

**EMERGENCY ADMISSIONS: A
JOURNEY IN THE RIGHT
DIRECTION**

The Trolley Tsar's View

HISTORY (1)

Emergency (A&E) Departments

- Overcrowded
- Understaffed
- Trolleys
- Waits
- Sickest patients seen by most junior doctors

HISTORY (2)

Emergency Admissions

- Scattered through hospital
- Safari ward rounds
- Few appropriate direct admissions
- Dying throws of acute medicine and acute surgery - emphasis on specialties



The NHS Plan

A plan for investment
A plan for reform



The NHS Plan

A plan for investment
A plan for reform

Presented to Parliament by the
Secretary of State for Health
By Command of Her Majesty

July 2000

Cm 4818-I

£15.00

HISTORY (3)

- The 4-hour target
- Rebirth of Acute Medicine as a specialty - RCP reports/training programmes
- Spread of Acute Assessment/ Admission Units
- NSF for Cardiovascular Disease

Seward et al. A confidential study of deaths after emergency medical admissions: issues relating to quality of care. Clin Med 2003

- Large busy DGHs
- Errors in 20% of cases
- Possibly contributing to death in 10%

The Emergency Department: Medicine & Surgery Interface Problems & Solutions, RCS (Eng) 2004

Key Recommendations

- Early senior-led decisions
- Assessment units
- On-take team with no other commitments
- Committed acute physicians based on AU

RCP RECOMMENDATIONS

There should be three acute
physicians in every DGH by 2008

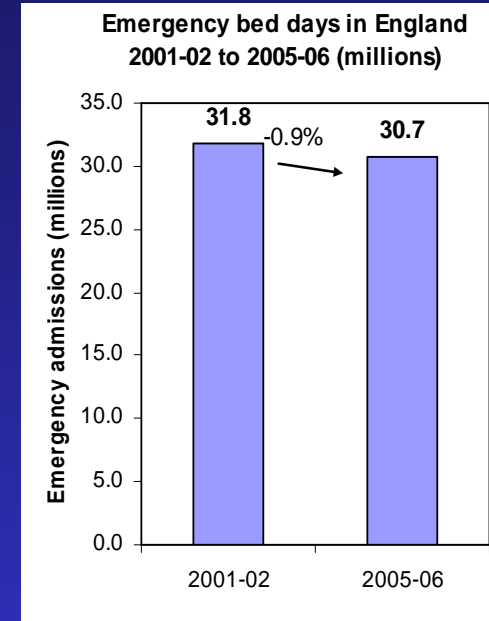
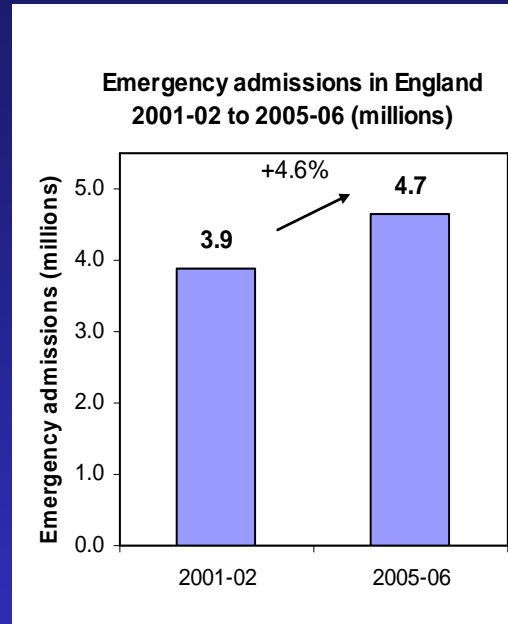
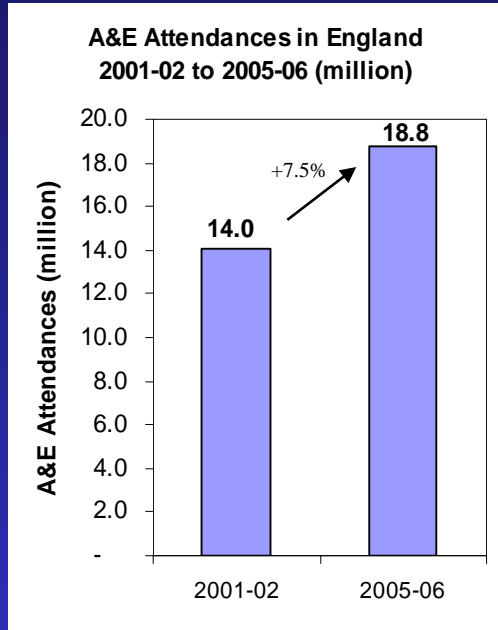
THE SIZE OF THE PROBLEM

- 80 million "urgent" visits to GP in hours
- 7 million OOH GP calls
- 7+ million NHSD calls
- 6 million 999
-
- 2-3 million WiC / MIU
- 14+ million A&E
- 2.5+ million Admissions

EMERGENCY ADMISSIONS

- 70% medical
- 60-70% elderly

Demand for emergency care is rising - A&E



Department of Health QMAE dataset

Hospital Episode Statistics (HES), The Information Centre for health and social care

*2006-07 figures are subject to revision when the final outturn figures are received

A&E attendances includes attendances at major departments, single specialty departments and other types of minor injury/illness services, including minor injury units and walk-in centres. Information on walk-in centres has been collected as part of the QMAE dataset since Q1 2003-04.

KEY FINDINGS (1)

- Median age 77 years
- 66% via ED
- 27% GP
- 79% Medical; 21% Surgical
- Most individual assessments ED or EAU

KEY FINDINGS (2)

- Majority of initial assessments good or adequate
- Majority undertaken by SHOs
- Poor documentation

KEY FINDINGS (3)

- Only 60% seen by consultant in first 12 hours
- Not possible to determine in 48%
- Only 6% deemed unnecessary
- Poor CT availability 15%
- Some diagnostic delays

KEY FINDINGS (4)

- 13% on inappropriate ward
- Poor handling of possible adverse events

NB 35% of patients had remedial factors

CONCLUSIONS (1)

- More acute physicians needed
- All on-take physicians and surgeons should be freed of other commitments
- Much earlier consultant review needed

CONCLUSIONS (2)

- 24-hour immediate diagnostics needed
- 48-hour time limit for AUs
- Consider acute care of the elderly team
- Direct admission to specialty wards where appropriate
- Better training needed

CONCLUSIONS (3)

Process and care have improved
in last 5-10 years

- but more action still required