

The Introduction of a Physician Associate-Led Surgical Ambulatory Emergency Clinic in The Highlands of Scotland

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Introduction

The delivery of surgical care in the Highlands has changed. Surgical Ambulatory Emergency Care (SAEC) was developed in to alleviate bed pressures, improve patient satisfaction and avoid unnecessary workload by scheduling unscheduled care¹. It provides safe and prompt assessment, investigation and management of patients presenting with acute surgical issues in a clinic-type setting and not a bedded setting. The risk of complications when patients are admitted to hospital are well-recognised² and alternatives to admission should be strongly considered. Bed-occupancy in hospitals has remained high following the COVID-19 pandemic and an ambulatory care setting can alleviate demand³.



Aim

We aim to identify whether SAEC is alleviating pressures in the surgical inpatient department since the introduction of a full-time Physician Associate in 2022. Additionally, we aim to determine whether it is used appropriately and cost effectively.

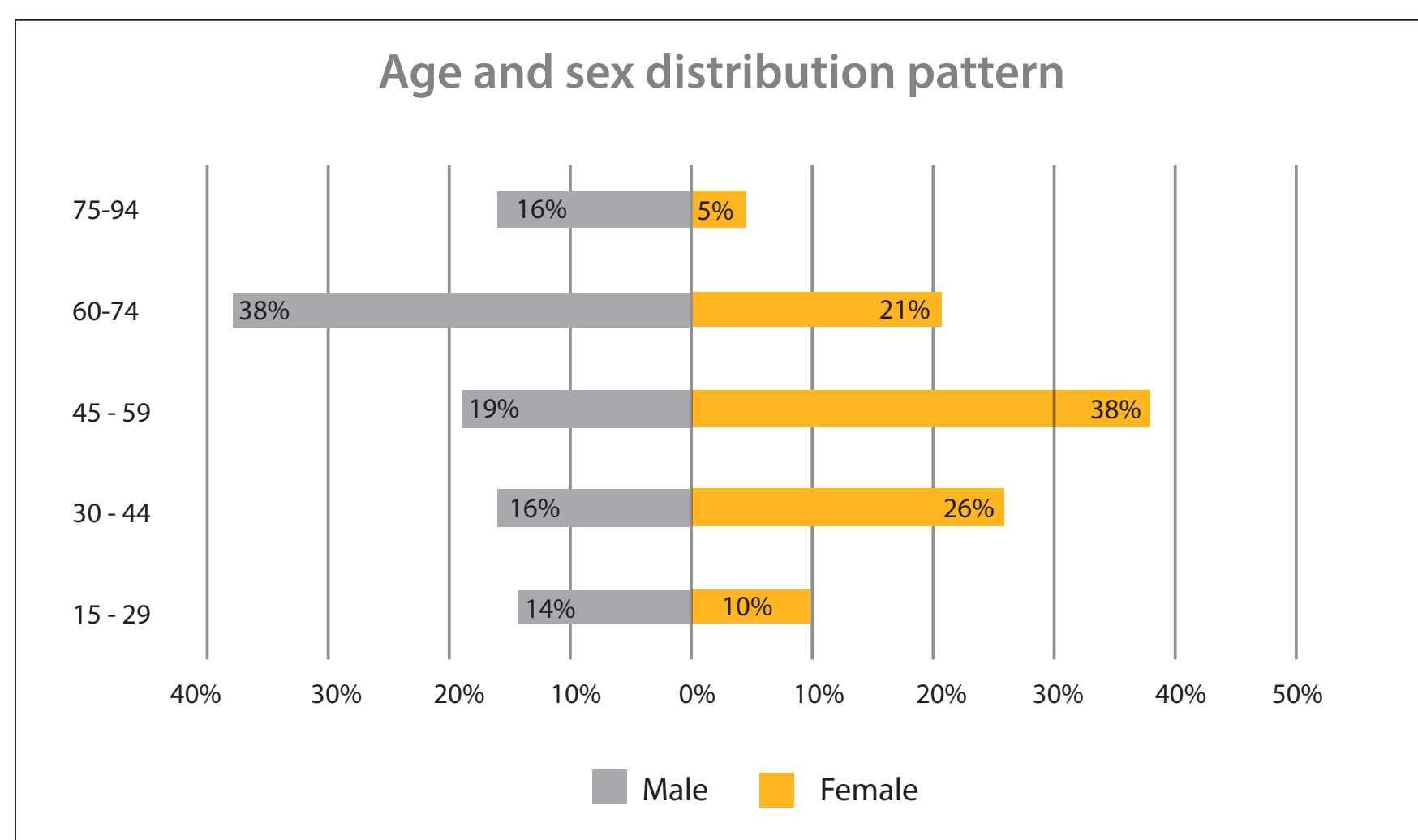
Method

Attendance was collected prospectively from the 1st September 2022 to 31st October 2022 using a dedicated data audit book, booking diary and Microsoft excel spreadsheet. Patient's individual review outcomes were gathered and the variables used for collection of data were agreed by the audit team.

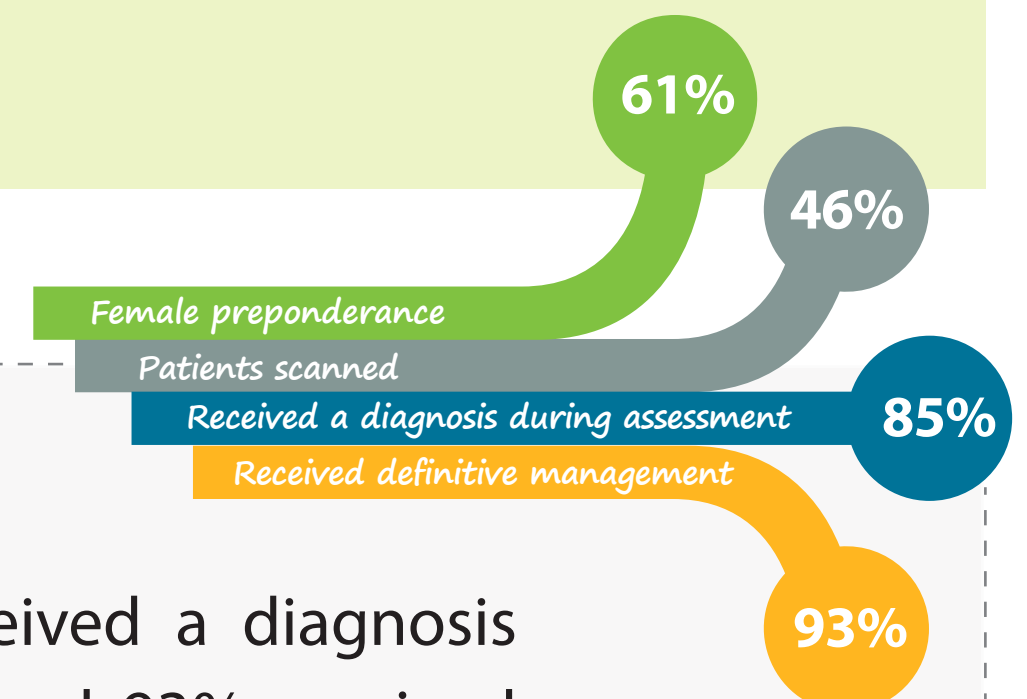
Results

Of the 165 patients referred to SAEC between September 2022 and October 2022, 90% were reviewed by the PA and 10% only by the consultant. On average, 3.7 patients were seen per day. The referral reasons were wide ranging: 64 referrals for abdominal pain in addition to abscesses, constipation, weight loss, vomiting, stoma reviews and more. The age of patients ranged from 20-91, with an age distribution pattern seen in Figure 1.

Figure 1: Comparison of number of patients by age group and sex



Female preponderance was observed (61%). 46% of patients had a scan. 85% of patients received a diagnosis during their assessment in SAEC and 93% received definitive management.



No patients made an unplanned re-presentation to an emergency setting within the week following their review. The average time spent in SAEC per patient was 2 hours 48 minutes. 17% of patients were admitted following review in SAEC, **preventing 116 admissions**.

This saved approximately £45,820 through admission prevention. In addition, **approximately a further £47,492** was saved as SAEC is PA led rather than consultant led.



Conclusion

Prior to the employment of a Physician Associate, Surgical Ambulatory Emergency Care did not provide a consistent service as it brought all patients to its surgical ward and required employment of a second consultant. Since the introduction of a Physician Associate, SAEC has improved patient flow and increased bed capacity whilst providing safe and high-quality care that is cost-effective. Acute surgical patients are promptly assessed, investigated and managed in SAEC. Future auditing could identify those patients admitted to the surgical ward who would have been appropriate for SAEC assessment as well as the wider impact of SAEC on admission prevention and our acute surgical wards.