The Emergency Department: Medicine and Surgery Interface Problems and Solutions

A REPORT OF
THE WORKING PARTY

2004

REVIEW DATE: 2008

1. The working party was established to identify the particular issues associated with the progress of the recommendations set out in *Reforming Emergency Care**, relating to the interface between the emergency department and medical and surgical specialities. This paper has been developed jointly by representatives of The Royal College of Surgeons of England, The Royal College of Physicians, the Faculty of Accident and Emergency Medicine and the British Association for Emergency Medicine in discussion with the Department of Health's National Clinical Director for Emergency Access, Professor Sir George Alberti.

Issues

2. In order to deliver the best service for patients arriving in the emergency department, we must ensure that all professionals work in an integrated way so that patients receive the best clinical care in the right setting as quickly as possible. This might mean breaking down barriers between professional groups, changing the way care is organised or changing and challenging traditional working practices.

3. The four-hour wait emergency department target has highlighted some key problems in ensuring that patients flow smoothly through the system. These include delays brought about by:

   > waiting for the results of investigations;

   > waiting for surgical and medical teams to respond to referrals from the emergency department;

   > junior members of specialist teams being the first point of contact, who then have to wait for a more senior member of the team to make decisions;

   > experienced emergency physicians and nurses having to refer patients who obviously need urgent admission to a specialty team to decide to allow that admission;

   > delays in identifying an expected date of discharge within 24 hours of admission to medical or surgical bed;

   > waiting for a medical confirmation of a decision to discharge a patient from hospital on the expected/agreed date of discharge.

Solutions

4. In the table (pages 4–8) are listed issues requiring prompt resolution and suggested actions that might be taken, and where responsibility should lie for taking that action.

5. The issues to be addressed are detailed in the first column of the table and are defined in four ways (second column). The four types of problem are:

   > *ED* – problems specific to the emergency department and where the solutions will be delivered within the emergency department;

   > *Interface* – problems that arise from the way the emergency department works with other parts of the hospital;

   > *Whole hospital/trust* – generic problems that affect the whole organisation;

   > *Whole system* – problems that will need to be resolved outside the hospital in order to support the better delivery of emergency care.

6. Proposed potential solutions, which are divided into four themes are listed in the third table column:

   > *Professional working practices* – those practices that can be delivered by professionals locally, with the support of professional bodies;

   > *Service organisation* – solutions that can be delivered locally by managers and clinicians working together to improve services;

   > *Local planning and, if required, investment* – where local planning and, if required, investment (against the existing national priorities) may be needed to ensure the right facilities are available to organise and deliver services effectively;

   > *National actions* – where only national organisations, eg government or professional bodies, can tackle barriers to local action.

* *Reforming Emergency Care* (2001) London: Department of Health. www.doh.gov.uk/capacityplanning

7. Finally, in the last column are identified those people or bodies who are likely to be responsible for taking action to implement the solutions.

8. While some issues can be tackled quickly, and will help trusts to achieve the four hour target, others will require on-going work over the next few years. Work should therefore start immediately to tackle all of the issues set out in this paper as they apply locally. The likely maximum implementation period needed for each action once underway is defined in the table key.

9. Communicating with patients and relatives about what is happening and meeting their human needs are outside the scope of this document but are important both in the emergency department and the hospital as a whole.

Professor Carol Black
President, Royal College of Physicians

Alastair McGowan
Faculty of Accident and Emergency Medicine

Sir George Alberti
National Clinical Director for Emergency Access, Department of Health

Mr Bernard Ribeiro
Vice-president, The Royal College of Surgeons of England

Martin Shalley
British Association of Emergency Medicine

Issue	Nature of problem	Possible solution	Nature of solution	Responsibility
1. Competing needs and challenges of balancing elective and emergency workloads	Whole hospital/trust	Proper understanding of the problem by chief executives, medical directors and Strategic Health Authority (SHA) Trust policy that on-call teams should be free of other commitments on 'take' days. Work towards separation of emergency and elective services, thereby freeing all levels of staff to undertake their on-call commitments. Promote use of emergency clinics, emergency and trauma theatre lists, and same day investigations to ensure urgent patients are dealt with appropriately. All hospitals receiving surgical emergencies should work towards having fully staffed and dedicated emergency theatres running during peak arrival times for surgical emergencies (usually 09.00–21.00). These theatres should have a dedicated emergency team and a consultant anaesthetist present during the stated period. Outside that period, a surgical team should be on call. High-level bed management investigation: > Use of external support where available eg Modernisation Agency bed management programme > Better discharge arrangements, for example: – discharge decisions seven days per week before 11.00 on all inpatients; – if not possible to discharge early from hospital maximise use of discharge lounge; – optimum use of single assessment process for complex discharges; – early involvement of social services in these cases. – Facilitated nurse/allied health professions – delivered discharge decisions with agreed criteria	Service organisation. Professional working practice. Local planning and, if required, investment	SHAs, acute trusts, social services, primary care trusts (PCTs). Local managers, clinicians

Issue	Nature of problem	Possible solution	Nature of solution	Responsibility
2. Demands of teaching and academic medicine	Whole hospital	Clarify sessional commitment for academic staff Identify consultants with the aptitude, desire and commitment to teaching. Include teaching commitments in these consultants' contracts, to ensure that the time commitment is recognised	Service organisation. Professional working practice	Trusts (working with universities). PCTs, trust (if investment needed)
3. Lack of integration of hospital-based emergency department with the wider health and social care community	Whole system	Establish proactive, robust unscheduled (emergency) care networks to include representatives from acute trusts, primary care trusts, out-of-hours services, NHS Direct, ambulance and mental health trusts, local councils, voluntary sector, social services etc.	Service organisation	All unscheduled care providers for the patient population in question
4. Patient care delayed by professional barriers	Whole system	Ensure optimum use of all healthcare professionals within the emergency care pathway, such as GPs, radiographers, nurses, physiotherapists, occupational therapists, pharmacists and social workers Need to provide better career structures for emergency care staff whilst promoting integrated care Develop cadres of staff to work across the emergency care pathway with staff training based in competencies and skills	Service organisation. Professional working practice	SHAs, acute trusts, PCTs, local authorities, ambulance trusts. Local managers and clinicians. Royal Colleges and professional bodies
5. Patient care delayed by poor management of clinical information	Whole hospital	Aim to implement a single record system across the acute trust, if necessary as a paper record until full implementation of the electronic patient record is complete.	Service organisation. Local planning and, if required, investment	Local managers and clinicians. Acute trust/ SHA
6. Shortages of consultants in many acute medical and surgical specialities	Whole hospital	Increase supply of consultants in line with national workforce targets Increase numbers of non-training grade doctors in acute specialities Consider increasing consultant numbers in emergency medicine and acute medical and surgical specialities	National action. Local planning and, if required, investment	Department of Health. Royal Colleges and professional bodies

Issue	Nature of problem	Possible solution	Nature of solution	Responsibility
7. Traditional use of most junior member of the admitting team as first point of contact with patients	Interface	Change practice to 'decision makers' being in early contact with patients. Ensure a senior decision-maker is available at every step in the patient pathway. Ensure staffing matches workload including known peaks and troughs	Professional working practice	Acute trust
8. Time taken for speciality teams to see patients referred to them by emergency department staff	Interface	A recommended way to address this is a commitment by all concerned that patients will be seen within a maximum of one hour of referral by an experienced doctor or consultant. An approach to be commended is to base a specialist registrar in medicine or other middle-grade medical doctor in emergency department and/or assessment unit	Professional working practice	Acute trust
9. Inability of emergency department senior doctors to admit patients directly	Interface	A number of ways can be found to address this locally: > One option is to allow senior doctors and nurses in emergency department who have the relevant experience to admit patients directly to clinically appropriate beds in an assessment unit or, in certain cases, speciality ward > Another option is to give these staff permission to admit patients direct to MAU and SAU after locally-agreed protocols and handover have been developed > A third option is to work towards a system of direct admission from A&E/ambulance to acute assessment areas. Many trusts will find a combination of increasing A&E admitting rights alongside a drive to improve specialist availability for emergency department referrals beneficial	Professional working practice. Service organisation	Acute team. Local managers, clinicians
10. Patient care delayed by over-'compartmentalised' hospital	Interface	Consider reorganising administrative structures so that emergency care encompasses emergency medicine, acute medicine, acute surgery, critical care and coronary care.	Service organisation	Local clinicians and managers. Acute trust

Issue	Nature of problem	Possible solution	Nature of solution	Responsibility
11. Constraints imposed by the implementation of the European Working Time Directive (EWTD)	Interface	Rotas will almost certainly need to be reworked in the light of EWTD. This is an opportunity to consider rotas that allow specialists to be free on day of 'take'. ***This is recommended***. Consider nurse specialists for in-patient cover	Professional working practice. Local planning and, if required, investment	Acute team. Local managers, clinicians PCT, acute trust, SHA
12. Absence of acute assessment units and observation units.	Interface	Work towards establishing acute assessment units and observation units/wards in all acute hospitals, appropriate to local needs Ensure acute assessment units (medical and surgical) and observation units are included in all new hospital plans	Local planning and, if required, investment. Service organisation	Acute trust, PCT, SHA
13. Lack of funding for acute physician posts and/or lack of suitable candidates	Interface	Trusts, with their commissioners, to work towards the RCP target. (RCP target is to have three physicians in acute medicine in every acute receiving hospital by 2008.) Department of Health and Workforce Numbers Advisory Board to consider Increasing training places Overseas recruitment to be used as appropriate All posts at foundation and basic surgical training levels should be part of programmes with effective educational supervision and regular in-service assessment.	Local planning and, if required, investment. National and local action	PCT, acute trust, SHA. Department of Health
14. Delays in obtaining initial radiological and laboratory investigations	Interface	Recommended actions include: > Committed radiology facilities staffed 24/7 > Point of care testing in emergency department/assessment unit.	Local planning and, if required, investment. Service organisation. Professional working practice	SHA, acute trust, PCT. Local managers and clinicians

Issue	Nature of problem	Possible solution	Nature of solution	Responsibility
16. Time taken to deal with common less-complex medical conditions. An example being groups of patients waiting longer than necessary (eg older people with stroke; recurrent COPD exacerbations; chest pain)	ED	Establish nurse-delivered protocols for common conditions and some more complex conditions (eg chest pain, fractured neck of femur) where possible Establish multi-professional agreed care pathways for more complex condition including admission rights to specialist beds Establish protocols for fast track admissions of specific patient groups by experienced doctor or consultant nurse/experienced nurse practitioner	Professional working practice. National action. Service organisation	Acute trust. Royal colleges, Department of Health. Clinical director, local managers, clinicians

Red, if action decided on implementation should require no more than 6 months
Amber, if action decided on implementation should require no more than 12 months
Green, if action decided on implementation should take no more than 18 months

The Royal College of Surgeons of England
35–43 Lincoln's Inn Fields
London WC2A 3PE
T: 020 7405 3474
W: www.rcseng.ac.uk

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