The Royal Wolverhampton NHS
NHS Trust

THE 12th INTERNATIONAL SCIENTIFIC CONFERENCE
THE SOCIETY FOR ACUTE MEDICINE

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Models of Acute Care – What does good look like in Wolverhampton?

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Flow, occupancy and mortality

Background 2014

- Fortress ED with staffing challenges, poor estate and training concerns
- All medical patients admitted through the acute medical unit (AMU)
  - 66% from ED - unchallenged admitting rights to with no feedback loop
  - 33% from GP via AMU clinic (poor access to a bed for treatment)
- All physicians taking equal turns to deliver 2 man rolling post take ward round for AMU ward and clinic – variable engagement and performance
- Large numbers of patients waiting to be seen on AMU at evening handover
- High early discharge rate from AMU
- Traditional medical ward rounds on specialty wards
- Steadily increasing bed base

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New Urgent and Emergency Care Centre (UECC)

Physician A and B
Principles of new model

- Unify the admission pathway for medical patients and prioritise according to clinical need – all medical patients come through ED
- RAT and Triage identify unstable patients and facilitate the delivery time critical treatment
- Joint senior decision making to
  - Facilitate right care at the earliest opportunity
  - Share learning to improve performance of ED and Physician A team
  - Facilitate ambulatory care as the default (home first)
  - ‘Lean’ the medical patient pathway (e.g. direct to specialty)

The new model - 7 Days

Physician A	Physician B
• Acute Physicians + acute minded specialists • 1 in 12 • ED 10:00 to 21:30 • Working with Reg A • Handover 21:30 • Sleep	• Medical specialty physician • 1 in 28 • AMU13:00-21:30 • Reg B + junior doctors Handover at 21:30 • On call overnight

What Physician A does

- Stabilises patients and ensures safe appropriate transfers
- Early senior decision making facilitates safe, effective and efficient care starting at the front door
- Converts potential admissions to ambulatory pathways
  - Adaptable approach
  - Experts in directory of services including community support options
  - Brokering with specialties (direct admissions and HOT clinics)

What Physician A doesn’t do

- Wait for patients to be clerked
- Disempower ED team to deal with medical problems
- Hand patients back to ED team
- Delay the movement from ED of stable patients who need admission

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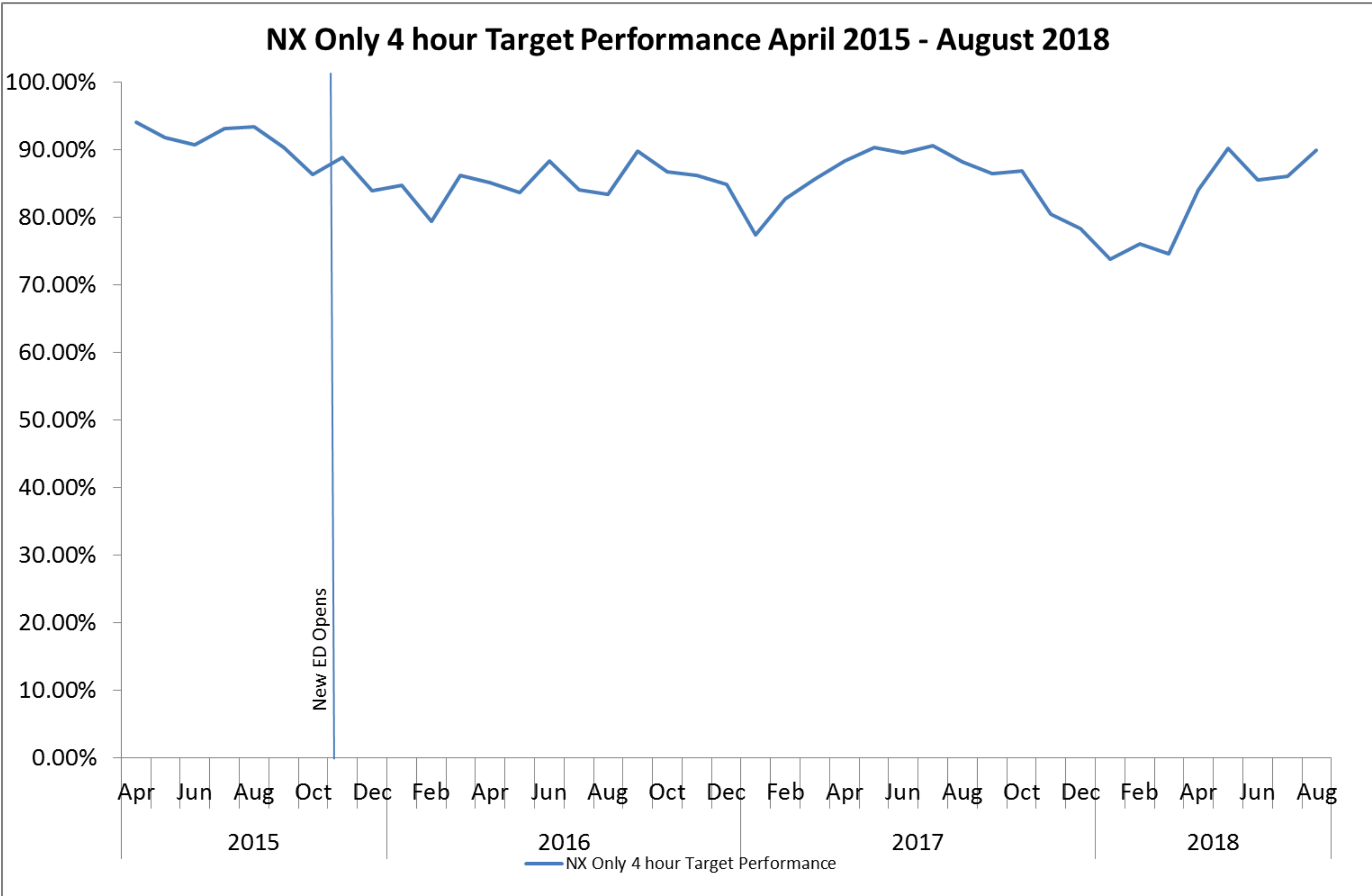

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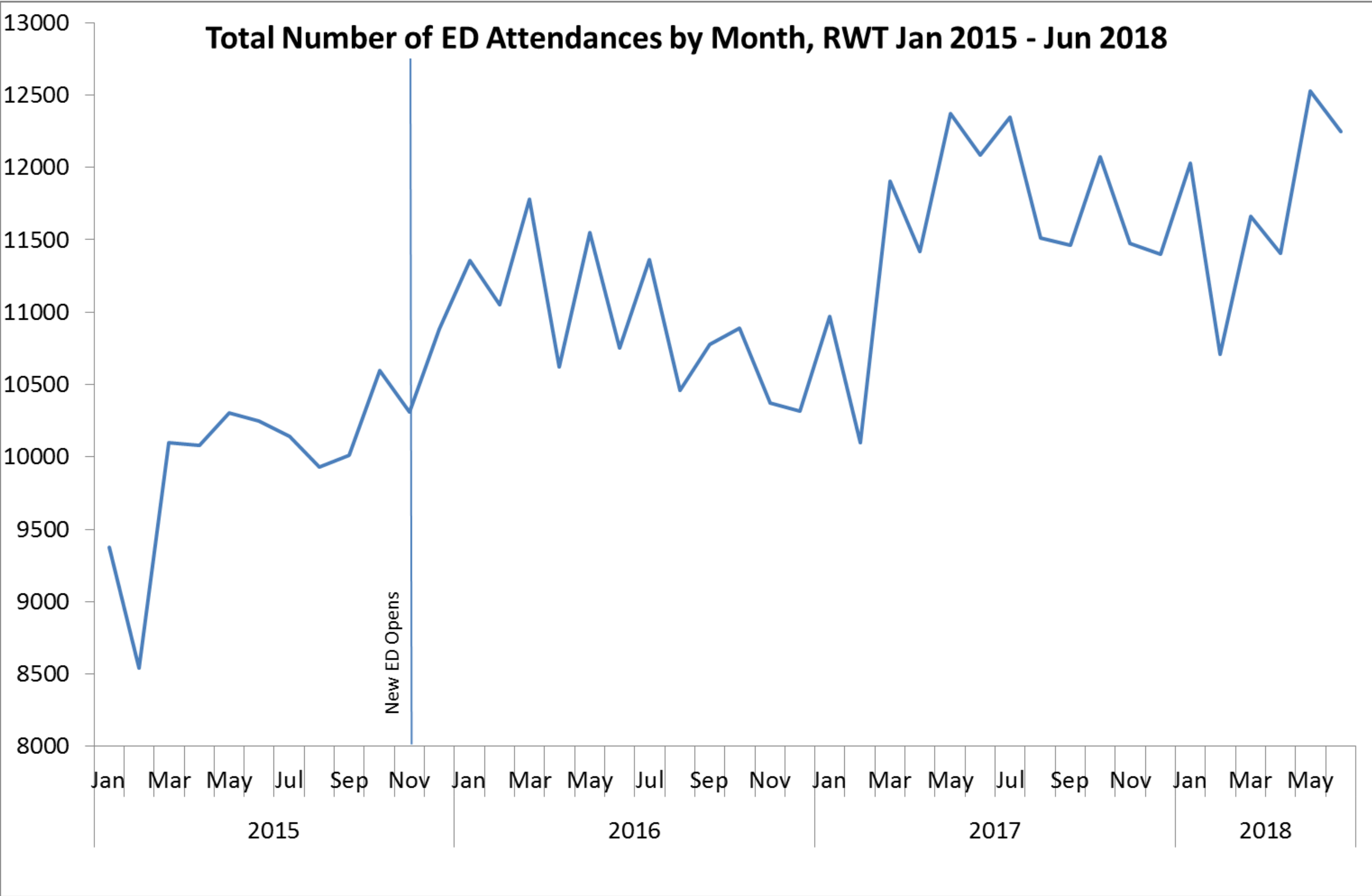

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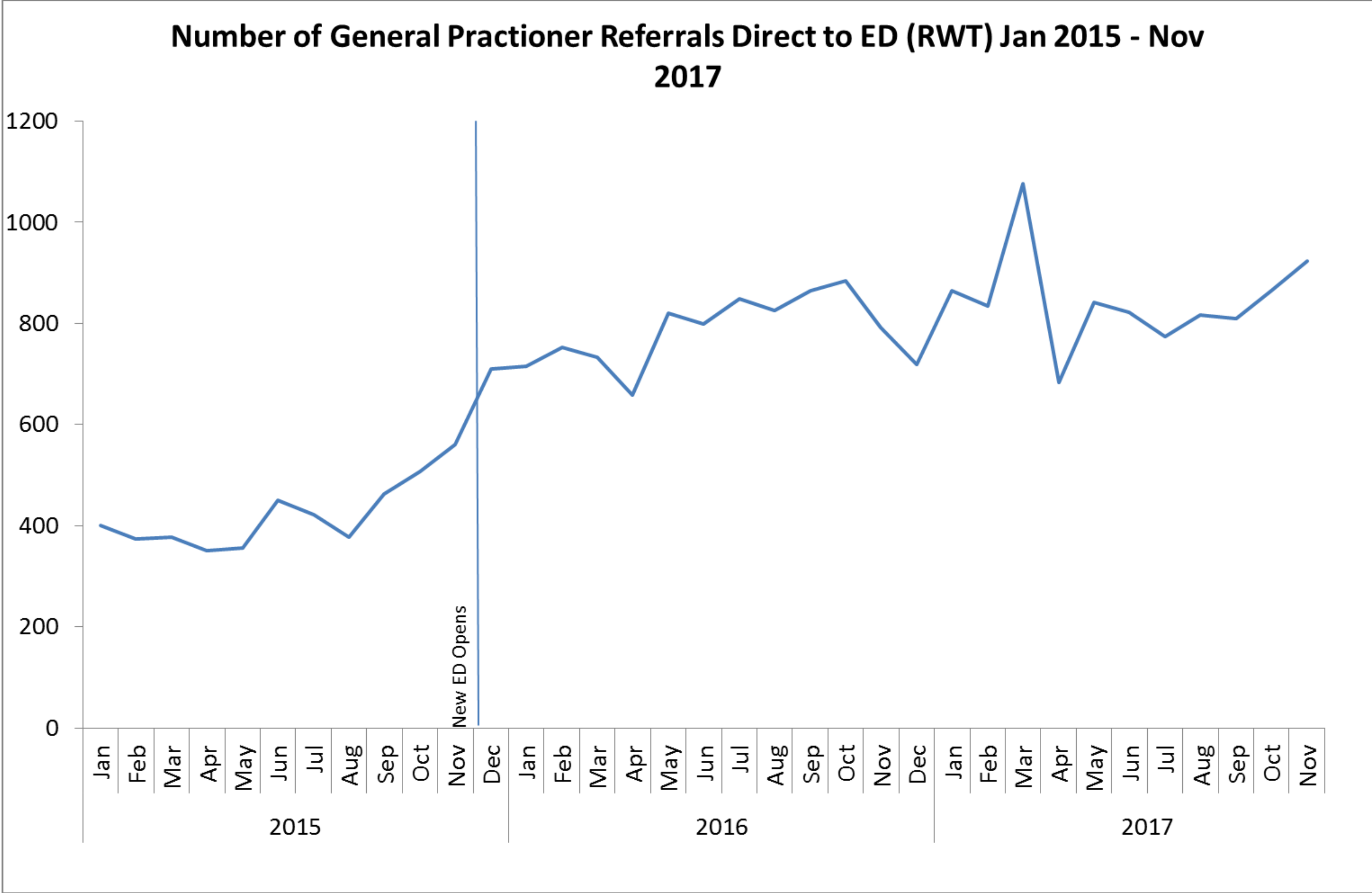

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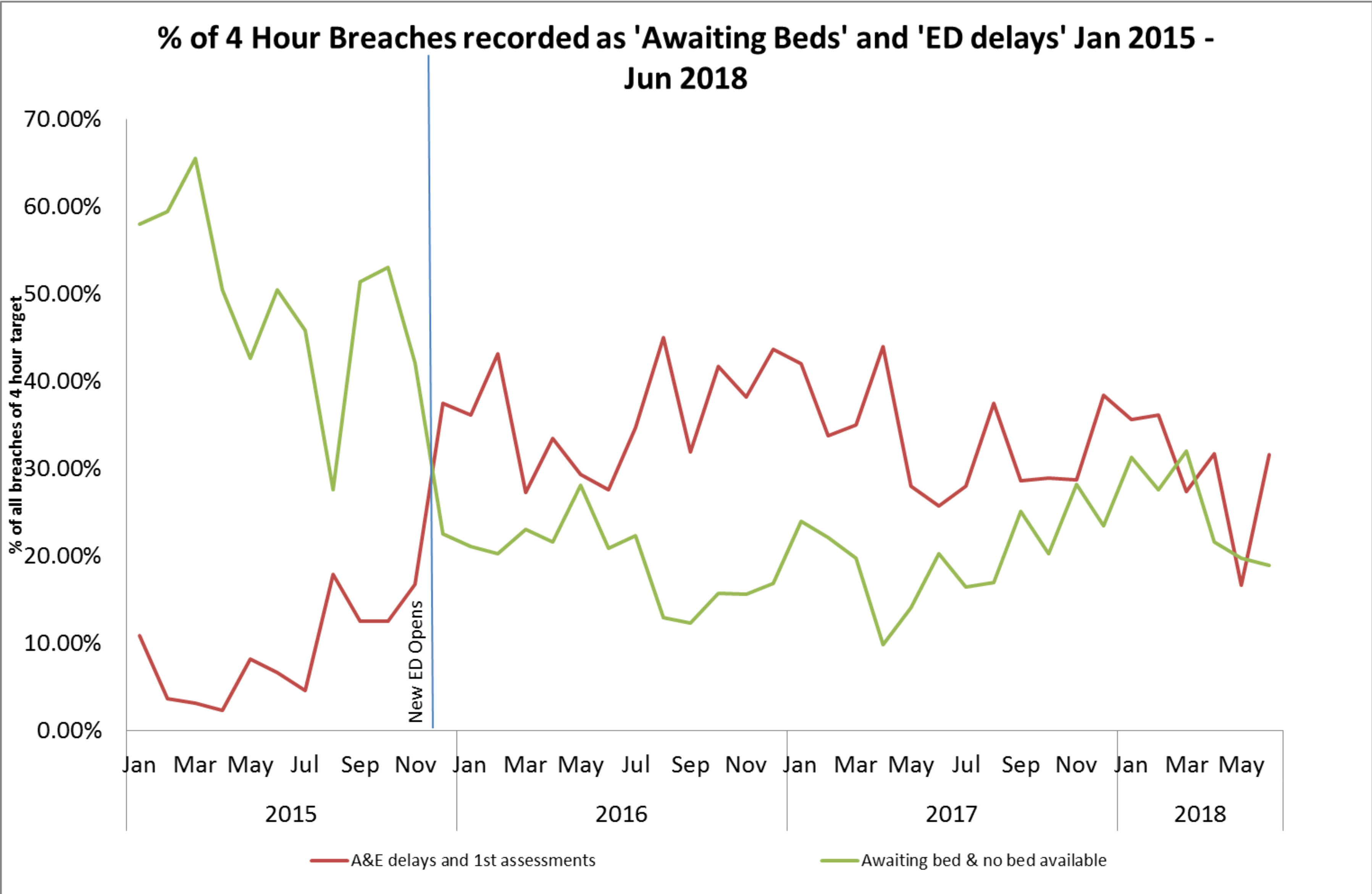

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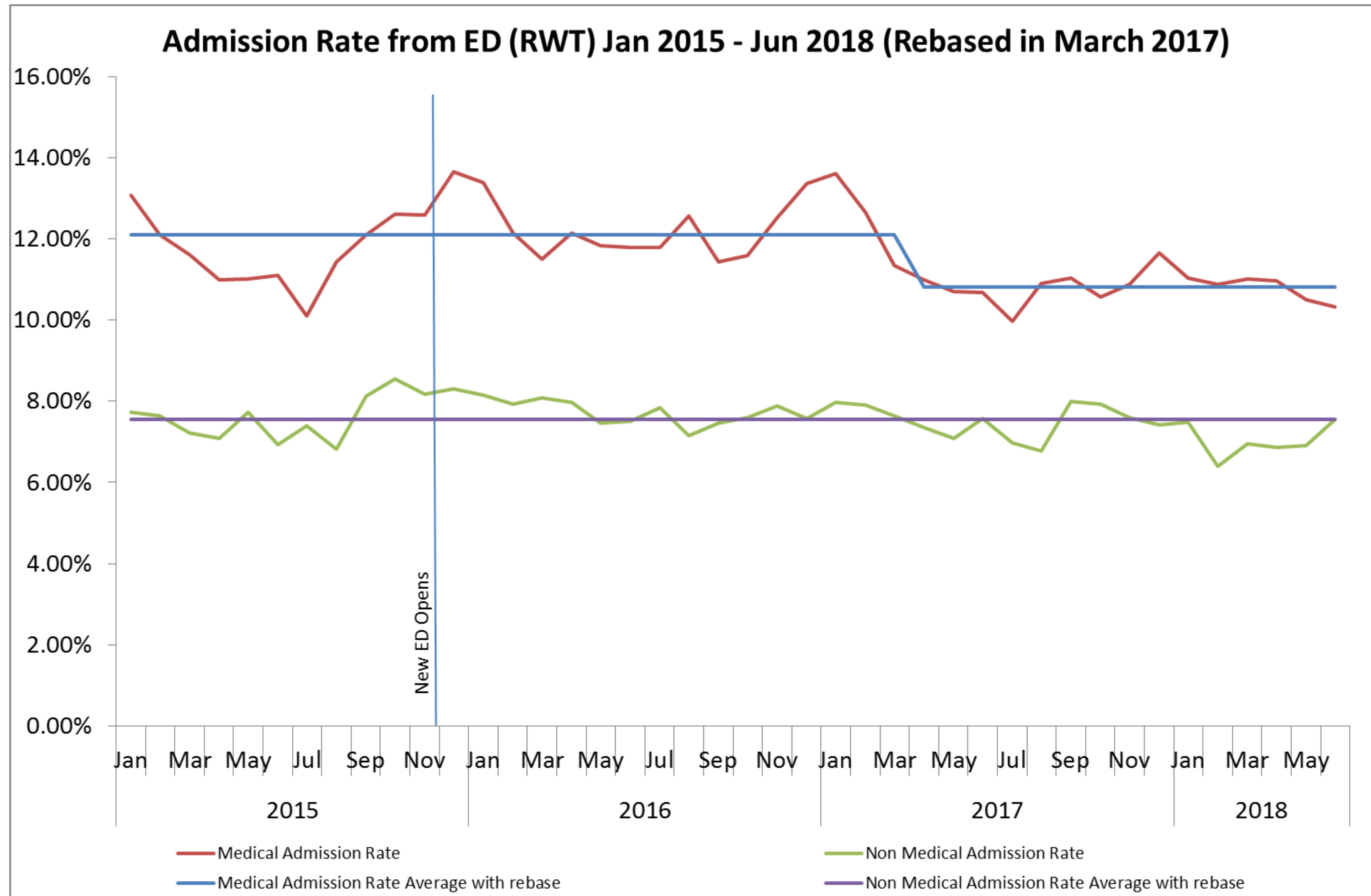

GP referrals diverted through ED when new unit opened

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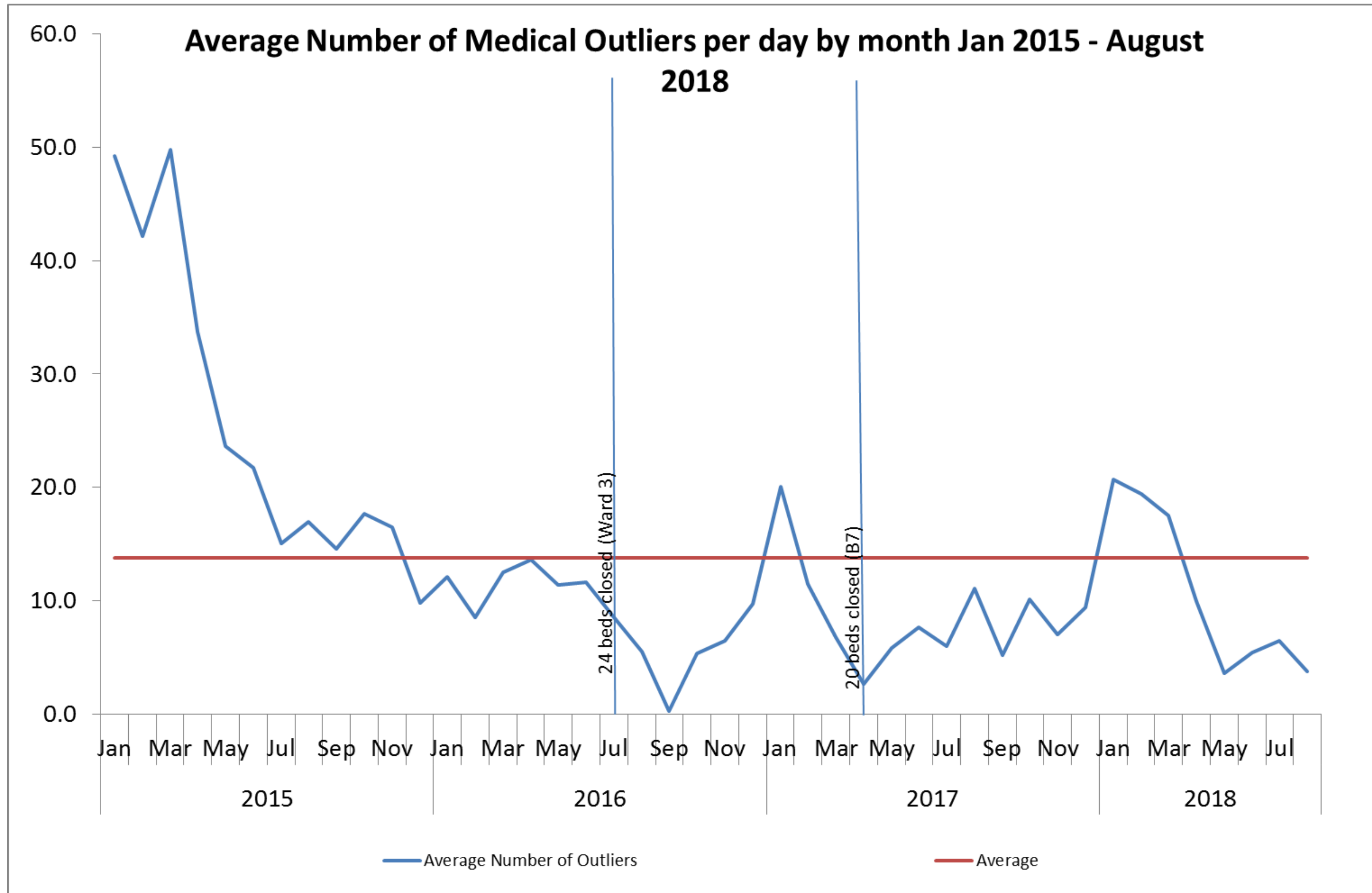
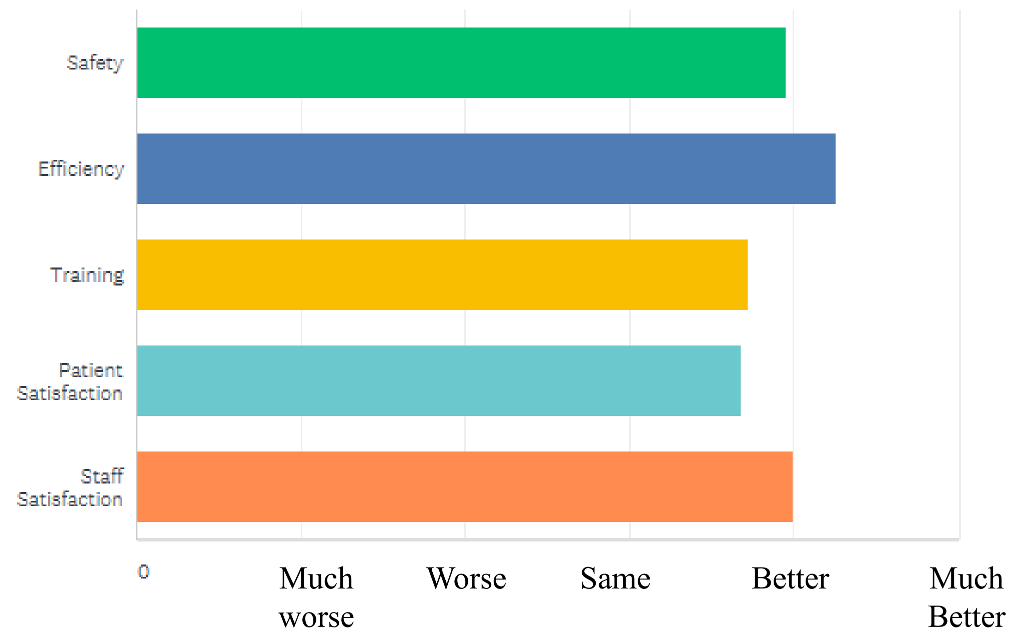
Outliers



Staff Feedback



Health warning!

- Beware effects on coding
  - Mortality statistics
  - Income

Summary

- Having ED and Acute Physicians working together in the emergency department (with services aligned around the model);

1. Reduces medical admissions (demand)
2. Leads to early senior review and management planning
3. Has been associated with improved flow of medical patients despite a reduction in the bed base
4. Is liked by all staff groups