in-reached into ED. It also took GP referrals. The area was staffed by Advanced Clinical Practitioners (ACPs). To avoid escalation, it was designed in such a way that it could not accommodate beds. The unit had begun seeing up to 30 patients a day which was a 35% increase before the start of the COVID-19 pandemic in March 2020.

## Created a larger SDEC in Boston

The IAC in Boston is an innovative model that only four other NHS organisations have adopted. The team was keen to retain its unique mix of medical and surgical SDEC, while tackling the problems that it had encountered. Alistair said:

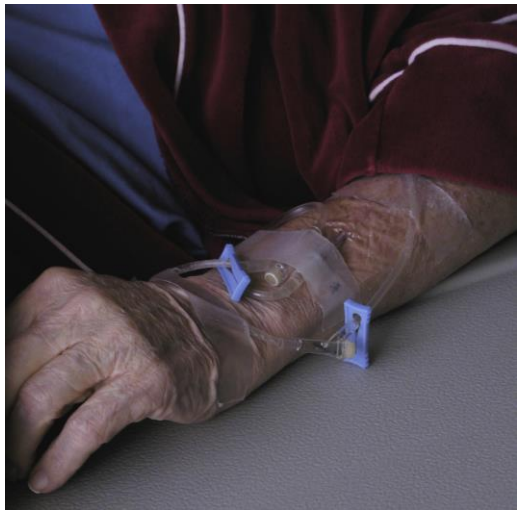
*"There are very few places that combine medical and surgical SDEC in the way that we do in Boston. It means that surgical teams don't have to admit patients, instead they can be brought back onto the unit the following day for any tests they need. In most places, the differences between the cultures of surgical and medical teams makes this type of integration impossible but we pioneered a more forward-thinking approach.*

*However, the ambulatory area could only accommodate eight patients at a time on trolleys. We began work on reconfiguring the area to be able to treat more patients. Following a three-day test of change, we planned the launch of the new larger SDEC but before this could be enacted, we had to implement command and control and entered into the 'manage' phase of our COVID 19 pandemic response.*

*Changes brought about by the pandemic mean the proposed reconfiguration was postponed but will be reconfigured as part of our 'restore' phase, with the medical part of SDEC moving inside ED to become four treatment rooms with a separate entrance. It is just one of a number of changes that are scheduled to take place as a result of COVID-19."*

## Frailty SDEC

The team also wanted to ensure that patients with frailty were not admitted to hospital unnecessarily. After a number of successful pilots, in Autumn 2019 it obtained funding to develop a new seven-day a week Frailty Service in Boston and Lincoln. The service, which was operational by February 2020, is led by a Trust wide Clinical Lead with each site enjoying a dedicated MDT team geriatric consultant, ACPs, OT and Physio AHPs . The team provides an in-reach service in both A & E and assessment wards with LOS <11hrs.



*"The Frailty service is making a sizable impact on our patients experience especially with hospital avoidance and we are now entering a very exciting phase on building on the Frailty SDEC capabilities post COVID-19."*

## GP engagement

GPs can refer patients directly into SDEC in Lincoln, Boston and Grantham. To ensure that patients, particularly those with frailty, were sent to SDEC rather than ED, the Trust carried out an engagement programme with local GPs, visiting all of the regional areas and giving face-to-face presentations to ensure that GPs understood the new system.

# Challenges

Throughout the AEC Accelerator Programme, the team in Lincoln faced a number of challenges, some of which were easier to overcome than others. Escalation was a significant problem for SDEC across the Trust, so the new units were designed so that they could not accommodate beds.

The transient workforce, which relied heavily on locums, made it difficult for staff in ED to recognise the pathways for medical, surgical and frailty SDEC. The team focused on communication across departments, with ACPs attending safety huddles and Emergency Physician in Charge (EPIC) training for consultants, to get the SDEC message across.

By far the greatest challenge came at the end of the project with the arrival of COVID-19. Out of a hospital of 920 beds, nearly 600 of them were empty and staff were redeployed to manage the treatment of COVID-19 patients, including the SDEC ACPs. ED was segregated into COVID-19 and non-COVID-19 patients.

Alistair said:

*"There were times at the height of the pandemic when we minimal patients in ED. Patient numbers have dropped off by at least 60% and all of our work with SDEC ground to a halt. We have seen a small increase in people coming into ED in the past two or three weeks but we're just not seeing the same sort of numbers as we did before. It is likely that services will have to change but the full long-term implications are unclear."*

## Success factors

The team at ULHT identified a number of factors that made the AEC Accelerator Project a success. The greatest of these was cultural change, with work to integrate medical, surgical and frailty, across departments to familiarise staff with SDEC pathways and engagement with GPs. Locating SDECs adjacent to ED and near to the Urgent Treatment Centre also proved significant as it helped to ease pressure on ED, improve ambulance handovers and create a better patient and staff experience. Despite the challenges of recruitment across the NHS, the Trust has found that being ahead of the game on SDEC meant there was less of a problem recruiting ACPs. Having full support from the Executive Team and Board also made a huge difference. But we also had a huge amount of support clinicians too and this supported its success.

Simon Evans, Chief Operating Officer and Programme Director said:

*"I have acknowledged the efforts involved and the success seen on all 3 sites in relation to creating robust pathways and processes to deliver SDEC to level achieved. I also recognise that the stable platforms put in place were disrupted with the advent of COVID 19. We will address this through our restore and recovery phases. We must also consider our plans for Green site working and the impact of this."*

Being part of the AEC Accelerator Programme helped to drive the changes that Lincolnshire wanted to make in SDEC. Alistair said:

*"We found the audit and analysis done by the Accelerator team particularly helpful and also their input into the driver diagram. The workshops were necessary to set the scene but, for us, the most useful part was their specific input into our Trust. Like everything, you get out of the programme what you put in. We got a lot."*

## What's next?

In the post-COVID-19 world, SDEC is likely to change again in Lincolnshire though exactly what the long-term changes will be remain to be seen. Already Boston and Lincoln have a consultant on the front door who acts as the navigator. Boston's dedicated SDEC will become four separate treatment rooms in ED. ED itself has changed, with new doorways and barriers to segregate COVID-19 and non-COVID-19 patients.

Alistair said "The future is going to be interesting and exciting. We will continue having to deal with COVID-19 and non COVID-19 patients and the challenge is how to do this in SDEC. Ambulatory patients are not coming into the Trust in anything like the same numbers but we are starting to pick up on surgical patients again. Patients with frailty have been greatly impacted and throughout the pandemic we have had Frailty ACPs operating in ED to assist with suspect COVID-19 patients. SDEC is the umbrella for a number of services – medical, surgical, frailty – relating to length of stay. We have moved on from AEC to something much broader."

For further information, please get in touch with:

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