

Acute Medicine:

A policy vision for improving urgent and emergency (UEC) care

Current position

NHS urgent and emergency care (UEC) provision is under significant strain in all 4 Home Nations. This strain is increasingly causing harm to patients. Overcrowding in Emergency Departments (EDs) and Acute Medical Units (AMUs) means patients do not receive timely, high-quality patient care. This situation is driven by workforce and capacity constraints. Whilst the COVID19 pandemic has accentuated and arguably expedited the crisis; the decline in urgent and emergency care provision has been developing over the last decade and it requires urgent action to ensure it has reached its nadir.

In January 2023, 42,725 patients waited more than 12 hours in England’s Emergency Departments for an inpatient bed. This compares to 16,558 in January of 2022 and 2,847 in January 2020. This increase is gravely concerning. As a result, acute medical care is now routinely being delivered by teams in Emergency Departments, often in corridors and other unsuitable environments rather than in appropriate wards, such as the AMU. Caring for patients in such inappropriate environments poses significant risk to patients and is associated with an increased risk of adverse events and mortality. Older patients particularly bear the brunt of this rapidly deteriorating situation.

Changes in population demographics in the UK, more effective treatments and increases in public expectation are causing a continual rise in the demand for acute medical care in hospital (see figure).

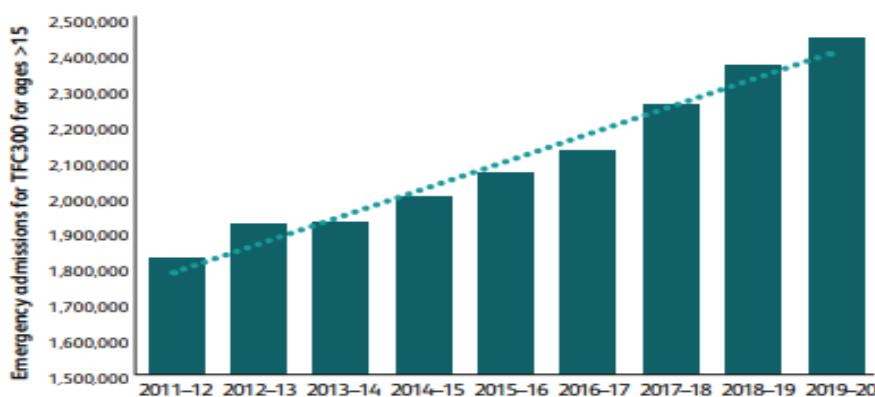


Figure: Acute Medicine GIRFT data showing the rise in acute medical admissions between 2011 and 2020.



Inspiring Excellence in Acute Medicine

The Society for Acute Medicine runs an audit (SAMBA) which monitors key measures in acute care clinical performance. Data from SAMBA shows a deterioration in many key measures. Acute medical patients are not only enduring long waits in Emergency Departments; but also increased waits to receive key interventions which enhance the safety of their care including initial clinical review, time to consultant physician review and monitoring of their physiological parameters.

Figure: SAMBA data showing performance in key indicators of acute medical performance from 2019-2022

Percentage (unplanned admissions) meeting Clinical Quality Indicator	Year							
	SAMBA22		SAMBA21		SAMBA20		SAMBA19	
	%	95% CI	%	95% CI	%	95% CI	%	95% CI
Early Warning Score within 30 minutes	68.8%	67.7-69.9%	78.6%	77.7-79.5%	74.9%	73.7-76.1%	81.3%	80.4-82.3%
Assessment by Tier 1 Clinical decision maker within 4 hours of arrival	78.7%	77.8-79.7%	87.4%	86.6-88.1%	84.4%	83.3-85.3%	87.7%	86.8-88.5%
Review by consultant within target time	49.8%	48.5-51.0%	67.8%	66.6-68.9%	61.9%	60.5-63.3%	68.6%	67.3-69.8%

The role of Acute Medicine: how to deliver improved UEC performance

Acute Medicine plays an essential role in the delivery of acute medical care across all acute hospitals. Over the past two decades, the role of Acute Medicine in improving patient care and the patient journey (flow through the hospital system) has been demonstrated; however unwarranted variations in the delivery of this care compromise our ability to provide optimal care no matter where the patient may present.

Acute Medicine continues to manage care in AMUs and delivers the majority Same Day Emergency Care (SDEC). The specialty continues to innovate and develop models that ensure safe and sustainable acute care; much of which is evidence-based, demonstrating that AMUs do make a difference. We work collaboratively with colleagues in Primary Care and Emergency Medicine and together our efforts afford a synergy in care for our patients. However, Acute Medicine is a distinct specialty that provides unique aspects of care that

President
Dr T Cooksley

President Elect
Dr N Murch

Secretary
Dr V Price

Treasurer
Dr M Wheble



Inspiring Excellence in Acute Medicine

are vital for our often vulnerable group of patients. This confers the specialty important insights into, and knowledge of, the challenges of the acute care system and potential solutions.

Acute medicine is at the heart of finding opportunities to mitigate the current crisis and for future provision of innovative, adaptive, high quality and sustainable urgent and emergency care. The fundamentals of Acute Medicine – AMUs and SDEC – alongside enhanced care areas and evolving Acute Medicine led hospital at home models are essential for UEC and whole system recovery.

Well-resourced analysis and understanding of patient flow informing the delivery of local services is imperative. Inadequate or inappropriate use of direct admission to AMU or SDEC pathways contribute to long waits in EDs. These waits are exacerbated by a lack of inpatient beds that can facilitate onward flow from the AMU. There is also a mismatch between staffing levels and peaks of activity that are exacerbated by workforce shortages. The ideal AMU needs sufficient capacity to process acute admissions and keep patients who do not require transfer to a speciality unit for up to 72 hours, as this continuity of care reduces length of stay. Bypassing AMUs to general medical or speciality beds can increase length of stay.

An increasing range of presentations no longer require that patients remain in hospital overnight and are managed through SDEC pathways. Thirty per cent of older people who do not need hospital care may be managed in a collaborative way between primary and secondary care in the SDEC setting where relevant investigations may be prioritised to avoid the need for an inpatient stay. If more intensive care is required over a short period of time studies have shown that acute medicine hospital at home models can provide care traditionally delivered in hospital. These can include senior clinician decision making, multi-disciplinary assessment and rehabilitation, physiological monitoring utilising digital technologies, delivery of intravenous treatments and escalation plans should there be a deterioration in the patient's condition. These can be supported by diagnostic investigations at the bedside including point of care blood tests and point of care ultrasound. Escalation of this model beyond the relatively early studies will require careful monitoring.

Alongside its core work, acute medicine can promote and deliver important public health messages. Delivering patient health education is often sacrificed in overburdened acute environments, with a lost opportunity to potentially mitigate future unscheduled admissions.

Patient complexity and expectation will continue to increase for the foreseeable future. Acute medical service must continue to evolve and adapt it is imperative that the proven fundamentals are not overlooked in the likely futile search for a “magic bullet”. High quality research, consistent implementation, and rigorous evaluation of new initiatives to understand acute medicine flow and performance are mandatory.

President
Dr T Cooksley

President Elect
Dr N Murch

Secretary
Dr V Price

Treasurer
Dr M Wheble



Inspiring Excellence in Acute Medicine

Key recommendations

Acute Medicine Workforce Delivery

Urgent workforce plans are required to ensure that high quality and sustainable acute medical care can be delivered. This is imperative across all the full range of health care professionals that work in acute medicine.

AMUs require adequate staffing which includes consultants and junior doctors, nurses, advanced clinical practitioners, physician associates, occupational therapists, physiotherapists, and pharmacists, in order to ensure that key national standards of care can be delivered. There needs to be a minimum nursing ratio of 1:6 trained nurse to patient ratio which should be increased in enhanced care areas. This comprehensive staffing needs to be provided 7 days a week. Acute Medicine hospital at home services and SDEC also need resilient workforce strategies to realise their full potential.

The workforce strategy must focus on both recruitment and, just as importantly, retention of staff.

Acute Medical Units (AMUs)

AMUs need sufficient bed capacity to process acute admissions and keep patients who do not require transfer to a speciality unit to stay for up to 72 hours. There needs to be sufficient capacity in AMUs to facilitate direct admission from both primary care and paramedic triage for patients who require acute medical care. Prioritisation of transfer of patients from EDs to AMUs needs to be based on clinical need.

Same Day Emergency Care (SDEC)

Hospitals need to continue to expand SDEC options for patients referred from primary care and NHS 111. This should be clearly communicated to primary care and patients receiving ongoing care. This will mean that more patients receive the right care at the right time and prevent ED attendance.

SDEC must be recognised as a distinct clinical service. It must not be converted to an inpatient facility during times of pressure. This has been shown to reduce the effectiveness of such units and decrease patient flow and is thus associated with increasing the pressure on urgent and emergency care pathways.

Hospital beds and social care provision

There needs to be an increased number of hospital beds that enables patients to be transferred and cared for in appropriate ward environments. These beds will also need to be adequately staffed. Hospitals must have occupancy rates of less than 92% to facilitate this, enabling timely flow to prevent ED and acute medical overcrowding, which in turn will reduce ambulance turnaround times.

President
Dr T Cooksley

President Elect
Dr N Murch

Secretary
Dr V Price

Treasurer
Dr M Wheble



Inspiring Excellence in Acute Medicine

Local authorities and local health systems should expand community care, including intermediate care and acute care follow-up schemes, to meet demands. This will help us to reduce the harms resulting from prolonged acute hospital stays. The NHS has passed the acceptable minimum limit for the number of beds required to adequate acute medical care. To optimise the use of beds, services must be provided to allow patients who no longer require hospital level care to be discharged; this is especially important for older people.

IT and Digital support

Appropriate IT infrastructure and support must be available. Digital solutions should be in place to ensure a clinical conversation can be used to direct patients to the most appropriate service/areas to meet their clinical needs. Effective and timely means of communication between primary care and acute medicine teams for both admission and discharge processes are essential.

President
Dr T Cooksley

President Elect
Dr N Murch

Secretary
Dr V Price

Treasurer
Dr M Wheble