Developing ACP led Ambulatory Care

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ACP lead/ lead for clinical transformation

Background/context

- How it all started:

  Spring 2013 - pilot of 1x ACP working with an acute consultant

  - developing the Ambulatory Care Unit to avert inappropriate admissions

  Autumn 2013 - six ACPs employed = 2 qualified & 4 trainees

- The team has since grown to 14.8 (7.8 qualified, 7 trainees), plus 3 speciality ACPs.

Advanced Clinical Practice

- Trust AP framework, clear line of sight of AP across the organisation
- Core AP competency – clear taxonomy of progression/ expectation regarding demonstration of level of practice
- Clear job description
- Consultant supervision

Advanced Clinical Practice

- Focus around 4 pillars – audit/QI/education/senior leaders
- 2013/14 focus on FY2 level of practice in a 'medicalised' model
- 2016 Competency update based on ACCS trainee portfolio/demonstration of core medical presentations management

ACP role

- Core clinical work within AAU/ACU/ED
- Sit on many governance groups
- DTC
- VTE
- Sepsis
- Clinical governance groups
- Workforce
- Mortality/ learning from deaths

Audit/QI

- Alcohol withdrawal/CWIA
- Delirium project
- AKI8 project
- Anaemia/ transfusion audit and pathway
- Falls

Education

- Nurse education sessions
- AMU teaching
- Trainee education/ACP leads for education
- Grand round
- Education packages

Ambulatory Care

- The team recognised the need to develop to support patient care/safety but also AMU/ED
- ACU average 4-5 ‘new’ patients per day plus 8 follow ups between 08.30-18.00 Monday to Friday in 2015
- 2015 Pilot of ACP taking all GP referrals successful, leaving the acute physician to be decision maker
- Aimed to see 20% of the medical take in 2016

Ambulatory Care

- Increase referrals from ED to ACU whilst reducing admissions to AMU
- In 2016 we increased capacity by investing in the team, and extended opening hours and created a development plan with the help of NHS Elect
- We met all our goals and supported the ED in achieving an improvement in their emergency care standard
- We became integral to the whole emergency care system.

2017/18

- ACU activity increased by 55%
- Reduction in overall admissions 18% less than previous year, despite overall numbers to the hospital increasing
- ACP team consolidation/development
- New 6.5 m capital funding to build acute assessment unit (AAU) combining medical/surgical assessment beds and ambulatory care, co-located with ED.

2017/18

- Undertook 2 rapid improvement events to plan our new model – ACP team heavily involved in planning/PDSA cycles prior to opening
- Opened on 24th April 2018
- April/May saw increased non-elective activity of 11% from previous year
- Surgical ACU – a new concept
- ACP in ED streaming 10.00-18.00 direct to AAU/ACU/primary care/community services

ACP autonomy

- Investment
- Time
- Education
- Shift away from traditional consultant led model and recognition of the level of practice
- Initially all ACP led discharged patients audited, no acute re-presentations/safety concerns
- Positive patient feedback

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What next ?

- Continue to work safely within our sphere of competence as a multi professional team
- Develop surgical service/knowledge/skills/relationships
- Senior ACP roles/recognition/understanding
- Benchmarking of ACP role in acute medicine
- Plan sustainable posts that retain our highly skilled team members

- Thank you
- Questions ?
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