



Ambulatory Emergency Care Department

AMBULATORY EMERGENCY CARE

Reviewing a new model of health
provision

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Foreword by our Chief Executive Officer

Healthwatch Hounslow (HWH) are pleased to present an evaluative review of the Ambulatory Emergency Care (AEC) service based at West Middlesex University Hospital (WMUH).

The numbers of accident and emergency attendances and of patients who are subsequently admitted to hospital are rising, putting pressure on emergency departments across the UK.

AEC is an emerging, streamlined way of managing patients presenting to hospital who would traditionally be admitted. Instead, they can be treated in an ambulatory care setting and discharged the same day – offering benefits to patients, carers, support workers and NHS trusts. HWH have engaged with the AEC service, patients and GP practices in Hounslow to ascertain the impact of the service, understand patient experience and understanding and raise awareness of appropriate access to service provision.

The work undertaken within this review will go some way to identify clinical and financial outcomes of the service, prevalence of conditions, prevention rates and if the needs of patients from diverse, hard to reach ethnic minority language groups and those with a need for British Sign Language (BSL) or visual impairments are realised.

To better understand the efficacy of the service, HWH have:

- Interviewed staff working within the AEC unit
- Interviewed 20 GPs practising in the community
- Interviewed 50 AEC patients
- Reviewed admission and discharge data, identifying prevalence rates, financial impact indicators and speed of service.
- Reviewed quarterly monitoring data
- Identified referral routes
- Reviewed information available to the community about the service.

HWH have sought to identify and support continued improvement in accessing and appropriately utilising the AEC service whilst presenting measurable outcomes and quantitative data appropriate to the day to day service delivery.

The service is extremely well thought of, comprising a clearly dedicated staff team who justify consistently positive feedback across patients and healthcare professionals. With better clarification and increased awareness of the service it could be utilised further than it currently is, ensuring more patients, who would traditionally be admitted, can be treated and discharged the same day, thereby reducing the cost of avoidable admissions, enabling more free beds and supporting better care at home.

Healthwatch are the consumer champions for health and social care. Undertaking this review enables the organisation to better understand access issues, representing a particularly diverse

community, to enable and support better access provision and reduce inequalities in health and social care.

Add scan of actual signature

Tim Spilsbury

Chief Executive Officer

Healthwatch Hounslow

October 2015

Acknowledgements

Healthwatch Hounslow wishes to thank staff of the Ambulatory Emergency Care (AEC) unit in West Middlesex University Hospital (WMUH) for encouraging us to take up this project and for their cooperation in helping us complete it. Without their collaboration and assistance, this work would have been impossible to have been undertaken and completed. We must specially thank Richard Ingrey, Service Manager, Division of Medicine, and Dr. Elora Mukherjee, Consultant, Acute Medicine Unit. Besides clarifying the way their unit functions, they also introduced us to AEC staff and sent us background information and reports. They also allowed us to obtain feedback from their patients and from GPs in WMUH's Urgent Care Centre (UCC). Other doctors and nurses in the unit helped by readily answering questions and completing Staff questionnaires. IV Nurse Practitioner, Oliver Lynch, invited me to a practical demonstration of his work with one of his patients for which I am truly grateful.

We are thankful to all those AEC patients / carers who completed our AEC Patient questionnaires. They were most cooperative by willingly agreeing to be part of our Survey. Their responses enabled us to get a good idea of how they perceive AEC services and care.

Outside WMUH, we are beholden to many GPs in various GP Practices in Hounslow for giving their time to respond to our Questionnaire for GPs. I had some opportunities to engage in brief conversations with some of them which gave me a direct insight into the positive side of

AEC services as well as some areas about which some GPs in the community had issues, concerns and even what they looked upon as barriers that needed tackling.

Out of the many GPs who helped, we would like to make special mention of the help and input from Dr. T. Mahmud of the Firstcare Practice, Dr. D.P. Tripathi of the Jersey Practice, Dr. Nasir Hannan of The Practice, Heart of Hounslow, Dr. Annabel Crowe of the Albany Practice and Dr. Patel, Dr. Payal and Dr. Kanani from various practices in the Heart of Hounslow. Among local Practice Managers, Vijay Jambulingam was most helpful in getting GPs to complete questionnaires as well as providing information.

We must also convey our sincere thanks to Dr. Arun Gupta, Consultant Ophthalmologist. Despite his busy schedule, Dr. Gupta volunteered to help and succeeded in persuade some local GPs known to him, to become interested and complete about a dozen AEC questionnaires for our Survey. In this regard, no less was the help given by Mrs Gupta, Sexual Health Practitioner, and Heart of Hounslow.

Within HWH, I am thankful to Tim Spilsbury, HWH CEO, for his insights and to Mystica Burridge, HWH Volunteer Coordinator & Support Officer for all her help and support.

Kusum Pant Joshi
Information & Policy Officer

Healthwatch Hounslow

Project Background

In early September 2015, Healthwatch Hounslow (HWH) began a Survey to review the Ambulatory Emergency Care (or AEC) service, currently based in the West Middlesex University Hospital (WMUH).

Why this Survey?

HWH decided to look at AEC at WMUH partly because we came across a number of positive reports about its services. Shortly after it was set up, WMUH commended its AEC unit in the following words: “In its first four weeks of opening, the AEC service saw 279 patients and avoided 136 patients being unnecessarily admitted meaning they received treatment and were then able to return home safely. Early feedback has been extremely positive”. A few months later in February 2015, they again wrote: *“The Ambulatory Emergency Care service ... in its first four months has made great progress in reducing unnecessary admissions, ensuring only those patients who require an admission actually get admitted, decreasing the amount of readmissions to hospital, providing ‘same day emergency care’ as an alternative to [hospital] admission and improving the patient experience.”*

The AEC’s image in the eyes of external assessors was no less positive. This is evident from observations made by the Care Quality Commission (CQC) in their March 2015 Report. Though the Report had identified some areas in WMUH’s A&E services where they believed the hospital had some room for improvement, they had openly praised WMUH’s AEC unit. Acknowledging its work they wrote: *“... the AEC is effective in reducing the number of inpatients and managing the increasing number of patients who require emergency admission following referral from a range of sources, which include direct referrals from GPs. They had also pointed out that ‘AEC patients were very positive about the care and treatment they received.’ ”*

Notwithstanding AEC’s positive image among users as well as the CQC, England’s well-recognised *“regulator of health and social care”*, we, at HWH, have the responsibility to champion the cause of patients and voice their concerns, we felt it was important for us to form our views about AEC services on the basis of our own independent investigation and data. Moreover, in spite of its positive assessment of WMUH’s AEC services, there were sections in the CQC Report that encouraged us in this direction. For instance, the Report had criticised WMUH’s public information and observed:

- (1) Their information is available only in English and does not reflect the diverse communities living in the borough. In this connection, it might be relevant for us to add that when HWH staff first visited the AEC in early 2015, AEC staff had been unable to give us any information whatsoever, not even in the English language. One of the Receptionists had explained that they had an information leaflet, but unfortunately, they had presently simply run out of copies.
- (2) Patients probably do not know the difference between A&E and AEC services. There was yet another factor that encouraged us to look at the AEC. Since the AEC unit was nearing its first anniversary, it seemed opportune for us to find out from patients and carers what they thought about the services and care offered by the AEC.

We also felt it would be useful to know whether Hounslow's diverse communities were using the AEC service and how their needs were being catered for. A question we had in mind at the outset was could Hounslow's health inequalities be reduced by improving access to AEC in general, and especially for hard to reach and new or emerging communities? With the cost of NHS services a leading national concern, increasing uptake of AEC has the potential to be immensely attractive especially to reduce hospital admissions and minimise inappropriate access.

Simultaneously, we felt it would be beneficial to gather what health professionals providing AEC services had to say about their work, the referral pathways, their achievements, successes and failures, the challenges or pressures they faced and their plans for the future.

Finally, we were keen to know the views of GPs in the community about AEC and its referral pathway, their level of information and familiarity with AEC, how much they were using it, if at all, and their estimation of the services received by their patients from AEC.

Carrying out all the above, we felt, could have multiple benefits. Firstly, an analysis of the information collated by us, would give us a clearer picture of the workings of AEC from the inside. Secondly, its benefits and strengths would become apparent. Thirdly, by spotting and highlighting any possible areas needing attention or change, our Survey seemed to have potential to help us contribute towards formulating recommendations to improve AEC services for patients. Finally, it was apparent to us that our Survey would assist us to gauge whether there was any scope for us to impact on AEC services by facilitating improvement and change within AEC services.



Our Method

To gather data, we planned to make visits to the AEC to talk to key members of AEC staff about their unit and their work. We also decided to engage with 50 AEC patients and/or their carers in WMUH to collate information about their experiences and views about AEC services received by them. We also decided to connect with a cross section of GPs in Hounslow. Besides some GPs working within the hospital, we decided to include community GPs in our Survey.

To implement our plan, we developed three separate Questionnaires – one for AEC patients and/or their carers, one for AEC staff and another for GPs in Hounslow. The questionnaire for AEC staff, aimed to gather their views (both positive and negative) about their experience of service provision. We wanted to gain an idea of their referral sources and referral pathways, the number of patients they handled, the diversity of the chief health conditions they catered for, whether there were any patterns that emerged from their records and if something specific needed to be done about any emerging trends/patterns/issues within the service.

The focus of our questionnaire for GPs was to gauge the extent of their familiarity with and their usage of AEC services and the AEC referral pathways. We wanted them to evaluate AEC and, based on their own experience, point out its strengths as well as its weaknesses and any negative features or barriers. To make sure our work was feasible and achievable within our limited time frame, we planned to contact 20 local GPs.

Our Aims

Based on our findings from AEC staff, GPs and users/carers, we wanted to identify good practices in service delivery and find out if there were any areas for improvement or change.

Besides finding out from providers and users about how the AEC was functioning in Hounslow, we wanted to ascertain whether the AEC unit in WMUH was catering to the needs of the local people in a way that is both safe and easy to access and if the care needs of patients from diverse hard to reach ethnic minority and newly emerging communities were being kept in mind. We were, therefore, keen to look out for any information resources about AEC services produced by the providers, to check if they were being produced in diverse formats so as to cater for diverse patient needs and also whether they were being displayed and disseminated in effective ways.

As regards AEC's public information, we wanted to examine information resources to see if they could be improved so as to increase public understanding, remove barriers, cater for diversity and enable people to gain easier access to AEC services, thereby improving the patient journey and health outcomes and concomitantly to reduce the cost impact of hospitalisation.

Overall, we felt that the findings of our AEC project might highlight service gaps and areas for improvement that could lead to improved service for patients, increase public access to and understanding of AEC services, reduce health inequalities and result in long-term cost cutting initiatives for the NHS.

OUR FINDINGS

BACKGROUND INFORMATION ON AEC

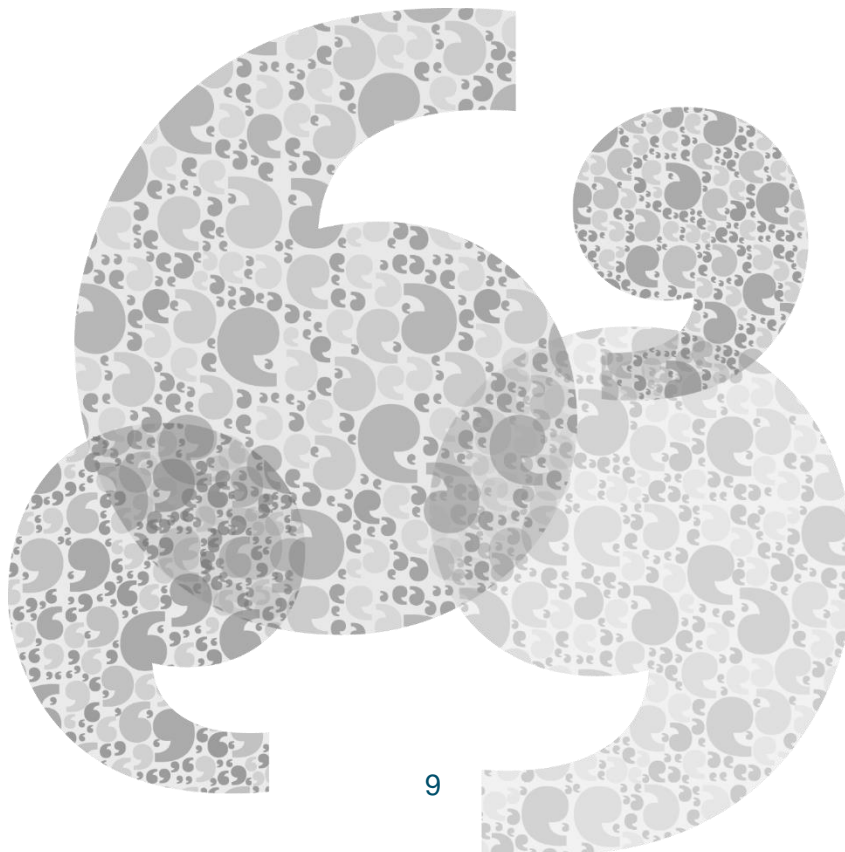
The AEC was an initiative that had begun in some parts of the country in response to the rising pressure of patients on Emergency Departments (ED) and an escalation of hospital admissions in the UK. Started on 6 October 2014 as a new Out of Hospital (OOH) service for patients, the WMUH's AEC was set up to reduce Non Elective (NEL) short-term and NEL admissions to hospitals for adults who were in need of urgent medical attention or care but who did not require hospitalisation. As proclaimed by its founders, the AEC philosophy is: *"No patient should stay in hospital if they can be discharged safely."*



What is Ambulatory Emergency Care (or AEC)?

Patients referred to AEC receive a patient-focused service where certain medical conditions exhibited by patients, are treated without the need for an overnight stay in hospital. They are given the same medical treatment that they would have received as inpatients.

The aim of the service is to provide the care required to treat patients during scheduled ambulatory care opening hours. After diagnosis by a senior clinician and treatment in AEC, patients can return home the same day. In some instances, they might be advised to return to the AEC unit for further treatment or a review or may even be admitted to hospital, if considered necessary.



How do patients find their way into the AEC unit?

Patients are not expected to arrive at the AEC unit without a referral. They are to be referred to the AEC unit by their GP or by other professionals, such as those from Hounslow's Integrated Community Response Service (ICRS)¹. There is a clear referral pathway for GPs (as for others), to refer patients to the AEC.

Process for GP Referral

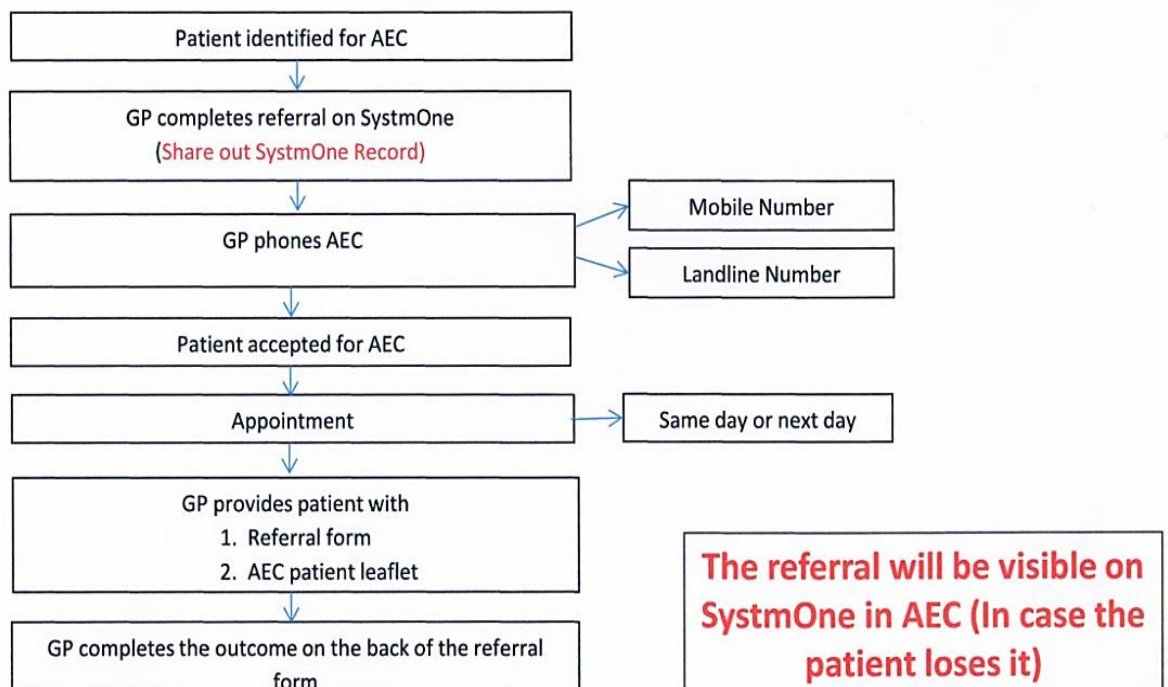


Diagram depicting the GP Referral Pathway to AEC

¹ The Integrated Community Response Service (ICRS) is a multi-disciplinary team made up of a GP, nurses, occupational therapists, physiotherapists, support staff, social workers, primary care mental health nurse and a handyman, who all work together around the patient's needs to avoid unnecessary hospital stays and to speed up the discharge process so patients can go home from hospital as soon as possible.

The AEC's Referral Model

A study of AECs in UK indicates there is a variety of referral models in the country, the main recognised models being the following:

- **Passive Model:** where ED or those in Primary Care refer patients to AEC;
- **Pull Model:** where clinical staff in ED identify and refer patients for AEC;
- **Pathway Model:** where patients are managed according to an agreed clinical pathway which has inclusion criteria. This can become exclusive as it often depends on pre-specified clinical criteria that might exclude many patients, especially those whose diagnosis is uncertain or those affected by more than one disease or disorder (or multiple comorbidities);
- **Process Model:** where AEC is located within emergency care and directly accepts all clinically appropriate patients referred to them.

Staff at WMUH's AEC informed us that their unit opted for a **Process Model** in preference to a Pathway Model. Interestingly, according to an October 2014 report by the Royal College of Physicians, the Process Model seems *"to have made the biggest improvement"*. Expanding on their selecting the Pathway Model, a senior member of WMUH's AEC staff explained that *"on advice from the NHS Elect Ambulatory Emergency Care Network, developing a 'pathway model' based on the 49 conditions excluded too many potentially 'ambulatable' patients. Therefore, as is now the more widely accepted model, we developed a process based model. This includes a wider catchment of patients."*

On what basis are patients selected for WMUH's AEC unit?

To identify potential ambulatory care patients from the general medical emergency in-take without a full clinical assessment and investigation, WMUH's AEC, like other AECs, has some clear criteria for selecting patients on the basis of what is known as an **AMB or Ambulatory Score**.

The AMB Score was developed through research by Dr Ala at the Royal Glamorgan Hospital in rural Llantrisant, South Wales. In a publication of the Ambulatory Emergency Care Network, the AMB score is described as *"a simple seven element scoring system that helps to identify which emergency referrals are potentially, suitable for ambulatory care. The MEWS (the Modified Early Warning Score) is used in conjunction with this to identify acutely ill patients at risk of immediate deterioration and other scores predict mortality. Prior to using the AMB score ... there was limited data to help ... identify which patients might be suitable for ambulatory care. The AMB system identifies a number of factors that suggest that the patient can be safely discharged the same-day, therefore making them suitable for ambulatory care"*.

The determining factors include: age, access to transportation (either own or public transport), whether family support or carers are available, whether the patient is acutely confused or whether IV treatment is anticipated, normality of temperature, oxygen saturation, systolic blood pressure, the MEWS score and whether they have been recently discharged from hospital. A patient can obtain a maximum AMB score of 7, and any patient who scores according to the agreed AMB score criteria, qualifies for referral to AEC.² *(Please see WMUH's AEC Referral Form.)*

AEC services are overseen on a daily basis by an advanced clinical practitioner. The present clinical lead is Consultant in Acute Medicine, Dr Elora Mukherjee and the Lead Nurse is Juan Xu. The AEC is staffed by a multi-disciplinary team (MDT) which is reported to have commenced with a dedicated team of 22 members. Drawn from a variety of backgrounds and specialisms, it includes medical consultants, registrars, junior clinical fellows, nurses, administrative staff and a pharmacist. AEC also enlists specialists from other parts of WMUH as and when required. For instance, for IV injections, the AEC has been accessing the Vascular Access Services on an ongoing basis right from the time of its inception in October 2014. It also uses locum and agency staff.

Talking to the IV Line Practitioner, Oliver Lynch, clarified to what extent his intervention and presence in the AEC has impacted favourably on controlling infection, reducing hospital admissions/re-admissions and improving patient experience.

² The *Amb* score is a simple test that is sensitive in predicting discharge within 12 hours of hospital assessment, and thus might select out potential AEC patients from the unselected general medical emergency in-take before full assessment and further investigations are undertaken. The score was initially derived from a small study from one hospital in a semi-rural setting.



The main features of AEC services in WMUH

WMUH's AEC unit is open every working day from 8am to 8pm. On weekends its services are available for a shorter duration between 11am and 2pm only.

According to the Chelsea and Westminster Hospital NHS Foundation Trust's new website, their AEC service offers high quality same-day care. It aims to ensure that no patient stays in hospital overnight, if they are able to go home safely the same day. It does so by assessing, diagnosing, treating and providing ongoing clinical care to those referred to them as outpatients. Members of the AEC staff make sure that any care needed by their AEC patients is begun quickly with easy and swift access to specialist clinicians and a range of diagnostic tests and treatments.

Staff in the AEC clearly showed outstanding ability to develop good rapport with patients referred to them. While we were there, we could see for ourselves from their behaviour that they had excellent people's skills and their fine combination of professionalism mixed with humanity and compassion had a generally calming and reassuring effect on patients.

As explained to us by AEC staff, prior to being seen by a doctor in the AEC unit, patients who arrive there undergo routine comprehensive tests performed on them by trained nurses. These include:

- Blood pressure (BP)
- Heart rate

- Temperature
- Heart tracing
- Finger prick test for blood sugar
- Urine sample
- Blood sample.

In some cases, patients are taken for other specific tests in the hospital, such as for:

- X-rays,
- CT scan ³ or
- Ultrasound. ⁴

As explained by AEC staff, after diagnosis, patients were offered medical treatments such as being administered intravenous (IV)⁵ antibiotics or other medication. We found that at times, medication for patients, such as antibiotics for IV administration ordered from the hospital pharmacy, necessitated a bit of a wait for AEC patients.⁶ We saw the IV treatment being carried out in the unit either by trained nurses or a specialist IV nurse, when required.

³ A CT or CAT, the full form being "computerized axial tomography", is a scan where the patient lies on a table that slides into a scanning machine. An x-ray beam rotates around the patient's body while detectors measure how much of the x-rays pass through the tissues and organs, indicating density.

⁴ An ultrasound scan, also referred to as a sonogram, diagnostic sonography and ultrasonography, makes use of high frequency sound waves to create an image of a part of the inside of the body, such as the stomach, liver, heart, tendons, muscles, joints or the blood vessels.

⁵ Intravenous (IV) literally means into a vein. IV medications are solutions administered directly into the venous circulation of the body via a syringe or intravenous catheter (tube).

⁶ An AEC patient who had to wait for a while for the IV medication to arrive from the pharmacy, was curious and a bit unhappy about why it was not dispensed more speedily considering that the pharmacy was not only located inside the WMUH, but was also just a stone's throw from the AEC unit. When we asked a pharmacist in WMUH to justify the time lapse, we were informed that it took them time to deliver the medication because, for ensuring patient safety, they had to carry out some essential checks before they could dispense medicines on prescriptions. (*For more on this, please see poster titled: Journey of a Prescription, given above.*)



Journey of a Prescription, WMUH

The speed of services provided

The AEC's test, checks, imaging and pathological examinations for patients are carried out within the AEC's working hours and within the hospital's premises. According to WMUH's document, **GP Matters** of February 2015: *"One of the key factors in delivering successful AEC services is early decision making, enabled by rapid access to diagnostics. This has very much been evidenced since the launch of the AEC:*

- **Pathology** – the AEC has 80% of all pathology requests carried out and reported within 1 hour and 93% within 2 hours.
- **Imaging** – 69% of CT scans reported on within 4 hours of the request being made and 50% of tests carried out within one hour of the request being made.
- **Non-obstetric ultrasound** – 96% reported within 2 hours of the test being carried out."

As evident from patient responses to our survey, AEC staff appear to have succeeded in improving the patient experience and clinical outcomes by providing better out of hospital care through specialists and trained staff with greater speed under the same roof (i.e. within WMUH) without patients having to go to different places, and by enabling a very high percentage of patients to return home safely the very same day.

The most common health conditions treated in AEC

As reported by AEC staff who participated in our survey, high-volume clinical scenarios such as deep vein thrombosis (DVT) or blood clot in a deep vein, cellulitis (a serious infection in the deeper layers of the dermis or skin), pyelonephritis (inflammation of the kidneys), chest pain, pulmonary embolism (PE) or a blood clot in the lungs were the most common health conditions they had been dealing with in the unit.

Serial number	HEALTH CONDITION DIAGNOSED	Volume/Frequency
1.	Soft tissue disorders	158
2.	Cellulitis	53
3.	Headache	31
4.	Pain in the limb	30
5.	Anaemia and iron deficiency anaemia	18
6.	Chest pain unspecified	15
7.	Abnormal findings of blood chemistry	13
8.	Phlebitis and Thrombophlebitis	12
9.	Ascites	11
10.	Pleural effusion	10

Chart showing the Top10 AEC diagnoses by volume (as per coding)
(Data for a period of three months)

This is generally corroborated by a report from WMUH titled *Spotlight on West Middlesex Hospital AEC* which has a list of top 10 conditions presented by AEC patients during a three-month long period in order of their volume or frequency. *(Please see Chart above).*

How long do patients generally spend in AEC?

The AEC aims to reduce patient waiting times and is expected to maintain a time standard to reduce risk for patients and improve patient experience. Though some clinical conditions are expected to take more than 4 hours to complete, the AEC is expected to monitor and audit its performance so that an earlier turnaround and completion time is achieved. Patients' emergency same day care must conclude before the closing of the AEC unit every day and the AEC had been able to do so.

Most frequent sources of referrals to the AEC

During our Survey, AEC staff listed the main sources of referral to their AEC unit to be the following:

- GPs
- A&E
- Urgent Care Centre (UCC) and
- Various sections from within the Hospital, (such as hospital wards or the Out Patients Department (OPD)).

It is evident from a report on the AEC unit for the month of April 2015⁷ that out of a total of 281 referrals for the month, the highest number of referrals was from GPs, closely followed by those from A&E, hospitals wards, the UCC and the OPD with the smallest number coming from a category labelled "Other". For actual numbers and percentages, please see the table below:

⁷ Our information is primarily derived from: *Ambulatory Emergency Care Unit, April 2015 Service Report*, WMUH.

Sources of referrals for the month	Actual number of referrals	% of total Referrals
GPs	65	23
A&E	63	22
Ward	50	18
UCC	48	17
OPD	47	17
Other	8	3



Some features regarding GP referrals to AEC

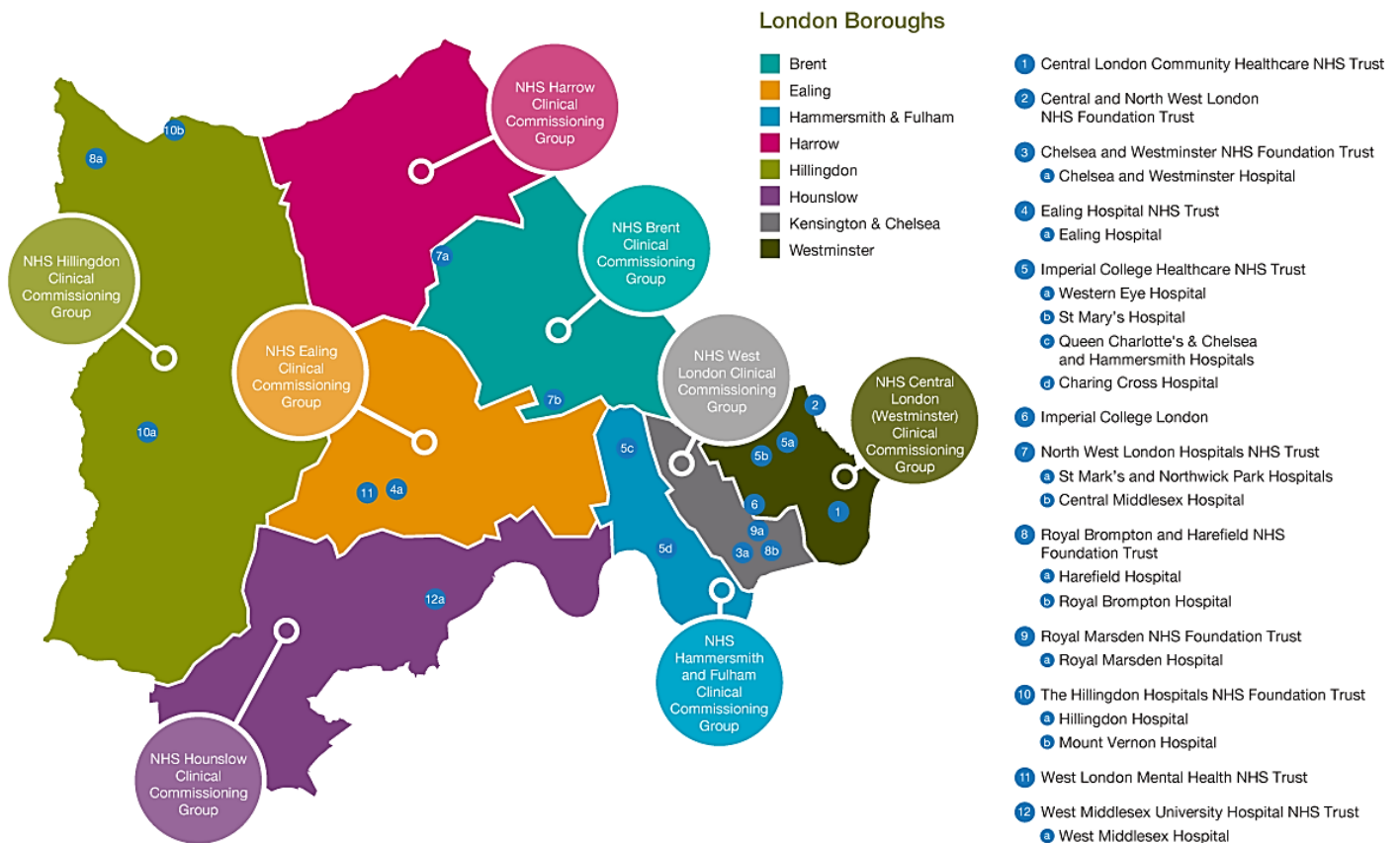
From the report it is also evident that referral from GPs has been showing an upward trend which the report attributes to the growth of “awareness of the service”.⁸ Between October 2014 and April 2015, GP referrals climbed from 45 to 65 the peak being 72 in March 2015. During this 7-month long duration, GP referrals totalled 340 which means that the average of GP referrals per month was 49.

Analysis of referral by GP locality and Clinical Commissioning Group (CCG) area for the month of April 2015 shows that an overwhelming majority of GP referrals was from the NHS Hounslow CCG (73%), followed by NHS Richmond CCG (14%), NHS Ealing CCG (7%) and the remaining 5 North West London CCGs accountable for between a mere 1.4% to 0% of the total of referrals from GPs.⁹



Map of North West London

⁸ *Ibid.*, page 5.



Partnership: North West London NHS CCGs

Some features regarding GP Locality and CCG area

Within Hounslow CCG, the largest number of referrals for April 2015 was from the locality of Brentford & Isleworth (27%), followed by Heart of Hounslow/Maswell (25%), Feltham (24%), Great West Road (18%) with Chiswick (4%) with the lowest number of referrals. Demography¹⁰ might offer a partial explanation for some of these variations though a deeper analysis will need to be carried out to gain a fuller understanding of this phenomenon.

Some features regarding referrals from OPD and Wards to AEC

Similar to GP referrals to the AEC, the report reveals that referrals from the OPD has increased over time, from a total of 31 in October 2014, to 47 in April 2015 with a peak in March 2015 when it had risen to 59. During this 7-month long period, OPD referrals totalled 280 which means that the average of OPD referrals per month was 40. Similarly, referral from Wards is mentioned in the report as having increased and more than doubled from 16 in October 2014 to 50 in April 2015.

¹⁰ A local GP who took part in our Survey saw a correlation between a GP Practice's client profile and its referral rate and said: "... when we look at increasing AEC uptake, we should look to work with practices whereby there are higher admissions for AEC sensitive conditions."

During a 7-month long period, Ward referrals totalled 208 which means that the average of Ward referrals per month was 30.¹¹

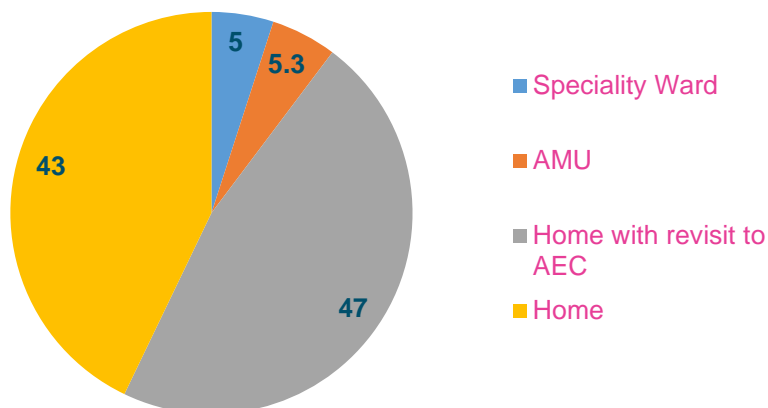
Some features regarding A&E and UCC referrals to AEC

Unlike GP, OPD and ward referrals, statistics for A&E and UCC referrals to the AEC is reported to have fallen slightly in the period between October 2014 and April 2015 from 113 to 111. Interestingly, peak months for referrals from A&E and UCC were December 2014 and January 2015, which seems understandable as they coincide with the cold winter months when UK hospitals were faced with unprecedented levels of demand from patients. **Irrespective of variations in referral rates from A&E and UCC, it is clear that AEC services have** resulted in reducing the pressure on A&E as well as UCC.

Discharge Destinations from AEC

According to an analysis presented in WMUH's report for the month of April 2015 titled *Spotlight on West Middlesex Hospital AEC*, the destination of patients discharged from AEC were as

Analysis of Discharge Destinations from AEC, WMUH



displayed in the pie chart. The percentage of those discharged to go 'Home' and those discharged to go 'Home with revisit to AEC' adds up to a highly impressive total of 90%. It also clearly indicates that by providing prompt and safe Out of Hospital care to patients needing emergency care and diagnosis, the AEC has been admirably successful in helping to keep more hospital beds free for those for whom hospitalisation cannot be avoided.

¹¹ The report does analyse the referral trends they present, but has mentioned that referral from outpatients, wards and the 'Other' category is under review.

AEC Financial Impact

Information about the AEC shows that by generally succeeding in preventing the need of admitting patients into hospitals, it has been instrumental in making substantial savings for the Trust. During the first 3 months after being established, *“New referrals from Primary Care, the Urgent Care Centre and A&E department alone are said to have resulted in 7.4 avoided admissions each operational day.”* According to WMUH’s *Spotlight on West Middlesex Hospital AEC: “The financial impact on the Trust in the first 6 months of AEC is estimated to be a net gain of £200,000 during the initial block contract.”* It also recorded the AEC’s Bed Savings to the hospital as 5.3 per annum, saving more than £500,000 thereby exceeding even the planned savings which had been set for a lower figure of £400,000. According to a June 2015 *NW London A&E Update*, the AEC has an average of 240 referrals per month with an estimated 8 hospital admissions avoided per day.



OUR FINDINGS

FROM AEC STAFF: Positive Outcomes

We received extremely positive feedback about AEC services from every AEC staff member who took part in our survey. This was evident from their responses to our questionnaire as well as whenever we engaged in conversations with them about their services.

Their comments reflected their positive estimation of the following characteristics of service provision to patients:

- Senior decision makers are available on site;
- The AEC unit constitutes a very good and cohesive MDT for patients;
- Their team is “a happy unit that works effectively and delivers high quality care”;
- They provide better services for patients;
- Patients get a service that is provided on a 1:1 basis;
- Patients receive urgent ambulatory care that is both prompt and professional;
- Patients are served by friendly nurses and other staff in a friendly environment;
- Patients are provided quick investigation and treatment;
- AEC’s efficient service avoids hospital admissions and is good for people who don’t need admitting;
- An interpretation service is available for patients whose first language isn’t English. The referral form has a question about whether the patient needs an interpreter;
- Patient expectations are high and patients are happy with the service.

FROM AEC STAFF

CHALLENGES AND CONCERNS:

- The need to come up to the high expectations of patients;
- Managing to carry out AEC work especially at times or days when patient density intermittently increases considerably ¹²;
- The pressures of reaching the finishing line on a daily basis, in other words to safely complete diagnosis, treatment and forward plans for every patient on each and every day before closing time;
- In addition to the above, there could be the extra pressure of having to find hospital beds for AEC patients who might need inpatient hospital treatment and care.

AEC staff also mentioned **some important GAPS or AREAS NEEDING DEVELOPMENT.**

These included the following:

1. The **inadequacy of the limited space presently available to the AEC unit** to carry out its multifarious work on patients presenting a wide range of health conditions through its MDT Team. The point that they needed more space to overcome the tendency of becoming cramped during peak times, was mentioned by many members of AEC staff.
2. **Need to raise awareness about AEC services and remit amongst GPs;**
3. **Need to improve information provided by GPs and others to patients referred to AEC about the AEC** and its workings;
4. **Need to increase awareness of referral pathways** among those who can refer patients to AEC;
5. **Need to recruit more staff** to overcome the limited physical capacity of the unit;
6. **Need for some more equipment such as for Ultrasound and Echo or echocardiography¹³** for diagnosis of various health conditions of AEC patients;
7. **Need to ensure “appropriate referral” of patients to AEC.**

HWH reviewed some of the aforementioned points and have sought to expand upon a number of them:

Point number 1 – Inadequacy of the space presently available:

¹² One staff member said that patient turnout could at times become rather dense and push patient numbers into the mid-50s per day.

¹³ An Echocardiogram (i.e., echo=sound + card=heart + gram=drawing) is a test that produces an image or video to evaluate the structure of the heart and the direction of the blood flow within it. Heart specialists, evaluate these images and assess heart function and produce a report of the results.

During HWH visits to the unit to meet AEC patients, we could see for ourselves how at times, the unit had the propensity to become congested with very limited space for patients, their relatives/ carers /friends, the wheelchairs of some patients and various members of the unit's MDT as they went about their business of talking to patients /carers and of attending to their diagnosis, medication and discharge etc.

The lack of adequate space was especially conspicuous on one of the days when Oliver Lynch, WMUH's IV Specialist Nurse, had come in to deliver IV medication to patients. Though impressed by his professionalism, it was clear that he and the nurse assisting him, had to really struggle to complete their job safely and quickly within the very restricted space at their disposal in the small patient cubicle on one far end of the unit.

Point numbers 2 and 3 – Need to raise awareness among GPs of AEC services and remit:

A considerable proportion of referrals to the AEC, emanated from GP practices, this was realised to be important by the AEC. This was evident from the fact that 4 MDT meetings have been held since the AEC service was launched. These were reported to have been a valuable investment of time both by Primary and Secondary Care clinicians. At a meeting held in late January this year, it had also been agreed that those GPs attending the MDT meetings would spend time on both the AEC unit and the Acute Medical Unit (AMU) as a pilot educational initiative with the potential to be rolled out to other GP colleagues.

Presumably in line with the above, we were also informed by a senior member of AEC staff that they were going to make a presentation to local GPs about AEC services in early September. However, we learned later that this awareness raising exercise planned for local GPs during a HEAT last month, had had to be postponed and would need to be rescheduled afresh.

Point numbers 2, 4 and 7 – Need for focussing on increasing awareness of the referral pathway:

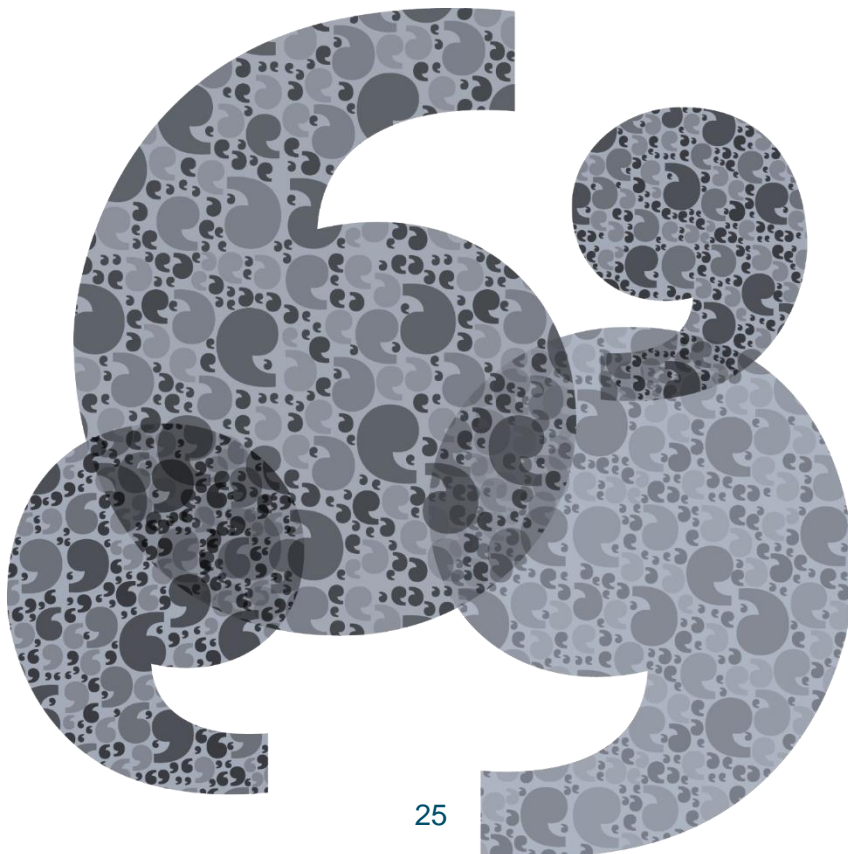
Some AEC staff felt that those who refer patients to AEC and especially GPs, need to gain a clearer understanding of the referral pathway. Despite having a clear AEC referral pathway, some AEC staff said that at times, their unit could become burdened with patients arriving in incorrect ways. This appears to happen, for example, when patients walk in without what they described as "appropriate referrals". They also mentioned that sometimes patients were wrongly informed or advised by those referring them, to simply "turn up" in AEC without waiting to be called by the AEC team.

For instance, during our Survey, an elderly and extremely frail female patient was wheeled into the AEC unit from A&E where she had arrived in a hospital ambulance that she had summoned for herself. Since she had come without a proper referral and was also unable to communicate in English (as it was not her first language), AEC staff had practical difficulties in identifying who she was and in understanding and attending to her needs. Consequently, though she received a lot of compassion from AEC staff¹⁴, she ended up having to wait for a considerable length of time before she could be provided any suitable medical assistance.

¹⁴ This was evident from the fact that an AEC nurse made tea for her and also made sure she drank it safely without dropping it over her clothes and getting scalded.

Point number 3 – Need to improve information provided by GPs and others to patients being referred to AEC about the AEC and its workings:

They must also provide correct and complete information to patients about the referral pathway, what to expect after arriving in AEC, that at times, they may have to wait for a while for their medication to arrive from the pharmacy or that they might even need to come in on the following or some other day for a scan.



OUR FINDINGS

FROM PATIENTS

Positive Outcomes

In keeping with FFTs (Family And Friends Test) regarding AEC services, the feedback we received from AEC patients and carers was extremely positive. This was evident from their being unanimous about the following:

1. They said that **they would recommend AEC services to their family and friends**. The general level of satisfaction and approval of the service is captured in the statement of one of the patients: *“I would recommend the AEC to my family and friends as you can get help really quick and you can find out what is wrong with you.”*
 - They made a number of **positive remarks about the staff which revealed they regarded them as efficient and professional as well as compassionate and humane in their attitude**. Some good examples of such comments were:
 - Staff are good and attentive.
 - Staff are polite, patient and caring.
 - Impact of staff is reassuring.
 - Staff are professional and helpful
 - Staff are very friendly, personable, remember you by name. You are regularly informed if waiting time exceeds expectations.
 - Everyone from the staff is very kind and take care of the patients. They are always smiling¹⁵.
 - Doctors and nurses are kind and warm and lovely.
2. They had **positive words about the level of care and attention they received and the ease of getting tests, diagnosis and treatment under a single roof**. Regarding ease of access, one patients had this to say: “It’s convenient and pleasant and all is done without having to go all over the place.” A patient who seemed to be delighted with the level of attention and care exclaimed he would give the AEC “100%”.
3. Though some felt the **waiting times** could be improved, most patients seemed to be comfortable with how long they had to wait. Some even said it was: “Brilliant” or “Almost immediate”
4. They generally said they received **helpful information and advice from AEC staff**. They clarified that the areas about which they were provided information included matters such as: medication, care and treatment at home, community care, when to revisit AEC or whom to contact if they needed any help after discharge.
5. When asked if they could suggest **any improvements, many said they “couldn’t think of anything”**. This evidently reflected not their lack of ideas, but their high level of patient

¹⁵ At one point during our Survey, there was even a short interlude of conviviality in the unit one day, when one of the nurses decided to add a special sparkle to the hectic but prosaic routine of AEC work, by resorting to taking a few dance steps that brought a smile to the faces of many of the patients as well as members of staff.

satisfaction with the staff and services.

FROM PATIENTS

Negative outcomes

- **Being put to great inconvenience due to being given wrong information by those who referred them to AEC.** Two patients complained that on a weekend, their referrer had asked them to reach the AEC unit at 9am. This had made it inconvenient for the patient because on weekends, it only opened at 11 am. So, when they arrived, it was closed. They had, therefore, been compelled by this misinformation to make two visits instead of just one for receiving AEC services. One of the patients was not happy that he/she had to return to the unit the next day as they had been unable to come back the same day.
- **Being kept waiting in the unit without clarity about what is happening and what will happen next.** They said it would be good to know what is happening and what they could expect to happen.

In support of this point, we would like to add that despite the high level of care and support given to patients, we did notice an elderly patient whose first language wasn't English, who said he felt a bit unclear at the end of his time in the AEC about whether he could leave or was should stay on for something further. It was apparent, that in such instances the lack of clarity could be the result of being treated by different members of the AEC's MDT and language barriers making things seems even more confusing or unclear.

- **Being kept waiting in the unit due to delays in the arrival of the medication for to be administered from chemist/pharmacy in the hospital.** Since they had no knowledge of the Journey of the prescription (described earlier) they failed to understand the delay especially since they knew that the pharmacy was located very close to the unit and in the same building in the hospital.

OUR OBSERVATIONS ON THE AEC'S PATIENT INFORMATION/COMMUNICATION

From among the above-mentioned points, we would like to examine and comment on the information being provided to patients referred to it. Initially, we were disappointed upon not coming across any leaflet or other information about the AEC. The only information resources we first noticed were some good posters placed prominently on the walls of the AEC unit. Later on, we spotted some printed leaflets produced by WMUH with information for patients on DVT and another leaflet with very useful information about the AEC and its services. Unfortunately, upon checking further, we realised that the posters were in English only. Likewise, all the printed leaflets for patients, were also in English only.

It wasn't that the service providers in AEC had forgotten that the local population also contained groups whose first language wasn't English. This was evident from the fact that at the tail end of the leaflets, they had added some lines that read as follows:

"If you would like to receive this leaflet in a language or format of your choice please contact pals.service@wmuh.nhs or call 020 8321 6261."



Deep Vein Thrombosis Poster in AEC

But, despite the admirable intention expressed in the lines quoted above, it must be realised that such an indirect method of soliciting translation requests has very slim chances of eliciting a response from local non-English speakers, for the simple reason that they can scarcely be expected to pick up and read this vital piece of information end of a leaflet in a language they neither generally speak, read or understand properly.

It does raise the vital question:

“How will someone who needs the information in another language or format know that they can request it in a language or format they need, unless they are able to read and understand the English leaflet? And, if they can read and understand English, they might not need the information in any other language/ format at all!”



OUR FINDINGS

FROM GPs

PLUS POINTS

Out of the 20 GPs who responded to our AEC Questionnaire for GPs, 19 were Community GPs from GP Practices in Hounslow. Irrespective of whether they were based outside or in the hospital, they generally expressed positive views about the AEC. This was evident from the following:

1. There was general agreement among those who had used AEC, that **it was easy to access**. Even a GP who had on one occasion found it hard to contact the service via mobile, commended its accessibility.
2. Most GPs who had used AEC, **praised the AEC team for being both accessible and helpful**.
3. Most GPs who had used AEC also said it was **efficient and effective**.
4. Most GPs also said they **would recommend the AEC since its services were very useful to sort out emergencies that do not need hospital admission**. One community GP admitted he had never referred any patient to AEC, but said he should use it.
5. One community GP said he had used AEC only once. Praising the service received they said “I can only think of once when I did use it and I was **impressed** at the time. **It was good for the patient.**”
6. Despite generally referring only a small number of patients (as little as between 0-2 and a maximum of 3-4 patients per month) to the AEC (for conditions such as DVT, pain – significantly, headaches and loss of consciousness, anaemia), the majority of GPs said they looked upon the AEC as a **positive force that was filling the gap when patients need more than what A&E and Urgent Care can offer** in terms of immediate intervention, but can be turned around the same day for a condition that can't wait for a referral.
7. In particular, the features **they listed as valuable were the speed of response, communication and flexibility offered by AEC staff**.
8. They added that **their patients have actually contacted their practice to say positive things about the AEC unit**.

FROM GPs

SUGGESTIONS FOR ACTION

In spite of their general approval of the AEC, there were areas where some GPs felt there could be improvements and change. These were as follows:

- 1. Awareness about AEC among GPs in the community:** Since it was still rather a new service, it would benefit patients if targeted efforts were made to further increase awareness about AEC services and its remit among local GPs¹⁶.
- 2. Information to GPs about the AEC Referral Pathway:** Some GPs felt there was need to increase information about referral pathway among GPs¹⁷ and other referees so that they have more clarity about it. This will also assist in passing on clear and complete information to their patients and help them to understand what to do, what not to do and know what to expect.¹⁸
- 3.** There was a also a suggestion that to maximise uptake of AEC services and benefit more patients, not only general information dissemination and awareness raising, but **identifying specific GP practices with patient profiles indicative of greater AEC-prone health conditions might be required.**
- 4. Onward referral from AEC, not referral back to GPs:** Some GPs expressed preference for **onward referral of patients from AEC, rather than their being referred back to the GP.** This was highlighted by AEC staff as well who would prefer to refer people forward or onward.

¹⁶ The Practice Manager of a local GP Practice with regular patient referrals to the AEC, extensive knowledge of its workings and also well-connected with other GP Practices in the borough, agreed that awareness raising about the AEC services among GPs, would be useful and that a HEAT event could be a good place to carry out such an exercise.

¹⁷ This need is evident from the following remarks from the side of GPs: “Although the [AEC] concept is great ... it is unwieldy and is too hard to guess who will get accepted” and “AEC’s referral pathway is vague.”

¹⁸ As mentioned earlier, some AEC staff are aware that community GPs, need to be provided a clearer understanding of the referral pathway to make AEC work more smooth sailing.

FINDINGS FROM GPs

Some Constructive feedback

- **Need for simplification of Community GP Referral Pathway to AEC, was a point strongly raised by a number of GPs who formed 25% of our sample.** Among this group, there were some who had succeeded in getting some of their patients referred to AEC and some whose patients had never had any success in accessing the AEC. They considered it restrictive and creating unnecessary barriers.
- **Criticism of the AEC's Referral Pathway was not based entirely on frustration with failure to get referrals. Thus, despite having successfully accessed AEC services, some GPs still strongly criticised the present system of referrals.** One of them clearly said that the process needed to be simplified and made easier and quicker to access by trusting GPs to refer patients appropriately. "GPs are not amateurs", remarked this GP with some pride tinged with annoyance. "They have vast experience, they know their patients well and understand their needs. They can surely be trusted to have the capability to identify suitable patients for AEC without having to go through processes that cause delay."

Echoing the same idea, another GP who had had no success with the AEC referral process remarked: "I think it [AEC] is an excellent idea but in my experience it has not delivered. I would like them [AEC] to accept our referrals." Expressing dissatisfaction with the referral pathway, yet another GP complained of being "passed from pillar to post."

- **Need to rationalise AEC's working hours: Instead of the AEC's present pattern of working, it needs to make adjustments with the work schedule of GP practices:** This was summarised in the following comment GP [work time] to stop taking referrals is frustrating. If you have the service, it should last throughout the normal NHS hours otherwise we keep having to thinking: 'Oo! What time, will they accept patients?' "



OUR RECOMMENDATIONS:

GP's & AEC: AWARENESS/INFORMATION/REFERRALS

- 1. There is need to improve understanding of AEC services and its remit and most importantly of the AEC referral pathway, among local community GPs in order to increase referrals.** Though GPs have started referring patients to the AEC, they are doing so in small numbers and some community GPs are not referring any patients at all. Moreover, some are failing to secure referrals, despite trying to access AEC for their patients. In other words, some GPs are using AEC, some aren't and some aren't succeeding in getting their patients referred. Improved understanding should help to change the present situation and increase referrals from GP practices.
- 2. It will also be useful for AEC and GPs to engage in a two-way conversation so that community GPs who are unhappy with the referral pathway, are given an opportunity to air their views.** This has positive potential for, perhaps as observed by experts in the field, "the most effective model starts with a clinical conversation between senior clinicians in the referring and receiving teams."
- 3. There is also need to provide clear information about the AEC's opening and closing times on each day of the week, especially weekends, to community GPs as well as to those referring patients from within WMUH.**

This will prevent them from misinforming patients about AEC timings. They also need to be provided with clear information about all the next steps so that they can inform their patients accordingly. This will inform patients to wait to be contacted before they come to the AEC and make them realise that they must follow instructions and not "just turn up" there at any hour.

- 4. To increase uptake of AEC services, perhaps stakeholders should look to working with practices with patient profiles with greater potential for AEC sensitive conditions and see what support can be given to those patient populations within such practices. HWH will be happy to help support such an initiative.**

INFORMATION & COMMUNICATION WITH PATIENTS

- 5. There is a need to provide appropriate, simple and adequate information to patients about AEC services in appropriate languages and formats.** The information must also be **disseminated in effective ways** via GPs and other professionals so that it reaches the target audiences/readers.
- 6. Likewise, it will be good practice to produce simple information for patients about some important health conditions affecting AEC patients and make sure these are made known and are accessible to the target audiences/readers in various formats.**
- 7. AEC's information leaflets and posters on DVT are excellent. However, it is not enough to produce information in English only. Although financial constraints might not permit**

production of translations in all the community languages used in Hounslow, perhaps, they could be produced in some of the main languages.

If even this is unaffordable, the best way forward might be to arrange for the translation of these words into some of the main community languages:

“If you would like to receive this leaflet in a language or format of your choice please contact pals.service@wmuh.nhs or call 020 8321 6261.”

To catch the eye of ethnic minority patients visiting AEC, perhaps it might be more beneficial for non-English users for WMUH to include the translations of the above-mentioned lines in at least some of the main ethnic minority languages used by the local people in Hounslow and to get them prominently displayed on the cover of their English leaflets.

8. AEC to refrain from providing information to and communicating with local non English speakers on their website through google translations and other such providers. *(For more on HWH’s view on Google translate, please see our recent report on GP Access also produced this year).*

9. We would recommend that instead of randomly using family and/or friends of patients and AEC’s bilingual staff (untrained in interpretation), as interpreters in the Unit, **it will be in the best interests of patients for AEC to provide professional interpretation through trained interpreters or via Language Line for those AEC users whose 1st language isn’t English.** Presently, GPs as well as AEC staff have access to professional interpreters and telephone interpretation, but also seem to be making use of relatives and friends of patients and untrained staff as interpreters.

FURTHER INVESTMENT IN AEC

10. We would also recommend that, if possible, the space available to the AEC unit in WMUH, be increased. This will help make the Patient experience more pleasant and enable staff to provide services with greater ease. Moreover, as uptake of AEC services increases in accordance with increased awareness of AEC services, we can anticipate that the need for more space will become even more pressing.

11. As AEC’s workload might increase as awareness about AEC services spreads, funds permitting, it might **be useful for the WMUH management to plan to induct additional staff into the unit.** This might be necessary to ease the pressures on AEC staff and to ensure patient safety and standards of care and health outcomes.

12. As mentioned by AEC staff, **it would be good for WMUH to consider arranging some finances for additional facilities in AEC to perform tests and diagnosis,** such as equipment for Ultrasound and Echo.

13. Finally, there is a small **piece of information sharing with patients that we feel can enhance the generally positive public image of AEC in the eyes of its users and also further improve the patience experience.** This concerns some chairs for patients that are placed in the AEC unit. Some, though not all, of these chairs, we noticed, have some special features such as getting converted into reclining chairs. If used, these reclining chairs can

make the patient experience of patients more comfortable and relaxing. But, we found that as the unit was ever so busy, many patients at times just sat on these chairs without using their special features. This was because apparently patients had not been made aware of them.

Just a bit more of information sharing by AEC staff, could help make a positive difference for patients!

Almost without exception, AEC users have an extremely positive view about the services they receive and have showered AEC with adjectives such as: professional, accessible, helpful, efficient, reassuring, compassionate, kind etc. AEC staff are rightfully both proud and passionate about the services they provide to their patients. They also appear to be aware of a few grey areas and eager to bring about changes to improve the quality of their care and make their services more smooth sailing. Despite some negative comments and suggestions for change, GPs are also appreciative of the idea behind AEC and its utility and service provision.

Despite the attractive financial gains attached to AEC services, the driving force presently is and must continue to be the development of quality services and continuous improvement of the patient experience.

HWH will be happy to assist AEC in raising awareness about AEC services and in helping them develop and disseminate their information resources in the interest of patients in general and especially of disadvantaged people whose first language might not be English. We will also look forward to any help we can give in helping AEC reach out to GPs for increasing referrals and making AEC more accessible.



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