Winter 2018/19 in the NHS: The solutions

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There is a relentless rise in pressure on inpatient beds in the NHS.

Earlier this year, an analysis by the British Medical Association found the number of overnight beds in the NHS in England had decreased by more than 14,000 since 2010 and more than 6,000 beds had been lost over the last four years.

In September, we welcomed the Department of Health and Social Care's £145 million investment to help NHS hospitals cope this winter – but warned the additional 900 beds this would cover falls 3,100 short of the number required last winter.

We all need to look at ways of mitigating this and helping our patients and one such process is called ambulatory emergency care (AEC).

This is an alternative to hospital admission for patients with acute problems who might otherwise have spent at least one night in a hospital bed but can now be cared for in a more outpatient-based type of setting.

This has obvious benefits for the patient in that they usually remain in their own clothes, remain mobile and get to sleep in their own beds. For the hospitals, it is a way of alleviating overnight bed pressures.

The Ambulatory Emergency Care Directory lists conditions that might possibly be treated in this way, with an estimation of potential for ambulatory treatment for each one. The majority of these are 'medical' rather than 'surgical'.

There are 21 conditions listed with a more than 60% potential for AEC; they include conditions such as suspected deep vein thrombosis, suspected pulmonary embolism, cellulitis, seizures and anaemia. It is estimated that roughly 70% of AEC care is for 'medical' conditions

From the recent Society for Acute Medicine Benchmarking Audit (SAMBA), 95% of acute medical units also worked an AEC area. In this study of more than 6,000 patients on a single day, 20.1% of these were first assessed in an AEC setting and 79.5% of these managed to go home on the same day. This was an increase on the previous year where only 16% were first seen in AEC areas and means at least 977 overnight bed stays were avoided that day.

However, there is great variation across the country in how AEC is used and to what extent, ranging from the disappointing 23% who did not see patients in a dedicated AEC for first assessment to the improbable 10% who claimed to see more than 40% in this area. The largest 'cohort' was the 46% of units that saw 20% or more of their patients in AEC.

In April 2018, NHS Improvement wrote that it thought hospitals could convert up to 30% of admissions to this model if all were resourced to provide the level of service needed for at least 12 hours a day, seven days a week.

Given how much pressure we are all under, it would seem reasonable to look at how much could be achieved in this area.

If, for example, the mean was raised to 25% of patients first seen in AEC, that could realise a further 238 overnight bed stays saved on the one day of our audit. That would equate to 14,042 potential overnight admissions over January and February.

However, that will take investment in services and supporting networks.

AEC is not an 'easy' option and relies on skilled staff with full support from many other services both in hospitals (particularly diagnostics) and in the community to support patients and processes.

One facet often not mentioned is the 'specialty support' for this outside acute internal medicine. Less than half of the hospitals in our data had support from specialist services, primarily respiratory medicine, cardiology, gastroenterology, frailty and cancer-related conditions, in the form of 'hot clinics' to provide more specialist ambulatory care.

We also need to find a long-term way of capturing this activity and obtaining a standard tariff that helps hospitals work in this way without jeopardising their performance figures or finance. We, in SAM, are looking forward to working with NHS Improvement and our colleagues in the Royal College of Emergency Medicine on this through the Emergency Care Data Set.

With winter rapidly approaching, AEC would seem to be an area that is beneficial to both patients and the service but is variably used throughout the country.

To evoke maximum benefit, a significant investment and national plan for this area is required.

In the interim, we believe the government and NHS leaders should realise urgently the potential of AEC to have a transformative effect on bed capacity and seek further advice from a broad base of experts to develop guidance on helping hospital trusts to utilise AEC as efficiently as possible.