

## Ambulatory Emergency Care

### *Background*

Emergency Department (ED) crowding is an increasing problem internationally. Causes are complex but analysis in the UK points to patients waiting for admission or discharge predominating as opposed to increasing attendances or inappropriate use of services<sup>1</sup>. Clinical teams specialising in Acute Medicine in the UK promote a model of care to manage patients without the need for admission into a hospital bed and limit attendance to ED - Ambulatory Emergency Care (AEC)<sup>2</sup>. The Netherlands, Australia & New Zealand have taken a similar route by developing Acute Medicine as a speciality with Acute Medical Units (AMU) delivering care as an alternative to ED, but they have yet to evolve the model to provide AEC to the same spectrum of medical conditions as seen in the UK<sup>3</sup>. This work evaluates what international teams looking to adopt the AEC model to improve ED flow and outcomes can learn from the UK experience.

### *Methods*

International, systematic literature search of current evidence base in the delivery of AEC:

- Emergency Care flow
- System-wide flow
- System-wide costs
- Patients outcomes - clinical & experience
- Enablers and barriers to successful models
- Comparable international models

### *Results*

Search results did not yield many papers for review or to accommodate a full international comparison. Published evidence around AEC is lacking and, as a result, and there are no agreed measures of successful models of AEC. Evidence of success is limited to case studies, conference proceedings and local audit. Yearly snap-shop audit in the UK appear to show improvement in conversion of patients from in-patient to AEC assessment on arrival to hospital<sup>4</sup> (bypassing beds) following uptake of the model, but no data concerning direct impact on system-wide or ED flow was available. No robust cost-effectiveness studies were found. Published evidence of patient satisfaction is limited to online, anecdotal reports, but the majority of reports are positive with most dissatisfaction resulting from lack of communication and long waiting times<sup>5</sup>. Clinical outcomes are confined to indirect system-wide measures with no published evidence of clinical or quality outcomes of use to evaluate AEC models for further learning. No published studies of the international application of AEC were found for comparison.

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<sup>1</sup> What's behind the A&E 'crisis'?. Briefing. Edwards N, Blunt I and Merry L. Nuffield Trust, 2015

<sup>2</sup> Acute Care Toolkit 10 - Ambulatory Emergency Care. Royal College of Physicians, 2014.

<sup>3</sup> Directory of Ambulatory Emergency Care for Adults. 6th Ed. Ambulatory Emergency Care Network at NHS Elect, 2018

<sup>4</sup> Society for Acute Medicine Benchmarking Audit. SAMBA 2017. Society for Acute Medicine, 2017

<sup>5</sup> Care Opinion (UK). Accessible at

<https://www.careopinion.org.uk/opinions?phrase=ambulatory&tcx%5B0%5D.tname=emergency#/?page=10>. Search terms "Ambulatory" and "emergency". Accessed 16/11/2018.

## *Conclusion*

AEC is promoted as best practice in the UK to minimise hospital admissions, improve emergency care flow, reduce costs of admission, prevent harm by avoiding admission, and provide patient-centred care according to clinical need and patient preference. Evidence of conversion of care from in-patient to out-patient is clear and the philosophy of AEC holds promise for preventing unnecessary hospital admission but the current evidence-base to support the intended flow, cost, clinical & quality outcomes is lacking, highlighting the need for research in this emerging, internationally important field of practice