

**Productivity in an Advanced Practitioner led Ambulatory Emergency Care Service:
A Quality Improvement initiative.**

Abstract (191 words)

Background: As organizations developed ambulatory emergency care (AEC) and same day emergency care, early access to a senior decision maker undertaken by experienced middle grade doctors or advanced practitioners (AP) is key. The Coronavirus pandemic interrupted normal service provision in 2020-2021, requiring service development whilst balancing staffing to provide the safest level of care.

Aims: The aim was to establish AP productivity, enabling ongoing evidence-based workforce planning.

Methods: The service development, an AP led AEC/SDEC at one hospital in the United Kingdom, followed the plan, do, study, act quality improvement model, collecting data from 1st May 2021 to 31st July 2023

Findings: During the first three months, the AP team had a productivity rate of 0.59 PPH compared to 0.69 PPH with the junior doctors. The following three months saw less junior doctor support allocated to AEC/SDEC and ongoing service provision AP led, and AP productivity increase to 0.79 PPH.

Conclusion: AP productivity in the first three months ranged from 0.61-0.65PPH, reflecting individual experience, enabling the medical workforce to focus on higher acuity patients. The service development demonstrated acceptable productivity with increasing patient numbers, enabling additional recruitment to the AP team.

Background

The concept of ambulatory emergency care (AEC) in healthcare service provision originated in the early 2000s and led to the publishing of the AEC Directory in 2007 and updated to the NHS Elect (2018) latest version. Same day emergency care (SDEC) is a more contemporary reference to AEC, but terms are interchangeable with the same underlying principle; a significant proportion of adult patients requiring emergency medical care can be managed without admission to a hospital bed and can be managed safely and appropriately on the same day (NHS Elect, 2018). Service re-design was crucial with an emergency care system under pressure, increasing admissions and bed occupancy (NHS Elect, 2018 and NHSE, 2019). The Long-Term Plan (NHSE, 2019) reported that the National Health Service England (NHSE) had begun implementing AEC/SDEC over the previous two years and committed to this model being embedded in every hospital during 2019/2020 for at least 12 hours a day and 7 days a week.

As organizations have developed this concept, early access to a senior decision maker has proven to be key. Although usually Consultant level doctors, it was suggested that these roles could be undertaken by experienced middle grade doctors or Advanced Nurse Practitioners (ANPs). Ten years ago, the Royal College of Physicians acknowledged that ANPs were emerging in this field and suggested that they were autonomously able to manage 30% of AEC clinical scenarios (Hamad and Connolly, 2018).

Historically, advancing practice in the United Kingdom (UK) was associated with nursing roles. ANPs in the UK have been recognized since 1992, with guidance on the nurse practitioner role (RCN, 2002 and RCN 2006) being first introduced in 2002. Within contemporary advancing practice today, what differentiates ANPs from advanced practice (AP) is that an ANP role is a job title for nurses who practice with a higher degree of autonomy and responsibility than registered nurses, compared to an AP which is a level of practice

rather than a specific job role or title (NHSE, 2023). In 2006, the Department of Health recommended that health departments work with stakeholders to review ANP career pathways and the educational preparation required for these roles (RCN, 2002, RCN 2008, DoH 2006, RCN 2007). A decade later, Health Education England (HEE), NHSE and NHS Improvement worked in partnership to develop a national multiprofessional framework for advanced clinical practice (HEE, 2017). This defines AP as being underpinned by a master's level academic award, which was not necessarily a key characteristic in early ANP roles (Hulse, 2022). The AP role encompasses four pillars of clinical practice (HEE, 2017) and is characterized by a high degree of autonomy, complex decision making, analysis and synthesis of complex problems and the ability to complete whole episodes of care (NHSE, 2023). Table 1 offers definitions of these roles.

The number of AP roles in the NHS workforce are growing but not at a rate to fundamentally alter the overall shape of the workforce (NHSE, 2023). AP can increase capacity in areas with a limited workforce and NHSE (NHSE, 2023) acknowledge that to continue to grow new models of care within SDEC, more APs are required. The NHS England Long Term Plan (NHSE, 2019) indicated the need for a sustainable balance between supply and demand across all staff groups in the NHS, however, with local services reporting vacancies of over 112, 000, a growing population with an increased life-expectancy of 13 years since 1948 (NHSE, 2023) and new models of care such as AEC/SDEC, APs are necessary.

One challenge is that operation of AEC/ SDEC models and staffing vary considerably nationally as highlighted in the SDEC staffing models document (NHSE and NHS I, 2021a). A small number of SDECs (n=4/11, 36.4%) allowed their APs to be more autonomous and with a wider scope of practice, assessing and discharging patients independently (NHSE and NHS I, 2021a). This report was the catalyst for our own AP led AEC/SDEC service development and is reported in this paper, following the SQUIRE guidelines (Ogrinc et al, 2016).

The project aims were to:

- Explore literature regarding productivity of APs in AEC/SDEC in the UK.
- Trial provision of an AP/ANP led AEC/SDEC service.
- Collect data to ascertain productivity for our AP/ANP clinician team.
- Act on the findings.

Methods

Context: Our AEC/SDEC and AP team

This NHS Foundation Trust is one of the larger Trusts in the South-West of England (NHSE 2020), with two large District General Hospitals (DGH). It has well established SDECs on both of its two sites that have been operational since 2013, with a workforce that regularly works across both sites. As with many hospitals and specialties, the Coronavirus pandemic (COVID-19) interrupted the service provision in 2020-2021. In the early months of 2021, AEC/SDEC service provision at this Trust were reviewed due to spikes in the number of patients with COVID-19, whilst balancing staffing to provide the safest level of care within acute medicine across both sites.

Intervention:

The intervention, a service development from May 2021 until July 2023, is presented in this paper following the plan, do, study, act quality improvement model. It was registered with the NHS Trust Faculty for Quality Improvement. The aim of this intervention was to set up an AP run AEC/SDEC to support ongoing service provision for medical patients requiring same day emergency care Trust wide. NHS ethics approval was not required as this was not classed as research. Confidentiality was ensured with the allocation of anonymous numbers to the AP team and no inclusion of patient identifiable information.

The project group, which included the AEC/SDEC AP team, and the Specialty Director for Acute Medicine led the service development. The Trust's Associate Professor of

Nursing subsequently supported data analysis, interpretation and writing for publication (from 2023).

Plan phase (January - May 2021)

During the planning phase a literature search was undertaken with the Trust's Library and Knowledge Service asking the question:

'What is the productivity of APs in same day emergency care in the UK'?

Literature searches were undertaken in 2021 and repeated in 2023, using the databases Cinahl, Ultimate, Medline, Embase and Emcare, limiting to 2011-2021, full text English language. Seven research papers were identified in 2021, five from the USA (which has a different healthcare system) and two UK papers that were older than ten years and were therefore rejected. The 2023 search yielded one additional research paper (Fenwick et al, 2020), demonstrating a paucity of evidence on productivity of APs in an SDEC in the NHS in the UK. This is unsurprising given that these AP roles and SDEC services are relatively new in the UK.

The RCP (2018) report indicated that ANPs are tier 1B independent competent clinical decision makers, and that tier 1 clinicians undertaking an initial assessment should take 1.5 hours per patient. However, this was specifically for ANPs rather than APs and stated that patients presenting acutely to hospital with medical problems in an AEC was out of the scope of the toolkit.

Fenwick et al (2020) was a one-year dual-centre retrospective analysis, which explored productivity (number of new patients evaluated per hour) of APs in an emergency department (ED) setting in two UK hospitals. They collected the number of patients seen by the attending APs and the number of patients who were seen by an AP as a senior review, and mapped against AP experience, patient acuity, and disposal. The number of patients

seen by a clinician within one hour was classed as patients per hour (PPH). Their results suggested that there was a mean productivity of 1.03 patients per hour per AP (attending), and 1.53 patients per hour (attending and senior review). The authors concluded that this finding should set a national benchmark for EDs and contributed to the evidence by reporting productivity in other clinician groups.

Do phase (June 2021) Implementation of an AP/ANP led AEC/SDEC service.

In June 2021, our AEC/SDEC team consisted of 5.2 Whole Time Equivalent (WTE) Advanced Practitioners (n=6 individuals). Two of these were employed in temporary Agenda for Change (AfC) band 8a AP posts, having completed a non-accredited master's in AP, one was employed as an apprentice AP (tAP) following an accredited master's pathway in AP and was new to post at that time, and three were employed in AfC band 7 ANP posts (one having completed a non-accredited master's in AP, and two undertaking a master's in AP) (table 1).

The impact of the COVID-19 pandemic served as the driver to trial provision of an AP/ANP led AEC/SDEC service at the smaller DGH site, rather than closing the unit and moving all ambulatory patients to the larger site or admitting the patients. It was anticipated that this could be beneficial to our patients and service provision. Prior to the intervention, the AEC/SDEC aimed to operate with a band 8a AP and one band 7 apprentice/ ANP working 8am-8pm each day, with consultant cover 9-5pm, with all new patients discussed at consultant level for decisions on ongoing care. At this time, the unit saw on average 14 patients per day. The consultant cover allocated to our AEC/SDEC was subsequently moved to cover patient care on the medical wards due to the COVID-19 pandemic.

The AP/ANP team could independently see, assess, treat, and discharge patients, but the autonomy of their clinical practice for different patient groups varied between practitioners. This cohort of patients presented with undifferentiated medical complaints and whereas, as previously discussed, APs can manage 30% of AEC clinical scenarios, it is where they have

acquired further education and training in this role (RCP, 2014). APs are expected to act on professional judgement about when to seek help (HEE, 2017) and SAM (2019) suggests that clinicians in AEC should have access to a more senior decision maker for review when the presentation is more complex. All team members had extensive clinical experience and expertise and were expected to evidence their clinical practice and ability to autonomously manage certain presenting conditions with a variety of different evidence tools to support the governance of their clinical abilities.

By the end of June 2021, AEC/SDEC clinical cover was consistently led by the AP/ANP team (two staff per shift), with senior medical support as required, provided from the acute medical consultant covering the acute admission ward (located away from AEC/SDEC) and the on-call medical registrar. With this senior support being located away from AEC/SDEC, accessing this support did have a negative impact on productivity. Patients are referred to AEC/SDEC primarily from either presentation to ED (either at triage or after clinical review), or via their GP after discussion with the acute medical consultant accepting acute medical referrals. In current day practice, 65%-70% are sent directly to our SDECs without presenting to ED. This benefits our EDs with 25-30 patients on average per day not arriving through our EDs, freeing ED for emergency care. A standalone Standard Operating Procedure (SOP) for AEC/SDEC outlined the scope to safely and efficiently manage adult patients who presented with an acute medical condition that could be managed through AEC/SDEC, with specific clinical exclusion criteria (Table 2) for patients referred there and was already part of the existing AP/ANP job plan.

Study phase (July 2021 to December 2021) AP/ANP Productivity Monitoring

With an absence of staffing models, we decided to collect data to ascertain productivity for our AP/ANP clinician team. The primary aim of the study phase was to determine the productivity of the AP/ANPs working within our service in the AEC/SDEC. Pre-implementation (do phase)

data from 4th May 2021 (accounting for the weekend and bank holiday Monday 3rd May) until 31st May 2021 was collected **by hand** as the baseline before the AEC/**SDEC** was changed to an AP/ANP led service. **The 'do' phase (implementation)** happened in mid-June; **therefore 'study' phase** data was collected from 1st July to 31st December 2021 from the AP/ANP led AEC/**SDEC**. Data about the number of patients who attended AEC/**SDEC** each day, was collected by hand from paper patient **and activity** records, with no reliable universal reporting of **AEC/SDEC** activity at that time. **The disadvantage of this was it relied on the information being kept up to date by the AEC/SDEC ward clerk and was assumed to be accurate as reasonably possible.** **As the data was** recorded by **the ward clerk and therefore** someone outside of the AP team limited bias. Data was recorded and descriptively analysed using Microsoft Excel. Each member of staff was allocated an individual number to maintain anonymity, **although with a small team, it may be easier for anyone working in the organisation to identify individuals.**

We recorded which clinician saw each patient, allowing us to calculate how many patients each of the clinicians attended (ANP, tAP, AP and junior doctor allocated daily to support AEC/**SDEC**). We cross referenced the hours worked by each individual monthly through staff rosters, and accounting for unpaid breaks. **Allocated non-clinical time was excluded.** There was no handover time to be accounted for with the service closing daily. We were then able to calculate an average number of patients per hour that clinicians worked. Monthly patients per hour (PPH) is recorded in table **4** (Summary of Productivity).

Where patients were seen by two clinicians, it was assumed that the first clinician's name in the records was the clinician who undertook the initial assessment, and the second clinician had offered opinion, review, or **received** handed over care. Patients were excluded from the data analysis if they had been seen by specialty consultants, nurse-led discharges and self-discharges.

Results

In the month prior to the service change (May 2021) N=202 patients were seen in the AEC/SDEC (table 4). Of these, n=123 patients (60.9%) were seen by members of the AP/tAP/ANP team and n=79 (39.1%) by junior doctors. During the three-month post service change study period (July to September 2021), AEC/SDEC was staffed with two of the AP team and a junior doctor. N=820 patients were seen in the AEC/SDEC (range 256-297 per month). Of these, n=592 patients (72.2%) were seen by one of the two members of the AP/tAP/ANP team in AEC/SDEC, n=228 (27.8%) by junior doctors. A total of 1160.5 hours were worked clinically by the AP/tAP/ANPs (table 3). This represents an hourly attending mean rate of 0.59 Patients Per Hour (PPH) for the APs (table 4). Compared to a total of 228 patients and 329 hours worked clinically by supporting junior doctors allocated to AEC/SDEC (July-September 2021), representing an hourly attending mean rate of 0.69 PPH

By October 2021, junior doctor numbers meant that AEC/SDEC could no longer have a designated junior doctor to support service provision, and service provision changed so that when activity increased during the day, the AP team called for help from the on-call take team, which meant that productivity could no longer be compared between the two staff groups. But numbers increased over the next three months with the AP team seeing n=759 patients in n=960 hours, representing an increase in an hourly attending mean rate of 0.79 PPH (table 4).

Over this six month period, when split into AP (AfC8a) and tAP/ANP (AfC7) groups, the mean attending rates were 0.65 PPH and 0.61 PPH respectively (table 4). The AP/ANPs have been registered in their base professions for 10-27 years (mean 23) (Table 5, Experience mapped against productivity). The number of years as an ANP ranged from 1 to 9 (mean 5.3), as a qualified AP ranged from 0 to 5 years (mean 4) (figure 1).

Act phase (January 2022 to August 2023)

Data collected in this phase continued to demonstrate evidence of increased activity and the need for additional staff. In January 2022, junior doctors were again allocated to AEC/SDEC but this only lasted for one month before returning to cover as required. By July 2022, the average number of patients seen in AEC/SDEC had increased from 14 to 20 patients per day, a 43% increase in activity per day with the same AP/ANP workforce. In August 2022, coinciding with junior doctor rotations, we were able to return to having allocated junior doctor support again to aid with the increasing activity. By the end of 2022, the whole AP/ANP team had attended 61% of the AEC/SDEC patients at 0.63 patients per hour. The qualified APs (AfC 8) attended 47.5% of the patients seen by the AP team at 0.71 patients per hour, compared to tAP/ANPs (AfC7) attending 52.5% at 0.57PPH.

We went on to successfully recruit two members of staff into the AP team in May 2023, increasing the headcount to eight (total 6.9 WTE) and then two further trainees in 2024. Seven of the team (6.3 WTE) now work in AP (AfC8a) roles, with three having achieved their MSc prior to 2017 when the multi- professional framework for AP in England was published, two having now successfully completed their apprenticeship in Advanced Clinical Practice and two having satisfied local agreements to transition to AfC8a. One of these APs has successfully completed the ePortfolio (supported) route and two have applied to start this process. One of the team remain in their ANP roles (AfC7) and is about to submit their dissertation to complete their Master's.

Since January 2024 we have adapted the acute medicine AP curriculum for use in our SDEC and AEC/SDEC (HEE, 2020) for 2024. All members of the AP team have 20% non-clinical provision within their job plans to facilitate working to the other three pillars of AP.

Discussion

We believe this is the first paper to specifically report on the development of an AP led AEC/SDEC in the UK. The main outcome was the creation of an AP/ANP led AEC/SDEC to overcome some of the contemporary challenges in acute medicine at this NHS Trust and meeting the Royal College of Emergency Medicine future workforce strategy (Hassan, 2018). Although limitations of this include a reliance on manual data collection and counting, and a relatively small AP team, the service development project demonstrated that the team of six advanced practitioners attended 72.2% of patients in the post intervention three-month study period. Based on the number of hours worked during that period, the average productivity was 0.59PPH for the whole AP team attending, and this increased to 0.79PPH in the following three months. Although not as high as the productivity (1.03PPH) reported by Fenwick et al (2020), it has increased as the AP team has become more experienced and innovative, with more opportunities for training and skills development. The introduction of our capability framework has allowed our AP team to identify areas of practice that they feel they need to develop clinically and organisationally. Support from the senior medical team has facilitated a multi-disciplinary team (MDT) approach which is supportive and has had a positive impact on the AP team's wellbeing. Direct comparisons should be considered with caution due to the differences between ED and acute medicine/AEC/SDEC services.

The main aim of this project was to inform and evidence one aspect (productivity) of the role of AP/ANPs working in one AEC/SDEC in the UK. It has been recognized that AEC/SDEC services nationally require more APs and fortunately, NHSE is investing in AP training so that 5,000 clinicians start these pathways yearly (NHSE, 2023a). Over the twelve months when our activity increased (July 2021-2022), we were able to quantifiably articulate a need to review our clinical staffing establishment and facilitate evidence-based workforce planning. As recognised by Fenwick et al (2020), productivity assists with workforce planning but is not a reflection of patient-centered outcomes, or the quality or safety of the care delivered. As the AEC/SDEC service continues to develop and the tAPs progress to become established APs

over the next 12-18 months, the productivity of the AP team will increase further. The recommendations for further data collection include:

- Data collection to measure whether our AEC/SDEC has a ceiling of capacity in terms of the number of patients we could safely manage with our current staffing levels.
- Increased PPH over time as APs develop with practice
- National benchmarking on AP productivity
- Embedding AP roles in SDEC
- Development of adequate governance and supervision for our AP team
- Further research on quality and safety outcomes beyond productivity

There are potentially several benefits of an AP led service, although these were not measured in this project and will form part of a subsequent review. The AP team in this AEC/SDEC offer consistency in service provision, compared to the transient group of junior doctors, within an acute medical rotation. The varying skill sets of these healthcare professional roles complement each other, allowing the more senior medical decision makers to provide care for more unwell patients requiring hospital admission in comparison to lower acuity patients in SDEC (NHS I and AEC Network, 2018), maximizing workforce capacity within the emergency healthcare environment. Strategically, working differently with new roles as part of MDTs offer more modernised careers, releases time to spend with patients and meets the needs of patients and changing population demand (NHSE, 2023).

Equally, when measuring performance of staff groups the PPH should be used with caution; staff will engage and work to the best of their abilities in an environment that encourages openness and honesty in a positive, constructive, and professional way, but it can also be perceived negatively (NHS E, 2023). When we first started measuring performance (in terms of productivity), the team felt under scrutiny and indeed perceived this initially as a negative performance measure rather than one that could be used to develop a positive key

performance indicator for SDEC and advancing practice.

Conclusion.

Our service development project, instigated to mitigate some of the challenges of the COVID19 pandemic, prompted creation of an AP led AEC/SDEC service. AP productivity ranged from 0.59-0.66PPH, reflecting individual experience, with attendance of up to 76.8% of patients, enabling the medical workforce to focus on the higher acuity patients.

Whilst the productivity figures were lower than other reported PPH rates (Fenwick et al, 2020), with ongoing training and support the growing AP team can continue to work and develop as a complementary part of the wider acute medical clinical team, offering a productive AEC/SDEC service

3668 words

Keywords

- Advanced Practice
- Workforce
- Productivity
- Same Day Emergency Care
- Ambulatory Emergency Care
- Acute Medicine

Key points

- Advanced practice (AP) roles can increase capacity in areas with a limited workforce and offer consistency in service provision, whilst the varying skill sets of AP roles and our medical workforce complement each other and work well together
- To develop new models of care within Same Day Emergency Care and acute medicine, more APs are required
- Staff work to the best of their abilities in open, positive and constructive environments
- Training and supporting an AP team will facilitate development of a complementary workforce

Reflective questions

1. How can AP teams adapt to support meeting the needs within Same Day Emergency Care?
2. How can ACP teams adapt to support meeting the needs within acute medicine?
3. How can AP productivity help with this? Is it important?

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