

ACADs (AMBULATORY CARE & DIAGNOSTIC CENTRES)

Abstract: In the ever evolving NHS change is the one consistent factor. For some change is exciting, for others it's threatening. No community likes to 'lose' its hospital, but what if change could bring a better local service? Brian Cowan reflects on the development of ACADs as a complimentary alternative to the traditional hospital site: a service and buildings redesigned around the patients. Chris Levison reflects on the practical implications the change could have on chaplaincy including: multidisciplinary team-working, spiritual needs, and closer community contacts. These papers were presented at the Chaplaincy Conference at Crieff in May 2000.

The Editors.

HAVE ACADs A ROLE IN THE FUTURE OF THE HEALTH SERVICE?

Brian Cowan

Ambulatory Care has become a term indelibly linked to service redesign in the NHS, and has become associated with new terminology such as 'ACAD' (Ambulatory Care and Diagnostic Centre) or 'walk in walk out centres'. Consequently it appears radical and exciting to some but threatening and dangerous to others. This is unfortunate as it ignores the basic fact that ambulatory care is not a new concept, it has been developing for years and in some of its guises it is very old fashioned.

What is Ambulatory Care?

Essentially this is any procedure which can be done on the same day, where the patient walks into hospital and walks out again having had an operation, an investigation, or a consultation.

The oldest form is the out patient consultation, which is still the first point of contact with the hospital service for most patients. Other developments are more recent.

The advent of the fibre optic cable has transformed the examination of body cavities and internal organs with flexible bronchoscopy, cystoscopy, and laparoscopy replacing more invasive procedures. The majority are done on an out patient basis under local anaesthesia or minimal sedation.

Imaging has changed as X Rays have been replaced by CT, MRI and Ultrasound scanning the vast ma-

jority of which are done as out patient visits. These new techniques have replaced exploratory operations, and have made the diagnosis of many conditions easier and more accurate.

Day surgery was a new concept only 20 years ago yet in the last 10 years day surgery rates for conditions like cataracts have increased from 1% to 90% in many parts of Scotland. Arthroscopy (internal examination of joints) has increased from 25% to 60% and other procedures have seen a similar increase as clinicians and patients accept the advantages of avoiding an unnecessary stay in hospital.

Other procedures are delivered on a day basis such as out patient haemodialysis, where patients may need to attend hospital as often as four times a week, and chemotherapy is sometimes given on a day case basis.

These changes in practice have altered the balance between the amount of care delivered from inpatient beds and in the Ambulatory Care part of the service. Currently Ambulatory Care comprises 85% of patient contacts with the hospital service. Obviously this statistic deals equally with a hip replacement with a 6-10 day length of stay in hospital and an out patient appointment, but it is an important measure when looking at ease of patient access to services.

Current Experience

The concept of placing all day case and out patient facilities in a separate building developed first in North America where the prime motivation was financial. Individual groups of clinicians set up ACADs separate from large hospitals and provided a full range of diagnostic and therapeutic services including surgery. Some of these ACADs work on a single specialty basis, usually plastic surgery or orthopaedics others provide a wide range of specialties. These thrived as their overheads were far less than a large hospital. They have been a success in the most litigious society on earth and have been copied with large hospitals now building separate ACADs on their campuses.

In the UK most attention has been directed at the impressive new purpose built facility at the Central Middlesex Hospital in London. Opened last year to a fanfare of publicity it is most often seen as a back-drop to Government announcements of new initiatives in the Health Service. It has allowed a redesign of services in one of the poorest areas in London, and is pioneering many initiatives including multi-skilling staff and linking community care to hospital services.

However the concentration on ACADs has diverted attention from centres such as the Jethro Arscott Unit in Bexhill Hospital which for the last 10 years has provided a full range of services including surgery and haemodialysis from a stand alone facility developed from a geriatric hospital. It is linked to a large District general hospital in Hastings, 7 miles away. It is popular with the local community who appreciate the benefits of local access to this range of services.

The Advantages of Ambulatory care

As the requirement for inpatient beds falls, as junior doctor and consultant hours of work fall, as specialisation increases the need for larger consultant teams then inevitably the number of inpatient sites will fall. While this benefits patients by providing higher quality specialist care available 24 hours a day it makes access to the services more difficult.

For an elderly patient the journey to hospital by public transport will be just as awkward for a 10 minute out patient appointment as for an in patient admis-

sion. Surely it makes sense therefore when planning the Health Service to take account of both local access and advances in technology to provide the majority of services near where the majority of patients live?

As a result of reconfiguring services for an area such as Glasgow where the current arrangement of 5 inpatient centres will reduce to two or three, the resulting problems of local access are obvious. Designing new hospital buildings, in addition to the new inpatient developments, which will provide a full range of day case and out patient services allows the majority of care to be provided from the site which the patients have used for the past 100 years, while allowing the development of new inpatient centres on fewer more distant sites.

The problems of winter demands on the Health service have also provided further reasons for considering the development of separate ambulatory care sites. Each winter as pressure builds up and beds are occupied by frail elderly patients with chest infections, elective surgery is regularly cancelled. This is usually minor or intermediate surgery of the type, which would be done in an Ambulatory Centre, and the separation of elective and emergency care should minimise cancellations.

Ten years ago as an anaesthetist I found the concept of day surgery very challenging. However, it rapidly became clear that with advances in surgical and anaesthetic techniques that it was possible to provide a high quality service and return the patient to home on the same day, pain free and fully recovered. If pre operative screening is good, and patient and procedure selection sensible then only around 0.5% of patients will need admitted following a day surgery procedure and the vast majority of these admissions are for the complications of analgesia such as nausea and light headedness. Day surgery and day investigations are popular with patients, perhaps once tasted hospital cuisine is not to be risked a second time.

Conclusion

To redesign services and reduce the number of inpatient sites, thus making hospital services less accessible to patients, and then fail to acknowledge that advances in Ambulatory Care now allow 85% of patient contacts to continue to be provided locally, is to attempt to deny that health care has

changed. It has moved away from its focus around beds and become focused on services.

The services should be redesigned around the patients and then the buildings designed around the services. That is the challenge currently offered it will be taken up around the NHS and will change

how we see hospital services develop in the next decade.

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CHAPLAINCY IN AN A.C.A.D.

Chris Levison

Introduction

The Chaplain's role in the healthcare setting already varies to a considerable extent. This depends on the nature of the site, the specialities being dealt with, the particular needs of differing kinds of patient and the Chaplain's own theological understanding of his/her ministry. Change of circumstance is affecting many chaplains in healthcare, most recently in particular those working in the realm of mental health who are exploring the ways in which they can be chaplains to those who are increasingly being encouraged to live in the community rather than in a hospital setting.

"Short Stay" Chaplaincy

The likely increase and development of ACADs in the future gives us another development of healthcare for which we will need to adapt. Many aspects of ACADs are not entirely new and a quick look at how we conduct our pastoral role in the present situation might help. Frankly, in my own case I probably pay less attention to those parts of my present hospital which are similar to an ACAD than to most other areas. The outpatient departments, the diagnostic imaging and testing areas, the day clinics and day treatment and day surgery units are visited by me less than the longer stay in-patient parts of the hospital. Within Accident and Emergency there is a role, but in a Minor Injury unit, that is harder to see. There is always a place for the provision of chap-

laincy to staff, but the majority of time spent by myself is with seriously ill, emergency, longer stay and in patients, the type of patient who will not be present in an ACAD.

A Scottish office circular described the functioning of an ACAD or "One Stop Clinic" as follows. "A patient referred to a one stop clinic will typically receive a specialist consultation, undergo a diagnostic test, receive their results and undergo treatment where necessary. Where immediate treatment is not feasible, the patient should receive a date there and then" (Scottish Office 1999). It is now becoming possible, to foresee, that breast surgery might take place on the same day as diagnosis, that patients undergoing hysterectomy might be discharged on day two, and those having hip replacement might leave hospital on day three. It is clear from these scenarios that the majority of the healthcare, at least in terms of time, will be given through community based health services. This in turn suggests that the wider community might also be the logical place where chaplaincy or spiritual support would need to be arranged. This type of change will affect chaplaincy in all Acute Trusts and not only in ACAD's.

Community Care

My own practice which I expect is not untypical, forces us to ask the question Is there a role for Chaplaincy in this new setting? Should we leave the spiritual care of short term patients to the

church and other faith communities, their ministers, priests and pastors, to those in the local community.? My answer to the second question determines in some ways my answer to the first. In an ideal world those who are spending most of their time in the community and home setting would be best cared for by the church or faith communities in which they live. In practice this may be done well for those who are active members of such communities but it will not be done for those who are not so visible or known to such communities. Some faith communities/churches do not feel a strong sense of pastoral responsibility to those who are not of their number, and even those who do, do not have the resources or the knowledge to cover the whole community effectively.

In short, those who have an active religious life may be adequately supported, but those whose needs are "spiritual" rather than "religious" would not. Some who clearly needed spiritual support would not necessarily find it or even be willing to seek it from established worshipping or faith groups. Instead of providing support for visitors, as at present, the need would be that of the carers or relatives at home. It is beyond the scope of this paper to examine that further.

Spiritual Needs

If we are serious about the provision of spiritual care to those who are ill, we have not only biblical injunction and pastoral need, but also modern health-care policy, directing that such provision is put in place. We need also to remember that although medical methods may be increasing in speed, efficiency and effectiveness, the patient's reaction and ability to cope is still dependent on the same factors as before which take place over a longer time scale. Sam Galbraith when he was Health Minister said "Same day diagnosis can reduce stress for patients and take away some of the worry associated with disease." (Health Minister 1999) However the coping mechanisms and concerns:- the hope, the confidence in those working with them, the sense of meaning in life, the questions, the worries about the future, the relationships a person has, fears of death or pain or estrangement -these are all still as real, even though the treatment may require much less time in hospital. It would be a mistake for us to think that because the hospitalisation is less, then the worries and the needs are correspondingly less. It

might be said that because a patient will receive less time being cared for in a hospital setting, the needs of other types of support might actually be increased. Healthcare policy over the last few years has shown increasing awareness of spiritual need as part of holistic care.

The argument for providing dedicated spiritual care through some sort of chaplaincy is strong, although just what that chaplaincy provision should consist of on the ground is not easy to discern. The need is by now fairly well established. It is the question "How?" which requires to be thought about.

Chapel or Quiet Room ?

It might help to recognise which types of provision would not be particularly appropriate. There would be no great need of a place for regular worship. Unlike an in-patient hospital an ACAD would be quiet at weekends and the provision of a regular service of worship would not be needed to provide the normalising role it does in longer stay situations. There would not be ward visiting as there would be few wards, and those in beds would be moving into or recovering from day surgery or tests. Those in waiting areas might appreciate a cup of tea, but not at that stage the ministrations of a chaplain moving along a waiting line however tactfully done.

Taking the nature of ACADs, there are various possibilities as to what might be appropriate. One of the characteristics of this kind of treatment centre is the speed with which diagnoses will be made. Bad news will often come as a shock and there needs to be a place and/or a person who helps people to cope or to gather their thoughts at such times. Many staff will do this, but some patients will need a place or a person with whom to talk about matters not specifically medical. A Quiet room, plain enough to be used by anyone, and the availability or presence of a chaplain will be important. The immediate stunning effect of bad news is not the time for counselling as such, but the sensitive presence and the offer of someone to talk to in the future is important. At times patients may be asked to make decisions about treatment more or less immediately. They might seek help in the making of such decisions. Reactions to bad news are also stressful for staff whose needs require to be catered for.

Multidisciplinary Teamworking

Some patients will be regular visitors to an ACAD for chemo or radiotherapy or other clinics and treatments. These people will often appreciate a relationship with chaplains who can share hopes and fears and help to humanise the high tech nature of some procedures. Medical or nursing staff would need to be encouraged to pass on their insights as to which patients were presenting unusual levels of stress or anxiety about their situation.

Patients who are being challenged by the needs of their illness to change their lifestyle/ eating/ drinking habits may well wish to talk about this to someone who is non medical. On going counselling, contact with support groups and enabling advice can often be valuable here. Information about such services would need to be part and parcel of the care given, placed in people's hands and described, not just left on tables and pamphlet racks. Members of the Chaplaincy team would need to be integrated as part of the advice and support team for people sent home. They would have to be aware of local community resources which can enhance spiritual well being in the broadest sense.

Conclusion

Some needs and provisions will remain the same such as the general availability to patients and staff. Others might be new or have a higher profile, e.g. follow up care or trained volunteers to accompany or transport patients, or staff a tea bar. Literature would describe the chaplaincy role largely in terms of listening and counselling, or the peaceful space of the Quiet Room. The availability through an on call

system of chaplains from various faith communities, including interpreter services, would be made clear. Information about support from other agencies, mutual help groups etc. would be freely available.

Some traditional activities of chaplaincy would not be appropriate and it will take, I expect, some considerable effort to establish and ensure that a proper and meaningful level of spiritual care is provided in a situation of faster and increasingly technical hospital care. It is crucial that spiritual needs do not get lost or forgotten in the drive for efficiency. A proper provision of chaplaincy is not alien to efficiency. Our task and challenge is to make it a soul mate.

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References

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Information about the one "working" ACAD can be found in Health Facilities Note 13 "Ambulatory care and diagnostics centres – the experience of Central Middlesex Hospital" London HMSO 1996