Clarifying the difference between EEMAC and Medical SDEC

A Position Statement from the Society for Acute Medicine

Purpose

Same Day Emergency Care and Extended Emergency Medicine Ambulatory Care are both important parts of urgent and emergency care. They are not the same service.

This statement clarifies the distinction between:

- **Medical Same Day Emergency Care**, delivered primarily by Acute Medicine specialists; and
- **Extended Emergency Medicine Ambulatory Care**, delivered by Emergency Medicine.

The aim is to support organisations in developing EEMAC and medical SDEC services safely, effectively and collaboratively, while maintaining clear governance, appropriate workforce planning, specialty accountability and accurate attribution of activity.

Key messages

1. **EEMAC is an Emergency Medicine model.**

   It is intended for selected Emergency Department patients whose episode of care can be completed in an ambulatory setting under Emergency Medicine governance.

2. **Medical SDEC is an Acute Medicine model.**

   It is intended for acute medical patients who would otherwise require admission and who benefit from same-day specialist assessment, investigation, treatment and discharge planning.

3. **The two models should not be conflated.**

   They may work alongside each other but should ideally be delivered in separate clinical areas. Where estate constraints require co-location, they must remain distinct in governance, inclusion and exclusion criteria, clinical responsibility, patient communication and activity reporting.

4. **Medical SDEC should retain its core admission-avoidance function.**

   Its purpose is to provide same-day specialist care for acute medical patients who would otherwise require admission, supported by agreed clinical criteria and clear Acute Medicine governance.

5. **Streaming alone is not sufficient to determine suitability for medical SDEC.**

   SAM supports early identification of patients who may benefit from medical SDEC. However, entry should follow appropriate assessment, differentiation and risk

stratification. Medical SDEC is an admission-avoidance service for patients who would otherwise require overnight admission; this requires clinical selection, not routine streaming.

Medical SDEC works best when suitable patients are actively selected or pulled by Acute Medicine teams, rather than routinely streamed from the Emergency Department. At the point of initial streaming, there is often insufficient clinical information to determine whether medical SDEC is the right pathway.

While redirection from ED may appear to offer short-term operational benefit, inappropriate streaming into medical SDEC risks sending patients to the wrong service, reducing capacity for those most likely to benefit, weakening admission avoidance and worsening wider hospital flow.

6. **Activity should be attributed accurately.**

   Medical SDEC activity delivered by Acute Medicine should be identifiable as Acute Medicine activity, including through Treatment Function Code 326 where applicable. EEMAC activity should be identifiable as Emergency Medicine activity within ECDS.

Definitions

Medical SDEC

Medical SDEC is the provision of same-day specialist Acute Medicine care for patients who would otherwise require overnight admission to an inpatient bed. Under this model, patients can be rapidly assessed, diagnosed, treated and, where required, followed up in an allocated setting, with discharge home the same day wherever clinically appropriate.

Medical SDEC has developed around consultant-led early assessment, rapid diagnostics, multidisciplinary working and Acute Medicine expertise in managing clinical uncertainty and risk. Its core function is admission avoidance.

SAM's statement **"SDEC: A need to pause and reset"** emphasises that SDEC should be focused on patients with an acute medical need who would otherwise have a meaningful probability of admission. It also highlights the importance of Acute Medicine actively identifying appropriate patients for SDEC, rather than allowing the service to become a passive recipient of undifferentiated front-door demand.

Patients suitable for medical SDEC usually have:

- an acute medical presentation;
- a meaningful probability of admission without specialist same-day intervention;
- a need for senior medical assessment or treatment;
- suitability for ambulatory management;
- and a realistic prospect of same-day discharge.

Medical SDEC is not a waiting area, discharge lounge, short-stay ward or ED overflow space. It requires Acute Medicine expertise, senior decision-making, access to timely diagnostics, multidisciplinary support and clear links with AMU, inpatient specialties, community services and virtual wards.

EEMAC

EEMAC is an Emergency Medicine service for selected ED patients who need ongoing assessment, investigation or treatment, but whose care can be completed without admission to an inpatient bed.

NHSE describes EEMAC as applying to patients expected to be discharged on the same day, with care concluded by the ED team within 8 hours of transfer to EEMAC.

RCEM guidance recommends that patients should only be referred to EEMAC from ED after assessment or consultation with a Tier 3 Emergency Medicine clinician or above, and that patients should be appropriately differentiated and risk stratified.

EEMAC should remain under Emergency Medicine governance.

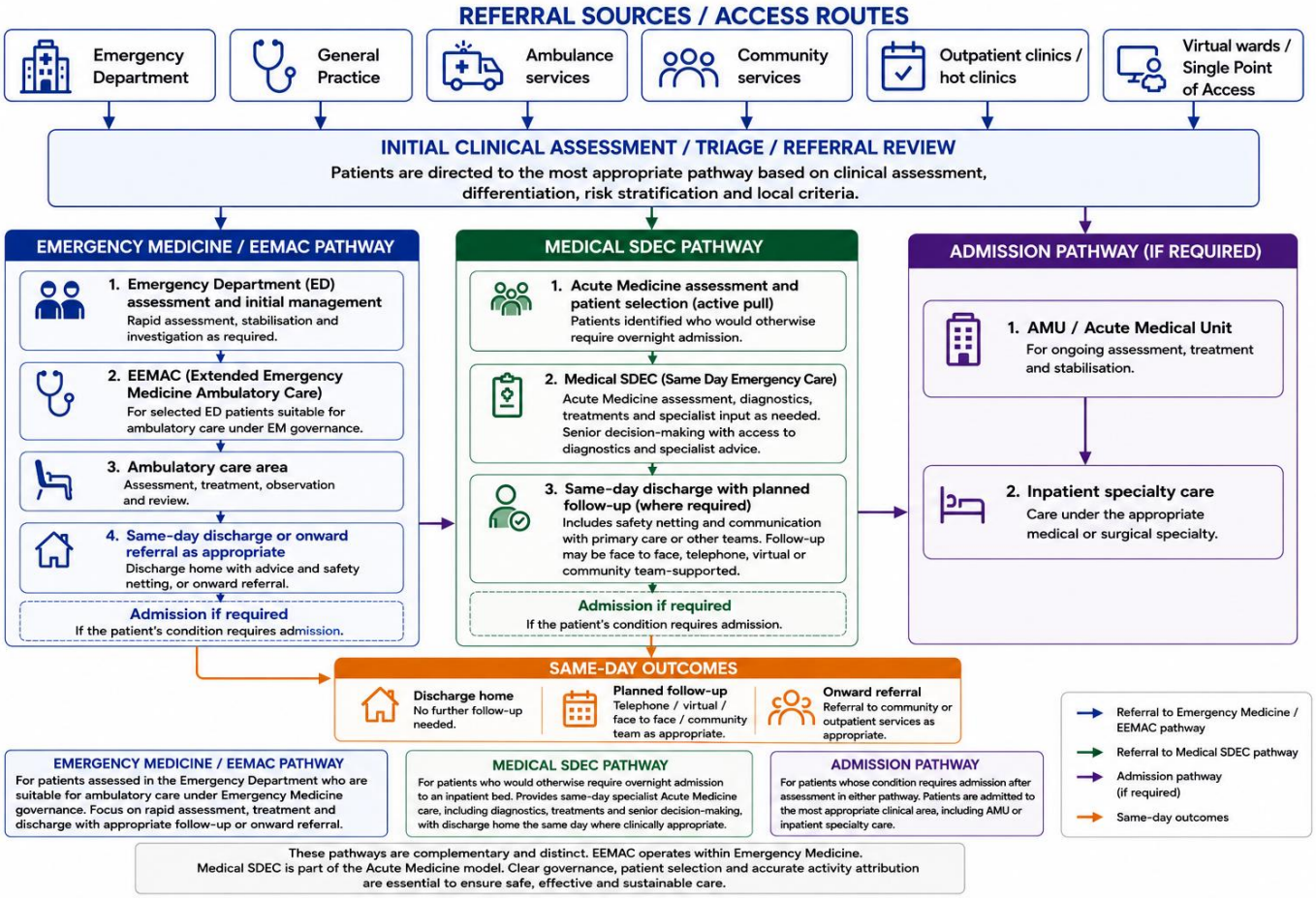

Figure 1. Relationship between referral sources, EEMAC, medical SDEC and admission pathways

Underpinning Principles

Conflating EEMAC and medical SDEC risks confusion for patients and staff, blurred governance responsibilities, inappropriate referral, loss of clarity around workforce and training requirements, and substitution of one model for another.

1. Patient selection

Medical SDEC and EEMAC serve different patient groups.

Medical SDEC is for acute medical patients who would otherwise be admitted.

EEMAC is for selected ED patients whose Emergency Medicine episode can be completed in an ambulatory setting.

Patients suitable for existing medical, surgical, frailty or other SDEC pathways should continue to be managed through those established pathways.

2. Governance

Clinical responsibility must be clear.

Medical SDEC patients should be managed under Acute Medicine governance.

EEMAC patients should remain under Emergency Medicine governance.

Where co-location is unavoidable, governance, clinical responsibility and activity reporting must remain distinct.

3. Entry into medical SDEC

SAM recognises that national policy and improvement programmes support early identification of patients who may benefit from medical SDEC. This is appropriate when it gets the right patient to the right team earlier.

However, SAM's **"SDEC: A need to pause and reset"** statement is clear that medical SDEC should not become a routine streaming pathway from ED without appropriate clinical assessment. Medical SDEC works best when Acute Medicine teams actively identify and, where appropriate, pull suitable patients into the pathway.

RCEM guidance is cautious about direct streaming into EEMAC, and states that patients should only be referred to EEMAC from the ED following assessment or consultation with a Tier 3 Emergency Medicine clinician or above, and that all patients should be appropriately differentiated and risk stratified before entering an ambulatory Emergency Medicine pathway.

SAM believes the same principle applies to medical SDEC. If streaming alone is not sufficient to determine suitability for EEMAC, it should not be regarded as sufficient to determine suitability for admission-avoidance medical SDEC.

Medical SDEC is intended for patients who would otherwise require overnight admission and who are likely to benefit from Acute Medicine-led same-day care. Determining this requires

clinical assessment, assessment of admission risk, suitability for ambulatory care and clarity about the need for Acute Medicine input.

Routine streaming into medical SDEC without appropriate clinical assessment may dilute the admission-avoidance function of SDEC, reduce capacity for patients most likely to benefit, increase duplication of assessment, create uncertainty around clinical ownership, obscure true SDEC activity and reduce measurable impact on admission avoidance.

SAM therefore supports a clinically governed model of entry into medical SDEC. Depending on local service design, this may include active selection or "pull" by Acute Medicine teams from ED, GP, ambulance, community and acute take referral routes.

The aim is not to delay care. The aim is to ensure that medical SDEC is used for the patients most likely to benefit from Acute Medicine-led same-day care.

4. Clinical appropriateness and performance standards

Neither EEMAC nor medical SDEC should be used as a performance workaround. Transfer to either pathway should be clinically appropriate, supported by assessment, risk stratification and a clear care plan, rather than driven primarily by time-based metrics.

5. Activity attribution

Accurate activity reporting matters. If EEMAC and medical SDEC activity are merged under generic ambulatory terminology, the true contribution of each specialty may be obscured.

Medical SDEC activity delivered by Acute Medicine should be identifiable as Acute Medicine activity, including through Treatment Function Code 326 where applicable. EEMAC activity should be identifiable as Emergency Medicine activity within ECDS.

This is important for:

- service evaluation;
- benchmarking;
- workforce planning;
- job planning;
- training;
- commissioning discussions;
- and future investment.

6. Workforce

Medical SDEC requires Acute Physicians, acute medical nursing expertise, advanced practitioners, pharmacists, therapists and administrative support.

EEMAC requires appropriately resourced Emergency Medicine staffing. Neither model should be developed by diluting the workforce required for the other.

Principles for local implementation

Local systems should:

1. Use **EEMAC** for Extended Emergency Medicine Ambulatory Care delivered by Emergency Medicine teams. Use **medical SDEC** for same-day emergency care delivered by Acute Medicine and other medical specialties.
2. EEMAC and medical SDEC should ideally be delivered in separate clinical areas. Where this is not possible because of estate constraints, they must remain distinct in governance, inclusion criteria, clinical responsibility, patient communication, operational oversight and activity reporting.

   Co-location should not result in a single interchangeable ambulatory area, as this risks confusion for patients and staff and makes accurate attribution of Emergency Medicine and Acute Medicine activity more difficult.
3. Use agreed inclusion and exclusion criteria for both services.
4. Ensure entry into medical SDEC is clinically governed by Acute Medicine.
5. Avoid routine streaming from ED into medical SDEC without appropriate clinical assessment.
6. Ensure EEMAC does not compromise the estate, staffing or function of existing SDEC services.
7. Recognise that some patients managed through medical SDEC may require planned follow-up review, either in person or virtually, over the subsequent days. Where this forms part of an agreed same-day care plan, it should be regarded as good clinical practice rather than failure of SDEC.
8. SAM supports a zero-tolerance approach to routine bedding in medical SDEC, with executive and senior operational support to preserve its same-day function.
9. Report medical SDEC and EEMAC activity separately.
10. Record specialty ownership, source of referral, route of entry, conversion to admission, same-day discharge, reattendance and outcomes.
11. Ensure both models are appropriately staffed, governed and evaluated.

SAM position

SAM recognises the role of EEMAC where it is appropriately governed, resourced and delivered as an Emergency Medicine model.

SAM considers high-quality medical SDEC to be a core component of Acute Medicine and strongly advocates for its continued development, protection and appropriate investment.

This position builds on SAM's **"SDEC: A need to pause and reset"**, which called for medical SDEC to be refocused on its core purpose: same-day specialist care for acute medical patients who would otherwise require overnight admission.

Medical SDEC should remain a distinct Acute Medicine service, with clear clinical governance, appropriate workforce, timely access to diagnostics, accurate activity attribution and protection from routine bedding or use as a generic front-door overflow capacity solution.

SAM supports early identification of patients who may benefit from medical SDEC. However, entry into medical SDEC should be clinically governed, criteria-based and appropriately assessed, differentiated and risk stratified.

Maintaining a clear distinction between EEMAC and medical SDEC is essential for patient safety, governance, workforce planning, training, accurate activity attribution and the future development of Acute Medicine services.

SAM supports collaborative working between Emergency Medicine, Acute Medicine, primary care, community services and other specialties, while advocating for clear definitions, robust governance and recognition of the specialist expertise required to deliver high-quality urgent and emergency care.

References

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2. NHS England. *The Model Emergency Department: high performing urgent and emergency care pathways*.
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4. NHS England. *The Model Acute Pathway: standards for care of acutely unwell patients in their first 72 hours in hospital*.
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6. Society for Acute Medicine. *SDEC: A need to pause and reset*.

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