

## Acute medicine and general practice:

a key interface in managing emergency care pressures

Scarcely a day goes by without a news report highlighting the pressures faced by the health service in delivering emergency care. Inevitably the spotlight usually falls on the emergency department (ED), where the '4-hour target' has ensured that data on waiting times have been reliably and accurately collected in hospitals across the UK for a number of years. The rising number of patients spending prolonged periods in the ED prior to discharge or transfer to another area of the hospital provides clear evidence of a service under increasing strain; however while the ED may be the best place to measure this pressure, many of the solutions to this lie elsewhere. Focusing solely on the 'symptom' in the ED is akin to treating chest pain with morphine: resolving the problem requires that we also identify and treat the cause.

So what is the cause of this 'crisis' in emergency care? The simple answer is that the demand on the service exceeds our current capacity to cope, both in terms of staffing and space. Demand is rising and our ability to expand capacity is limited by recruitment challenges and the need for financial austerity: so the problem is getting worse. We need to find better ways to manage demand and make the most cost-effective use of our capacity and our workforce. It all sounds so simple, so why, despite years of trying does it feel like we are no further on?

### CONTROLLING THE DEMAND

Much of the focus over the past 10 years has related to the management of demand for hospital care. However, it should be recognised that the number of patients attending the ED is not the principal cause for ED crowding. Indeed the overall numbers of patients attending EDs are higher during the summer months than they are in January and February, when the pressures are at their highest. This may partly explain why the proliferation of community-based alternatives has done little to ease the pressure which they were designed to reduce. An enhanced 111 service, with greater clinical involvement as recently proposed by NHS England, may help to improve access and triage to the most appropriate service, particularly during 'out of hours' periods.<sup>1</sup> However, it is likely that some patients will continue to choose to attend the ED with a problem which

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could have been managed effectively by their GP. Previous studies have suggested that GPs working in the ED investigated, prescribed, and referred less than junior hospital doctors,<sup>2</sup> and may provide a cost-effective way of managing a selected group of patients;<sup>3</sup> however sustaining this benefit may be more difficult with some suggestions that GPs adopt the investigation practices of hospital staff over time. A report from the Primary Care Foundation raised concerns about the safety of the alternative approach of 'redirection' of patients to primary care, on arrival at ED.<sup>4</sup> The College of Emergency Medicine has recently suggested the provision of an out-of-hours primary care service adjacent to every ED to improve safety and simplify this process for selected patients.

### MANAGING THE FLOW

Controlling demand will provide part of the solution, but the pressure will not ease unless we can also manage the flow of patients out of the Emergency Department. Analysis, by Warwick University, of national data from the winter of 2012–2013 indicated that the group of patients who waited longest to be transferred out of the ED, were those who required hospital admission.<sup>5</sup> This group accounted for almost all of the rise in the proportion of patients waiting over 4 hours during this period. Factors which influence availability of a hospital bed therefore have a significant impact on crowding in the ED. Acute medical units (AMUs) play a vital role in improving patient flow into and through the hospital, by ensuring a consultant-led, multiprofessional approach to the early management of medical patients who are admitted to hospital in an emergency.<sup>6</sup> Some hospitals have also explored the use of GPs

in managing selected groups within the AMU.<sup>7</sup>

### MAINTAINING SUFFICIENT CAPACITY

The recent Royal College of Physicians of Edinburgh consensus statement on patient flow identified the need for appropriate levels of capacity to be maintained to enable effective flow to be achieved.<sup>8</sup> All too often, hospitals run their capacity at or near 100% occupancy; when each day begins with all beds full in the AMU a vicious circle ensues, with a backlog of patients building up, delaying their assessment and slowing the process of investigation, treatment, and discharge. When hospital capacity is constrained, patients may be 'boarded' in wards which are not designed to meet their clinical needs, which further adds to the delays, as well as impacting on patient experience and outcomes.<sup>8</sup>

### KEEPING THE BACK DOOR OPEN

Maintaining capacity at the 'front door' requires flow to be maintained at the hospital's 'back door'. The increasingly complex needs of many of the patients who are admitted to hospital, coupled with a squeeze in social services' budgets over the past year has led to a rise in the numbers of patients in hospital beds whose discharge is delayed after their medical problem has been resolved. This problem is compounded in winter, when the combination of Christmas holidays and the increased needs of the older population often adds to the backlog. Better integrated care and community-based frailty schemes may help to avoid admission for some of these patients; however it is important to recognise that many of the patients whose social needs delay their discharge from hospital have medical needs

at the time of admission. It is often only after this problem has been resolved that it becomes apparent that the patient's package of care no longer meets their ongoing needs. There is a danger that diversion of resources to 'admission prevention' will result in even more prolonged hospital stays for this group of patients unless both ends of the process are tackled simultaneously. Early senior review and multidisciplinary 'comprehensive geriatric assessment'<sup>9</sup> with discharge planning as soon as possible after admission will help to identify these patients' needs earlier in their hospital stay; however it is often the capacity of the social care system which will determine the length of time these patients spend in hospital.

### CLOSER COLLABORATION IS THE KEY

There have been repeated calls for greater collaboration across traditional boundaries, and yet the silos of primary, secondary and social care can often seem to be as entrenched as ever. Improving communication at the interface between acute medicine and general practice is crucial to provide a better understanding of the capacity constraints outside our own areas. The opportunity to spend an educational day on our acute medical unit (AMU) has proved popular with local GPs, and has often provided as much learning for the AMU team as it has for the GP. Social media may provide another innovative solution: a simultaneous joint session on 'breaking down barriers in health care' provided delegates at last autumn's RCGP and Society for Acute Medicine conferences with the opportunity to share their different perspectives on these challenges via Twitter. Pressures exist right across the health and social care system: we must tackle these together if we are going to make a difference in the future.

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