

Consensus statement

Coordinated and consistent emergency and urgent medical care

February 2022

The Royal College of Physicians (RCP) and the NHS England and NHS Improvement Getting It Right First Time (GIRFT) programme recognise the unprecedented challenges faced by clinicians during the pandemic, and acknowledge the time commitment and hard work that individuals and teams have put in for the benefit of patient care. As well as addressing the elective care backlog, we are also faced with an increase in urgent and emergency presentations. To help teams address these pressures, we recommend that a coordinated approach across medical specialties is required to meet the needs of patients who have emergency and urgent medical presentations.

A coordinated approach requires consistent 7-day clinical care and advice across the urgent care pathway. Continued development informed by best and innovative practice is required by all clinical teams and hospitals to meet current and future demands. Each recommendation in this statement may be normal practice in some organisations, but seem aspirational or hugely challenging in others. The recommendations are informed by knowledge of what can be delivered when resources are in place or become available, and when clinical leaders are supported. They aim to drive change, but also to understand the challenges and how these have been overcome by pioneers in these areas.

Modern medical teams, while led by consultants, have highly skilled professionals from different disciplines with specialist or advanced practice skills, who play an essential part in delivering these recommendations.

There has been considerable emphasis on patient presentation and initial assessments over a number of years. A whole-pathway approach is required, with equal emphasis on care planning and delivery at each stage, including following discharge from hospital.

Modern medical teams have to balance acute care, planned diagnostic/therapeutic pathways and management of long-term conditions. Each of these, along with national guidance, will contribute to managing emergency and urgent medical presentations. It is important that we all work together to deliver the best care for our patients. Local improvement priorities towards these standards will be influenced by this balance, which is particularly challenging where there are workforce gaps.

In addition, there are important interdependencies, for example with diagnostics and pathology. We need to work together with these and other specialties to ensure timely diagnoses to facilitate and optimise the patient pathway.

Rapid access to a senior decision maker* for specialty advice and assessment

Acute medicine teams play a central role as rapid senior decision makers for patients presenting acutely with medical conditions.

- > Acute medical units require adequate capacity and staffing to enable senior decision making throughout 24 hours, focused at peak presentation times, and with continuity for up to 72 hours for some patients. They can enable cross-specialty input for patients with medical conditions.
- > In-reach to acute medical units by medical specialty teams. For high-volume acute specialties and conditions, such as cardiology, respiratory, geriatrics, gastroenterology and diabetes, this should be a routine commitment each day, advising acute medicine teams on individual patient management. For lower-volume acute specialties and conditions, daily availability should be planned. (Where geography prevents this from happening physically, remote access may be appropriate.) There should also be access to specialist opinion.
- > Access within 30 minutes to consultant medical specialty telephone advice for a senior decision maker from other specialties and GPs during normal hours and out of hours. This is to ensure that appropriate pathways can be followed for patients presenting with urgent needs, including for patients who do not require admission. Providing a specialty consultant of the week allows continuity of care for ongoing review of patients by either primary or secondary care, as required.
- > Local Clinical Networks should facilitate equal access for patients who require specialist input and ensure agreed arrangements for patient transfer or local delivery of specialist care, dependent on patient need.

- > Acute medicine physicians also provide assessment in emergency departments (EDs) and should liaise with medical specialties as required to meet individual patient needs.
- > Where possible, centres should provide a senior decision maker who receives all referrals from primary care, but also from the ED and other areas to provide alternatives to admission.
- > Same-day emergency care (SDEC) units are increasingly providing assessment, care planning and delivery for patients who may not require admission to a hospital bed, where the patient would benefit from their input. These are predominantly delivered by acute medicine teams.
- > Medical specialties should provide same-day assessment of patients presenting urgently, to avoid admission where appropriate and facilitate early discharge. This may be in SDEC units or via arrangements such as 'hot clinics'. Enhanced recovery should be the default for all patients, to allow early mobilisation and prevent deconditioning while ensuring timely discharge.

Ward-based care beyond acute medical units

Ensure that patients transfer to medical wards with the best specialty expertise to meet their needs

- > Clinicians should work alongside bed management teams and operational managers to ensure that patients transferred from acute medical units are receiving appropriate specialty care when required. To enable this, organisations need to use demand data to facilitate the best balance of specialty beds and resources.
- > Patients with general medical needs and with multiple medical problems should be cared for by medical specialties utilising their generalist skills and incorporating advice from

*A senior decision maker within a medical specialty is a member of the multidisciplinary team who can enact appropriate pathways of care for the patient, including discharge, transfer to specialist area, follow-up, specialist investigations or procedures.

multi-professional specialists, which may be via networks. The RCP provides guidance across medical specialties.* Multidisciplinary care delivery is required for most of these patients.

- > Multi-specialty care will be required for some patients. Clear responsibility for care coordination should be in place. Shared care may be required for some patients.

7-day specialty consultant-led ward rounds[†]

These are delivered through coordination of the team, to ensure:

- > daily assessment and care planning – ideally face-to-face review and a board round review later in the day
- > timely investigation and treatment
- > discharge planning, including ‘criteria-led’ discharge planning.

Specific guidance on weekend ward medical teams is provided by the RCP,[†] and multidisciplinary support should also be provided. Where workforce challenges prevent this in each specialty, the role of the generalist physician with networked specialty support is particularly important.

Efficient use of resources for ward rounds

- > Ward rounds should follow the RCP’s guidance on modern ward rounds.[‡]
- > Base ward and ‘buddy’ ward systems should be used to avoid safari ward rounds.
- > Surgical wards should be ‘buddied up’ with the appropriate medical specialty ward to assist in this and to provide surgical colleagues with easier access to a medical opinion, eg renal and urology, diabetes and vascular, gastroenterology and gastrointestinal surgery.

The nurse involved in the patient’s care and who is able to provide an overview of patient status must be made available for ward rounds to ensure that vital information is disseminated during and after the round.

Discharge and post-hospital early follow-up

- > Planned discharge dates and times must be provided as part of multidisciplinary decision making, as recommended in best modern ward round practice.[‡]
- > Clinical criteria for discharge should be agreed as early as possible in the patient’s episode of care; these can then be implemented by the appropriate member of the multidisciplinary team. These should be monitored, and reasons for failing to achieve the date should be identified and then learnt from.
- > Arrangements for early follow-up of patients with specialty and general medical needs must be prioritised to ensure continued recovery, identification of complications or follow-up of investigation results. This should be at a time interval that meets the patient’s needs, by an appropriate team member. This must be incorporated into job plans.

Virtual wards

- > Virtual wards provide daily assessment and coordination of care for people during acute illness, including physiological monitoring, and provide increased home care where required. Community- and hospital-based staff should work together to provide appropriate care planning and delivery for people in their own homes during acute phases of illness and recovery, when this would reduce hospitalisation.
- > Different models of care and levels of support for community-based practitioners by medical specialty teams are required for patients for whom hospital admission is avoided at acute presentation (step up) or early discharge is enabled (step down). Both elements require formal planning within work plans, and supportive technology and administration.

*Example. RCP, 2021: *Supporting people who have eating and drinking difficulties*. www.rcp.ac.uk/projects/outputs/supporting-people-who-have-eating-and-drinking-difficulties

[†]RCP, 2018. *Guidance on safe medical staffing*. www.rcp.ac.uk/projects/outputs/safe-medical-staffing

[‡]RCP, 2021. *Modern ward rounds. Good practice for multidisciplinary inpatient review*. www.rcp.ac.uk/projects/outputs/modern-ward-rounds

Local clinical leaders, operational managers, system and network leaders must work together to prioritise improvements in care that move towards achieving these recommendations to meet patients' and the healthcare system's needs. Through implementation of these recommendations, patients should receive appropriate care in the appropriate place and at the appropriate time. It is important that physician activity is accurately job planned.

A webinar series developed by the RCP/GIRFT Clinical Pathway Improvement Group to provide further insight into how coordinated and consistent emergency and urgent medical care can be delivered is [available for viewing on RCP Player](#).

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