



Planning for Tomorrow, Today

Date: 8 December 2015

Telling SAM your winter tale

The winter of 2014/2015 was not pleasant. The number of patients we cared for was both unprecedented and relentless and the volume of activity was not healthy for patients or staff. However, the stoical nature of our teams meant that, on the surface, we appeared to cope. To make things better, we need to articulate a clear picture of the problem and more importantly, how we can make things better. **We want know what the winter is like at your hospital.**

Last winter we had ten years of service development in acute internal medicine that allowed us to cope as our processes were well established.

For example:

- Well organised AMUs with cohesive multi-professional teams
- Ambulatory care
- Working towards the standards in our key performance indicators
- Seven day services

Whilst last winter was extremely challenging, acute internal medicine played a pivotal role in keeping the NHS afloat. **Many of us buckled, but did any of us break?**

As this winter gets underway, we are outlining some simple measures that units may wish to collect. We all know what it is like when things are extraordinarily busy. However, for SAM to support our members and, most importantly, improve care for patients, we need to tell the outside world why things are bad, with measurable examples.

To plan for tomorrow today, we need to describe the problem. We suggest two simple initiatives:

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- **Measuring capacity, to address the question ‘Are we Full?’**
- **Focus on services for older people.**

Measuring Capacity. Are We Full?

We are not suggesting that units systematically collect all the data. Instead, we are outlining some **simple ways to measure and describe activity when capacity is close to the limit**; measurements that will allow us to speak a common language.

This winter we want to hear your stories and, if possible, **use one or more of the measurements in the list below to tell us if you think you are buckled or broken**. In future years we can consider a winter SAMBA (Society for Acute Medicine Benchmark Audit) but, for this year, we simply want to hear your stories illustrated with some simple numbers.

Our suggested measurements are:

- 1) Has the hospital gone on its highest level of escalation, for example black alert or a local equivalent, including implementing a major incident plan (whether declared or not)?**
- 2) What is the daytime bed occupancy?**
- 3) Is there exit block from AMU and are your patients being transferred to a non-specialty ward?**
 - a. Admitted to an inappropriate ward/non-specialty ward directly from the Emergency Department?**
 - b. Transferred from AMU to an inappropriate ward/non-specialty ward?**
 - c. Waiting on AMU for over 24 hours for a specialty bed?**
- 4) Are patients being clerked and having a senior review in a timely fashion?**

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The first item is self-evident.

Bed occupancy is traditionally measured at midnight and the published figures bear little resemblance to what we see during the day. Therefore, units might wish to measure their bed occupancy at a fixed point in the working day and we suggest 4pm. The true bed base includes patients in AMU plus those waiting for a bed, for example, waiting in the Emergency Department or sitting in a ward day-room awaiting discharge. Having real-time bed occupancy for AMU above 100% might not in itself define 'broken', however, it will reflect the level of activity above and beyond the established bed base.

Our colleagues in Emergency Medicine use the term 'exit block' for times when patients need a bed but one is unavailable. In acute medicine, we are frequently unable to send patients to a ward, as there are no specialty beds. This hinders patient flow into AMU. The knock-on effect is that patients are sent directly from AMU to a ward which cannot meet their specialty care needs; moving patients to these wards is wrong and should be considered as a clinical incident.

Lastly, we already have quality indicators which we measure in the annual SAMBA audit. Measuring the time to see a competent clinical decision maker and a senior decision maker will be valuable and provide a comparison to our performance at other times of the year.

Older People

SAM is aware that many units have developed some excellent services for older people. This winter we want to hear how the services you provide for frail and older people are making a difference.

Older people and patients with complex care needs, or multi co-morbidities, make-up the largest proportion of our work. Providing the best medical, nursing and therapy care is not difficult. Recipe book medicine is not the solution; the challenge is meeting the needs of the individual, every time.

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SAM fully supports initiatives such as the Silverbook (<http://www.bgs.org.uk/index.php/bgscampaigns-715/silverbook>) and Frailsafe (<http://www.frailsafe.org.uk/>).

One clear and consistent message is that a prolonged hospital stay and confinement to bed is not in the long-term best interests of older people. Facilitating early discharge with a shared care plan between patients, their families and our multidisciplinary teams is the way forward. This message is not new; the question is how we do it consistently.

In the medium to long-term, all units should put in place the right services to care for older people, assuming this is not already the case. For those units new to this journey, SAM already has excellent examples which we can share. By facilitating safe, early discharge, we will invariably prevent unnecessarily long hospital stays and, above all, improve the healthcare outcomes for our older patients.

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