### Ambulatory Care Unit Standard Operational Policy

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<th><strong>Document Control</strong></th>
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<tbody>
<tr>
<td><strong>Reference No:</strong></td>
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<td><strong>Version:</strong></td>
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<tr>
<td>004</td>
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<tr>
<td><strong>Lead Director:</strong></td>
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<tr>
<td>Dr Mo Aye</td>
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<td><strong>Document Managed by Name:</strong></td>
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<td>Ambulatory Care Unit Standard Operational Policy</td>
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### Consultation Process

The following work groups and committees have been involved in the consultation process:
- Ambulatory Care Working Group
- Department of Radiology
- Pharmacy
- Medicine Transformation Programme Board
- Integrated Hospital Team
- Intermediate Care Team
- Discharge Liaison Service
- City Health Care Partnership
- Humber NHS Foundation Trust
- Yorkshire Ambulance Service
- Patient Transport Service
- Local Authority Social Services

### Key words (to aid intranet searching)

- Target Audience
  - All staff
  - Clinical Staff
  - Non-Clinical Staff Only
  - Managers
  - Medical Staff Only

### Version Control

<table>
<thead>
<tr>
<th>Date</th>
<th>Version</th>
<th>Author</th>
<th>Revision description</th>
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<tr>
<td>17/11/14</td>
<td>DRAFT 004</td>
<td>Dr Mo Aye</td>
<td>1. Medical model specified</td>
</tr>
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1.0 INTRODUCTION

1. Ambulatory care is defined as ‘clinical care, which may include diagnosis, observation, treatment, and rehabilitation, not provided within the traditional bed base or within the traditional outpatient services that can be provided across the primary/secondary care interface.’

2. Prospective data on acute medical admissions at Hull Royal Infirmary suggest that as many as 40% of patients can be treated on ambulatory basis.

3. About 15% of currently unscheduled attendances can be seen as scheduled urgent care, which may include expedited diagnostics, rapid-access specialist review and planned treatment sessions.

4. More than 50% of ambulatory attendances can be seen, treated and discharged on the same day (zero length of stay, 0-LoS)

5. Although ambulatory care has been in place at Hull Royal Infirmary since 2010, constraints in physical environment and staff resources have limited its scale and scope.

2.0 PURPOSE OF THE STANDARD OPERATING PROCEDURE

The purpose of the Standard Operating Procedure (SOP) is:

1. To ensure that staff who participate in the delivery of the ambulatory pathway understand their defined roles, responsibilities and accountability, and

2. To deliver key objectives:
   - Improvement in quality of clinical care:
     - Greater consistency of care through reduced clinician variability
     - Better and more timely access to specialist input
     - Avoidance of iatrogenic harm
   - Improved patient experience
   - Operational effectiveness:
     - Reduced time in hospital
     - Reduced number of medical admissions
     - Alleviation of crowding in ED by avoiding boarding of GP-referred medical patients in ED

The service must collect auditable data to drive improvements in clinical outcomes and to demonstrate impact on efficiency and effectiveness of care.
3.0 PERIOD OF OPERATION
The unit will be operational from 0800–2200 every day, including weekends.¹ Last patient arrival to ACU should be no later than 2000.

4.0 AREA CAPACITY
- Purpose-built modular build facility at Hull Royal Infirmary
- Maximal capacity 35, which consists of 30 lounge-type chairs and 5 trolleys
- 5 rooms for assessment/consultation

5.0 ELIGIBILITY CRITERIA
The following criteria must be met for an ACU attendance:

1. The patient must be ‘ambulant’
   a. Able to transfer and mobilise without assistance
   b. Where there is baseline limitation in mobility, then there is no significant deterioration in mobility so as to preclude safe discharge
   c. There is no clinical need to be confined to bed

2. The patient’s clinical needs fall into one or more of the following:
   a. Diagnostic exclusion – e.g. low probability PE
   b. Time-limited assessment, observation – e.g. mild to moderate exacerbation of asthma, undifferentiated chest pain
   c. Specific schedulable treatment – e.g. transfusion for chronic anaemia
   d. Specific disease pathways: for conditions which may be managed in the community with appropriate outreach from specialities, e.g. heart failure, COPD.

3. On balance of probabilities, the clinician believes that the patient is likely to be discharged on the same day (0-LoS)

4. There are no known barriers to discharge with 0-LoS

NOTE:
- All GP admissions should be considered for ambulatory care unless there is clear evidence to the contrary.

¹ It is the intention of the service to run the ACU on bank holidays but this will only be possible in the Phase 2 of medical transformation when expansion in the number of acute physicians have taken place.
• Age per se should not preclude older patients from attending ambulatory care. If (a) the patient’s clinical needs are purely medical, (b) the condition is best managed in ambulatory care setting and (c) the patient has no care needs to preclude discharge then the patient should be seen in ambulatory care in preference to the Elderly Assessment Unit (EAU).

6.0 EXCLUSION CRITERIA

1. Medical condition requires hospitalisation.

2. Significant deterioration in mobility precluding safe discharge.

3. Non-medical conditions: acute undifferentiated abdominal pain, bleeding per rectum, re-attendances following surgery.

NOTE:

• The Ambulatory Care Unit (ACU) must not be used to hold patients post-discharge (i.e. a discharge lounge function) or those awaiting review from another specialism (e.g. Mental Health).

7.0 ACCESS TO THE AMBULATORY CARE UNIT

Effective patient selection and streaming is crucial for the effective functioning of both ACU and AMU. The decision on whether a patient should attend ACU should be based on four questions:

<table>
<thead>
<tr>
<th>Is the patient clinically stable?</th>
<th>Normally this means NEWS &lt;4. Patients with higher scores may be managed depending on clinical judgement.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the patient functionally capable of being managed in ACU?</td>
<td>The patient should be able to attend to their toileting and feeding needs.</td>
</tr>
<tr>
<td>Would this patient have been admitted to hospital before ACU existed?</td>
<td>If no, the patient should not be referred to ACU or AMU.</td>
</tr>
<tr>
<td>Could the patient’s clinical needs be met better by another service?</td>
<td>This depends on availability of alternatives, which in turn will develop over time.</td>
</tr>
</tbody>
</table>

7.1 Referrals from General Practice and from ED junior doctors

Ultimately there will be a single access number for all medical admissions. It is envisaged that a majority of patients attending ACU will be from GPs.

---

2 Royal College of Physicians: Acute Care Toolkit 10. Ambulatory Emergency Care.
1. Senior clinical input is needed at the point of referral to direct suitable patients to the Ambulatory Care Unit.

2. Access call will be answered initially by administrative staff, who will take the demographic details of the patient.

3. All GP calls and calls from ED doctors of F2 – ST3 grade will be passed to the ACU clinician. In the first instance, it will be the ACU senior nurse. ACU senior nurse may involve the ACU Consultant or Acute Medicine Registrar in the discussion.

4. The following are the expected outcomes of the clinician-to-clinician dialogue:
   a. Attendance at the ACU. The referring clinician should advise the patients that they might not need to be admitted and be discharged on the same day.
   b. Admission to Acute Medical Unit (AMU)
   c. Re-directed to Elderly Assessment Unit (EAU)
   d. Direct admission to a specialty ward
   e. Planned admission to a specialty ward
   f. Planned attendance to ACU for acute medicine input
   g. Planned attendance to ACU for specialty input
   h. Planned appointment for a rapid access specialty clinic
   i. Advice only with mutually agreed management plan, no attendance or admission

5. GP-referred patients must not be re-directed to ED except where it is clear that there is acute physiological decompensation requiring resuscitation.

6. GP-referred patients may be diverted to ED by Yorkshire Ambulance Crew if there is clinical deterioration and the patient needs resuscitation.

7.2 Admission from ED Interventional Triage

1. ED Senior Nurse at Interventional Triage may refer a patient directly to ACU if it is felt that the patient will be best served by the service. The RCP AEC principles ("Four Questions" above) apply.

2. ED Senior Nurses at Interventional Triage should be able to recognise patient who is deteriorating, has deteriorated or are likely to deteriorate further. These patients should be seen by ED doctors initially.

3. Self-presenting patients who should be seen, treated, and discharged within 4 hours should also be seen, treated, and discharged in ED.

4. Referral ≥ requires a dialogue with ACU Senior Nurse as above.

5. As a guide, Ambulatory Care Score (AMB Score) can be used. It is emphasised that this tool is to aid decision but not for dogmatic adherence.
<table>
<thead>
<tr>
<th>Score</th>
<th>Female</th>
<th>Male</th>
<th>0</th>
<th>-0.5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td>&lt; 80 years</td>
<td>&gt; 80 years</td>
<td>0</td>
<td>-0.5</td>
</tr>
<tr>
<td><strong>Access to transport</strong></td>
<td>Yes</td>
<td>No</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>** Likely to need IV Rx**</td>
<td>Yes</td>
<td>No</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td><strong>Acutely confused</strong></td>
<td>Yes</td>
<td>No</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td><strong>NEWS</strong></td>
<td>NEWS = 0</td>
<td>NEWS ≥ 1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td><strong>Discharged within last 30 days</strong></td>
<td>Yes</td>
<td>No</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td></td>
<td>7.3</td>
<td>8.0</td>
</tr>
</tbody>
</table>

### 7.3 Admission by ED Seniors

ED Seniors (Consultants and ST4+ Registrars) may send a patient directly to ACU without the need for a clinician-to-clinician discussion. Admin staff will register the patient upon instructions from the ED senior.

### 8.0 ACU OPERATIONAL STANDARDS

The following table describes operational standards for the ACU.

<table>
<thead>
<tr>
<th>Task</th>
<th>Role</th>
<th>Time frame</th>
<th>Time required (min)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial access call</td>
<td></td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>'Meet-and-greet'</td>
<td>CSW</td>
<td>Upon arrival</td>
<td>5</td>
</tr>
<tr>
<td>Observations: NEWS</td>
<td>CSW</td>
<td>Upon arrival</td>
<td>15</td>
</tr>
<tr>
<td>Initial assessment and tests ordered</td>
<td>Senior Nurse or Consultant or Registrar</td>
<td>15 minutes after arrival</td>
<td>10</td>
</tr>
<tr>
<td>Phlebotomy</td>
<td>CSW</td>
<td>15-30 minutes after arrival</td>
<td>5</td>
</tr>
<tr>
<td>Consultation with clinician</td>
<td>Any of: Consultant, Registrar, CMT (preferably CT2 trainee), Senior Nurse</td>
<td>30 minutes after arrival</td>
<td>20</td>
</tr>
<tr>
<td>Review test results (where appropriate) and final sign-off</td>
<td>Consultant or SpR</td>
<td>Median time: 4h</td>
<td>10</td>
</tr>
<tr>
<td>Generation of ambulatory care discharge letter</td>
<td>Any clinician, countersigned by</td>
<td>15 minutes after final sign-off.</td>
<td>10</td>
</tr>
</tbody>
</table>
### Task

<table>
<thead>
<tr>
<th>Task</th>
<th>Role</th>
<th>Time frame</th>
<th>Time required (min)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant/Registrar</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For admitted patients: DTA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL TIME</td>
<td></td>
<td></td>
<td>75</td>
</tr>
</tbody>
</table>

In line with the RCP Acute Care Toolkit 10 recommendations, the time standards in ACU should match the Clinical Quality Indicators for ED:

- Time to initial assessment: 15 minutes
- Time to medical assessment (time to Dr 1): 60 minutes

The service has considered but chose not to follow the recommendation for completion of episode within 4 hours. The ACU will see patients who will have justified clinical need to be in the unit for more than 4 hours, e.g. for blood test for troponin. The patient should not be moved from ACU if the setting is best suited to patient's needs even if it means a stay of longer than 4 hours. However, the anticipated mean length of stay will not be greater than 6 hours, which is a significant reduction on current performance.

### 9.0 RECORD KEEPING

1. Pending transition to Lorenzo, present documentation for Medical Ambulatory Care will be used on ACU.

2. With each Finished Consultant Episode (FCE), a letter will be sent to the GP.

3. This will be analogous to a clinic letter. It should list:
   a. Acute presentation
   b. Working diagnosis
   c. Investigations and treatment initiated by ACU
   d. Further diagnostics and follow up if any
   e. Request to the GP

4. The GP should not be asked to do tests or arrange clinics which are directly related to the clinical episode for which the patient attended ACU/AMU. It is our duty of care to organise appropriate onward care.

5. The letter will be dictated on G2 (or Dictaphone if no access) within 24 hours of when the patient is discharged.

6. The letter will be typed and faxed on the same day Monday to Friday, or the next working day after weekends and bank holidays.
10.0 WORKFORCE

1. The estimated time required for each patient is 75 minutes per patient. Assuming ACU attendances of 30-35 per day, it would require a minimum of 40 man-hours for ACU.

2. For medical staff: each patient takes 20 minutes for initial consultation and 15 minutes for consultation prior to sign off. This requires 35 minutes per patient.

3. For 35 patients, this will need 20 hours of doctor’s time.

4. For normal weekdays, 11.5 hours of consultant time is being allocated.

5. The non-Consultant grade doctors’ time
   a. Acute Medicine Registrar 6 hours
   b. 1 x SHO (CT1 or above), 8 hours
   c. 1 x SHO (flexibly deployed)

6. Nurses:
   a. 1 x Nurse Practitioner (hours)
   c. Band 5: 0900-2200
   d. Band 5: 0800-2100

7. 2 x CSWs
   a. CSW: 07.00-20.00
   b. CSW: 09.00-10.00

11.0 NURSING MODEL

11.1 Senior Nurse
The Senior Nurse on duty will be responsible for taking initial calls when an admission is requested and transferring the GP direct to a Consultant should direct dialogue be required. This nurse will be responsible for ensuring patients destined for the unit move swiftly from ED. Upon arrival in the unit, patients will be screened and have a National Early Warning Score (NEWS) calculated within fifteen minutes. At this point, initial investigations will be ordered. Under some circumstances, patients may require transfer to either AMU or EAU. The Senior Nurse will stream the patients to the correct clinician according to need and allocate a responsible nurse to coordinate and manage the pathway.

11.2 Role of Practitioners
Nurse practitioners will be on duty initially Monday, Tuesday, and Fridays and when possible Sundays. The senior Nurse will stream appropriate patients to the Practitioners who will autonomously manage their own caseload of patients from initial assessment to discharge. The practitioner will be responsible for ensuring that each patient is proactively managed on the pathway and that appropriate discharge advice is given to the patients and any follow up arrangements are organised as per unit policy.
11.3 Support Staff Responsibilities
Responsibilities will include undertaking all phlebotomy and transporting patients between departments also supporting the Medical Teams in Rapid Access Clinics.

11.4 Band 5 Nursing Team
These staff will be allocated their own caseload of patients by the Senior Nurse and be responsible for the delivery of the prescribed management plan. Proactive management of each patient on the pathway from initial assessment to discharge is required. This nurse will be responsible for ensuring patients for whom she is responsible receive appropriate discharge advice and that follow up arrangements are organised.

12.0 MEDICAL STAFFING MODEL

12.1 CONSULTANT LEVEL STAFFING

Monday-to-Friday

1. The ACU will have dedicated Consultant presence (‘ACU Consultant’).

2. There will be 3 separate shifts: 0900 – 1300, 1300 – 1700, and 1700 – 2030. The rota may be constructed so that the same Consultant may undertake 2 contiguous shifts.

3. The ACU Consultant has no responsibility for patients on the Acute Medical Unit (AMU).

4. The Consultant will start the 0900 shift on ACU and review those patients admitted via the Acute Medical Unit overnight who are considered ambulatory with potential for immediate or same-day discharge.

5. During each shift, the Consult will:
   a. Supervise and support other staff (senior nurse or medical registrar) in taking calls from GPs and from ED junior doctors and signposting them either to ACU, AMU or re-direct to Acute Frailty Unit (AFU).
   b. Supervise and support the registrar or the ‘SHO’ (core medical trainee) on ACU.
   c. See some patients de novo (i.e. without prior medical input) or review others after initial assessment and management by the registrar or the SHO.
   d. Sign-off discharge.

Saturday and Sunday

6. The ACU Consultant shift will be 1200 – 1800.

7. The ACU Consultant will support the AMU and AFU flexibly depending on operational need.³

³ The AMU will retain the morning and evening post-take ward rounds by the General Physicians. The AFU will have a ‘round’ by the DME Consultant, covering ESSU and the wards but not dedicated Consultant session as in weekdays.
**Bank holidays**

8. There will be no ACU shifts on bank holidays.

9. Empirical data indicate that the attendances during bank holidays are generally low and relatively fewer patients can be managed through the ACU. It is neither cost-effective nor practicable to run ACU as in weekdays.

**Trainee-grade level staffing**

10. Trainee-grade level staff include the Acute Medicine Registrar (‘Registrar’) and core medical trainees (‘SHO’).

11. The following table summarises trainee-grade staff allocation.

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<thead>
<tr>
<th>Grade</th>
<th>Weekdays</th>
<th>Weekends</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registrar</td>
<td>0900 – 1700</td>
<td>None</td>
</tr>
<tr>
<td>SHO 1</td>
<td>0900 – 1700</td>
<td>0900 – 1700</td>
</tr>
<tr>
<td>SHO 2</td>
<td>1200 – 2000 flexibly deployed between ACU and AMU</td>
<td>1200 – 2000 flexibly deployed between ACU and AMU</td>
</tr>
<tr>
<td>SHO 3</td>
<td>1500 – 2200, flexibly deployed between ACU and AMU</td>
<td>1500 – 2200, flexibly deployed between ACU and AMU</td>
</tr>
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</table>

**Medical Staffing Matrix**

<table>
<thead>
<tr>
<th>Time</th>
<th>Consultant</th>
<th>Registrar</th>
<th>SHO 1</th>
<th>SHO 2</th>
<th>SHO 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>09:00</td>
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<td>10:00</td>
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<tr>
<td>22:00</td>
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</tbody>
</table>

**13.0 BOARD ROUNDS**

It has been agreed that board rounds involving the nurse in charge and consultant will take place two hourly, starting at 10.00, to ensure timely escalation, prioritisation of investigations and best deployment of the team. These rounds will be focussed and standardised with clear information requirements.

**14.0 ESCALATION**

1. There should be no crowding in ACU, i.e. there must not be more patients in the unit than can be accommodated. This needs to be managed through an escalation process.
2. When the ACU is full (above 35 capacity), the patients who would otherwise attend ACU should be seen and treated in the Acute Medical Unit (AMU). AMU medical and nursing staff will attend to these patients. They must not be held in ED.

3. ACU should dedicate its resource to attend to existing patients on the unit, creating capacity.

4. Patients destined for ACU cannot be lodged in ED under any circumstances once a decision to admit has been made.

15.0 INTERFACE WITH PATIENT PLACEMENT

1. All ED patients with a decision to admit (DTA) to ACU must be placed on ACU within 30 minutes.

2. The last patient will be admitted at 2000 and AMU kept fully informed of any bed requirements.

3. It is expected that patients will be discharged and that pathways are proactively managed to avoid overcrowding in AMU.

4. At 0800, patients with ambulatory needs will be immediate transferred from AMU. The Senior Nurse in ACU is responsible for working with support staff to ensure these patients are pulled through to create capacity for AMU.

16.0 OUTPUTS

1. Discharge/no follow up

2. Discharge/follow up

3. Managed attendance

4. Admission: specify DTA

5. Specialty

6. Deferred attendance

17.0 RAPID ACCESS CLINICS AND INTERFACE WITH OTHER SPECIALTIES

There is a process in place to book patients for tests then bring them back the next day (See Appendix 1 – pending) This will be organised following clinician to clinician dialogue when deemed appropriate.

17.1 Neurology

There will be a daily clinic held within the ACU am with four slots. Access to these slots will be via ACU, AMU, EAU or scheduled following clinician-to-clinician dialogue.

17.2 Cardiology

A Cardiologist will be available every afternoon to see patients in any of the acute medicine streams and will also be directed to see patients who have been admitted and require early
Cardiology intervention. A prioritised list of appropriate patients will be made and updated at each board round.

17.3 Rapid Access Chest Clinics
These clinics will be held every day in the Chest Clinic on the first floor. Patients will access the clinics via ACU, AMU, EAU or scheduled following clinician-to-clinician dialogue.

18.0 INTERFACE WITH PRIMARY CARE
Primary and secondary care will work together to provide ongoing care outside of hospital to avoid a full admission. This process aims to strengthen links with GPs, community and social services. Shared integrated governance arrangements will be in place.

19.0 TRANSPORT
Patients will be encouraged to use their own transport. Where possible, arrangements will be made to get scheduled patients in earlier, as early review will ensure more chance of delivering ‘same day’ care.

20. INTER-RELATIONSHIP WITH AMU
1. 20 for everything
2. + 5 escalation

20.0 PATHWAYS

21.1 Diagnostics
M.A. to model the number of diagnostics required. Hot reporting. Priority for both areas as for ED. Clinical Support to review impact of the move.

22.2 IT