Rebuilding the NHS: better medical pathways for acute care 2022

Urgent update, immediate priorities, and recommendations

December 2022

In 2020 as we learned from the pandemic, we said that urgent and emergency care in the NHS needed transforming immediately and made 10 recommendations for UK governments, the NHS, and local systems. These recommendations remain pertinent and appropriate, but the situation for patients and services has become even more critical.

Currently in the NHS patients with acute medical presentations are often

- delayed at home before being brought to hospital, with the risk of deterioration
- spending prolonged periods of time in overcrowded emergency departments, with delayed assessment and treatment, poor experience, and without the care they require if they need to be admitted
- delayed in moving from acute medical units to appropriate inpatient wards
- cared for on multiple wards, creating poor continuity and patient experience, and increasing time in hospital
- delayed in leaving hospital because of difficulties with social care provision
- at risk of readmission, because of pressures to be discharged earlier in their recovery.

We must be honest with the public and patients that, with current workforce constraints, NHS professionals cannot always provide the care that they would want to, and that we are prioritising those with greatest need.

We have published our recommendations for the medium to longer term in more detail with respect to care in the community in emergency departments, and for urgent medical care. But at this time of crisis, with patients and clinicians fearing worsening pressures over the coming months, we must prioritise interventions that might be deliverable despite current constraints.

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For patients with acute medical presentations, primary care, emergency medicine, acute medicine and specialty medicine must be enabled to work most effectively together. The Royal College of Emergency Medicine (RCEM), Royal College of General Practitioners (RCGP), Royal College of Physicians (RCP), Royal College of Psychiatrists and Society for Acute Medicine (SAM) believe that we have a professional and ethical duty to collaborate to improve patient care.

Local clinical leaders and managers will continue to work together to improve care for patients, and we strongly recommend self-assessment and the development of urgent plans against our priority recommendations.

Patients with acute medical presentations require:

Improved communication between professionals

- Simple[1] telephone access for primary and community care clinicians to senior physicians for advice and navigation over 24 hours.
- Referral communications should be structured to ensure that actions can be focused and timely, and patients are clear what to expect.
- Discharge communications sent digitally from hospitals to general practice must clearly explain how the hospital will follow up, and any actions that need to be undertaken by the patient's regular GP team and the patient themselves.
- The ability for hospitals to communicate directly with a GP when there is an urgent need to discuss admission or discharge arrangements e.g., practice bypass telephone number. The agreed route should be used in such a way that it does not undermine continuity of care within general practice.

Improved logistics

- Same-day or next-day urgent care assessment in SDEC units or 'hot clinic' slots, with same-day access when required aligned to when patients present.
- Direct admission to acute medical units and, where appropriate, specialist units from primary and community care, whenever possible.[2]
- Prioritisation of transfer from emergency departments to acute medical units based on clinical risk, not solely time.
- Same-day or occasionally next-day inpatient cross-speciality assessments when required.
- Acute medical receiving areas to have the same priority of investigations as emergency departments.
- System-wide and real-time bed management to maximise the best possible location of care.

[1] Single telephone number adequately staffed to prevent delays in answering and multiple calls.
[2] Receiving capacity can be based on predicted admission numbers and times, thereby preventing unnecessary delays due to crowding and duplicate assessments in emergency departments.

Improved continuity of care

- Multidisciplinary care planning through board rounds and ward rounds, with continuity of care from senior decision makers.
- Planned follow-up after discharge by the appropriate team member.
- Urgent specialist contact arrangements for people with long-term conditions who may deteriorate or develop complications of treatment.

These interventions must be incorporated into protected clinical time within teams to enable them to happen consistently.

Updated recommendations

1. UK governments should increase and prioritise investment in primary care, social care, mental health and ambulance services. This will enable us to deliver more care in primary care settings and the patients' homes 7 days a week. This care includes end-of-life care, falls assessment and prevention, treatment of minor injuries, and dressings and catheter care.

2. Before making any changes or introducing new options, hospitals and local health systems should systematically consider the impact of their plans on equality. They should carry out a rapid impact assessment to make sure that plans are not going to exacerbate health inequalities. Where possible, they should aim to improve access.

3. Quick-access telephone lines for communication between secondary care and primary care. This will increase the ability of primary care to be the gateway to accessing the most appropriate services and minimise avoidable referrals. Providing phone access should be planned into clinical teams' workloads.

4. Local health systems must develop a 7-day range of options to which NHS 111 (and equivalent Phone First helplines) and primary care can direct patients. These include pharmacy, minor injury units, urgent care units and out-of-hours GP services, as well as secondary care services. This will strengthen the ability of general practice, 111 and 999 services to deliver consistent, clinician-validated advice as standard. The emergency department shouldn't be the out-of-hours default.

5. Hospitals should urgently expand same day emergency care (SDEC) options for patients referred from primary care and NHS 111. These should involve a wide range of generalist and specialist clinicians and be clearly communicated to primary care and patients receiving ongoing care. This will mean more patients receive the right care at the right time, and prevent emergency department attendance.

6. All hospital specialties must prioritise patient flow and work to eliminate delay. Patients with a specialty referral need a rapid response and a treatment plan that minimises

unnecessary admission. This will enable them to be moved from ambulances quickly and treated in safe areas.

7. Diagnostic and support services (including all members of multidisciplinary teams) must be available 7 days a week to maintain patient flow. The standards identified by the Royal College of Radiologists should be used.

8. 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.

9. People experiencing a mental health crisis or who have acute physical or mental health needs should receive equitable specialist access in all hospital settings with parallel assessments. Mental health crisis initial assessment when presenting to emergency departments should be within one hour, 24 hours a day, 7 days a week, by an integrated liaison psychiatry service wherever possible.

10. Discharge planning should commence on admission and be optimised so that patients discharged from hospital are transferred to an environment with tailored support for their health and care at an appropriate time of the day.

To discuss anything in this statement, or for more information, please contact us via policy@rcem.ac.uk, policy@rcgp.org.uk, policy@rcplondon.ac.uk, policy@rcpsych.ac.uk or communications@acutemedicine.org.uk.