Society for Acute Medicine Benchmarking Audit

SAMBA 2024 Report

A National Audit of Acute Medical Care in the UK

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Welcome to SAMBA24

The Society for Acute Medicine Benchmarking Audit (SAMBA) 2024 provides a snapshot of the care provided for acutely unwell medical patients in the UK over a 24-hour period on Thursday 20th June 2024.

Meeting the NHS Emergency Access Standard and improving acute care performance remain key priorities, yet progress has been challenging. Metrics measured exclusively in the emergency department (ED) do not directly assess the effectiveness of acute medical services, despite their critical role in delivering timely and high-quality care. SAMBA addresses this gap by focusing on the processes of care within acute medical services, using key metrics to evaluate delivery and identify opportunities for improvement.

This report is written for the benefit of all those involved in acute medical care, including healthcare professionals, healthcare commissioners, all UK governments and, most importantly, patients and the public.

The report has been sponsored by the Society for Acute Medicine (SAM). Everyone involved in conducting the audit provided their time voluntarily. Collecting data and running SAMBA at participating hospitals is a huge undertaking and therefore both the Society and the SAMBA team extend a massive thank you to all of those involved at each site.

Our hope is that the insights gained through SAMBA can be used to improve the care we provide for acute medical patients.

Executive Summary

SAMBA24 took place on Thursday 20th June 2024, with follow-up data collected 7 days later. Acute medical teams from 159 hospitals within the UK collected data on operational performance, clinical quality indicators and standards for acute care set by SAM,[1] NICE,[2] the RCP and RCPE.[3, 4] Data was collected from 9913 patients.

Key findings

Performance against clinical quality indicators

- 73.3% of unplanned admissions had an early warning score recorded within 30 minutes of arrival to hospital
    - This target was met by 73.1% in Winter SAMBA24, 73.3% in SAMBA23, 68.8% in SAMBA22, 78.6% in SAMBA21, 74.9% in WinterSAMBA20, and 81.2% in SAMBA19.
- 75.8% of unplanned admissions were seen by a tier 1 clinician within 4 hours of arrival to hospital
    - This target was met by 78.8% in Winter SAMBA24, 81.7% in SAMBA23, 78.7% in SAMBA22, 87.4% in SAMBA21, 84.4% in WinterSAMBA20, and 91.0% in SAMBA19.
- 48.2% of unplanned admissions who required a medical consultant review were seen within the target time
    - This target was met by 51.9% in Winter SAMBA24, 52.9% in SAMBA23, 49.8% in SAMBA22, 67.8% in SAMBA21, 61.9% in WinterSAMBA20, and 69.6% in SAMBA19.
    - This target was least likely to be achieved in unplanned admissions initially assessed in the Emergency Department who arrived between 08:00-20:00 (21.9% seen within 6 hours).

Outcomes at 7 days

- 30.9% of patients (unplanned admissions) were discharged the same day (30.6% in Winter SAMBA24, 32.9% in SAMBA23, 28.9% in SAMBA22, and 31.5% in SAMBA21)
- 36.3% of patients had an inpatient hospital admission that lasted for 1-7 days (40.7% in Winter SAMBA24, 38.1% in SAMBA23, 41.1% in SAMBA22, and 22.2% in SAMBA21)

Overall message

Performance in SAMBA24 was broadly aligned with SAMBA23 but remained below the levels seen before the COVID-19 pandemic. Acute medical services have succeeded in preventing additional declines in clinical quality standards, though the achieved levels still fall short of ideal benchmarks.

Although rapid transfer to an Acute Medical Unit (AMU) remains the gold standard, less patients are being treated via this pathway, with persistent access block shifting medical care into the Emergency Department (ED). Consequently, acute medical services have significantly adapted their established practices to maintain acceptable standards of patient care. Same Day Emergency Care (SDEC) continues to account for a consistent proportion of the acute medical workload, with only modest year-on-year increases. This plateau suggests that after the initial efficiency gains, further expansion of the model has become more challenging.

Emergency medicine remains the primary route of referral, with many patients continuing to be assessed within the Emergency Department. Worryingly, a significant minority of medical assessments in the emergency department now take place in the corridor, highlighting the ongoing pressures on space and capacity within acute care services.

Setting the scene

Acute medical services across the UK continue to operate under significant pressure, mirroring challenges faced across the urgent and acute care pathway.[5, 6] Acute medicine performance is assessed using time-based clinical quality indicators, reflecting the need for rapid assessment, investigations, and management.[7] The use of time-based clinical quality indicators in acute medical services reflects an assumption that timely care is a surrogate for both efficiency and patient outcomes. It is based on the premise that faster assessment, investigation, and management lead to improved clinical outcomes, reduced complications, and more effective resource utilisation. Performance measured by SAMBA declined in the post-COVID period, with a sharp drop in summer 2022 and no sign of recovery in 2023.

The structure and delivery of the services provided by acute medicine varies between hospitals, including changes adopted as a response to pressure, including COVID-19 (ongoing since early 2020)[8, 9], as well as 'winter pressures'[10], expansion of Same Day Emergency Care (SDEC) services, and adoption of various specialised services such as frailty units, respiratory support units, enhanced care beds, virtual wards and hospital at home. [11-13]

SAMBA24 aims to assess the same key clinical quality indicators as previously, to help us understand how performance in 2023 compares to previous years, and how patients move through our acute medicine services.

Acute medicine

Acute (internal) medicine provides immediate, specialist management of unwell adult patients, usually over the age of 16, presenting to hospital with medical conditions.[3] Patients may be referred from multiple sources, including emergency medicine, primary and community care, paramedics (e.g. within ambulance services), and outpatient secondary care services.

Acute medicine services aim to provide rapid, high quality assessment and treatment for a wide range of patients, from those who can be managed through SDEC,[14] to those who are physiologically unstable and require escalation to higher level care, e.g. admission to an Intensive Care Unit. Acute medical care must be timely, organised, well-led and delivered by the right staff – aiming to ensure the patient is in the right place at the right time.

The Society for Acute Medicine was founded in 2000, and over the last 25 years has expanded and developed a network of consultants, trainees and multidisciplinary members, delivering education, quality improvement, collaborative research, twice yearly conferences, and the SAMBA audit, as well as engaging with other organisations and advocating for improvements in care for our patients.

SAMBA

The Society for Acute Medicine Benchmarking Audit (SAMBA) aims to provide a comprehensive snapshot of acute medical care. The audit has taken place annually, over a pre-selected 24-hour period in June, since 2012.

SAMBA aims to:

1) compare the care delivered through acute medical units (AMUs) and same day emergency care (SDEC) services provided by acute medical teams against the Clinical Quality Indicators (CQIs) set for AMUs by the Society for Acute Medicine in 2011
2) enable individual AMUs to compare their performance to that of their peers.

The definitions of compliance with the CQIs used in SAMBA24 are unchanged from those used since SAMBA19 onwards, to facilitate comparison between the results.[15-17]

Clinical quality indictors:

Clinical Quality Indicator 1: All patients admitted to an AMU should have an early warning score (EWS) measured upon arrival.

Compliance is defined as a full set of physiological observations recorded within 30 minutes of arrival to the hospital.

Clinical Quality Indicator 2: All patients should be seen by a competent clinical decision maker within 4 hours* of arrival on AMU, who will perform a full assessment and instigate an appropriate management plan.

**In most cases, it is expected that clinical assessment and initiation of appropriate management should be undertaken in much less time, with patient assessment prioritised in accordance with clinical need.*

This time interval is measured from the time of arrival at hospital to time of first review by a competent clinical decision maker, whether in ED, SDEC, or AMU. This is the person performing the first assessment (clerking) and does not include brief assessment during a triage process. A competent clinical decision maker, as defined by the RCP, may be an ACP (Advanced Clinical Practitioner), PA (Physician Associate) or any grade of doctor.

Clinical Quality Indicator 3: All patients should be reviewed by the admitting consultant physician or an appropriate specialty consultant physician within 6 hours of admission to hospital (if admitted within daytime working hours) or within 14 hours of admission to hospital (if admitted outside daytime working hours).

This time interval is measured from the time of arrival at hospital to the time of the first consultant physician contact, whether in ED, SDEC, or AMU. Daytime working hours are 08:00-20:00.

Definitions

Definitions of compliance are unchanged from previous rounds of SAMBA from SAMBA19 onwards. The background to these definitions is discussed within the SAMBA19 Report.[15]

In keeping with definitions used in the last 3 years, time intervals are measured from arrival to hospital, for all ports of entry. This provides a more accurate reflection of a patient's hospital experience. Although most patients start their journey in the ED, some patients will be admitted

directly to AMU or SDEC. Many medical patients never reach the AMU, being discharged from ED, admitted directly to other wards, or redirected to SDEC. For patients referred from the ED, the total waiting time from arrival at hospital reflects the function of both the ED and acute medicine teams and its interpretation is therefore different to the interpretation of waiting times for patients who are admitted directly to AMU or SDEC. To aid interpretation, we have also presented information about time to review and location of review by a medical clinician. Individual units are encouraged to think about their local context and processes when interpreting the results.

Hospital Participation

Participation in SAMBA is voluntary for acute medicine services, but is now recognised by HQIP. The full list of hospitals who took part in SAMBA24 is available in Appendix 1. Participating units have a bespoke report of their performance provided to registered participants at each unit. Any queries regarding local reports should be directed to samba@acutemedicine.org.uk.

Organisation & Methods

SAMBA is planned and conducted by the SAMBA Committee. The current questions included in SAMBA have been developed with input from the SAMBA Academy and the SAM QI committee.

SAMBA24 was promoted to SAM members via email, on X/Twitter and via the SAM website. New units were able to register through the SAM website, with all the documents needed to participate available on the website. The same database provider has been used since 2022, however units were required to re-register to ensure they had received the updated documentation for SAMBA24.

Who and When?

Recruitment to SAMBA24 was open to all hospitals in the UK receiving acutely unwell medical patients. Non-acute and community hospitals were excluded. Acute medicine teams in participating hospitals were asked to register with their local audit office and Caldicott Guardian.

The audit included all new patient referrals to acute medicine on Thursday 20nd June 2024 between 00:00 to 23:59 hours and patients returning as a planned attendance to SDEC within these hours. The data for patients returning to SDEC is not used in all the analyses below and the reader is guided through the data included in each section.

Data Collection

For SAMBA24, online software was used for data entry. Study data were collected and managed using REDCap electronic data capture tools hosted at the University of Birmingham.[18, 19] REDCap (Research Electronic Data Capture) is a secure, web-based software platform designed to support data capture for research studies, providing: 1) an intuitive interface for validated data capture; 2) audit trails for tracking data manipulation and export procedures; 3) automated export procedures for seamless data downloads to common statistical packages; and 4) procedures for data integration and interoperability with external sources.

No identifiable patient data is entered through the online portal. Individual sites create a Masterlist linking patient study codes to a local identifier. This is stored securely at each site, separate to any anonymised raw data.

SAMBA24 included both unit data and patient level data. Unit level data included information regarding size of AMU and hospital, and provision of SDEC services.

Acuity of illness was assessed using the National Early Warning Score 2 (NEWS2).[20]

Within the results, units with missing data on an individual item are excluded from analysis and therefore the denominator may vary for each item.

Disseminating SAMBA data

Results are available to each participating unit to show their performance against the CQIs. The results available to each unit show their unit outcomes compared to anonymised results from other units, allowing them to benchmark their performance. National results are collated into a National SAMBA Report and have previously been published in peer reviewed journals[7, 16, 17, 21] and presented at SAM conferences.

Results

Unit participation

165 units submitted patient data for SAMBA24, from 159 hospitals (Figure 1). Five hospital sites submitted data from an Acute Medical Unit and separate frailty services. One participating hospital site has a SDEC service, but no Acute Medical Unit or inpatient services on site.

Of these participating units, 121 submitted unit data alongside patient data.

Patient data was submitted for 137 hospitals in England, 6 in Northern Ireland, 8 in Scotland, 7 in Wales and 1 in Jersey.

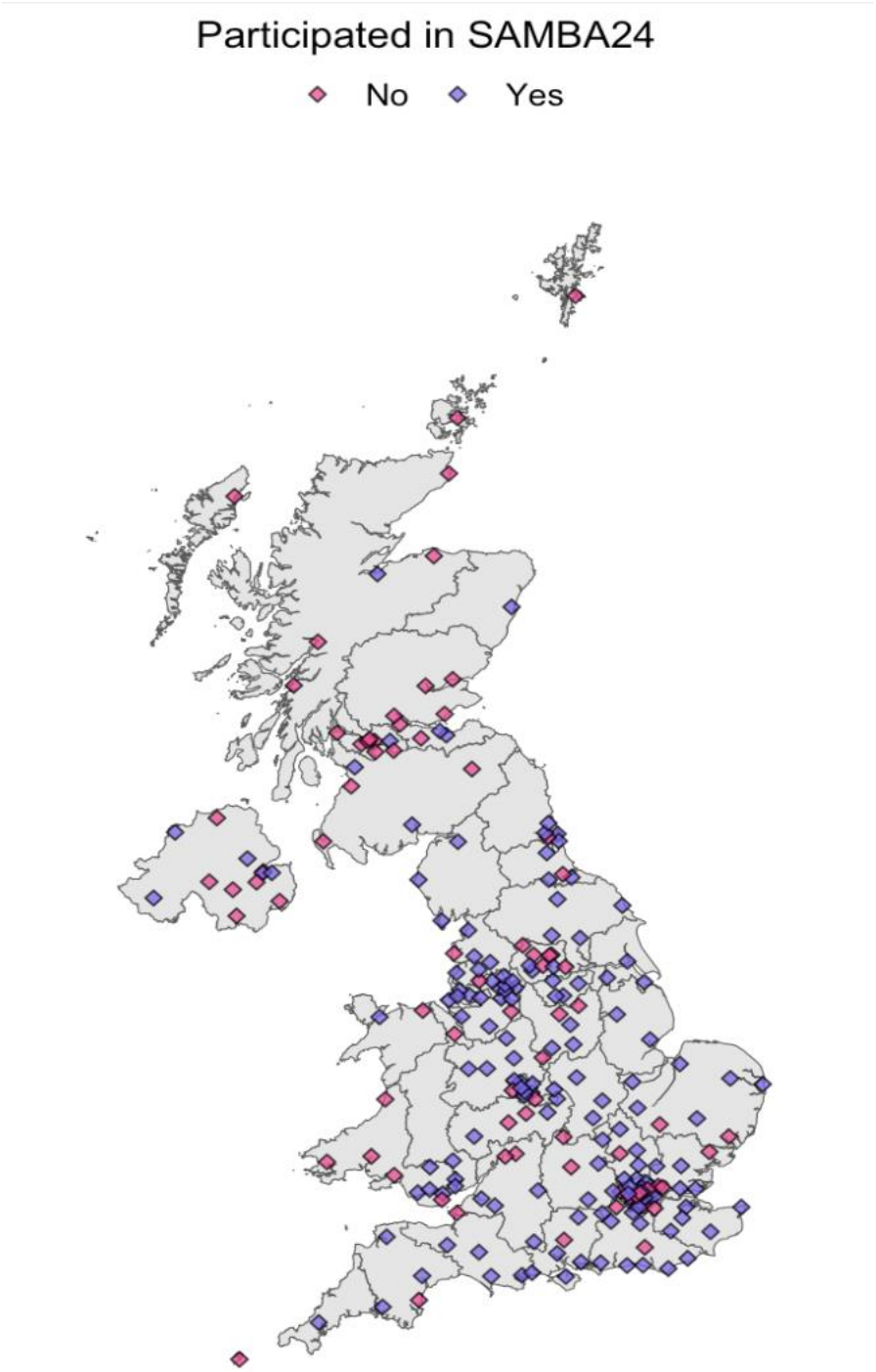
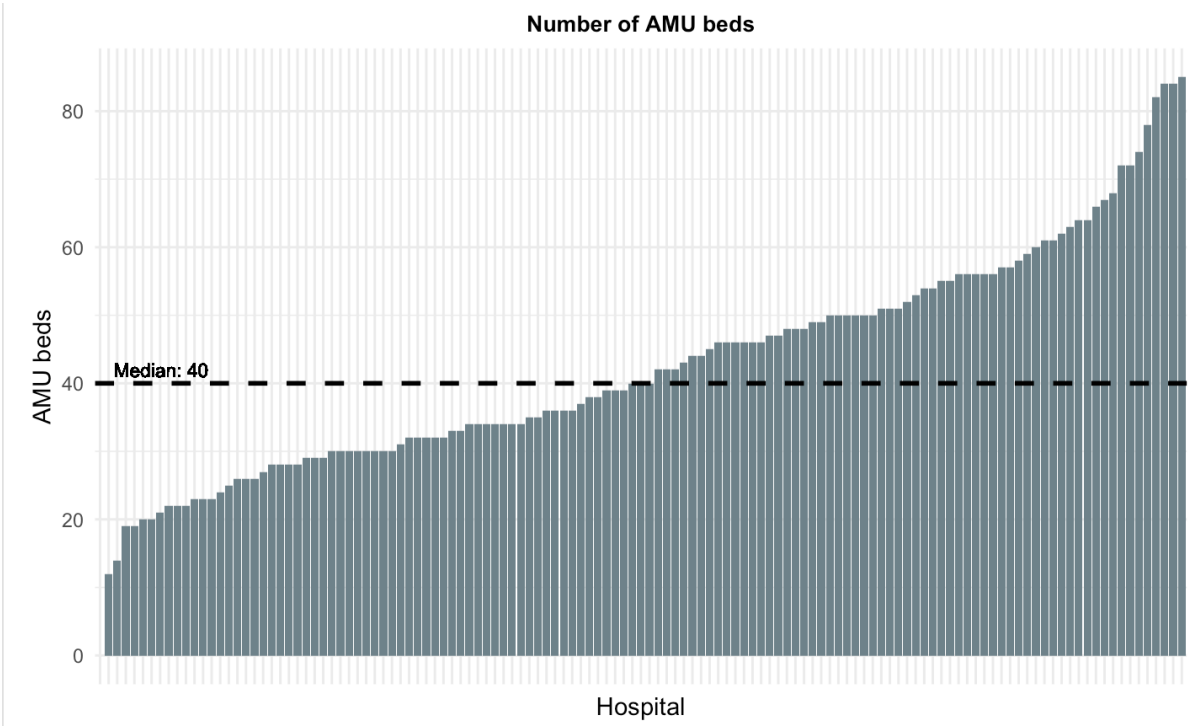


Figure 1: Participating units in SAMBA24. All hospital sites in UK with a Type 1 Emergency Department shown.

Figure 2: Number of AMU beds at each participating unit



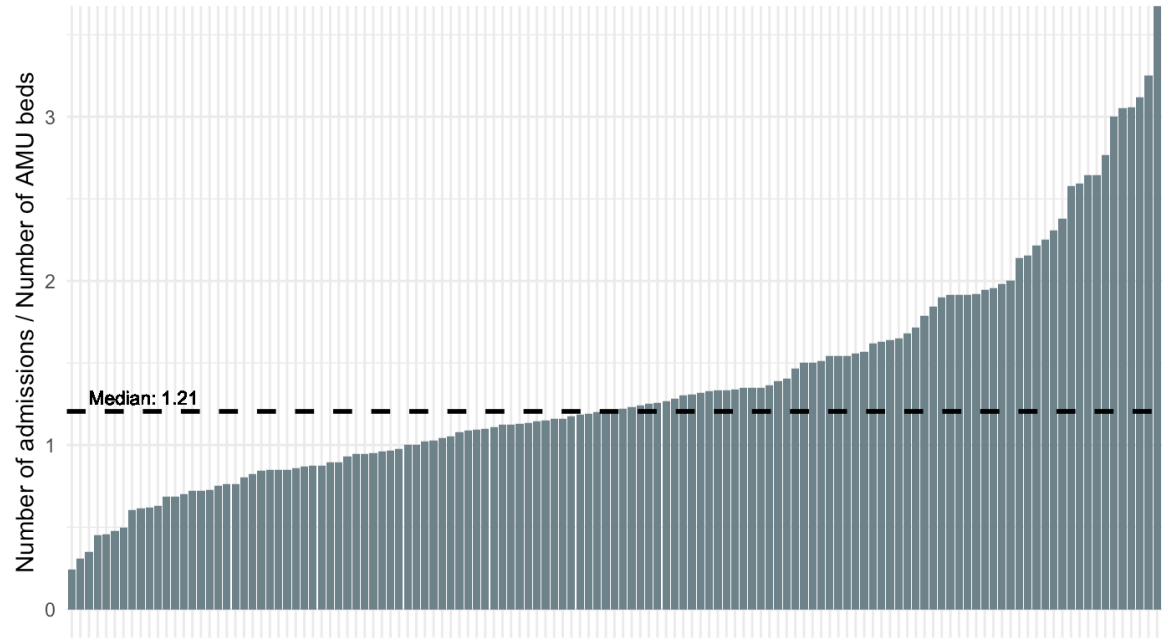


Figure 3: Ratio of admissions to AMU beds at each participating unit

The services

Participating hospitals with inpatient services ranged in size from 120 to 1800 total inpatient beds. The median number of inpatient beds at participating hospitals was 508 (interquartile range (IQR) 388 694). The median number of AMU beds per unit was 40 (IQR 30-54, range 0-90) (Figure 2) and the median ratio of admissions to AMU beds was 1.2 (Figure 3).

5 participating hospitals (3.5%) did not have an on-site ED.

33 (20.3%) units had an enhanced care area/unit within their acute medicine service. These units had a median of 7 enhanced care beds (IQR 5-9, range 4-18).

66 units (40%) reported that their acute medicine service included a separate short stay ward, with a median 25 beds (IQR 16-32, range 3-106).

Same day emergency care

Operational patterns across SDEC units reveal considerable variation in start and finish times for accepting new patients. Most units (98, 69%) start accepting patients between 08:00-08:59; 2.6% start between 06:00-07:59 and 25.0% start between 09:00-10:00. Finish times for accepting new patients were more variable (Table 1). Patient feedback surveys for SDEC patients are conducted in 80.9% of services.

Table 1: Finish times for accepting new patients to SDEC services.

Finish time for accepting new referrals to SDEC	
16:00-16:59	3.2%
17:00-17:59	9.6%
18:00-18:59	18.9%
19:00-19:59	4.5%
20:00-20:59	30.2%
21:00-21:59	8.3%
22:00-22:59	26.5%
23:00-23:59	11.0%

Patient level data

The patients

9913 patients were included in SAMBA24.

The median number of patients seen per unit was 56 (IQR 40-75, range 4-164) (Figure 4).

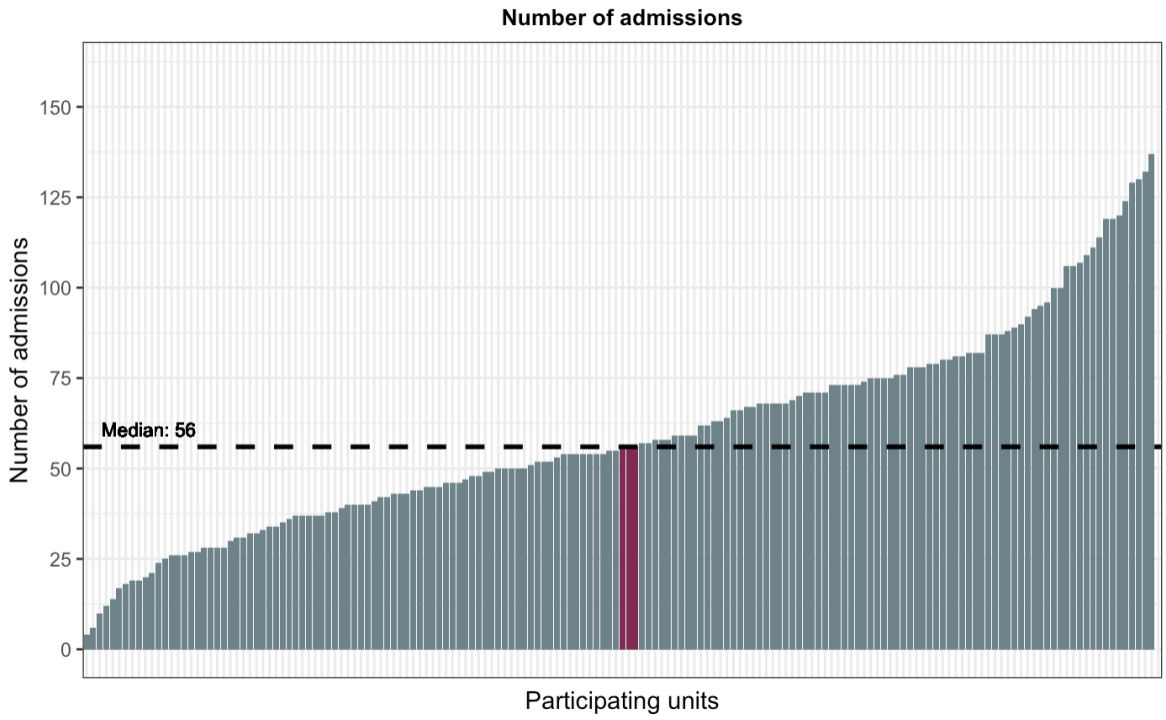


Figure 4: Number of admissions per unit participating in SAMBA24. Units ordered on x-axis by number of patients seen during the 24 hours of data collection. Planned and unplanned admissions included. Red marks median unit performance.

Demographics

- 54% of patients were female (SAMBA21 54%, SAMBA22 52%, SAMBA23 53%)
- 24% were aged 80 years and above (SAMBA21 26%, SAMBA22 27%, SAMBA23 25%)

Scheduled returns

- 13.7% of patients (1356 patients) were scheduled returns (SAMBA21 9.2%, SAMBA22 12.6%, SAMBA23 14.6%)
- The percentage of patients seen on the day of data collection who were scheduled returns varied between units (Figure 6)

Location before admission

- 4.3% were admitted from a care home (nursing or residential) (SAMBA21 5.4%, SAMBA22 5.0%, SAMBA23 5.1%)
- 0.4% of patients were homeless (SAMBA21 & SAMBA22 0.4%, SAMBA23 0.7%)
- 1.2% were transferred from another hospital (SAMBA21 & SAMBA22 1.1%, SAMBA23 1.2%)

Readmission

- 21% of unplanned admissions had been discharged from hospital in the last 30 days (SAMBA21 18%, SAMBA22 & SAMBA23 20%

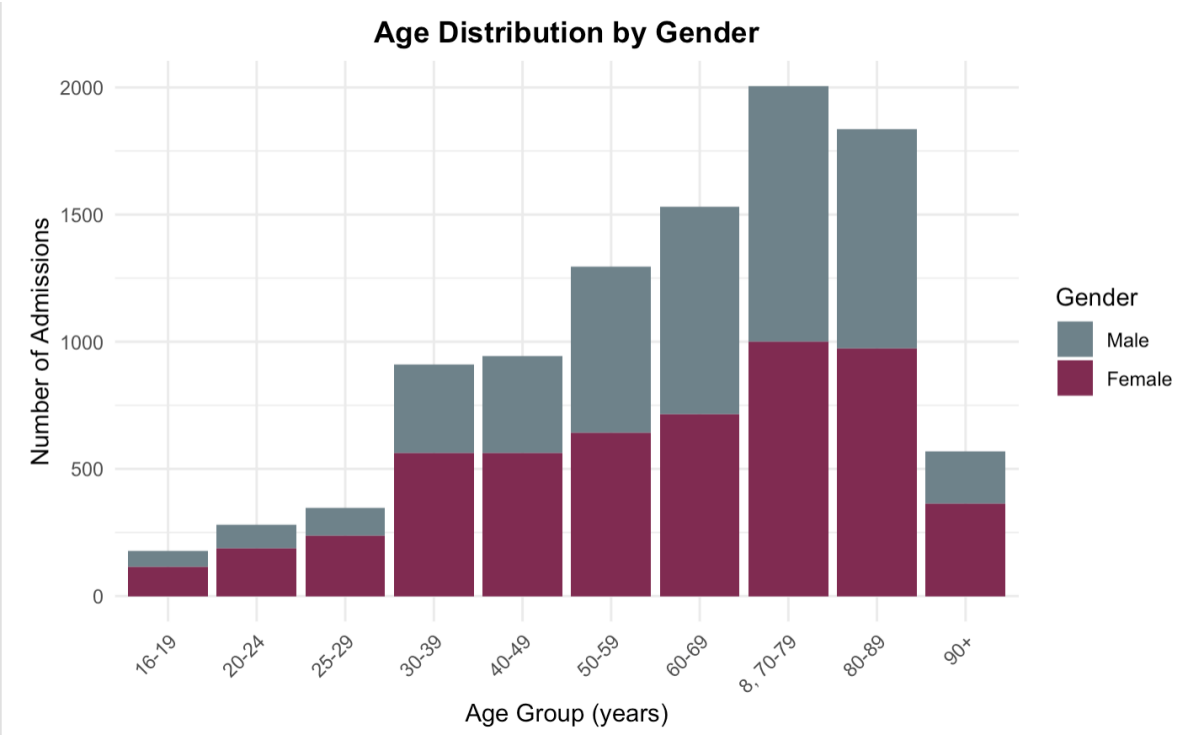


Figure 5: Age distribution of patients included in SAMBA24. Note: age categories vary in size between 16-29 years.

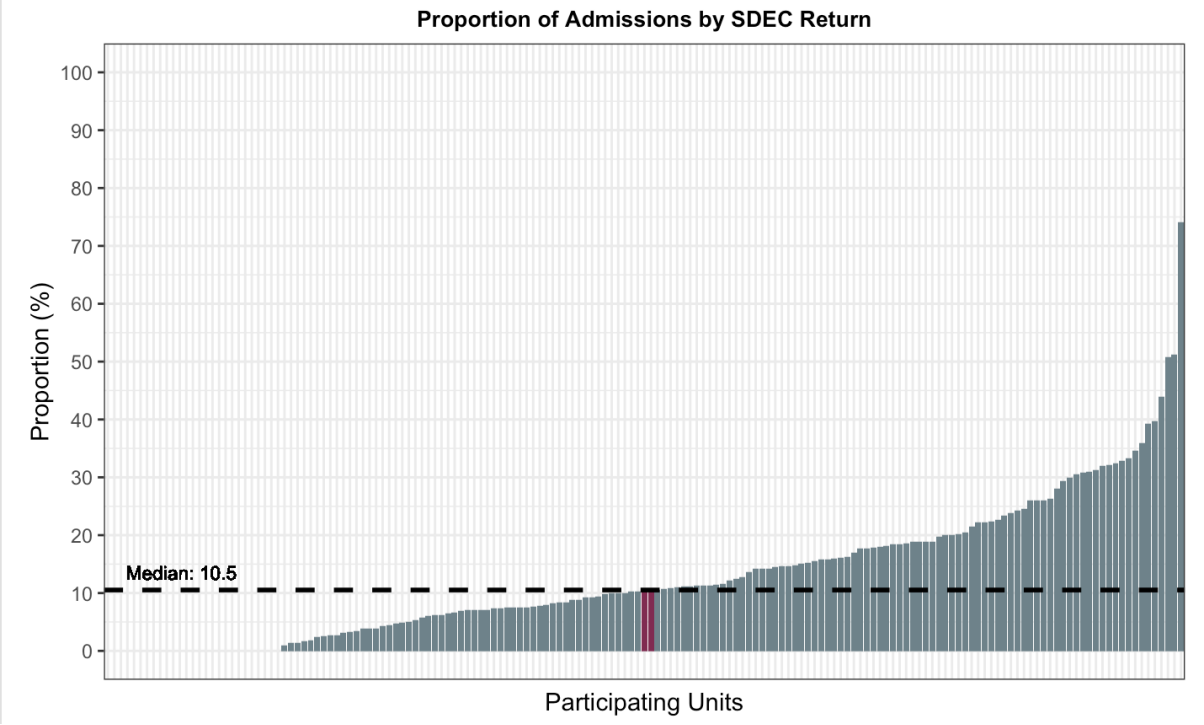


Figure 6: Percentage of admissions that were planned re-attendances. Participating units ordered by percentage that were planned reattendances. Twenty-seven units reported no planned reattendances on the day of the audit.

Early warning scores

71% of unplanned admissions had a NEWS2 of 0-2 on arrival (Figure 7).

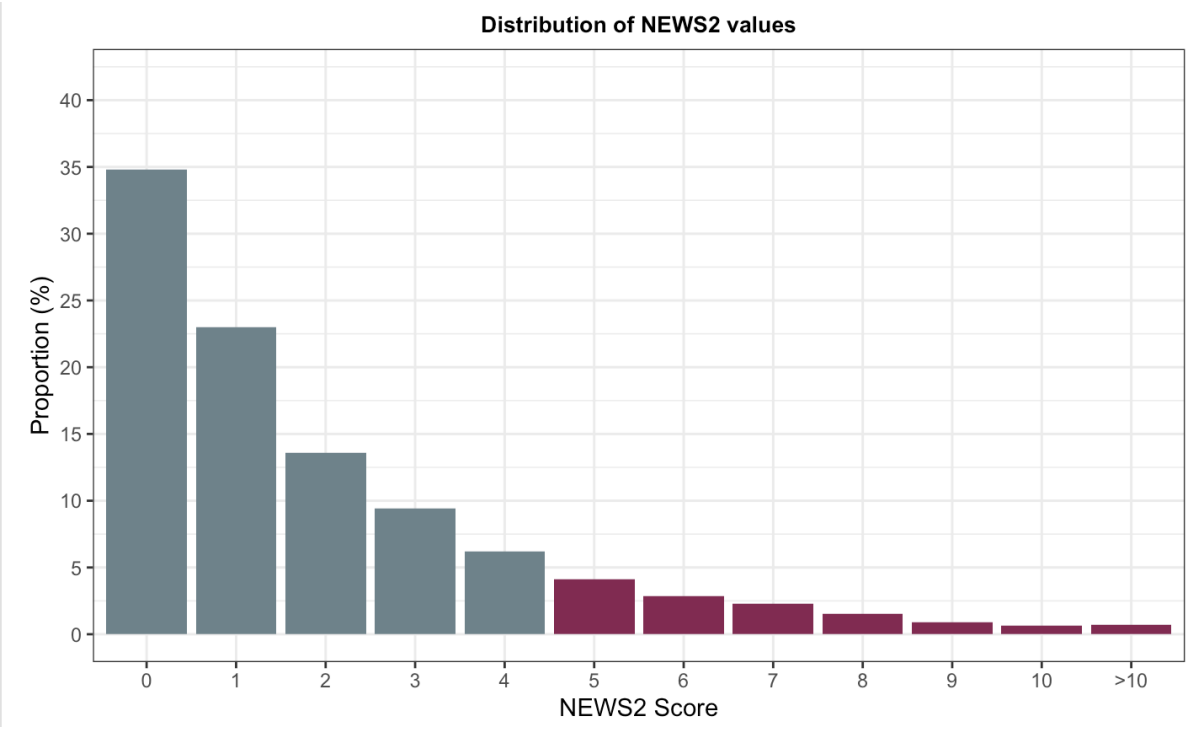


Figure 7: NEWS2 score on arrival to hospital. NEWS2: National Early Warning Score 2. NEWS2 values greater or equal to 5 are highlighted in red

Patient pathway

During the study period, a total of 9,913 patient attendances were recorded. Of these, 8,550 (86%) represented unplanned admissions, as opposed to scheduled returns to SDEC. The following analysis pertains specifically to unplanned admissions. The most common source of referral was the ED, accounting for 56% of cases. Initial assessment and/or consultant assessment was conducted in the corridor in 858 (17.2%) of those accessing acute medical services through the emergency department (analysis excluded 7.9% of cases where variable not recorded).

Table 2: Who referred patients to acute medicine?

	Source of referral			
	Emergency department	**Primary care**	**Paramedic**	**Within hospital**
SAMBA24	56.8%	24.8%	5.7%	4.3%
SAMBA23	61.0%	24.9%	5.5%	4.9%
SAMBA22	67.6%	23.4%	3.0%	3.1%
SAMBA21	70.0%	21.8%	3.0%	4.0%
Winter SAMBA	66.1%	25.9%	2.2%	4.5%
SAMBA19	60.1%	28.1%	1.8%	8.8%

Note: Percentages do not equal 100% due to referrals from other sources.

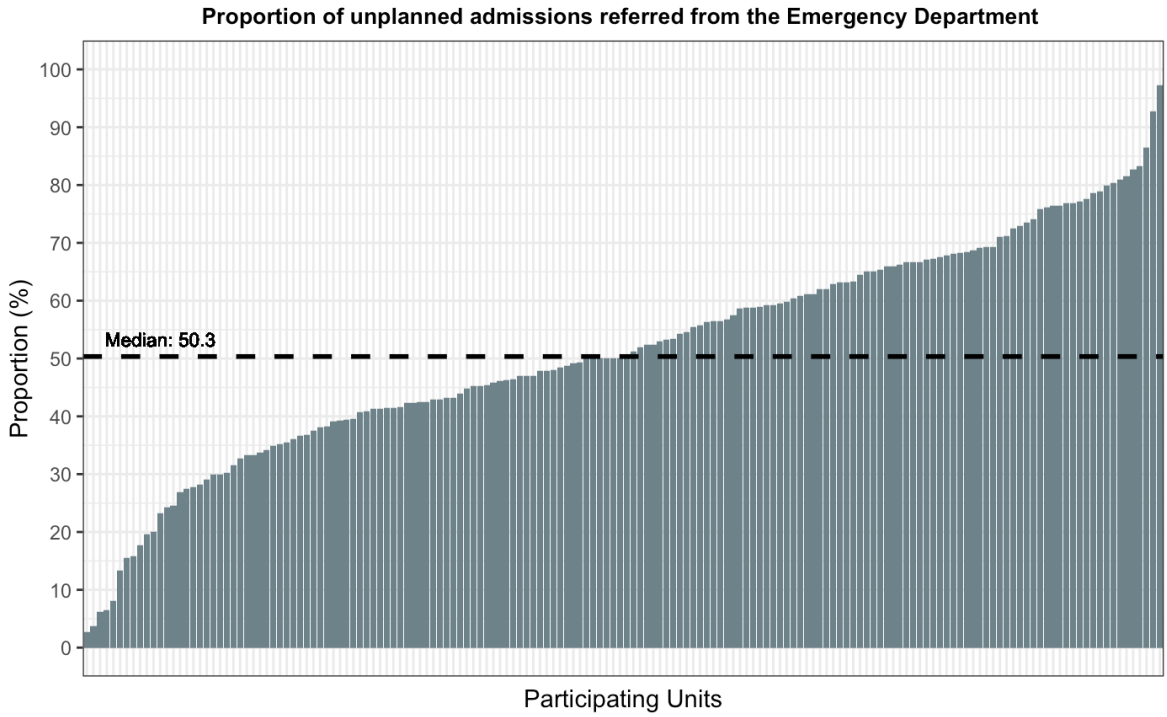


Figure 8: Percentage of patients (unplanned admissions) included in the audit who were referred from the Emergency Department. Units ordered along x-axis by percentage of patients referred from ED. Note: two units did not see any patients that had presented to an ED/were not in a site with an ED.

Time of day

The majority of unplanned admission presented to hospital during daytime hours (79.7% arrived at hospital between 08:00 and 19:59).

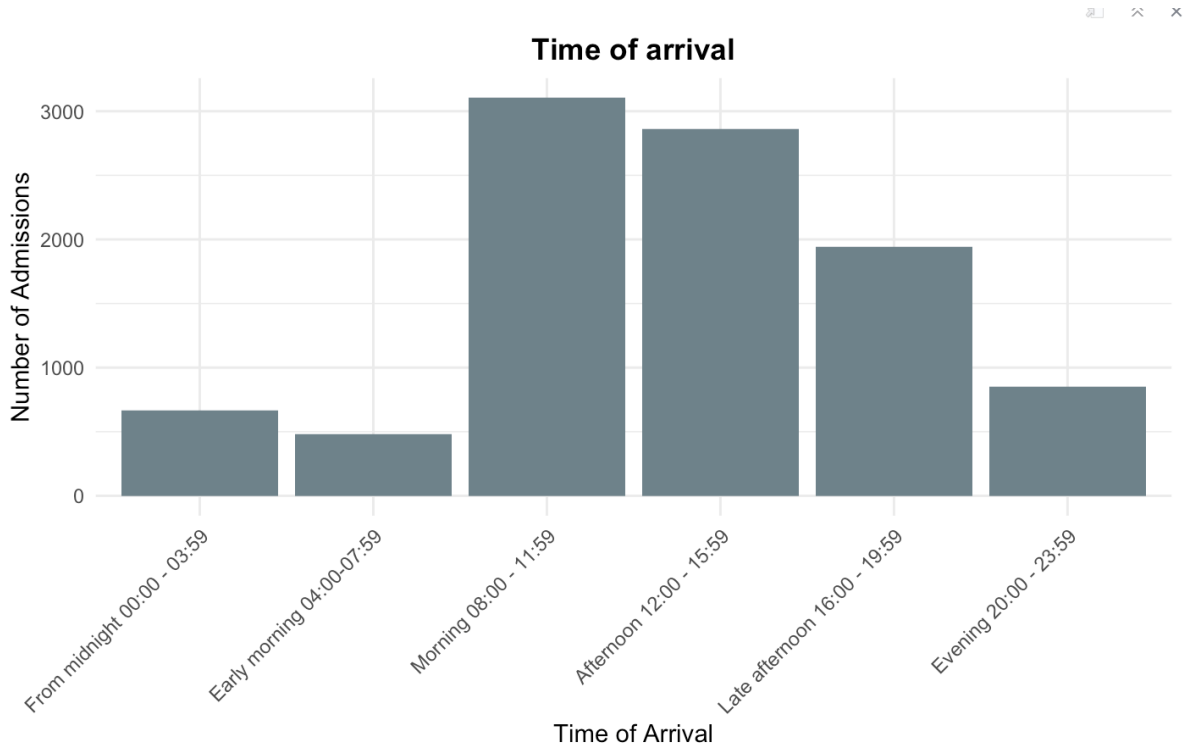


Figure 9: Unplanned medical admissions stratified by time of arrival to hospital

Location of first clinician assessment

SAMBA records the first clinical assessment performed by a competent clinical decision-maker, which may be carried out by the medical team, emergency medicine team, or a specialty clinician.

56% of unplanned admissions (4795 patients) had their first clinical assessment performed by a member of the emergency medicine team. The location of first clinician assessment is shown in Figure 10. Initial assessment by the medical team was undertaken in the ED in 45% of patients (SAMBA21 41%, SAMBA22 52%, SAMBA23 48%).

In patients that had an initial assessment in the emergency department the total time in the department was recorded in 90.6%; of this group, 14.8% were in the ED for over 24 hours prior to admission, transfer or discharge. (Figure 11)

Location of first medical team assessment

The location of the first assessment by a member of the medical team in also shown in Figure 10.

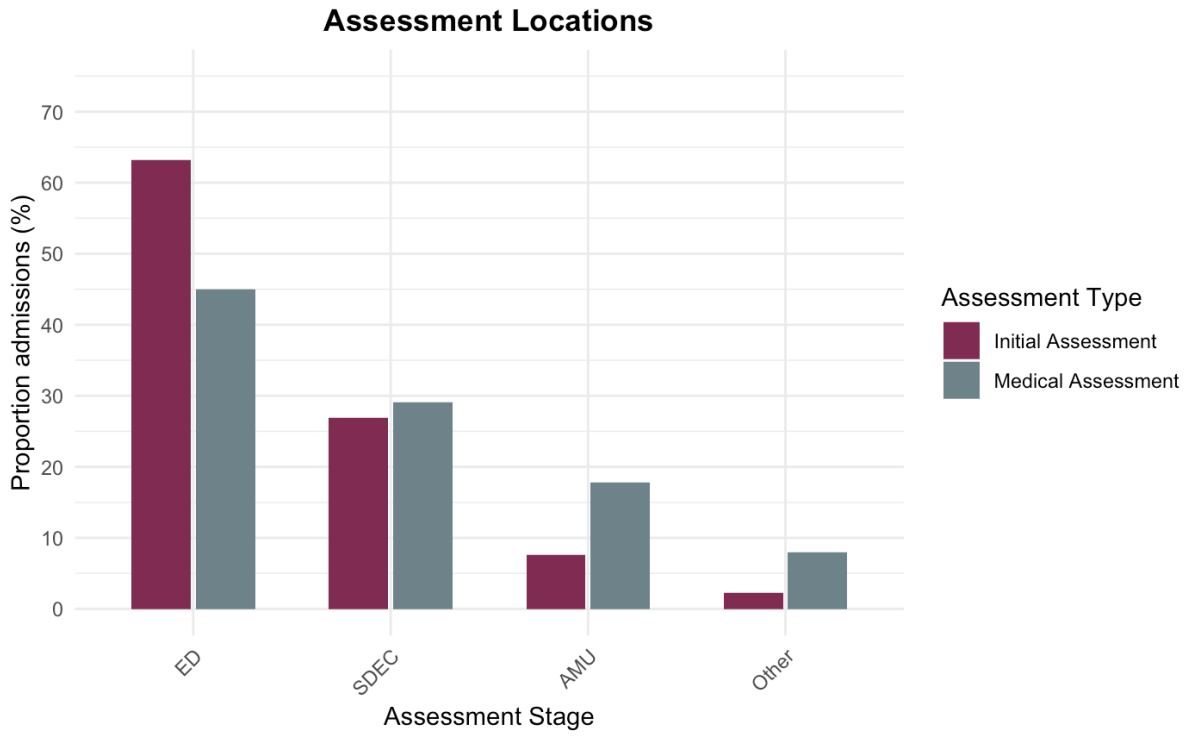


Figure 10: Assessment location for unplanned admissions. Location of first clinical assessment and first assessment by the medical team. Patients who were scheduled to return excluded. ED: Emergency Department; AMU: Acute Medical Unit; SDEC: Same Day Emergency Ca

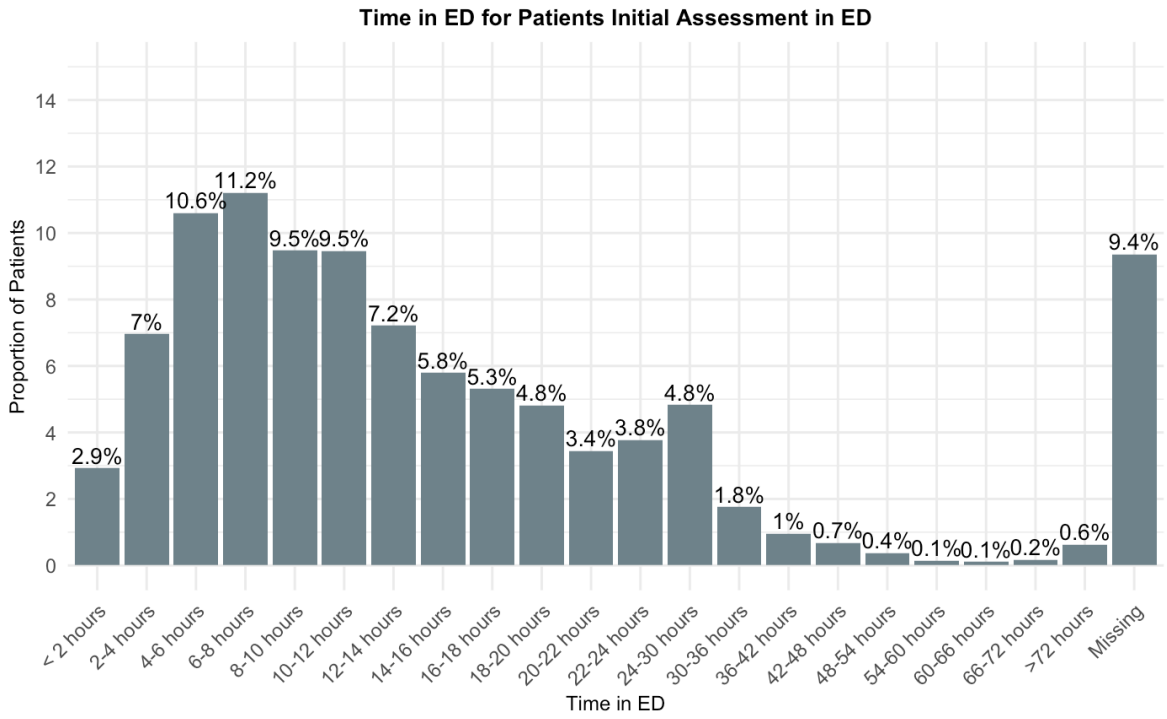


Figure 11: Time spent in the ED from arrival in patients with location of initial assessment recorded as the emergency department. (NA = response not recorded)

Patient journey

Patient journey for unplanned admissions is summarised in Figure 12. This is a simplified diagram – pathways taken by patients through their hospital admission are complex.

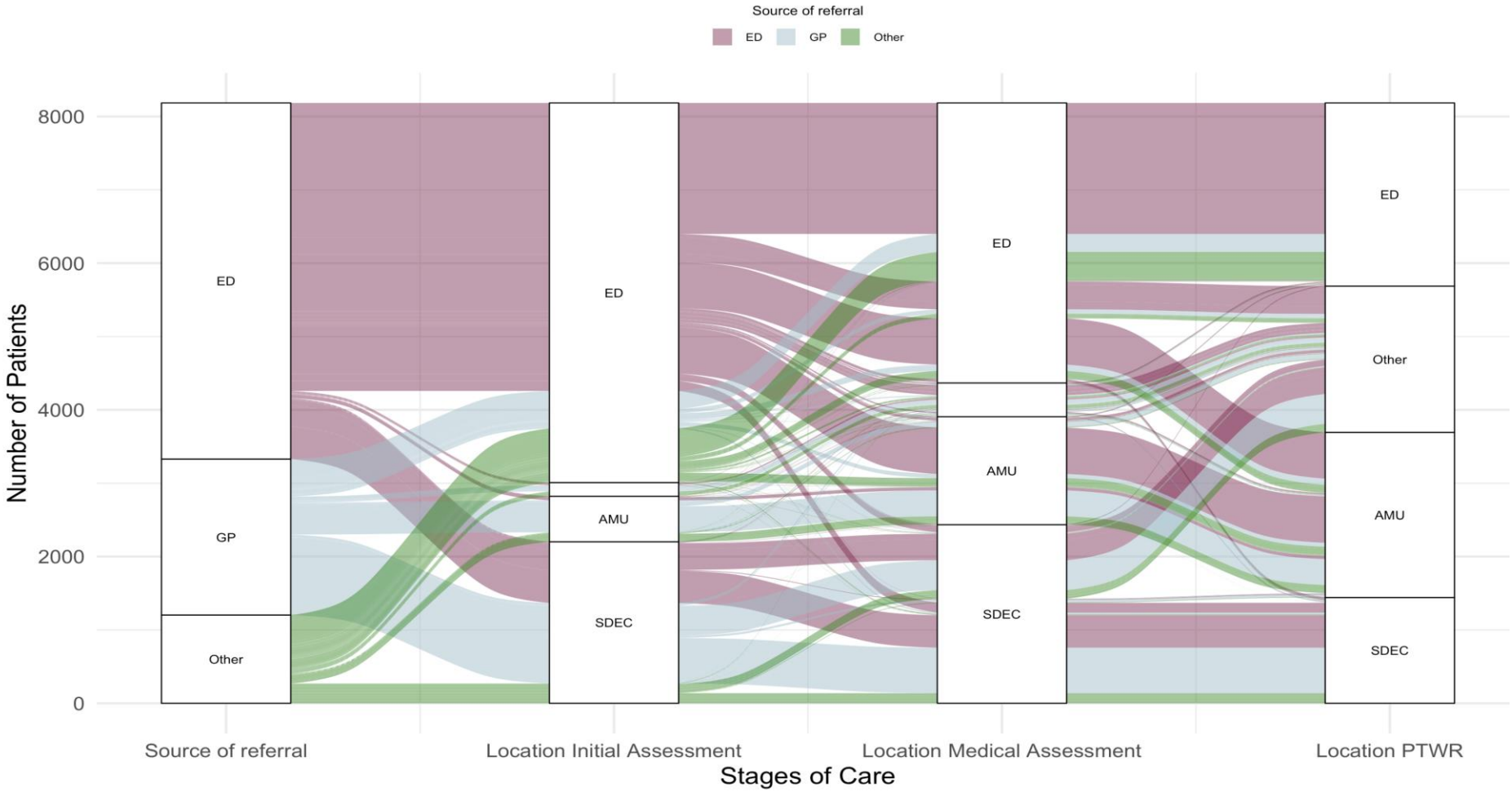


Figure 12: Sankey diagram of patients' initial journey through acute medical admission. ED: Emergency Department, AMU: Acute Medical Unit; SDEC: Same Day Emergency Care. Note: numbers may not reflect overall total due to missing data.

Same Day Emergency Care

The location of initial assessment was undertaken in SDEC in 26.9% of admissions. Variation at the unit level is shown in Figure 13. The initial assessment by the medical team was SDEC in 30.5%. Variation at the unit level is shown in Figure 14. One third or more of admissions were seen by the medical team in SDEC in 33.1% of units (SAMBA22 25.4%, SAMBA23 35.5%). No initial assessments were conducted by the medical team in SDEC in 20 units.

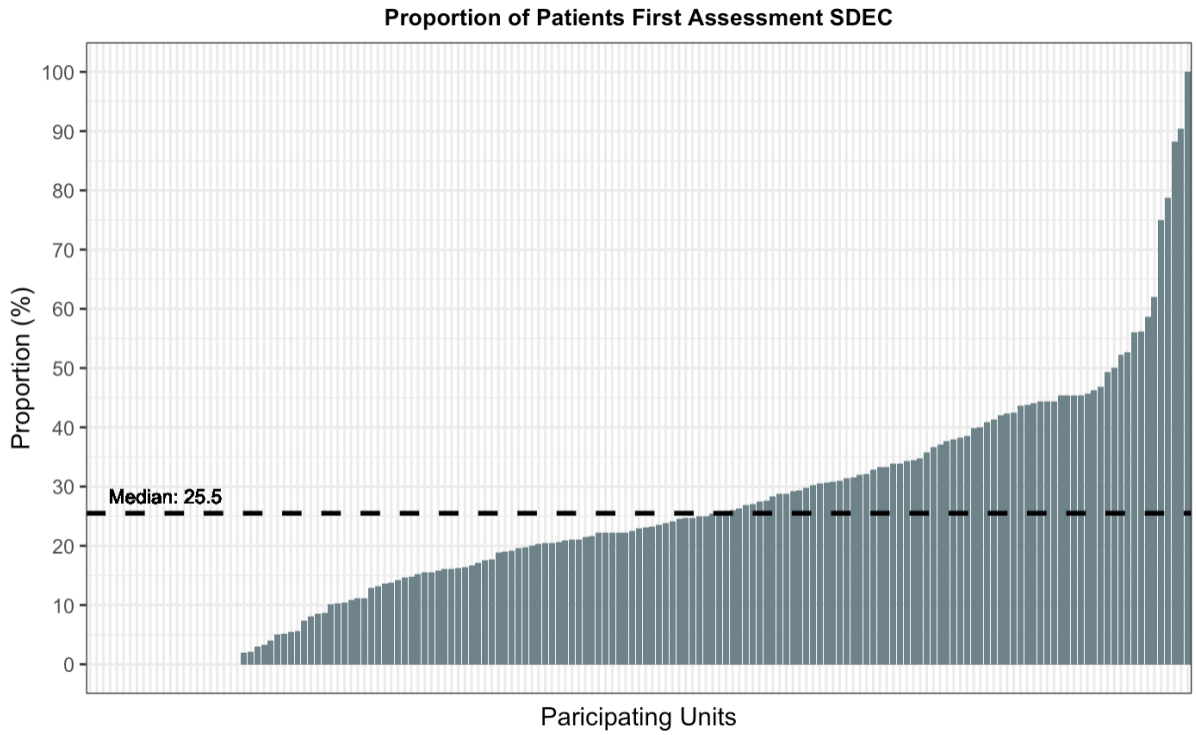


Figure 13: Percentage of patients who received their first assessment in Same Day Emergency Care (SDEC). Units ranked along x-axis by percentage seen in SDEC.

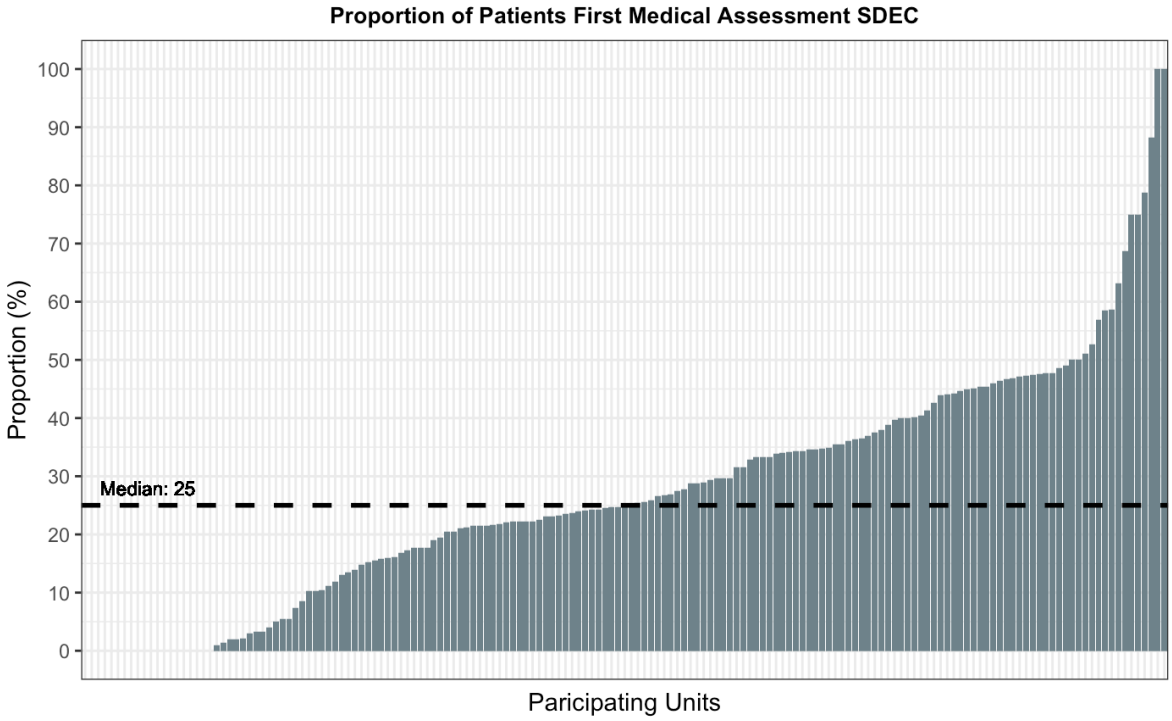


Figure 14: Percentage of patients who received their first medical assessment in Same Day Emergency Care (SDEC). Units ranked along x-axis by percentage seen in SDEC.

Clinical Quality Indicator Outcomes SAMBA24

Clinical Quality Indicator 1: Early warning score within 30 minutes

73.3% of unplanned admissions had an early warning score recorded within 30 minutes of arrival to hospital (95% CI 72.3-74.2%). Variation in performance across participating units is shown in Figure 15.

Table 3: Percentage of unplanned admissions meeting target of Early Warning Score measurement within 30 minutes of arrival to hospital, by initial assessment location

CQI 1	**Location of initial clinical assessment**		
Percentage achieving target	**ED**	**AMU**	**SDEC**
SAMBA24	**76.7%**	**61.5%**	**79.4%**
Winter SAMBA24	72.6%	75.4%	74.8%
SAMBA23	74.0%	73.4%	72.2%
SAMBA22	67.9%	67.2%	73.3%
SAMBA2021	78.4%	75.3%	82.3%
Winter SAMBA20	75.7%	70.3%	76.9%
SAMBA19	81.6%	80.0%	81.2%

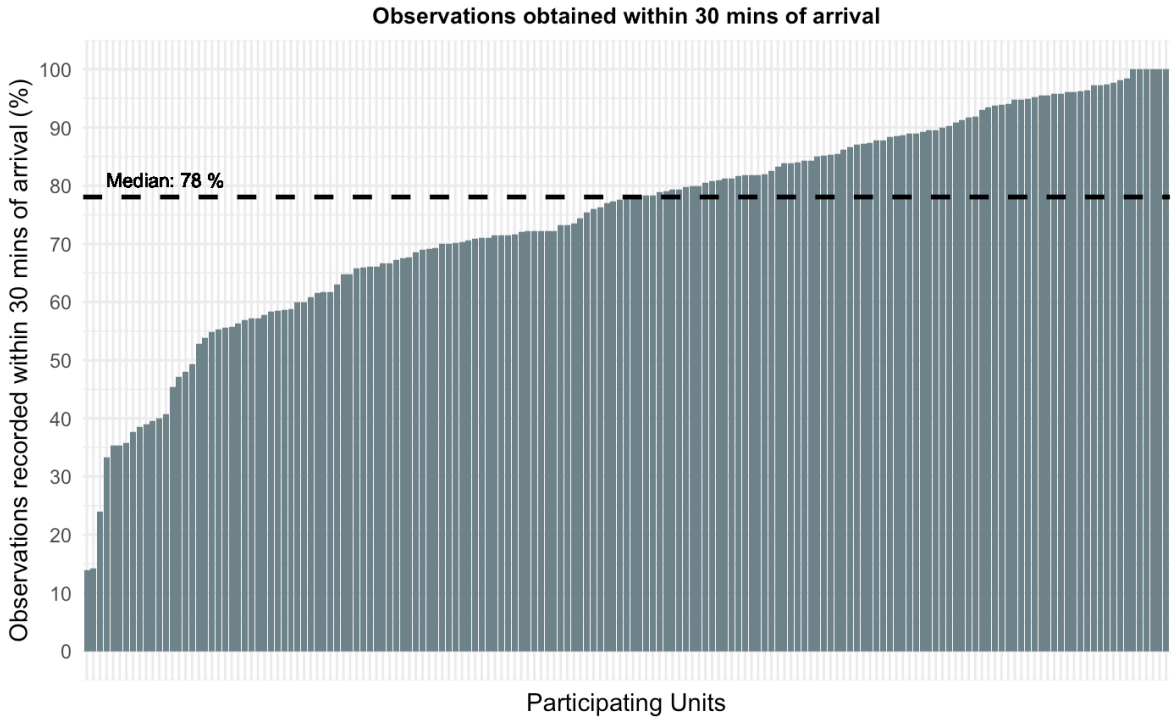


Figure 15 Percentage of unplanned admissions where target for Early Warning Score measurement within 30 minutes of arrival achieved, for participating units. Units ranked along x-axis.

Clinical Quality Indicator 2: Assessment by clinical decision maker within 4 hours

75.8% of unplanned admissions were seen by a tier 1 clinician within 4 hours of arrival to hospital (95% CI 74.9-76.7%). This target was met by 91.0% in SAMBA19, 87.4% in SAMBA21, 78.7% in SAMBA22 and 81.7% in SAMBA23.

Comparison of individual unit performance is shown in Figure 16.

Table 4: Percentage of unplanned admissions meeting target of assessment by clinical decision maker within 4 hours of arrival, by initial assessment location

CQI 2	**Location of initial clinical assessment**		
Percentage achieving target	**ED**	**AMU**	**SDEC**
SAMBA24	**73.8%**	**61.8%**	**84.5%**
Winter SAMBA24	77.4%	80.5%	81.6%
SAMBA23	79.8%	76.6%	87.8%
SAMBA22	76.1%	77.9%	88.6%
SAMBA2021	86.4%	83.5%	93.9%
Winter SAMBA20	83.7%	78.6%	91.8%
SAMBA19	86.7%	81.9%	94.7%

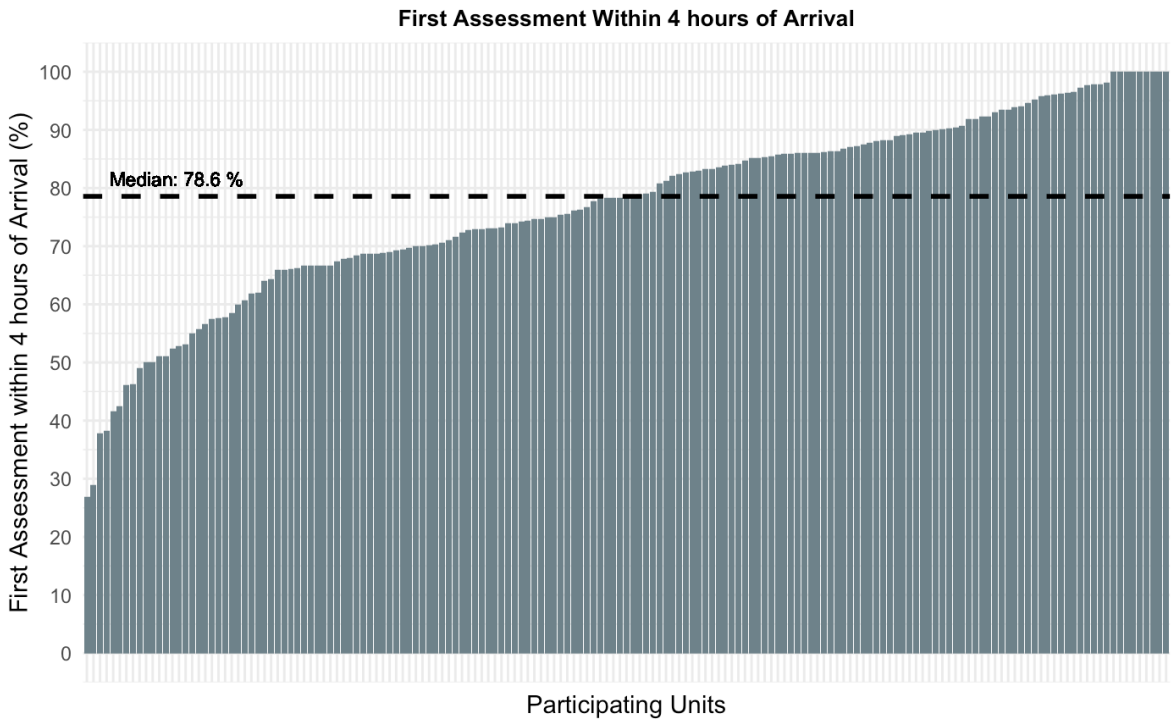


Figure 16: Percentage of unplanned admissions where target for clinical decision maker review within 4 hours of arrival achieved, for participating units. Units ranked along x-axis; median unit performance highlighted in red. §

Clinical Quality Indicator 3: Assessment by consultant within target time

Overall, 48.2% of unplanned admissions who required a medical consultant review were seen within the target time (95% CI 48.2-49.4%). This target was met by 69.6% in SAMBA19, 67.8% in SAMBA21, 49.8% in SAMBA22 and 52.9% in SAMBA23. Comparison of individual unit performance is shown in Figure 17. Two units achieved this target for all of their patients who required consultant review.

18.1% of unplanned admissions did not require a consultant review (SAMBA21 12.3%, SAMBA22 15.3%, SAMBA23 17%). A breakdown is shown in Table 6.

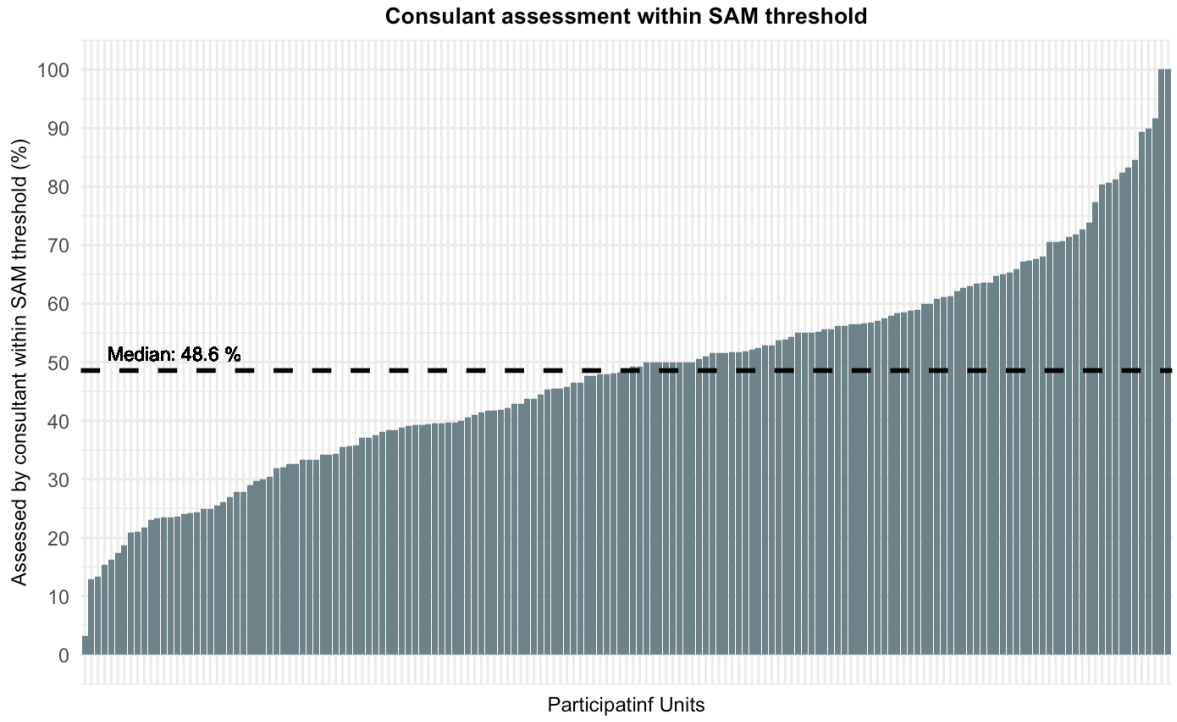


Figure 17: Per unit, percentage of patients where consultant review was achieved in the target time. Target time 6 hours for arrivals from 08:00-20:00; 14 hours for arrivals from 20:00-08:00. Units ranked along x-axis – note that units will not be in same order in the three graphs. Median unit performance highlighted in red.

Table 5: Percentage of unplanned admissions achieving consultant review within the target time, by location of initial clinical assessment.

CQI 3	Location of initial clinical assessment		
Percentage achieving target	**ED**	**AMU**	**SDEC**
SAMBA24	38.4%	51.0%	85.5%
wSAMBA24	41.6%	65.9%	84.2%
SAMBA23	43.5%	60.8%	86.5%
SAMBA22	41.9%	60.2%	87.8%
SAMBA2021	62.9%	76.4%	88.5%
Winter SAMBA	57.0%	68.0%	82.1%
SAMBA19	62.1%	74.3%	88.0%

Table 6: Patients who were seen by the medical team where consultant review within time target was not needed.

Reason consultant review was not needed	Number of patients
Discharged by another team member	1200
Solely required investigations/intervention	50
Self-discharged before consultant review	92
Transferred to another specialty after assessment by the medical team	36
Transferred to ICU before consultant review	12

Time of day & Initial assessment location

Completion of clinical quality indicators depending on time of day are shown in Table 7.

Table 7: Percentage of unplanned admissions where CQI achieved depending on arrival time and initial assessment location.

	Location of initial assessment		
	ED	**AMU**	**SDEC**
CQI 1			
00:00-08:00	80.9%	75.0%	80.2%
08:00-20:00	76.0%	60.5%	79.5%
20:00-00:00	74.9%	61.2%	61.2%
CQI 2			
00:00-08:00	64.5%	47.5%	48.9%
08:00-20:00	77.5%	63.1%	86.4%
20:00-00:00	68.0%	60.0%	55.0%
CQI3			
00:00-08:00	71.2%	87.2%	94.6%
08:00-20:00	23.8%	44.6%	84.1%
20:00-00:00	69.1%	80.7%	90.0%

Note: Only a small number of patients were seen in SDEC who arrived outside daytime hours

Outcomes at seven days

Figure 18 shows patient outcomes at 7 days for all unplanned admissions.

30.9% of unplanned admissions were discharged on the day of arrival (SAMBA21 31.5%, SAMBA22 28.9%, SAMBA23 32.8%). Of those that were discharged on the day of arrival, 70.2% had their initial clinician review in SDEC and 23.5% in the ED; 77.1% had their first medical team assessment in SDEC, 12.7% in the ED and 5.5% on AMU. Variation in the rate of same day discharge at the hospital level is shown in Figure 19.

Of the patient that were discharged on the day of arrival, the location immediately prior to discharge was SDEC in 85.5%. In patients that did not have their initial assessment in SDEC, the location of care immediately prior to discharge was SDEC in 37.5% and the emergency department in 34.7% (Figure 20).

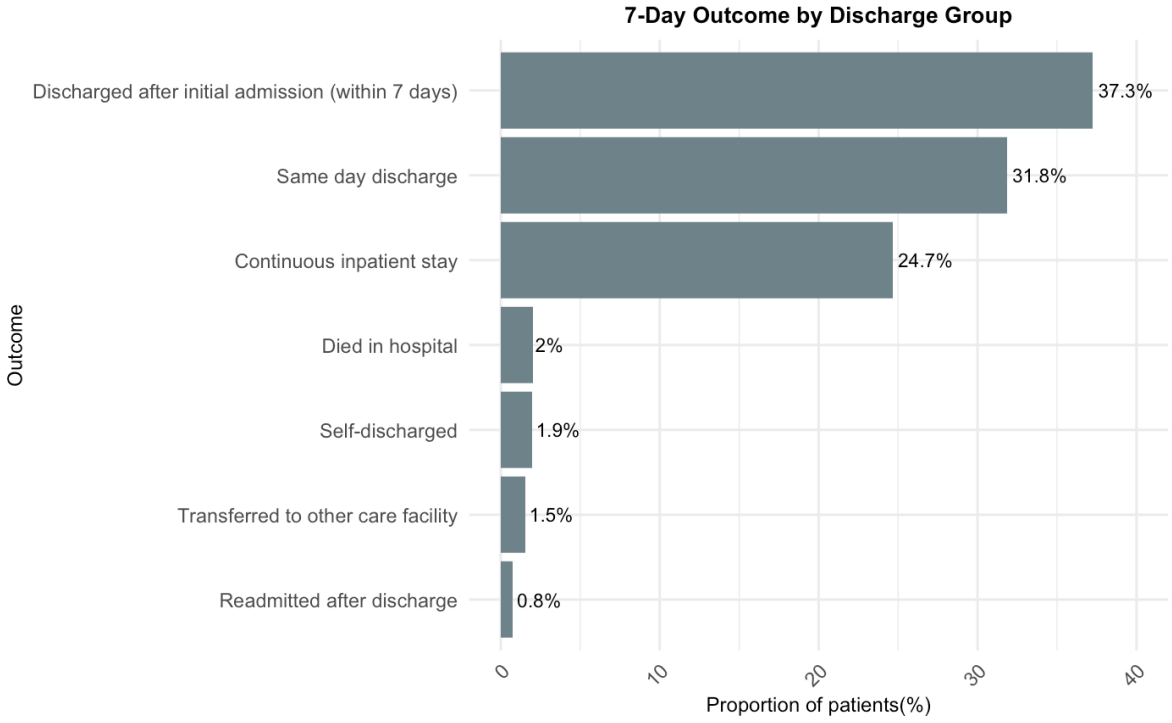


Figure 18: Patient outcomes at 7 days for unplanned admissions

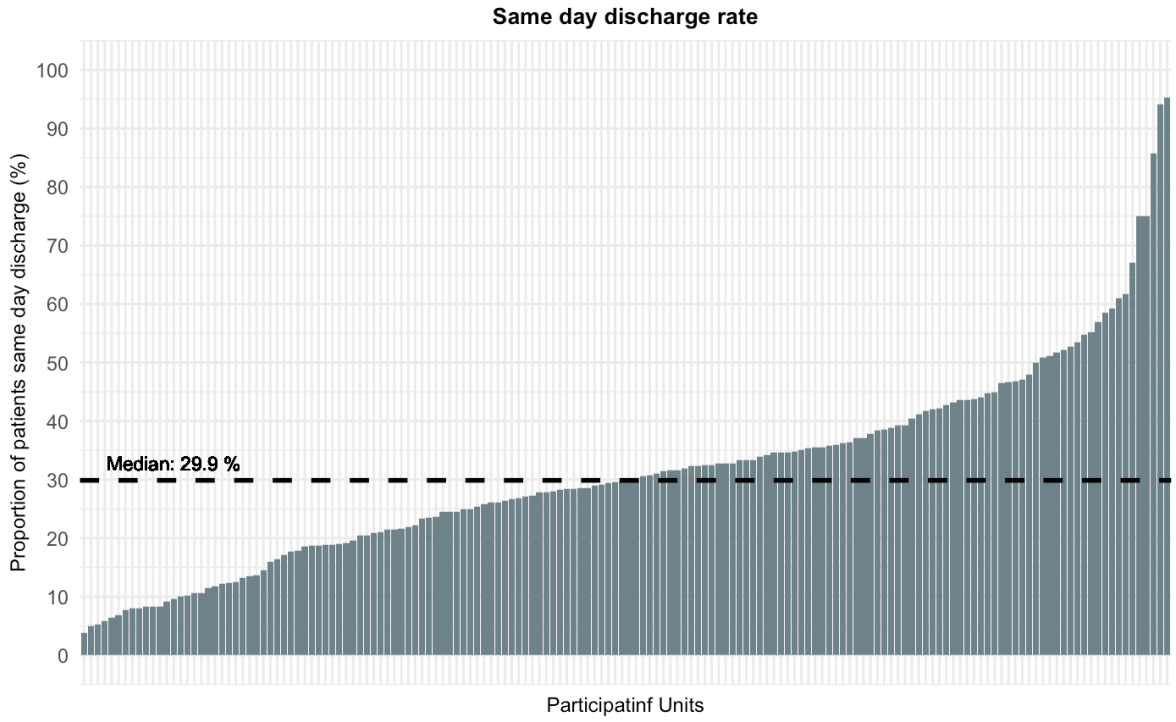


Figure 19: Percentage of patients discharged without overnight admission. Units ordered along x axis. Median unit performance marked in red.

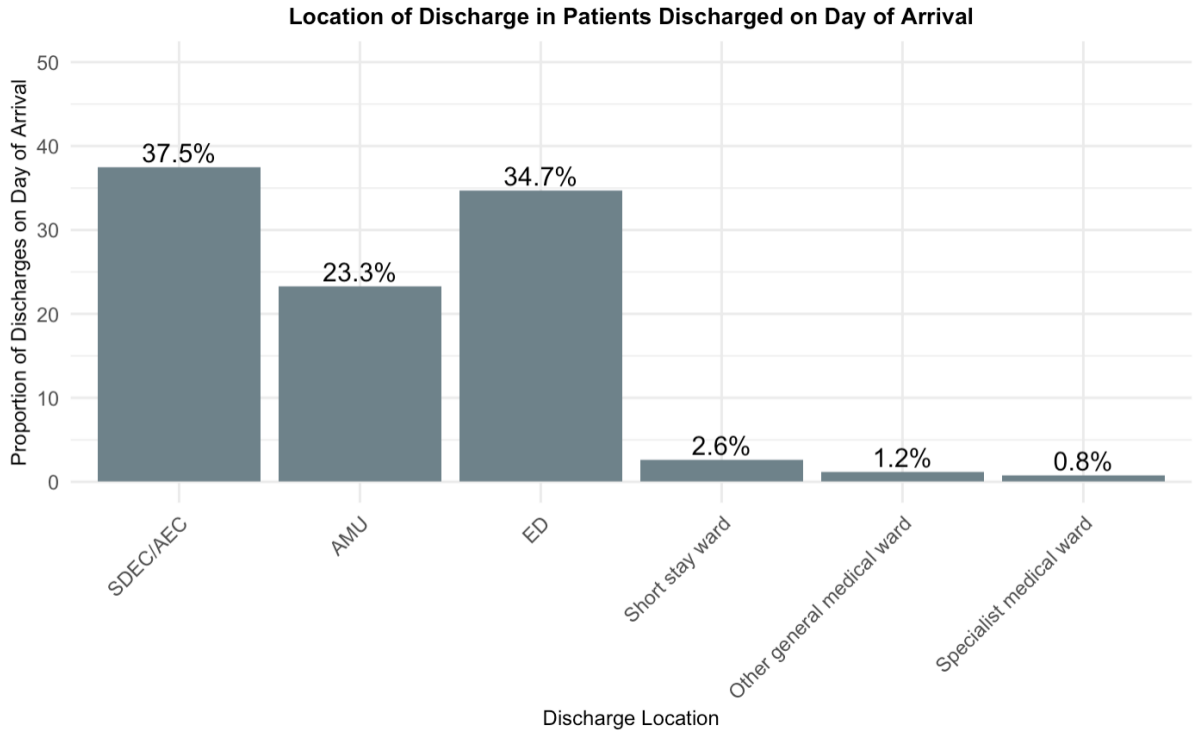


Figure 20: Location immediately prior to discharge amongst those discharged without overnight stay amongst patients not initially assessed in SDEC areas.

Summary & Discussion

What has SAMBA24 shown?

SAMBA provides a nationwide overview of acute care across the UK and is the only national resource dedicated to understanding and benchmarking performance in acute medical care. While performance across key measures in SAMBA24 remains lower than in recent years, the rate of deterioration appears to have slowed, and compared to SAMBA23, performance has been broadly maintained. Results are also in line with those observed in Winter SAMBA24 (from a smaller sample), suggesting that seasonal pressures have become less pronounced post-COVID, with acute care services now operating under sustained demand throughout the year.

The acute care model is designed around the principle that patients should be rapidly transferred to the AMU once they meet the threshold for admission. However, SAMBA data indicates that this is no longer the predominant pathway in practice, suggesting a shift in how acute admissions are managed. Nearly 15% of medical patients arriving via the ED remained there for over 24 hours, effectively using the ED as an extension of the AMU. Nationally mandated metrics, such as decision-to-admit times and care guidelines based on assessments following admission to a medical ward, are increasingly misaligned with current practice. Concerningly, one in five patients referred to medicine via the emergency department were assessed by the medical team in a corridor, highlighting the urgent need to reassess how acute medical care is delivered and measured. While key performance metrics, such as time to initial assessment and consultant review, have been maintained, demonstrating the resilience of acute medical teams, this alone does not address the underlying pressures. The factors driving these challenges are complex, reflecting a mismatch between demand and capacity, alongside broader issues with patient flow, ED crowding, and AMU access block. While improving efficiency in acute medical processes is important, it is only one part of a much more complex picture. Proposed solutions must be carefully considered to ensure they support, rather than inadvertently divert, a resource-constrained team from its primary function, providing high-quality care for patients with acute medical illness requiring admission.

Acute medical services have adapted their care models to deliver an increasing proportion of acute medical care through same day emergency care (SDEC), in line with national policy in recent years. In SAMBA24, around a third of all acute medical activity took place in SDEC, a figure consistent with SAMBA23, highlighting a sustained shift in acute care delivery. However, there remains significant variation in the use of SDEC between individual services. The Sankey diagram illustrates that most initial assessments in SDEC originate from GP referrals, while only a comparatively small proportion of

patients are transferred to SDEC without first undergoing an initial assessment in ED. This highlights the effectiveness of SDEC in diverting GP-referred patients away from ED, where they would otherwise have been assessed. However, the role of direct transfers to SDEC without an initial ED assessment within the wider acute care system is complex. Further research is needed to understand its impact on efficiency, patient experience, and demand for inpatient care.

In 2024, NHS England released the SAMEDAY strategy, a framework for the development and delivery of SDEC. It reinforces the core principle of SDEC: enabling specialists, where appropriate, to assess, diagnose, and treat patients on the same day of arrival who would otherwise have been admitted to hospital. The latter part of this definition is crucial, simply increasing the number is unlikely to deliver the intended improvements in system performance. Clinical quality indicators, including initial assessment and consultant review, have consistently been better for patients assessed in SDEC. Although the SDEC model facilitates rapid clinical assessment for select patients, it raises concerns about potential inequalities, as acute medicine was originally designed to prioritise the care of the sickest individuals. If earlier access to senior decision-making and diagnostics is predominantly available to younger, lower-acuity patients, disparities in care for those with more complex needs could widen.[22, 23] Maintaining high-quality care for patients who require traditional inpatient, bed-based care on the acute medical unit must remain a priority and should not be compromised as SDEC expands. Much of the same day emergency care (SDEC) activity currently takes place outside the designated geographic location of SDEC. While most patients discharged on the same day initially presented via SDEC, for those not immediately triaged there, same-day discharges were achieved at broadly similar rates from both SDEC and the ED. This suggests that the principles of same day emergency care are being applied across different acute care settings, rather than being confined to a specific location.

Limitations

As with previous SAMBA cycles, variation persists both in performance between units and in how each centre structures its acute services. Some of this variation is random and occurs by chance, while other differences may reflect underlying structural and operational factors. Further evaluation using appropriate methodologies is needed to better understand the factors driving this variation and the extent to which service structure influences performance.

SAMBA captures a 24-hour snapshot of performance, but variation is likely to occur over time. Some units may experience significant fluctuations in achieving quality indicators on a daily or weekly basis. Some of this variation may be due to random chance, while other fluctuations could reflect genuine differences in service delivery or demand. Further work is required to assess how this single-day snapshot reflects longer-term performance, for example, by extending data collection periods or leveraging electronic health record data.

While SAMBA helps identify areas for improvement and provides an overview of acute medical service performance, it is not designed to determine which aspects of acute medical care deliver the best outcomes, nor does it contain the level of detail needed to fully explore and explain the variation observed.

Next steps

We plan to continue developing SAMBA to ensure it remains a valuable resource for supporting improvements in clinical care across participating centres. Future enhancements may include enabling units to be identifiable, expanding data collection to different time periods to assess variation in performance, and leveraging the growing digital capabilities of hospitals. We will also continue to refine the survey questions to reflect current priorities identified by SAM and professionals working in acute medicine.

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Appendix 1: Participating units

We would once again like to emphasise that SAMBA cannot take place without the involvement of the enthusiastic volunteers at each hospital site, involved in registering the audit, collecting data, and uploading information to the database.

If we have missed any participating units from this report, we would be happy to amend the online version. If we can help, please contact us at samba@acutemedicine.org.uk

England

Aintree University Hospital	Liverpool University Hospitals NHS Foundation Trust
Arrowe Park Hospital	Wirral University Teaching Hospital NHS Foundation Trust
Barnet Hospital	Royal Free London NHS Foundation Trust
Barnsley Hospital	Barnsley Hospital NHS Foundation Trust
Basildon University Hospital	Mid and South Essex NHS Foundation Trust
Basingstoke and North Hampshire Hospital	Hampshire Hospitals NHS Foundation Trust
Birmingham City Hospital	Sandwell and West Birmingham NHS Trust
Birmingham Heartlands Hospital	University Hospitals Birmingham NHS Foundation Trust
Bristol Royal Infirmary	University Hospitals Bristol NHS Foundation Trust
Broomfield Hospital	Mid and South Essex NHS Foundation Trust
Calderdale Royal Hospital	Calderdale and Huddersfield NHS Foundation Trust
Chelsea and Westminster Hospital	Chelsea and Westminster Hospital NHS Foundation Trust
Chorley and South Ribble Hospital	Lancashire Teaching Hospitals NHS Foundation Trust
Conquest Hospital	East Sussex Healthcare NHS Trust
Countess of Chester Hospital	Countess of Chester Hospital NHS Foundation Trust
County Hospital	University Hospitals of North Midlands NHS Trust
Country Hospital Hereford	Wye Valley NHS Trust
Cumberland Infirmary	North Cumbria Integrated Care NHS Foundation Trust
Darent Valley Hospital	Dartford and Gravesham NHS Trust
Darlington Memorial Hospital	County Durham and Darlington NHS Foundation Trust
Derriford Hospital	University Hospitals Plymouth NHS Trust
Diana, Princess of Wales Hospital	Northern Lincolnshire and Goole NHS Foundation Trust
Dorset County Hospital	Dorset County Hospital NHS Foundation Trust
Ealing Hospital	London North West University Healthcare NHS Trust
East Surrey Hospital	Surrey and Sussex Healthcare NHS Trust
Eastbourne District General Hospital	East Sussex Healthcare NHS Trust
Epsom Hospital	Epsom and St Helier University Hospitals NHS Trust
Fairfield General Hospital	Pennine Acute Hospitals NHS Trust
Friarage Hospital	South Tees Hospitals NHS Foundation Trust
Frimley Park Hospital	Frimley Health NHS Foundation Trust
Furness General Hospital	University Hospitals of Morecombe Bay NHS Foundation Trust

George Eliot Hospital	George Eliot Hospital NHS Trust
Gloucestershire Royal Hospital	Gloucestershire Hospitals NHS Foundation Trust
Good Hope Hospital	University Hospitals Birmingham NHS Foundation Trust
Great Western Hospital	Great Western Hospitals NHS Foundation Trust
Harrogate District Hospital	Harrogate and District NHS Foundation Trust
Hinchingbrooke Hospital	North West Anglia NHS Foundation Trust
Huddersfield Royal Infirmary	Calderdale and Huddersfield NHS Foundation Trust
Hull Royal Infirmary	Hull University Teaching Hospitals NHS Trust
James Paget	James Paget University Hospitals NHS Foundation Trust
Kettering General Hospital	Kettering General Hospital NHS Foundation Trust
King's College Hospital	King's College Hospital NHS Foundation Trust
King's Mill Hospital	Sherwood Forest Hospitals NHS Foundation Trust
Kingston Hospital	Kingston Hospital NHS Foundation Trust
Leicester Royal Infirmary	University Hospitals of Leicester NHS Trust
Leighton Hospital	Mid Cheshire Hospitals NHS Foundation Trust
Lincoln County Hospital	United Lincolnshire Hospitals NHS Trust
Lister Hospital	East and North Hertfordshire NHS Trust
Luton & Dunstable University Hospital	Bedfordshire Hospitals NHS Foundation Trust
Maidstone Hospital	Maidstone and Tunbridge Wells NHS Trust
Manchester Royal Infirmary	Manchester Hospitals NHS Foundation Trust
Medway Maritime Hospital	Medway NHS Foundation Trust
Milton Keynes University Hospital	Milton Keynes University Hospital NHS Foundation Trust
Musgrove Park Hospital	Somerset NHS Foundation Trust
New Cross Hospital	The Royal Wolverhampton NHS Trust
New Queen Elizabeth II Hospital	East and North Hertfordshire NHS Trust
Newham University Hospital	Barts Health NHS Trust
Norfolk & Norwich University Hospital	Norfolk & Norwich University Hospitals NHS Foundation Trust
North Devon District Hospital	Northern Devon Healthcare NHS Trust
North Manchester General Hospital	Manchester University Hospitals NHS Trust
North Middlesex University Hospital	North Middlesex University Hospital NHS Trust
Northampton General Hospital	Northampton General Hospital NHS Trust
Northern General Hospital	Sheffield Teaching Hospitals NHS Foundation Trust
Northumbria Specialist Emergency Care Hospital	
Northwick Park Hospital	London North West University Healthcare NHS Trust
Peterborough City Hospital	North West Anglia NHS Foundation Trust
Pilgrim Hospital Boston	United Lincolnshire Hospitals NHS Trust
Pinderfields General Hospital	Mid Yorkshire Hospitals NHS Trust
Poole Hospital – AMU	University Hospitals Dorset NHS Foundation Trust

Poole Hospital - RACE Unit	University Hospitals Dorset NHS Foundation Trust
Princess Alexandra Hospital	The Princess Alexandra Hospital NHS Trust
Queen Alexandra Hospital	Portsmouth Hospitals University NHS Trust
Queen Elizabeth Hospital	Lewisham and Greenwich NHS Trust
Queen Elizabeth Hospital	The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust
Queen Elizabeth Hospital	University Hospitals Birmingham NHS Foundation Trust
Queen Elizabeth Queen Mother Hospital	East Kent Hospitals University NHS Foundation Trust
Queen's Medical Centre	Nottingham University Hospitals NHS Trust
Queens Hospital Burton	University Hospitals of Derby and Burton NHS Foundation Trust
Rotherham Hospital	The Rotherham NHS Foundation Trust
Royal Berkshire Hospital	Royal Berkshire Hospital NHS Foundation Trust
Royal Blackburn Teaching Hospital	East Lancashire Hospitals NHS Trust
Royal Bolton Hospital	Bolton NHS Foundation Trust
Royal Bournemouth Hospital - AMU	University Hospitals Dorset NHS Foundation Trust
Royal Bournemouth Hospital - OPAU	University Hospitals Dorset NHS Foundation Trust
Royal Cornwall Hospital	Royal Cornwall Hospitals NHS Trust
Royal Derby Hospital	University Hospitals of Derby and Burton NHS Foundation Trust
Royal Devon and Exeter Hospital	Royal Devon and Exeter NHS Foundation Trust
Royal Free Hospital	Royal Free London NHS Foundation Trust
Royal Lancaster Infirmary	University Hospitals of Morecombe Bay NHS Foundation Trust
Royal Liverpool Hospital	Liverpool University Hospitals NHS Foundation Trust
Royal Preston Hospital	Lancashire Teaching Hospitals NHS Foundation Trust
Royal Shrewsbury Hospital	The Shrewsbury and Telford Hospital NHS Trust
Royal Stoke University Hospital	University Hospitals of North Midlands NHS Trust
Royal Surrey County Hospital	Royal Surrey NHS Foundation Trust
Royal Sussex County Hospital	University Hospitals Sussex
Royal United Hospital Bath	Royal United Hospitals Bath NHS Foundation Trust
Royal Victoria Infirmary	Newcastle Upon Tyne NHS Foundation Trust
Salford Royal Hospital	Salford Royal NHS Foundation Trust
Salisbury District Hospital	Salisbury NHS Foundation Trust
Sandwell General Hospital	Sandwell and West Birmingham NHS Trust
Scarborough General Hospital	York and Scarborough Teaching Hospitals NHS Foundation Trust
Scunthorpe General Hospital	Northern Lincolnshire and Goole NHS Foundation Trust
South Tyneside District Hospital	South Tyneside and Sunderland NHS Foundation Trust
Southend University Hospital	Mid and South Essex NHS Foundation Trust
Southmead Hospital	North Bristol NHS Trust
Southport District General	Southport and Ormskirk Hospital NHS Trust
St George's Hospital	St George's University Hospitals NHS Foundation Trust

St Helier Hospital	Epsom and St Helier University Hospitals NHS Trust
St Mary's Hospital	Imperial College Healthcare NHS Trust
St Richard's Hospital	University Hospitals Sussex NHS Foundation Trust
St Thomas' Hospital	Guy's and St Thomas' NHS Foundation Trust
Stepping Hill Hospital	Stockport NHS Foundation Trust
Stoke Mandeville Hospital	Buckinghamshire Healthcare NHS Trust
Sunderland Royal Hospital	South Tyneside and Sunderland NHS Foundation Trust
Tameside and Glossop Integrated NHS Foundation Trust	
The James Cook University Hospital	South Tees Hospitals NHS Foundation Trust
The Princess Royal Hospital	The Shrewsbury and Telford Hospital NHS Trust
The Royal London Hospital	Barts Health NHS Trust
The Royal Oldham Hospital	Northern Care Alliance NHS Foundation Trust
Tunbridge Wells Hospital	Maidstone and Tunbridge Wells NHS Trust
University College Hospital	University College London Hospitals NHS Foundation Trust
University Hospital Coventry & Warwickshire, University Hospital Coventry & Warwickshire NHS Trust	
University Hospital Lewisham	Lewisham and Greenwich NHS Trust
University Hospital of North Durham	County Durham & Darlington NHS Foundation Trust
University Hospital Southampton	University Hospital Southampton NHS Foundation Trust
Walsall Manor Hospital	Walsall Healthcare NHS Trust
Warrington Hospital	Warrington and Halton Hospital NHS Trust
Warwick Hospital	South Warwickshire NHS Foundation Trust
Watford General Hospital	West Hertfordshire Hospitals NHS Trust
West Cumberland Hospital	North Cumbria Integrated Care NHS Foundation Trust
West Suffolk Hospital	West Suffolk NHS Foundation Trust
Wexham Park Hospital	Frimley Health NHS Foundation Trust
Whipps Cross University Hospital	Barts Health NHS Trust
Whiston Hospital	St Helens and Knowsley Teaching Hospitals NHS Trust
Whittington Health	Whittington Health NHS Trust
William Harvey Hospital	East Kent Hospitals University NHS Foundation Trust
Worthing Hospital	University Hospitals Sussex NHS Foundation Trust
Wythenshawe Hospital	Manchester University NHS Foundation Trust
Yeovil Hospital	Somerset NHS Foundation Trust
York Hospital	York and Scarborough Teaching Hospitals NHS Foundation Trust

Northern Ireland

Altnagelvin Area Hospital	Western Health and Social Care Trust
Antrim Area hospital	Northern Health and Social Care Trust
Craigavon Area Hospital	Southern Health and Social Care Trust

Royal Victoria Hospital, Belfast	Belfast Health and Social Care Trust
South West Acute Hospital	Western Health and Social Care Trust
Ulster Hospital	South Eastern Health and Social Care Trust

Scotland

Aberdeen Royal Infirmary	NHS Grampian
Dumfries and Galloway Royal Infirmary	NHS Dumfries and Galloway
Raigmore Hospital	NHS Highland
Royal Alexandra Hospital Paisley	NHS Greater Glasgow and Clyde
Royal Infirmary of Edinburgh	NHS Lothian
University Hospital Crosshouse	NHS Ayrshire and Arran
University Hospital Monklands	NHS Lanarkshire
Western General Hospital	NHS Lothian

Wales

Nevill Hall Hospital	Aneurin Bevan University Health Board
Prince Charles Hospital	Cwm Taf Morgannwg University Health Board
Princess of Wales Hospital	Cwm Taf Morgannwg University Health Board
Royal Glamorgan Hospital	Cwm Taf Morgannwg University Health Board
Royal Gwent Hospital	Aneurin Bevan University Health Board
University Hospital of Wales	Cardiff and Vale University Health Board
Ysbyty Gwynedd	Betsi Cadwaladr University Health Board

Other

Jersey General Hospital