



Féidhmeannacht na Seirbhíse Sláinte  
Health Service Executive

Clinical Strategy and Programmes Division



ACUTE  
MEDICINE



ROYAL  
COLLEGE OF  
PHYSICIANS  
OF IRELAND

# Framework for Ambulatory Care On the Acute Floor

September 2018  
National Acute  
Medicine Programme  
(NAMP)



## 1.1 The Urgent Need for Ambulatory Care

**The ESRI Report**<sup>1</sup> has brought into sharp focus how the unprecedented future growth and increased ageing of the population will impact on the health system in Ireland. By 2030 there is an expected increase of 14 – 23% in general population terms with a 69% growth in the 65+ years category and 90% projected increase in the 80+ years category. Despite the 65+ years patient cohort representing only 13% of the population they received over 40% of day case procedures in 2016 and almost 50% of patients receiving care in the health system are aged over 85 years<sup>2</sup>. Based on current trends and converting the population health needs into acute hospital service requirement its estimated that demand for inpatient bed days will increase by 37% while Emergency Department attendance is projected to increase by over 25%<sup>1</sup>.

**The Oireachtas Committee on the Future of Healthcare: Sláintecare Report** (2017)<sup>3</sup> outlines that health care provision must shift from the current hospital centric system to an integrated model of care led by community and primary care. The Sláintecare report rightly insists that the focus of healthcare should be on planning for the increasing prevalence of chronic disease such as heart failure, diabetes and COPD which are expected to rise by over 20% within the next 5 years and account for the majority of GP visits and acute hospital bed days' utilisation. The current management of COPD alone, is recognised to be inefficient with poorer patient outcomes and hospitalisation rates unacceptably higher than other OECD countries<sup>3</sup>. Currently Ireland has relatively low levels of chronic diseases prevalence in comparison to other OECD countries. This is likely a consequence of a relatively younger population. However many of the risks which increase the likelihood of chronic disease such as smoking, alcohol consumption, obesity and physical inactivity are comparatively high in Ireland. Therefore it is reasonable that this, coupled with an ageing population will result in much higher rates of chronic disease in the future leading to associated demand on hospital and health care resources<sup>2</sup>.

The SláinteCare Report has directed that the health system needs to become more efficient and cost effective and reconfiguration to primary care should mean less demand on acute hospitals. In anticipation of this it is suggested that a four hour waiting time target for Emergency Care should be achievable and hospital management should be held accountable for breaching this and other targets<sup>3</sup>.

**The Health Service Capacity Review** (DOH 2018)<sup>2</sup> delineates the crisis within the acute hospital system and the need for urgent reform. Bed occupancy is running at almost 100% consistently which is above acceptable international trends and represents an increasing risk of harm to patients and staff.

### PUBLICATIONS & REFERENCES

1. ESRI 2017 <https://www.esri.ie/pubs/RS67.pdf>
2. Health Service Capacity Review 2018 <https://health.gov.ie/wp-content/uploads/2018/02/71580-DoH-Dublin-Report-v6.pdf>
3. SláinteCare 2017 <https://www.oireachtas.ie/parliament/media/committees/futureofhealthcare/Oireachtas-Committee-on-the-Future-of-Healthcare-Slaintecare-Report-300517.pdf>
4. NAMP Report 2010 <https://www.hse.ie/eng/services/publications/hospitals/amp.pdf>
5. [Developing an Acute Floor Model for Ireland V1](#) October 2017
6. UK Ambulatory Emergency Care Directory <https://www.ambulatoryemergencycare.org.uk/Tools-and-Resources/AEC-Directory>
7. Royal College of Physicians 2013 [https://aace.org.uk/wp-content/uploads/2013/07/urgent\\_and\\_emergency\\_care\\_a\\_prescription\\_for\\_the\\_future](https://aace.org.uk/wp-content/uploads/2013/07/urgent_and_emergency_care_a_prescription_for_the_future)
8. NHS England 2015 <https://www.england.nhs.uk/wp-content/uploads/2015/06/trans-uec.pdf>
9. SAMBA 2017 <http://www.acutemedicine.org.uk/national-reports/samba-report-2017/>
10. NHS Improvement National Priorities for Acute Hospitals 2017 [https://improvement.nhs.uk/documents/1426/Patient\\_Flow\\_Guidance\\_2017\\_13\\_July\\_2017.pdf](https://improvement.nhs.uk/documents/1426/Patient_Flow_Guidance_2017_13_July_2017.pdf)
11. National Quality Improvement & Assurance System (NQAIS Clinical) <https://www.healthatlasireland.ie/>
12. [Quality care for Older People with urgent & emergency care needs](#) [http://www.bgs.org.uk/campaigns/silverb/silver\\_book\\_complete.pdf](http://www.bgs.org.uk/campaigns/silverb/silver_book_complete.pdf)
13. UK Ambulatory Emergency Care Network <https://www.ambulatoryemergencycare.org.uk/Tools-and-Resources>
14. UHG 2017 – Patient flow project

Although it is acknowledged that more beds are needed in the short and longer term, significant change to working practices is the only way of preventing current trends from continuing or worsening. The review expresses the view that increasing capacity alone is likely to be counterproductive as new beds are likely to be occupied by current unmet need and simply increasing capacity may hinder much needed reform and improvements in the ways of working that a modern health system demands <sup>2</sup>. The Capacity Review considers the potential scenario of reforming patient flow through hospitals with recommended initiatives including 'home by 11', better throughput in AMU and a national adoption of an Ambulatory (Emergency) Care Model.

The Capacity Review highlights that there is a wealth of data showing the impact altering patient flow has on reducing ALOS, reducing emergency to inpatient admission conversion ratio and reduction in delayed discharges. The demographic scenarios presented in the capacity review highlight the need for better access to diagnostics including direct primary care access and longer opening hours, and a coordinated approach to improving models of care across the Acute Floor. The review projects that, in addition to other specialties carrying out similar restructuring, the shift towards an Ambulatory Model could reveal a 20% reduction in ALOS across all hospital groups, a 30% increase in day case activity and a 40% increase in Acute Medical Activity <sup>4</sup>.

**1.2 The Acute Floor Model for Ireland** <sup>5</sup> presents an opportunity for aligning services on the acute floor to Ambulatory Care. The Acute Floor concept relates to co- or proximally-located integrated acute services within a Model 3 or 4 hospital for patients presenting for unscheduled care. On presentation, patients are rapidly streamed by an appropriately trained clinical staff member to the appropriate clinical area of expertise including Acute Medicine, Emergency Medicine and Acute Surgery.

Implementing Ambulatory Care across the Acute Floor demands that patient flow has a strategic and purposeful focus on same day, high quality urgent care and priority on avoidance of inpatient admissions at all times. The data presented in this report, pertaining to Acute Medical patients, will show that many of the acute presentations in medicine are ambulatory sensitive conditions however the data collection and analysis is applicable to all services across the Acute Floor.

**Ambulatory Care** is defined as clinical care provided on a "day basis" that is not provided within the traditional hospital bed base or out-patient service. It includes diagnosis, observation, treatment and rehabilitation...Ambulatory care will have competent clinical decision makers. There will be immediate access to diagnostic support to facilitate "one stop" rapid diagnosis, treatment and/or reassurance (NAMP) <sup>4</sup>.



**1.3 The Framework for Ambulatory Care in Acute Medicine:** The National Acute Medicine Programme (NAMP) Report (2010)<sup>4</sup> proposed the development of an Ambulatory Care as a safe and effective alternative for patients who require urgent care without having to stay overnight in hospital. It is care of a condition that is perceived either by the patient or by the referring practitioner as urgent, and that requires prompt clinical assessment. Ambulatory Care must be high quality care, designed to ensure the best outcomes for patients. It is the responsibility of those delivering the care to ensure that resources are deployed in the most cost-effective manner (Report on the Acute Medicine Programme 2010<sup>4</sup>).

Since the NAMP report in 2010 many Acute Medical Units have implemented Ambulatory Care, which has reaped enormous benefits in terms of reduced demand on bed capacity, improved processes for urgent care, transformed working practices for acute hospital staff, in addition to developing accessible urgent care services for GP colleagues and most importantly being able to deliver high quality, safe care to acutely ill patients without requiring an overnight hospital stay. When considering the urgent demand to reconfigure access to acute hospitals and reduce demand on capacity the focus of urgent and emergency care should shift to an Ambulatory Model, which preserves acute hospital beds for only the sickest patients. When successfully implemented Ambulatory Care leads to a change in mindset, it requires appropriate streaming, access to diagnostics and the re-organisation of working practices. It is cost effective, improves patient outcomes and experiences, prevents overcrowding of Emergency departments and is clinically safe<sup>6,7,8</sup>

The NAMP target of 25% same day discharge for acute medical patients in Irish hospitals is reflective of current trends. From January 2015 to December 2017 same day discharge rates in Model 4 hospitals has varied significantly across the range of 5% to 25%, averaging at 16.4%, rates are considerably higher in hospitals who follow the NAMP pathway. Model 3 hospitals averaged at 27% with the lower acuity Model 2 hospitals same day discharge rates averaging at almost 45%.

The UK has seen a significant upsurge in Ambulatory (Emergency) Care over that last few years with the Ambulatory care growing significantly across Surgical and Gynecological services. In Acute Medicine there has had a 60% increase in Ambulatory (Emergency) Care activity across sites in recent years and in 2017 almost 90% of patients in Acute Medical units reviewed for the SAMBA17 survey completed their care and were discharged home the same day<sup>9</sup>. The commitment to Ambulatory Care in the UK has been prioritised and NHS England requires that acute hospitals must deliver AEC services 14 hours per day, seven days per week and should expect to convert at least one third of patients to same day discharge across the spectrum of acute specialities<sup>10</sup>.

The National Acute Medicine Programme (NAMP) has developed this framework to assist services on the Acute Floor to develop Ambulatory Care by presenting a current profile of acute medical activity in Irish hospitals with a particular focus on the utilisation of beds and demand on acute services from patients presenting with the highest volume of clinical conditions, all of which can be categorised within the spectrum of chronic disease (Source NQAIS clinical<sup>11</sup> Data is available in main report)

#### AMBULATORY CARE PATHWAYS

There are many Ambulatory Care Pathways already in existence across AMU/AMAU/MAU's in Ireland. The Common Conditions data provides a list of what pathways exist for common clinical conditions and where they can be found.

**1.3.1 Application of the Ambulatory Care Framework in Acute Medicine:** The Ambulatory Care Framework outlines the factors critical to the successful implementation of sustainable, effective Ambulatory Care. The data presented is relevant to Acute Medicine however the framework is transferable across all urgent and emergency care specialties. **The Critical Factors** outlined at the end of this report have been identified after an appraisal of how Ambulatory Care is delivered in the UK and where there has been successful implementation of Ambulatory Care Pathways within AMU/AMAU/MAUs in Ireland. This framework will provide all staff working on the Acute Floor with guidance on implementation and/or escalation of Ambulatory Care.

**1.4 Using data to identify suitable Clinical Conditions:** The data provided is a guide for services to show the metrics they can and should be looking at in their own data. An analysis of the Healthcare Inpatient Enquiry (HIPE) system & the National Quality Assurance & Improvement System (NQAIS Clinical) was used to identify all Acute Medicine diagnoses (primary diagnosis on discharge). The data report lists the top 25 clinical conditions in Acute Medical patients across all 34 acute hospitals in Ireland in 2017. In addition to the volume of presentations, the ALOS per condition and the overall bed days used (BDU) is outlined and is separated out to the two admission streams AMAU and Non-AMAU. Non-AMAU includes ED admissions, emergency admissions from 'other sources' and elective medical admissions to hospital.

Furthermore the top 25 clinical conditions seen in Acute Medical units are listed and disaggregated by Model 2, 3 & 4 Hospitals. Appendix one contains this data for each individual acute hospital. An additional top 25 clinical conditions list is also provided for patients aged 75 years and over. Having

the list of clinical conditions seen in the over 75 year age group can help focus services to the relevant ambulatory sensitive conditions to assist with the development of Ambulatory Care aligned to the 'Frailty at the Front Door' model which is utilised and successfully implemented in the Geriatric Emergency Medicine Service (GEMs) in St Luke's Hospital Kilkenny, and which NAMP recommends should be replicated across all Acute Floor services as a priority.

Frail older patients should be a priority for Ambulatory Care as hospital admission in this patient cohort creates its own specific challenges in terms of increased length of stay, increased functional decline and increased risk of admission to long term care instead of back to their home<sup>12</sup>.

For each clinical condition listed there is an indication as to whether an Ambulatory Pathway exists, in Acute Medical Units, currently in Ireland. Furthermore the UK 'Directory of Ambulatory Emergency Care for Adults' (2018)<sup>6</sup> is referenced in terms of the potential to

convert to Ambulatory Care rated from low to very high. The Directory, first published in 2007 by the NHS, drew together contributions from specialists in emergency care and using International Classification of Diseases coding data (ICD – 10). A list of conditions that can potentially, with appropriate and prompt access to diagnostic services and specialist advice, be clinically managed outside hospital in an ambulatory setting was compiled.

#### Top 25 Clinical Conditions

*The top 25* clinical conditions that Acute Medicine patients presented with across all acute hospitals in 2017 on page 30

*The top 25* clinical conditions in AMAU patients in 2017 across Irish Hospitals are listed on Page 32

Top 25 AMAU Clinical conditions in 75+ year patient cohort on page 33

*Appendix One* lists individual hospitals

## NEW WAYS OF WORKING

SVUH - have developed an IT supported Virtual clinic designed by Acute Physicians & ANP and managed by ANPs had led to a significant reduction in follow up attendance and safer Ambulatory Care for patients

UHG AMU – 75% of cardiac investigations done within 6 hours – AMU patient satisfaction rating >98%

SLHCK – GEMs 24/7 identification of frailty on streaming on Acute Floor

CUH – TIA Ambulatory Pathway led to 50% reduction in admission, reduced ALOS, reduced number of tests

OLOL – Nurse led DVT pathway, admission avoidance with proper assessment, nurse follow up until treatment

Its inception came about because of new commissioning arrangements which required a reduction in hospital admissions and this demanded a shift towards Ambulatory Care. The directory identifies high volume admissions data across the clinical spectrum, using the coding of conditions and removal of those patients with the same primary diagnosis who have multiple comorbidities or major complications.

The directory lists clinical conditions for which admission to hospital could be avoided in 10-90% of cases, the purpose of attaching a percentage of potential is so that when services are considering where to focus ambulatory care they apply the potential % to the volume of patients with the attached code and then calculate the potential to increase by applying the lower range and upper range. This provides a range of potential when considering ambulatory sensitive conditions in the context of local service.

The top 25 clinical conditions in Ireland data lends itself to this process as many of the conditions are the same as in the UK. This is discussed in more detail in the data section (excluded here). The UK directory also lists relevant ICD codes<sup>6</sup>. The codes have not been added to the clinical conditions lists here but a search on NQAIS clinical can identify the codes attached to patients on discharge.

The directory is useful as a guide, *however* it should be used with caution. In the UK many

primary care services are established to support acutely unwell patients at home and thus avoid hospital attendance. Similar services are not as well established in Ireland and therefore many patients with the a similar level of acuity who would be managed in primary care in the UK may be admitted as an inpatient in Ireland because of a lack of services in primary care.

An example of this is COPD patients whom, which according to the UK Directory, have only a 10-30% chance of having a same day discharge. However, the UK has established '*Hospital-at-home and assisted-discharge schemes*' which can manage lower acuity COPD patients at home and are considered an alternative way of caring for patients with exacerbations of COPD who would otherwise need to be admitted to hospital. This indicates that those COPD patients who require transfer to hospital are of higher acuity and thus are more like to be admitted as an inpatient thus the Low potential for Ambulatory Care.

One of the most useful findings from the UK directory is the assumption that patients presenting with Ambulatory sensitive conditions who have a 0-2 d LOS should be targeted initially for developing Ambulatory Care. Many of the conditions within the top 25 list have a 0-2 d LOS with lower ALOS for those patients admitted through the AMAU stream as it includes same day discharge patients.

The Non AMAU stream for patients is predominately through the Emergency Department and patients ambulated through ED without hospital admission are not captured on HIPE. This is a significant disadvantage as it hinders the ability to capture a complete picture of the experience of acute medical patients in Ireland or the Ambulatory Care services currently within ED's in Irish hospitals. The Emergency Medicine Programme is working with the healthcare pricing office (HPO) to code ED activity using ICD – 10 codes specific to Emergency Departments.



**NAMP recommends** that targeting those clinical conditions that are in the top 5 (or 10) of the list which have a LOS of <2 days is a good starting point for applying the framework. This will identify why patients were kept overnight but discharged in less 48 hours and what is required to convert this to same day discharge.

**1.5 Recording Activity & Pricing of Ambulatory Care:** Since the development of Ambulatory (Urgent) Care in the UK a tariff based system has been developed to create a pricing structure for Ambulatory Care activity and to incentivise best practice care although we have yet to develop this system in Ireland. New patient activity in AMU (and ASAU) is recorded on The Healthcare Inpatient Enquiry system (HIPE) and has a price attached to it.

#### ACTIVITY PRICING

NAMP are working with the HPO to develop definition criteria for Ambulatory Care Activity. It is essential that accurate activity is recorded to support the development of an Ambulatory Care pricing model.

However to develop a pricing structure for Ambulatory Care it is essential to record it as specific activity, not just for a first attendance of patients but also where there is ongoing treatment or assessment over a short time period without hospital admission. Currently HIPE does not record this activity as it is classed as outpatient (or review) activity rather than new activity. However this is not a true reflection of the labour intensity or resource demand and does not consider the inherent risk accepted by the Ambulatory Care service for managing care and treatment on a day basis which would traditionally have only deemed appropriate for inpatient admission.

The NAMP is collaborating with the HPO to build a pricing mechanism for this but first the activity needs to be recorded in its own right as Ambulatory activity rather than as a review. Guidance will be provided to units on how Ambulatory Care activity is defined and should be recorded.

It is also important to acknowledge that an incentive exists, to admit patients to Irish hospitals, because of the income derived from inpatient admission of patients who hold private medical insurance. This income will be lost if Ambulatory Care service becomes fully functional for relevant patients. Currently 12.7% of income for acute hospitals derives from Private health insurance. SláinteCare plans to remove private health insurance from acute hospitals and replace the expected €649m income from public funding over a phased basis. Under this plan the provision of private services in public hospitals will be eliminated.

SláinteCare outlines the benefits that will be gained by ensuring expansion of services in primary care and by ensuring healthcare is delivered at the lowest level of complexity that is safe, efficient and good for patients. Additionally it highlights the need for a system wide response to address long wait times, delayed access to diagnostics and poor experiences of patients referred for urgent care. The Ambulatory Care Framework aligns with this approach and any potential loss of income should not be seen as a disincentive to develop an Ambulatory Care service that avoids inappropriate hospital inpatient admission and is safer & better for patients.

### Critical Factor 1: 'Identify Clinical Conditions'

**Provides further detail on the type of data that can be gathered to assist services when reviewing the needs of their own patients and aligning to the Ambulatory Care Framework**

**1.6 Selecting & Streaming Appropriate Patients:** is fundamental if Ambulatory Care is to become a success. If the incorrect approach is taken to the selection and streaming of patients Ambulatory Care will fail resulting in a continued culture of reliance on inpatient admission. The pathways approach exists across many Acute Medical Units in Ireland where Ambulatory Care Pathways exist for specific conditions. These have shown tangible benefits in decreasing overall length of stay and increasing volume of same day discharge.

Although the clinical conditions data is vital to inform service design it is important that Ambulatory Care does not become too pathway specific which risks excluding other relevant patients who would benefit from Ambulatory Care.

A process model can help to avoid this risk. Many Ambulatory Emergency Care Centres within the UK with existing pathways in place have learned that adopting a process approach, where

**all patients are assumed suitable for Ambulatory Care if clinically stable until proven otherwise**, has increased the success of their Ambulatory Care Models and the volume of patients moving through Ambulatory Care. This approach has contributed to a change in working practice and mindset that all patients who are clinically stable have potential to be ambulated and the service is designed around that process <sup>13</sup>.

A process approach which is neither well planned, nor monitored can lead to inappropriate patients being streamed and consequently a higher than desirable 'conversion to inpatient' ratio. The NAMP advises that the process approach where all potential patients should be considered for Ambulatory Care is highly effective and workable once there is clear inclusion and exclusion criteria and there are appropriate resources available, particularly access to diagnostics over the extended time period normally reserved for emergencies only, to ensure patients are likely to have a same day discharge, or receive ambulatory care over a short time period, e.g. 72 hours, without a hospital admission. This requires extended working hours and movement to 7 day opening across AMU/AMAU's on the Acute Floor and increased access to clinical diagnostics & HSCP services.

Streaming: UHG have a highly skilled GP working full time streaming patients appropriately to all services and actively discharging patients

The Acute Floor Model will move Streaming to the Front Door

### **Critical Factor 2: 'Stream Appropriate Patients'**

**Streaming appropriate patients is ultimately about clinical collaboration and communication across urgent and emergency care services and with primary care and is considered one of the Critical Factors**



**1.7 The Challenges and Risks:** of making Ambulatory Care the first and preferred pathway for all patients must be mapped out and solutions sought before there is commitment from Acute Floor staff and colleagues to invest in and develop Ambulatory Care.

The boarding of patients effectively shuts down Acute Medical (& Acute Surgical) Units and obstructs the ability to deliver existing services or plan any future potential increase in activity. In units where there has been active measures to prevent boarding, productivity has increased dramatically and assisted in reducing patient admissions and LOS of medical patients streamed through AMU compared with those through ED.

Other challenges including the allocation and protection of diagnostic slots and having designated high priority OPD clinic slots to allow egress from Ambulatory Care services. This needs to be in place if Ambulatory Care is to work. This requires discussion, collaboration and consensus with colleagues in other departments e.g. radiology and cardiology to ensure they have a good understanding of what can be achieved by introducing Ambulatory Care, given that it will require a change in working practices and planning from them also. The NAMP is currently compiling recommendations on minimum requirements in workforce planning and access to clinical diagnostics to align with implementation of the Ambulatory Care framework.

Finally, the expectations of the patient and their family needs to be well managed. A model focused on same day discharge can be unfamiliar to many service users. Ambulatory Care tends to rate very highly on patient satisfaction surveys, when services have outlined the benefits of same day care and provided comprehensive patient information through leafleting and signs and where GPs have prepared patients in advance for potential same day care<sup>12</sup>. Effective egress out of the Ambulatory Care service will require building links with community and primary care services including Community Intervention Teams, Residential services Public Health Nursing and GPs. Early engagement with these colleagues to support early discharge and follow up treatment and care is essential.

### Boarding Stops Progress

The Acute Medical Unit in CUH is considered a Centre of excellence in their adoption of the Acute Medicine Pathway.

Patient Flow pathways include:

- Direct streaming from Ambulances to AMU
- ED Triage Nurse to AMU CNM transfer
- ED doctor to AMU doctor transfer
- Protected GP slots for Ambulatory Care Pathways
- Direct GP referral for urgent review to AMU

All of the above ceases when AMU is used for Boarding

MMUH – has a 'No boarding in AMU' policy documented on their surge capacity protocol

Between January - August 2018 9,795 patients were boarded in AMU/AMAU's across Model 3 & 4 hospitals

**Critical Factors' 3 : 'Protect Environment & Resources' & 4: 'Map out Processes, Challenges & Risks'**  
**Provide guidance on factors that need to be considered when planning on implementing or expanding Ambulatory Care**

**1.8 Why Focus on Ambulatory Care?** Ambulatory Care is about harnessing the skills, knowledge and experience of staff working in urgent and emergency care. It requires early access to senior decision makers whilst reorganising services in a patient centred way so that the 'assess, treat and complete' model is a same day service rather than an inpatient model and is safe, of high quality and effective for high volumes of acutely unwell patients.

#### IS AMBULATORY CARE **BETTER**?

**Is it Better for Patients?** IN UK 1/3 OF ADMITTED PATIENTS ARE SEEN, DIAGNOSED, TREATED AND DISCHARGED SAME DAY TO CONTINUE THEIR TREATMENT AT HOME OR IN A COMMUNITY SETTING - PHYSICIANS AND CLINICAL TEAMS AGREE THAT BY IMPLEMENTING AEC MEANS MANAGING EMERGENCY CARE PATHWAYS SIGNIFICANTLY IMPROVES PATIENT EXPERIENCE.

**Is it Better for Staff?** MANY STAFF EXPERIENCED IN DEVELOPING AMBULATORY CARE HIGHLIGHT THAT SUCCESS COMES FROM THE WHOLE TEAM WORKING TOGETHER TO REORGANISE AND REDESIGN PATIENT CARE DELIVERY THROUGH COLLABORATION, COMMUNICATION AND COMMITMENT. THIS APPROACH INCREASES THE PROFILE OF AMBULATORY CARE AND LEADS TO INCREASED LEARNING AND EDUCATIONAL OPPORTUNITIES, BETTER USE OF RESOURCES, LESS WASTE AND INCREASED STAFF SATISFACTION

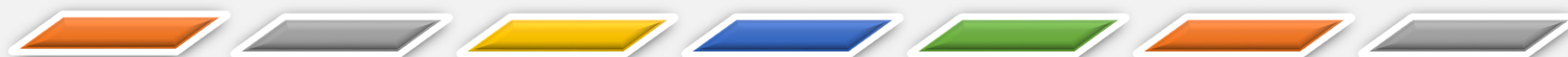
**Is it Better Care?** IT DEMANDS A SHIFT AWAY FROM THE TRADITIONAL MODEL WHERE A QUICK ASSESSMENT IS MADE PRIOR TO A WAIT FOR ADMISSION AS INPATIENT SO THAT DIAGNOSTICS AND TREATMENT CAN CONTINUE, CREATING EXTENDED WAITING AND DELAYS AND UNNECESSARY DEMAND

**Applying the Framework:** This document is the first part of the Ambulatory Care Framework. It provides the rationale for developing and delivering a robust, sustainable Ambulatory Care service for acutely unwell patients accessing Acute Hospitals in Ireland. The Critical Factors outlined on the following pages are not selective but rather should be used in a combined way to map out how Ambulatory Care could work within existing services.

#### Critical Success Factor 5: 'Measure Impact'

Provides guidance on measuring Activity, Patient experience and Quality Improvement Approach to Service Development

## *Framework for Ambulatory Care Critical Factors*





# Framework for Ambulatory Care Critical Factors

## 1. Identify Clinical Conditions

### •Process & Pathway – Use Data – Can the ANP Lead? – Monitor Conversion Rate

- Avoid assuming that you need predictable outcomes or specific pathways only
- Don't focus on specific or preferred specialty – Acute Physicians manage many conditions and Ambulatory Care should be considered for all
- Do not exclude older, frail patients, Ambulatory Care should be frailty attuned
- Ensure that the conditions are relevant to Ambulatory Care not filling a void caused by gaps/delays in other services
- Conversely identify conditions that are not moving through Acute Medicine on an Ambulatory Care pathway but should be, if not, why not?
- What is the total volume of patients?
- What are your top ten clinical conditions?
- How many of those are moving through Ambulatory Care currently?
- How can more be converted?
- What is current ALOS per condition
- Look at the conditions which have a high % 1-2 day LOS; what prevented these from being same day discharge? Can they be converted to same day discharge?
- Advanced Nurse Practitioners can be at the forefront of developing Ambulatory Care
- Many services already have ANP & Nurse led pathways
- UK AEC expects a conversion rate of 10% approximately, this should not be seen as a failure of the Ambulatory Care
- Monitoring the conversion rate is useful to identify patients that may have been streamed inappropriately which can be expected initially

## 2. Stream Appropriate Patients

### •GP as Senior Decision Maker – Push/Pull – Clinical Communication – Keep Patient Informed

- Slots for GP referrals to Ambulatory Pathways should be protected
- Additional slots should be given for urgent GP referral
- The GP as Senior decision maker means GP referred patients are streamed without triage
- Start small and increase to avoid over promising slots that may be removed
- Significant education and information with GPs on principles of Ambulatory Care & appropriate referral to urgent care
- GPs are instrumental in ensuring patients understand Ambulatory Care
- Senior clinical decision maker is essential at point of streaming
- Use National Early Warning Score (NEWS) to determine whether patient is clinically stable (score <4 is UK benchmark)
- Develop own exclusion & inclusion criteria
- Ambulatory Care staff need to pull patients from Emergency Medicine
- All staff across Acute Floor, Ambulance & Primary Care need to push to AC
- This requires collaboration, communication and consensus across Acute Floor & with key stakeholders
- Direct Referral from Ambulance is efficient and can help to spread an understanding of Ambulatory Care
- Initially Ambulatory Care model may need to be 'sold' to sceptical colleagues until benefits are realised
- Need to have effective egress out of Ambulatory Care
- Need protected OPD follow up slots to avoid unnecessary returns to Ambulatory Care
- Ensure Ambulatory activity is distinguishable from other review activity

# Framework for Ambulatory Care Critical Factors

## 3. Protect Environment & Resources

### •Design for Ambulatory Care - Environment - Facilities - Resources

- 'Treat to discharge' mindset is essential for all staff
- This means rapid access, diagnosis & treatment for all
- This means NEWS within 15 minutes & Senior decision maker within 60 minutes
- Training & Education of all staff will be required to explain why Ambulatory Care is essential
- Mixture of chairs and trolleys most beneficial use of patient space
- Aim to turn over chairs AND trolleys at least twice per shift
- Waiting area for initial assessment/streaming and also as a waiting area between treatment
- Treatment room/space for invasive procedures required
- Close proximity to diagnostics very beneficial especially for mobile patients
- Boarding of patients in Ambulatory Care area must be forbidden
- Surge Capacity protocol lists Ambulatory Care as last possible area for boarding
- Senior management recognition & written directive to support no boarding policy
- Appropriate equipment provided and protected for Ambulatory Care service
- Protected and allocated dedicated Ambulatory Care slots in Diagnostics including Radiology, Vascular and Cardiology
- Using common conditions data can support rationale for requirement for diagnostics
- Ambulatory Care recognised as Urgent care service so access to HSCP team, diagnostics should focus on same day 'treat to discharge' model
- Culture of recognition of positive benefits of Ambulatory Care must be fostered
- Promote culture of engagement from colleagues across hospital to promote admission avoidance
- Availability of Short Stay Ward proven to be beneficial in keeping LOS <48 hours for patients who must be admitted

## 4. Map Out Processes, Challenges & Risks

### •Current State vs Future State - Primary & Community Services - Documentation - Out of Hours Follow up -Time to Adapt

- Current State: conduct an initial mapping exercise, look at how patients are streamed, examples of good practice and what facilitates them and current challenges that are potential barriers to the Ambulatory Care model
- Consider reasons why conditions with obvious Ambulatory potential are not being converted. Local or cultural Issues should not be ignored, it is better to identify these as challenges early so solutions can be sought
- Changing working patterns and reconfiguring services will be required so it is important to engage early with as many people as possible who can assist in the process or provide solutions
- Future State: Map out what a realistic, sustainable Ambulatory Care service would look like, use the critical success factors as a guide, then document what is preventing your service from delivering this
- Engage with primary and community services, OPAT, CIT are examples of services that may be available
- Robust documentation is required to reduce the risks when converting inpatient care to Ambulatory Care. Documentation must be comprehensive and processes must be in place to be able to share vital information with other key stakeholders such as GP, community care etc.
- Discharge information must be shared within 24 hours
- Consider who should have responsibility for Ambulatory Care patients who may present outside the hours of the service, there must be solid communication streams in place to reduce risk of harm
- Time is required to allow any new service to be adopted and for staff and patients to adapt to new ways of working, there should be an acceptance that one of the challenges is keeping staff engaged and committed during periods of frustration
- Consider other potential initiatives that can transform practice – virtual clinic, IT tracking systems
- Constant monitoring is required to evaluate service development in real time, rather than retrospectively

# Framework for Ambulatory Care Critical Factors



## 5. Measure Impact

•KPIs - Activity - Patient Experience - Quality Improvement

- Impact of Ambulatory Care must be measured if it is to be scaled up
- Should be a mixture of qualitative and quantitative measures
- Volume of new referrals
- Patients who have once only Ambulatory Care – essential process measure to develop pricing system
- Ambulatory Care Activity completed within 72 hours as OP - essential process measure to develop pricing system
- Volume of conversion to Inpatient and why?
- BDU by these patients
- Initial purpose of developing service can provide outcome measures
- Is there a reduced LOS & reduced overall ALOS linked to common conditions data?
- Is there an increase in same day discharge linked to common conditions and pathways?
- Is there increasing numbers of patients overall? – throughput should increase with trolleys/chairs turnover

- What is impact on PET <6 hours – this could be negatively impacted initially if same day patients stay longer to complete treatment
- Where are referrals originating? – this will highlight how well service is known
- What follow up care was arranged (OPAT, CIT, Specialist OPD) – this can also show gaps in follow up care
- NEWS score should be audited to assess clinical stability of referred patients
- Patient satisfaction surveys should be carried out & can help to inform patient information documentation
- Patients with same clinical conditions not referred to Ambulatory Care should also be reviewed – this will highlight issues around referral, potential for extended opening hours, increase or further spread of service
- Once Ambulatory Care service is established – 7 day & 30 day readmission rates should be audited to ensure that there is no increase in these rates

## Next Steps:

***The National Acute Medicine Programme will assist services to adopt the critical factors so they can develop or enhance their Ambulatory Care service – Guidance documentation & templates will be provided***



