“The importance of nurses in emergency care/maximising the role in Surgical AEC”

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Health and Social Care Policy Agenda

- **Five year forward view – new models of care**
- **7 day care – 'weekend effect'**
- **Integration**
  - Health and social care
  - Primary and secondary care
  - Mental and physical care
  - STPs
- **Shifting care from acute to community**
  - Having staff in the right place
  - Discharge from hospital
- **NHS funding and productivity**

STPs

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Re-shaping UEC delivery

- GP OOH changes, junior doctor working time restrictions
- Greater integration = ↑ investment in community nursing, social care, and GP services
- Hospitals changing the way they treat patients (England – ED redesign)
- Improving flow within hospitals through improved discharge

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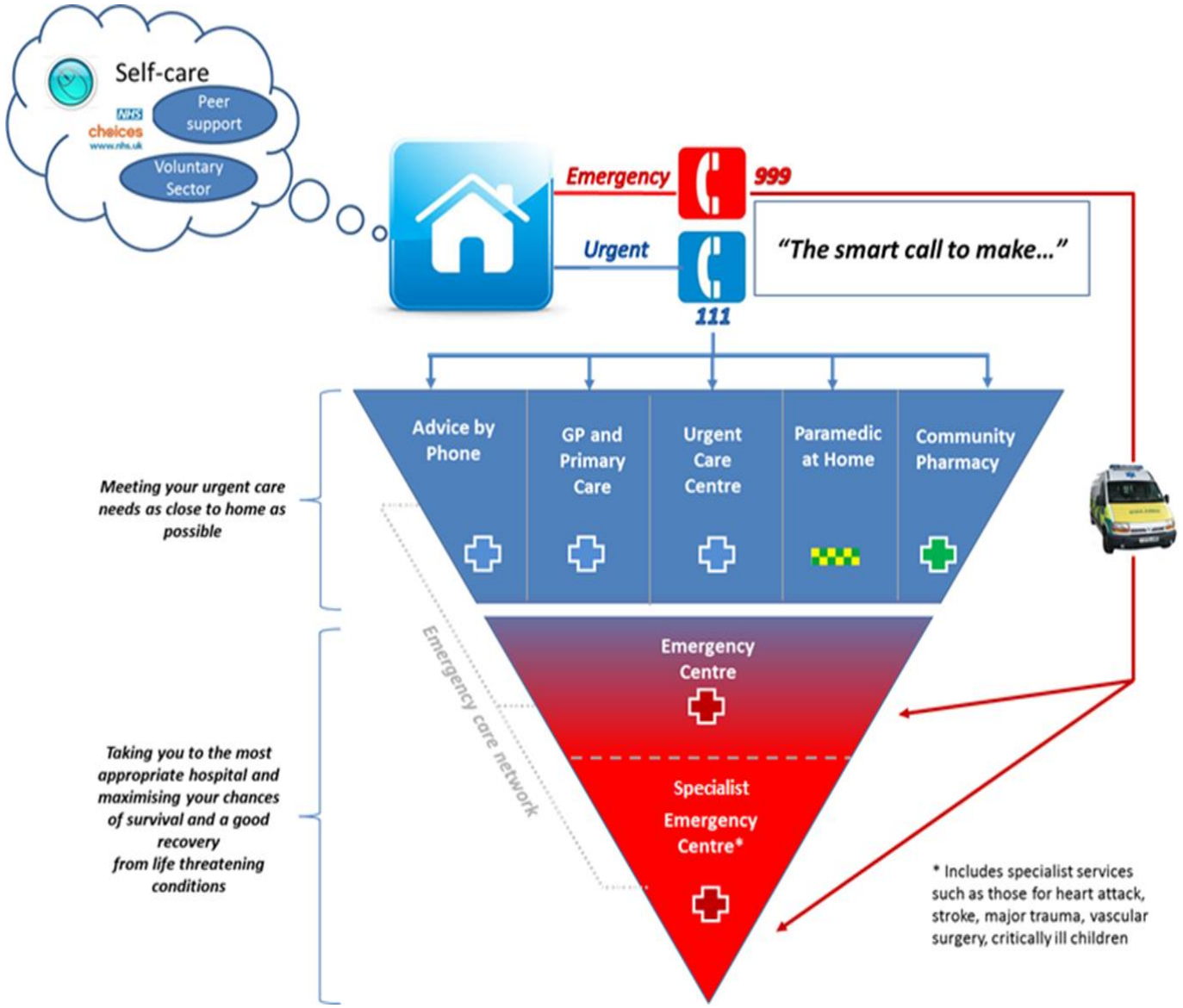
Self-care
Peer support
NHS choices
www.nhs.uk
Voluntary Sector
Emergency
999
Urgent
111
"The smart call to make..."
Advice by Phone
GP and Primary Care
Urgent Care Centre
Paramedic at Home
Community Pharmacy
Meeting your urgent care needs as close to home as possible
Emergency Centre
Specialist Emergency Centre*
Emergency care network
Taking you to the most appropriate hospital and maximising your chances of survival and a good recovery from life threatening conditions
* Includes specialist services such as those for heart attack, stroke, major trauma, vascular surgery, critically ill children

George Eliot Hospital NHS
NHS Trust

Hospital and community based services to more than 300,000 people across Nuneaton & Bedworth, North Warwickshire, South West Leicestershire and North Coventry.

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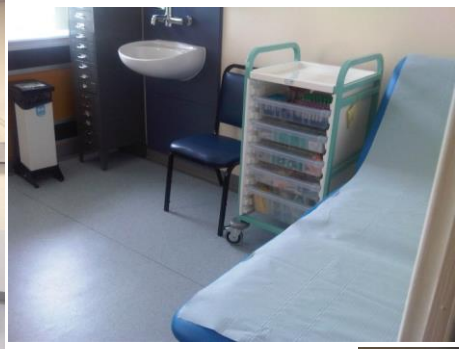
Ambulatory Care Unit

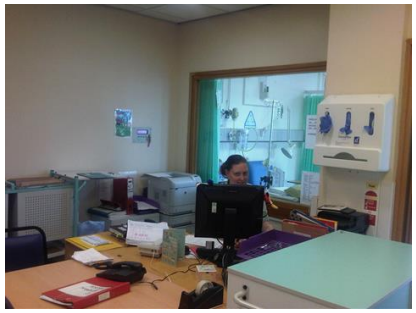
George Eliot Hospital NHS
NHS Trust

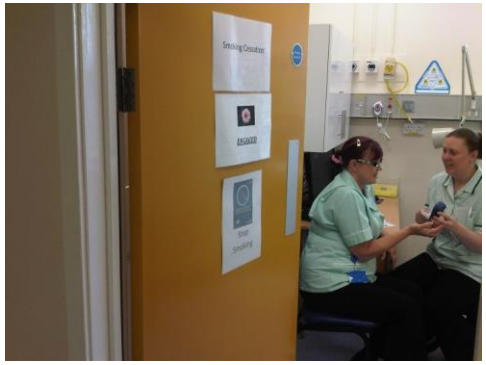
Nursing Times Awards 2014 Winner

- **Open** – Monday – Friday – 08:00-20:00 and sat/sun 8am-5pm
- Full time Advanced Nurse Practitioner 8a
- Clinical sisters (7)– x 2 with health assessment & prescribing
- Clinical sisters (6) x 3-with health assessment
- Support/ admin staff x 2
- Nurse Consultant cover & Acute Physician (pm clinic) – in conjunction with AMU

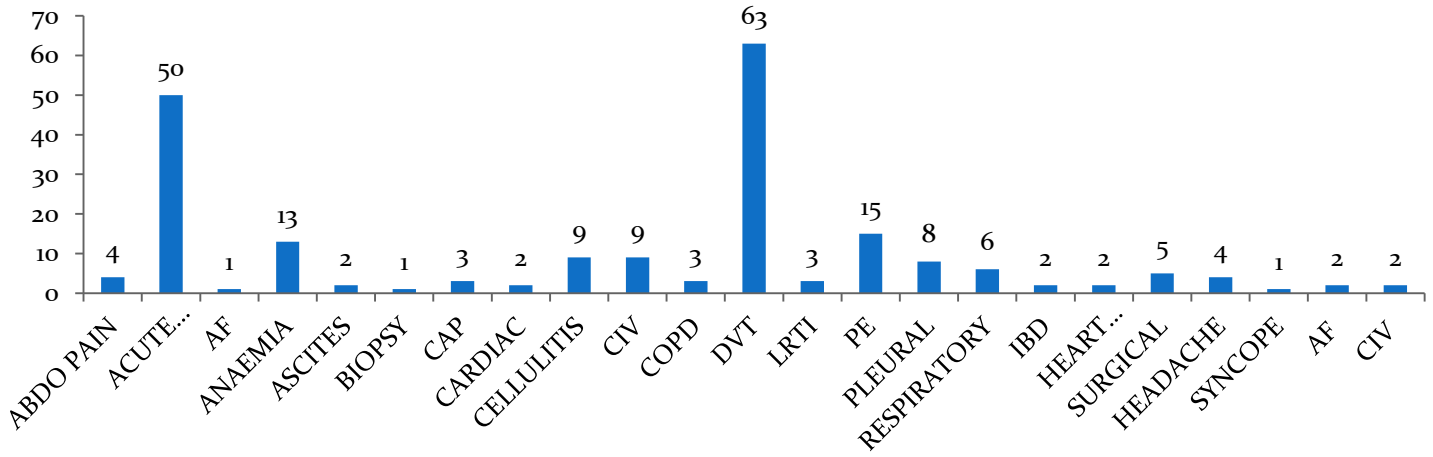
- **Pathways**:
- Deep Vein Thrombosis
- Cellulitis – ERON class 2
- Lower Respiratory Tract Infection and Community Acquired Pneumonia
- Complex respiratory infections
- **Anaemia requiring transfusion**
- Ascites and Pleural Effusions
- **Abdominal pain in patients who are clinically stable**
- Bronchiectasis
- Para-thyroid post op care
- Infections requiring **IV antibiotics** eg:
  - Pylonephritis
  - Echoli UTI
  - Wound infections
  - Soft tissue infections
  - Smoking Cessation
  - **Surgical site infections**






Smoking Cessation

Ambulatory Care Pathways February 2016

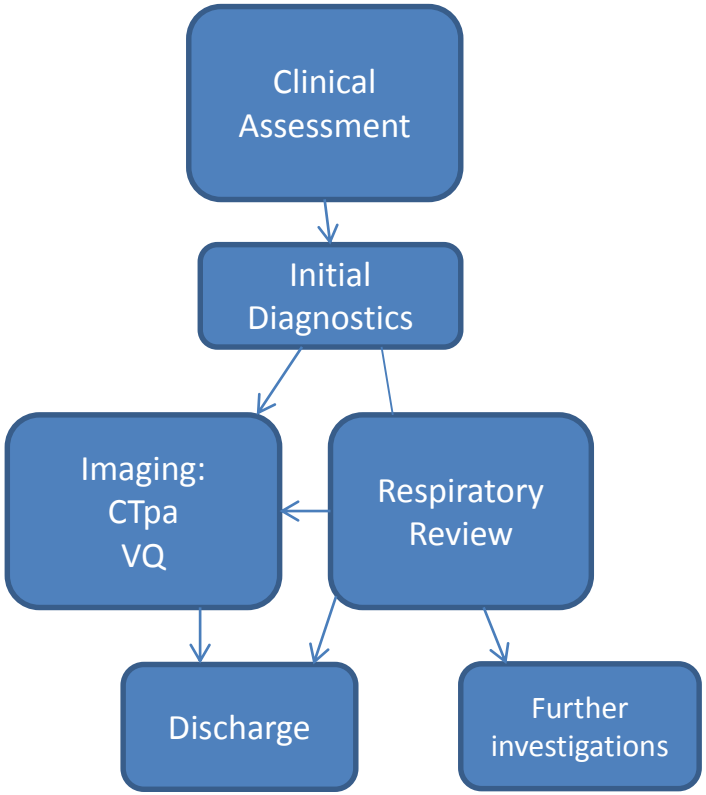


Pulmonary Embolism

- ACU had managed suspected DVT effectively and had respiratory & anticoagulation input
- Approx. 50% of suspected PE's can be treated on an ambulatory/ outpatient basis.
- New BTS Ambulatory Guidelines due soon
- SPESI Risk Stratification:

Prognostic Variable	Score
Age >80	+1
History of Cancer	+1
History of Chronic Cardiopulmonary disease	+1
Heart Rate ≥110 bpm	+1
Systolic BP <100 mmHg	+1
Oxygen saturation <90%	+1

Score of 0
usually suitable.
1+ (or pregnant/
Liver problems)
Must have agreement
by consultant



Pilot: 15th Aug – 15th October 2015
Audit:

36 Patients in total
42% of patients progressed to Imaging
14% were positive for PE (2)
1 patient – Primary adenoma
1 patient – enlarged nodes
2 patients had an effusion or consolidation
No patients were admitted
or had any adverse events.

Sustaining and Evolving

- Ambulatory Care needs to increase & improves patient journey however area's are being used for extra capacity beds
- Maintaining standards & positive patient feedback
- Data is powerful

Data

Month	February
Amount of GP calls	278
No. Directed via ACU	94
Admitted from GP calls (after being seen in ACU)	4
% of GP calls diverted to ACU/advice	36%
Advice only	7
Ambulatory Care :	
patients seen (non-gp calls)	179
patient episodes	444
admitted	5
Total Patients seen in ACU for month	273
Early discharges	60
Admissions avoided	203
Bed days saved	800

	Standard	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Number of GP calls		212	207	237	258	278
Number directed to ACU via GP calls	see 50% increase in GP referrals seen in ACU from the base line in January within 6 months	92	70	85	63	94
% of GP calls converted to ambulatory care (including advice)	increase by 50% from January baseline	46%	35%	38%	27%*	36%*
Admitted to wards from GP calls	Less than 10%	3.26%	2.85%	1.09%	6.30%	4.25%
Total new patients (including gp calls)	see 50% increase in referrals from the base line in January within 6 months	256	228	225	204	273
ACU follow up appointments	Excluding IV medication referrals the follow ups will be <30% of new referrals	18	17	15	13	15
Admitted via ACU including GP referrals	<10% of total new patients	9	5	11	8	9
Community IV medication/ VTE follow up* episodes	>50% within 12 months from baseline in January	366	340	297	156*	156
Admission avoidance	50% increase on base line in January	193	185	158	144	203
friends and Family -* score from ambulatory patients	90%	100%	100%	100%	100%	100%
No of complaints received *		0	0	0	0	0
Early Discharges		41	31	41	32	60

Surgical Ambulatory Care

Surgical Ambulatory Care becomes reality at UHSM

20 March 2017 jamesgray Categories: admission avoidance, Delivering efficiency savings, ECIST Network, Fabulous Stuff, Service pathway improvements, The 5127 Award 0 Comments

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University Hospital of South Manchester NHS Foundation Trust (UHSM) for a number of years have been developing their Ambulatory Care (AEC) offer and in January 2016, UHSM looked to expand this with a month long pilot for Surgical Ambulatory Patients.

The Surgical Ambulatory Care Receiving Unit (SACRU) was developed to reduce the number of non-elective General Surgical admissions, by having a dedicated Emergency General Surgeon(s) to assess, diagnose and operate on patients who were previously being admitted to an inpatient bed.

SACRU led by Consultant General Surgeon Miss Patrizia Capozzi and with support of the Trust's Service Transformation Team and their Senior Programme Manager James Gray commenced the pilot with a number of clear of objectives including:

- Fast-tracking self-presenting patients through ED from triage
- Reduce the number of unnecessary emergency general surgery admissions
- Facilitate accelerated ward discharges
- Reduce the number of GP patient referrals coming into ED
- Point of contact for patients, DNs, GPs • Expand Emergency General Surgery services
- Provide a more enhanced patient focused service
- Ensure all patients are seen by a consultant within 14 hours of presentation
- Drive care quality improvement

During the pilot, SACRU was delivered by a single Consultant undertaking a morning ambulatory clinic Mon-Fri (8:30 – 12:30).

Over the 4 week pilot period, 19 days of activity were completed. During that time a total of 133 patients were seen of which 72% were new patients, 17% were reviews and 11% were telephone reviews.

The success of SACRU was measured during the pilot period through the number of admissions avoided (83/62%), ED re-attendances avoided (34/26%). Only a small percentage (8%) of those patients seen within SACRU, were admitted to a surgical inpatient bed or referred to another speciality (4%).

The pilot averaged 4.2 admissions avoided per day based on the opening hours of 8.30am to 12.30pm.

Based on this anticipated activity that would be seen through the unit, by extending to a 12 hour service and increasing the opening hours by an extra 8 hours per day seven days a week would provide a projected 154 admissions avoided per month. This avoidance equates to a potential saving of 10 inpatient beds which could be used for extra elective activity or to help manage the demand of non-elective medical patients.

In July 2016 UHSM's Management Board agreed to fund a fully operational SACRU in line with National expectations for 7 day services.

The integration of SACRU is serving to enhance the offer available to patients and ensure that Emergency General Surgery is optimised to improve patient flow and quality of care further. Whilst the unit is currently not fully operational past 12.30pm Monday to Friday, the introduction of two new Trainee Advanced Nurse Practitioners, Rachael Hine and Gail Sharpe will help support the development of the unit and the provision of services to patients at UHSM and across South Manchester moving forward.

Surgical Ambulatory Care

- Different models and options
- Collaboration and cross health economy working
- Map current pathways and referral points
- Can be a grow bag for advancing practice….
- Senior decision makers essential
- Direct contact with general practice beneficial
- Commissioner
- Financial drivers such as best practice tariff
- Current in patient models not sustainable

What are the ambitions of a Royal College?

- To ensure and drive up standards of care
- To ensure and drive up standards of (nursing) education across the UK.
- To influence (health and nursing) policy in the UK and globally.
- The voice of nursing: the authoritative organisation on nursing issues. Nursing is diverse and a wide range of scope and responsibility.

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Professional Forums

- 35 across a wide nursing agenda – ranging from 12,000 members to 400
- Perioperative
- Advancing Practice
- ENT
- Ophthalmic
- Fertility
- Children's & young people x5
- Critical care and in-flight
- T&O
- Neuroscience
- Gastro & Stoma Care
- Emergency Care
- Defence

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RCN Advanced Level Nursing Practice Credentialing

RCN Credentialing

Recognising advanced level practice in nursing

www.rcn.org.uk/credentialing

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RCN definition of Advanced Practice

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As a body concerned with the developing profession we define Advanced Practice as:

"Advanced practice is a level of practice, rather than a type of practice. Advanced Nurse Practitioners are educated at Masters Level in advanced practice and have been assessed as competent in practice using their expert knowledge and skills. They have the freedom and authority to act, making autonomous decisions in the assessment, diagnosis and treatment of patients." - scope of competence

What is ANP Credentialing?

An assurance process to recognise advanced practice in nursing in the following areas:

1. Experience – across 4 pillars
2. Qualifications - Msc
3. Competence – ST3

And promote practice that is in accordance with the four pillars of advanced practice

Pillars of Advanced Practice

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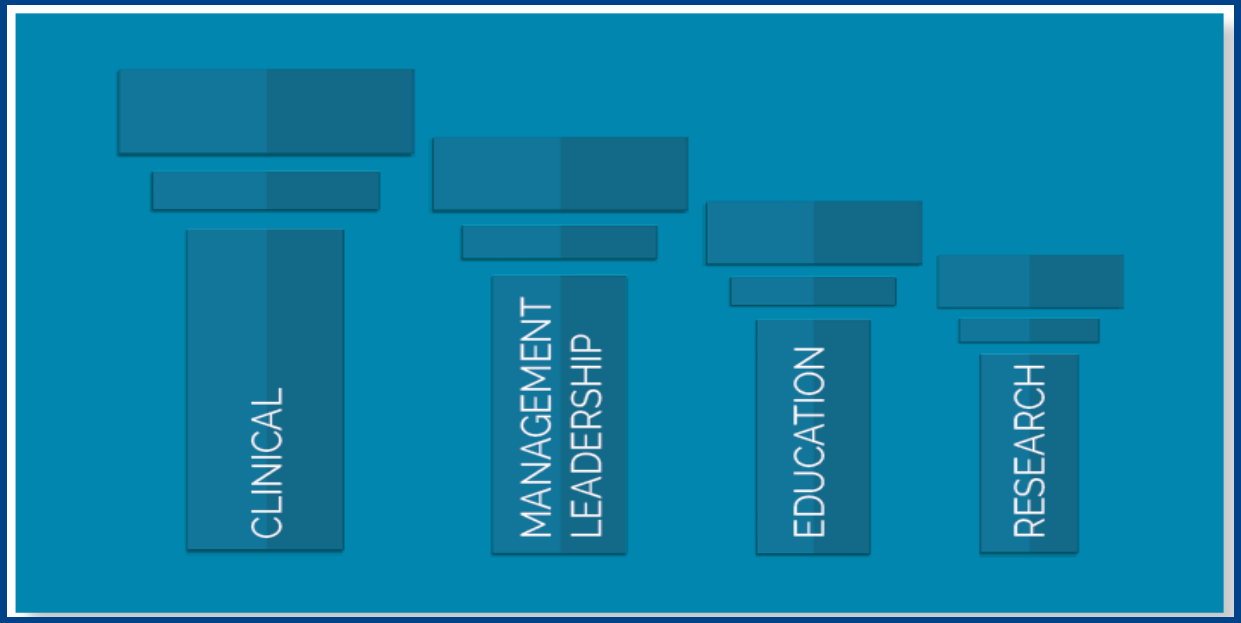

RCN Credentialing

Recognising advanced level practice in nursing

www.rcn.org.uk/credentialing

Criteria for the credential

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- Relevant Masters degree.
- Prescribing rights.
- Experience and competence mapped against the 4 pillars of advanced practice.
- Work plan and clinical reference.
- Evidence of CPD over previous 3 years.

Transitional arrangements

- Until December 2020 nurses who don't meet the above criteria can apply.
- There are a series of "models" against which experience, competence & education can be mapped.
- These will be assessed on an individual basis.

Surgical Extended Team

- Collaboration with Royal College of Surgeons
- Surgical Care Practitioners
- Advancing practice
- Health assessment and prescribing skills
- Masters in Advancing Practice…apprenticeships coming
- Autonomy key
- Working across the patient journey

Exciting times for innovation and development of SAEC and nurses are in a pivotal role to develop and deliver…..