



THE 12th INTERNATIONAL SCIENTIFIC CONFERENCE
THE SOCIETY FOR ACUTE MEDICINE

Bournemouth International Centre
20 – 21 September 2018

Models of care

1: There is no one model and they change often



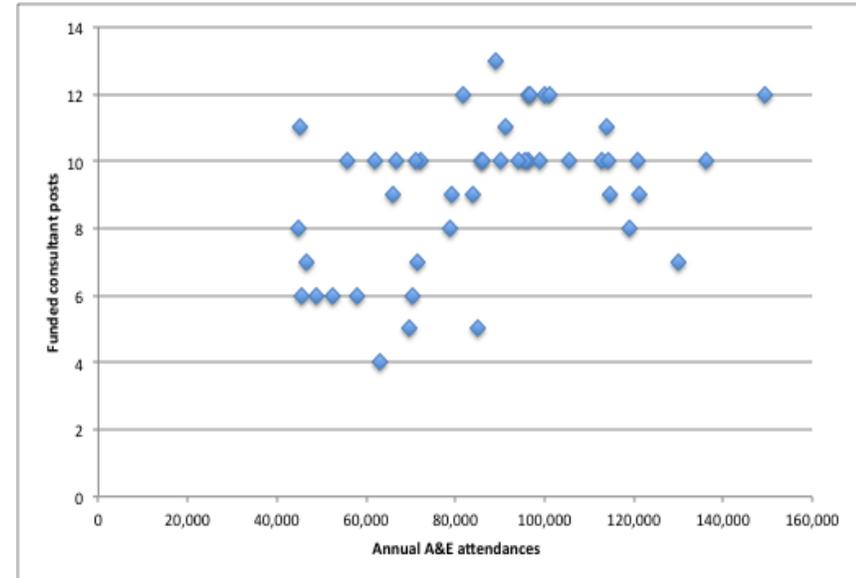
"They're continuously designing and redesigning"
Clinical Director, Site 35

No trust felt that it had the ideal model of care – or anything very close – resource constraints driving “second best”.

Emergency Departments

- 17 considered purpose of ED = triage
- 8 presented 'packaged' pts to Medics
- Rest managed patients with Medics
- Little direct referral to specialties
- Mixture of 'push' and 'pull' systems
- Little relationship between ED size and staffing
- Huge variation in other support
 - High levels of physio, OT
 - Less social work & discharge support
 - Frailty & MH liaison low

Funded ED consultant posts vs annual ED attendances

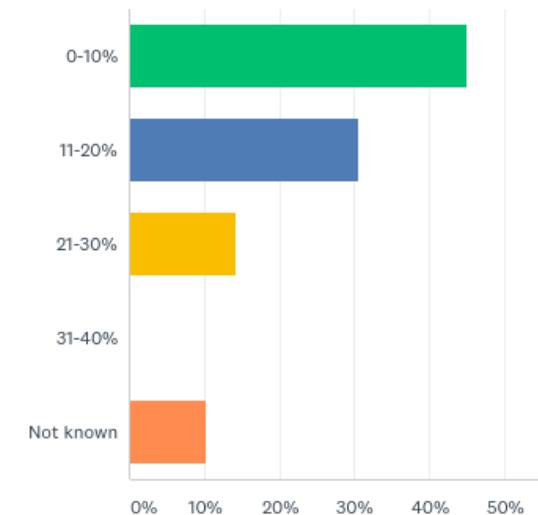


Source: Nuffield Trust analysis – NHS Digital & Survey results

Ambulatory Emergency Care

- Only one trust did not have AEC
- No two services alike
- See relatively few patients
- Majority for the primary assessment of patients
- Minority offered 'hot clinics' or follow-up
- Half are 5 day only

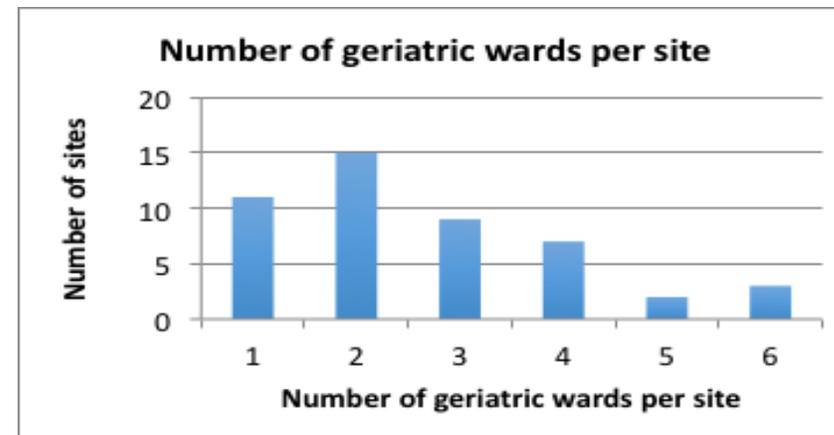
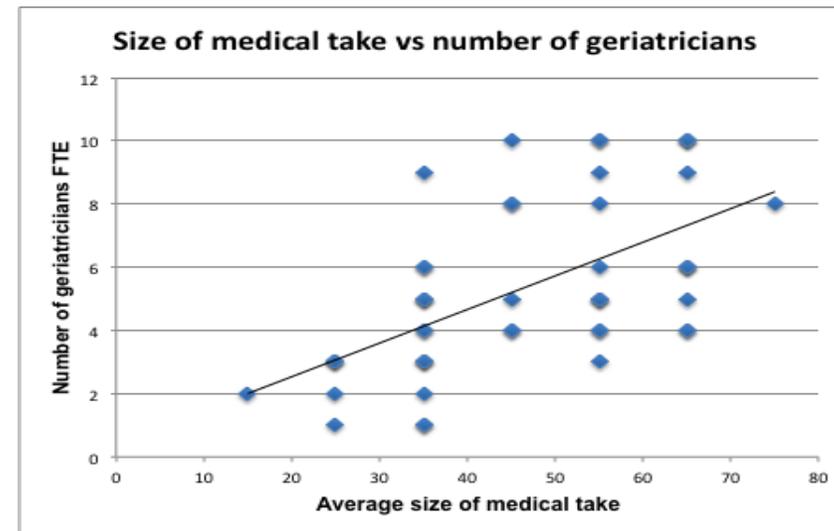
Percentage patients with acute medical problems that go via ambulatory emergency care



% Sites – Survey Responses

Frailty services

- Variation in numbers of geriatricians and beds devoted to care of elderly
- 56% sites had frailty unit – varied in size from 10-30 beds.
- Variation in referral criteria – age and/or condition
- Some aspiring to a model similar to critical care outreach.



Acute Medical Unit (AMU)

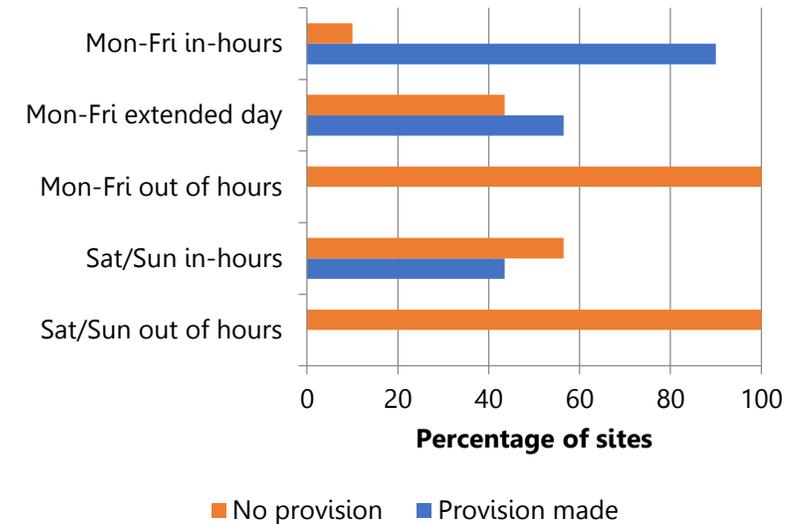
- Same enormous variation as in other bits of the system
- Majority of acute medical patients go via AMU
- Variation in size, process (inc LOS) and staffing (esp MDT)

Variation in medical cover for the acute medical unit over the week

The number of acute physicians on the AMU during the day varied from 1 to 4. The tendency is for acute physicians to cover the AMU Monday to Friday within working hours.

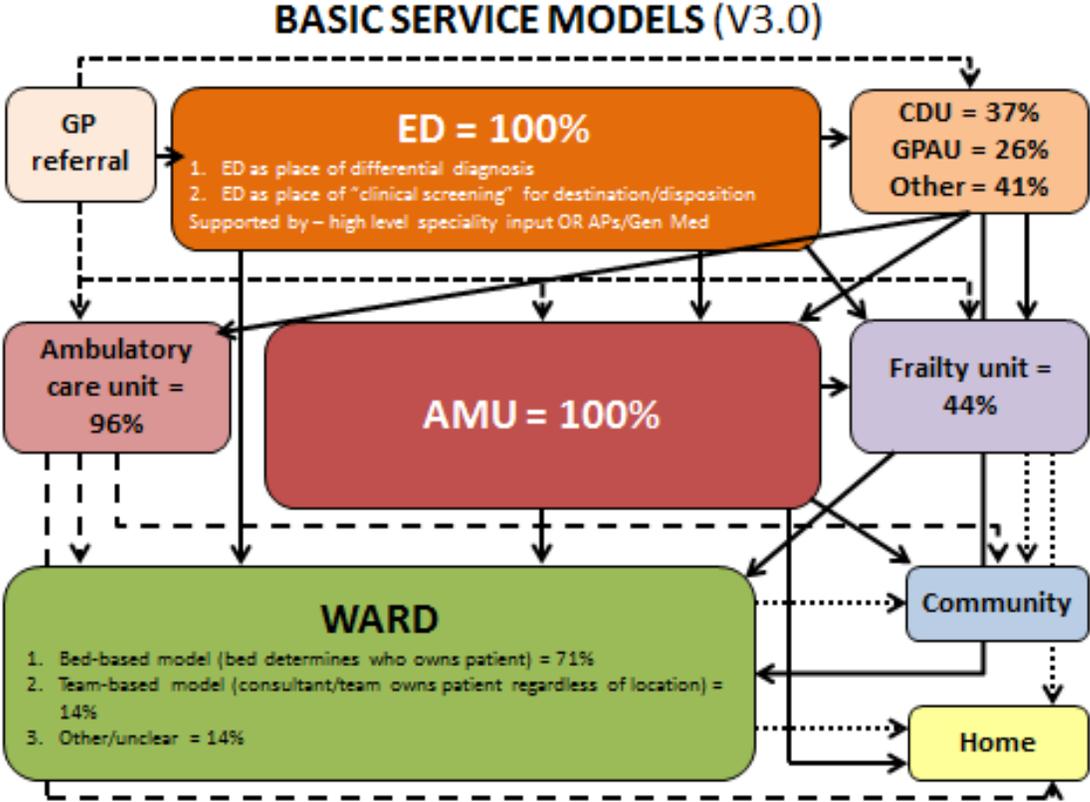
“We’ve also put on additional acute physician rounds at weekends and I would say that’s probably again in response to the acuity and the sickness of some of the patients we’re now seeing.” Director of Operations, Site 24

When do acute physicians provide primary cover for the AMU?



Source: Nuffield Trust survey

2: Too many front doors & carve outs?



Problems with carve outs and silos

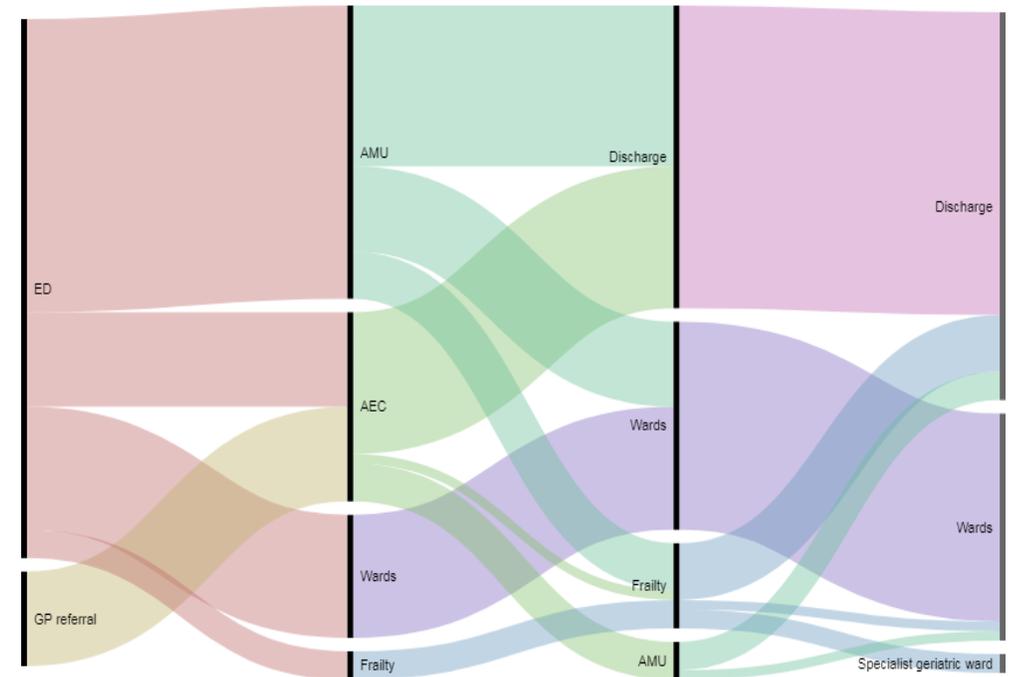
NB These observations may not apply to larger hospitals

- Spreading scarce resources too thinly
- Legitimizing the construction of fortresses
- Can create multiple handoffs and duplication
- An excuse to exit the take:
- GI bleeds
 - 1.33 per 1000 population pa
 - only 3% required OGD after 12 midnight (2007 BGS Survey)
 - = ~10 per annum for population 250 000

3: It's more complex than the planners think

- Patients are following increasingly complex and fragmented pathways, involving multiple transfers of care responsibility between professionals (see figure).
- There are many permutations of pathways within and across sites – depending on time of day and local practice.
- For example, some sites allow direct referrals to their frailty units either from the ED or from GPs, while others do not.

Pathways of care on one site for acute medical patients:
Sankey diagram - breadth of pathway proportional to flow of patients



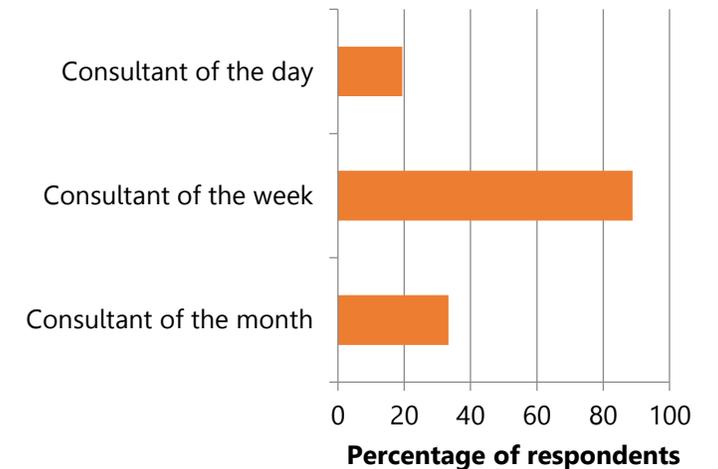
4: Continuity is suffering

- Moves between different components of the system resulted in complete discontinuities
- Medical work frequently being repeated each time the patient moved location.
- It is not uncommon for patients to be passed between different medical teams four or five teams during a single hospital stay.
- The majority of acute medical patients spend all or the first few days of their hospital admission in an acute medical assessment unit (AMU)
- Consultants on the ward for 1 day or for week at a time

Variation in approach to consultant cover for wards, with some sites trying to improve

- In the majority of cases patients are managed by the medical team responsible for their ward.
- Only 12% of sites had specialists managing patients – irrespective of their location.
- Consultant cover was delivered across wards in varying ways
- The degree to which patients had a consultant who retained overall responsibility for their care also varied across specialties. There was rarely a model that was consistently applied across a hospital.
- A few sites were trying to improve ward cover provided by consultants including increasing cover at weekends and more systematic reviews of patients.

Which models of consultant cover are used by specialties in the hospital?



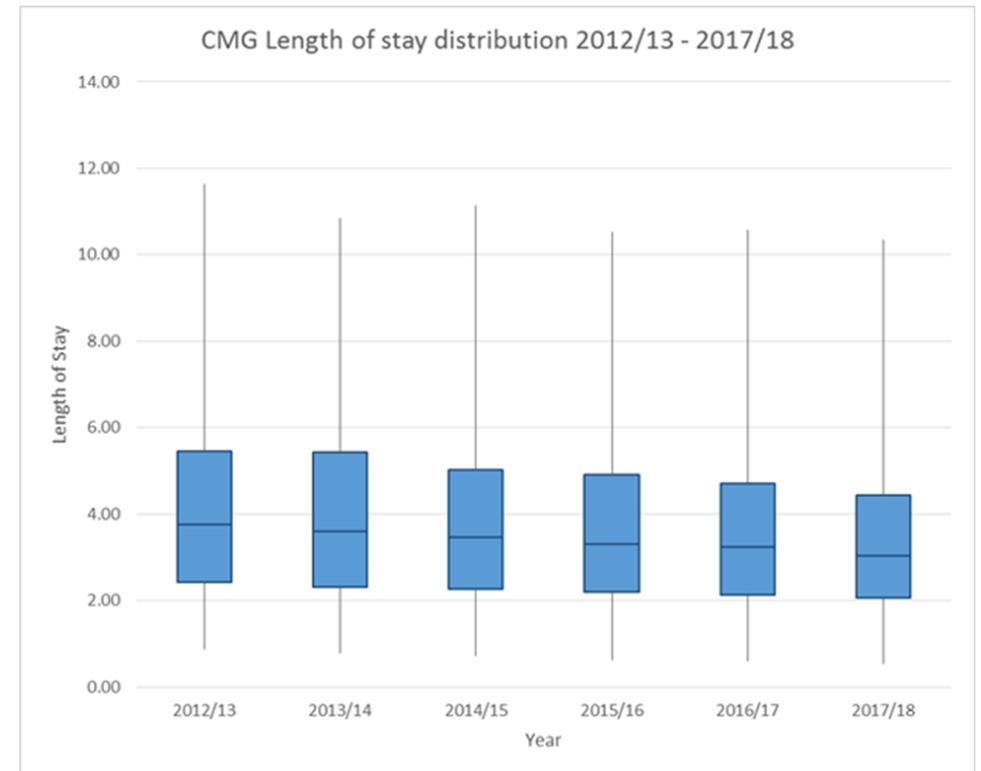
5: Little link between performance & model

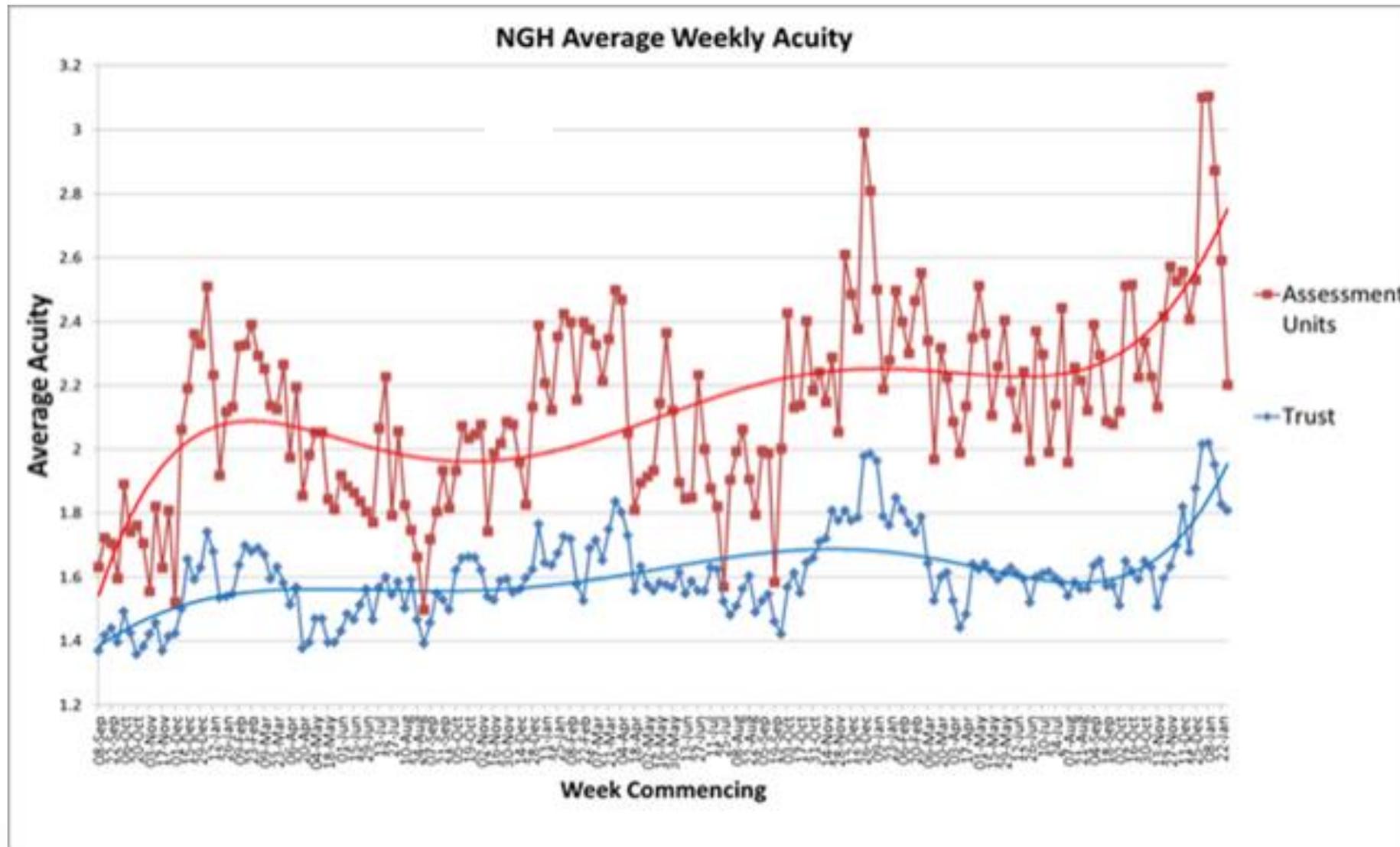
Except that:

- More transfers mean more extended stays
- Smaller units tend to have a longer LOS

6. Changes over past 5 years indicative of increasing pressure on acute medical services

- Some changes linked with changes to coding e.g. pneumonia, septicemia
- Overall increase in activity by 25-30%
- More short stay and long stay
- Shorter LOS -reduction in LOS partly but not completely linked with rise of numbers of very short stay cases
- Increasing survival accounts for a lot of growth
- 1/3 now have multiple conditions compared with 1/10 in 2006





7: The current model of service, including the configuration of beds, does not match patient need

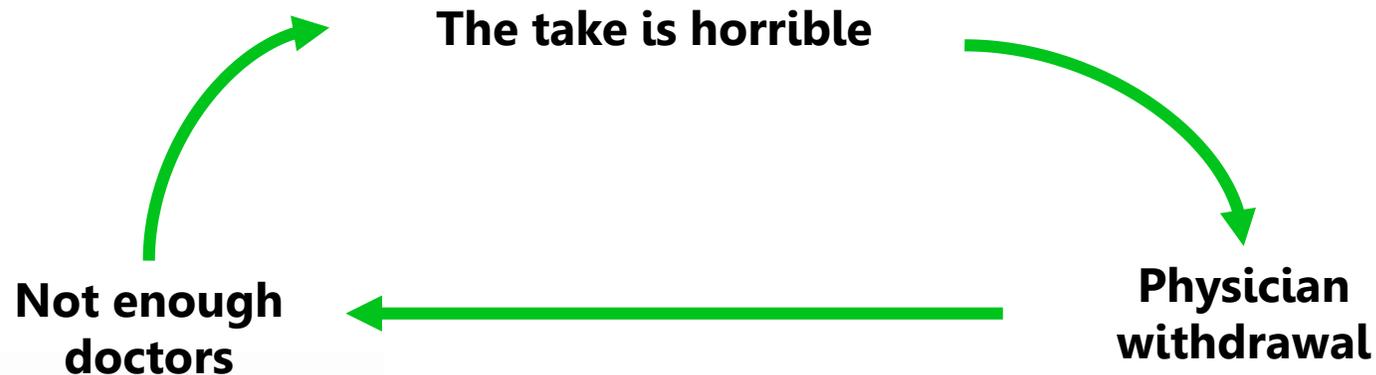
- Little matching of wards to case mix

“So, if you’re in a gastro ward, you’ll be looked after by a gastro consultant: you may have a respiratory problem but you’ll be looked after by a gastro consultant. If you then move wards and end up on a cardiology ward, you’ll then be looked after by a cardiologist. **So we’ve got care, at the moment that is based on location of patient as opposed to patient need.**”

Medical Director, Site 6

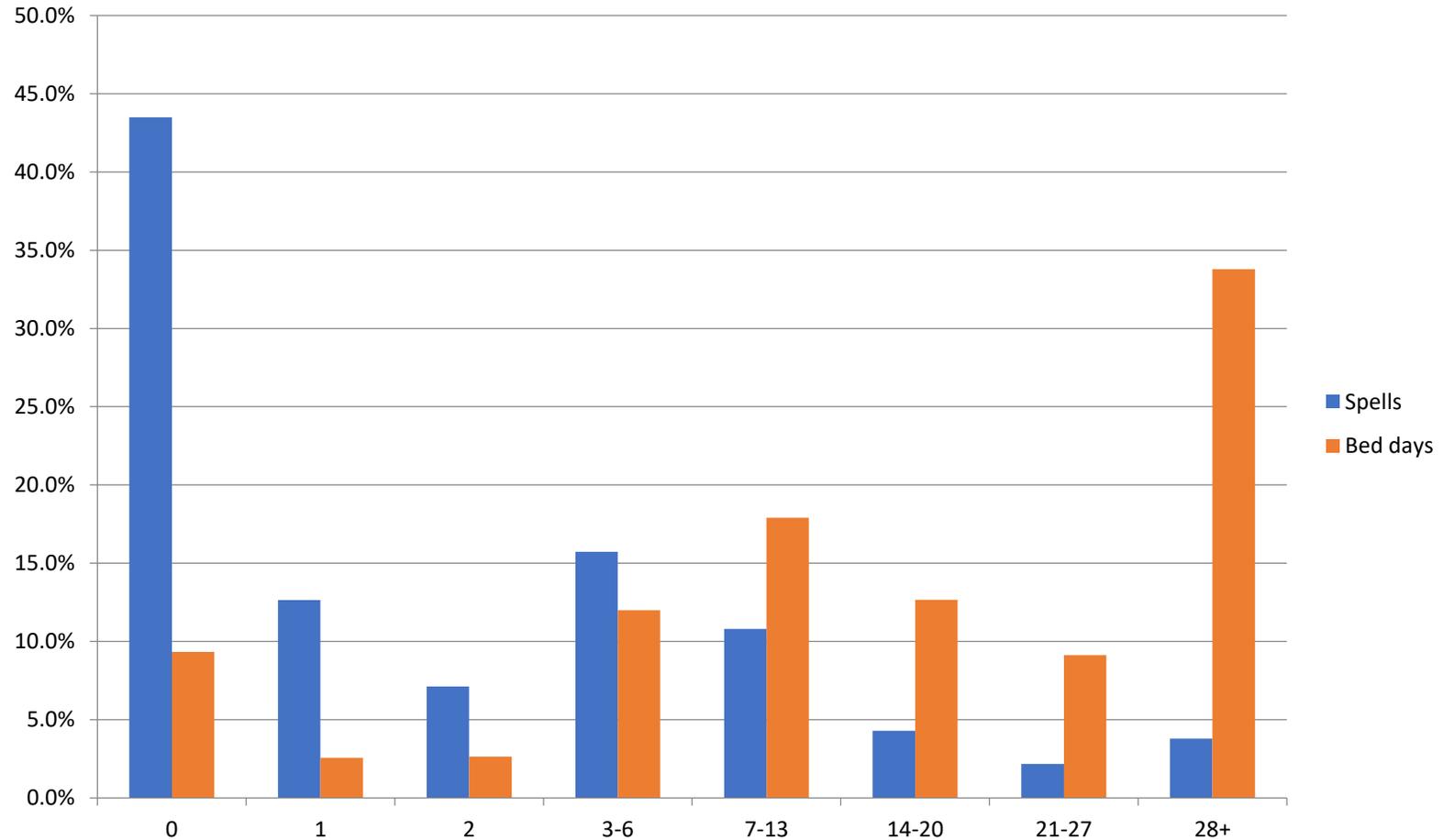
8: The cycle of doom

- NHS planning allow specialists to retreat from the take *prior* to Acute Physician recruitment
- Insufficiently attractive Acute Medicine jobs = not enough Acute Physicians
- Further retreat of other specialists from the take



9. Extended stays offer significant opportunities

Medical specialties
All episodes



Some key messages from this

- Optimizing bits of the system does not produce a global optimum
- Some actual design is required
- Acute medicine cannot do it alone!

Steps to sort this out

- Matching services to the needs of the community
 - This too often done at a service level not the hospital
- Create a unified front door team – the acute hub
 - Rapid streaming
 - Move when the patient has a dx and a plan (so revise 4 hrs)
 - Review whether carve outs are appropriate
- Rethink workforce issues
 - Restore continuity where possible
 - Stop any further carved out specialty rotas
 - Develop new staff roles to support the front door & night time cover
- Prioritise culture and co-operation

Some actions....

- National focus has been on ED and four hours
- Major expansion in ED staffing
- Not enough attention given to the medical part of this process
- Time for the different specialties to argue for a shift of attention