THE SOCIETY FOR ACUTE MEDICINE

# Same Day Emergency Care: A need to pause and Reset!

Acute Medicine has been at the forefront of developing SDEC (Same Day Emergency Care) or Rapid Assessment and Care (RAC) in Scotland, ever since pioneering Ambulatory Emergency Care at the turn of the century. As such, it is not a new initiative, but has evolved, and will continue to do so. It currently manages approximately 30% of the acute medical take across the UK[1], without which urgent and emergency care (UEC) services would rapidly collapse.

Ambulatory approaches are fundamental to the practice of Acute Medicine and medical SDEC is designed to manage patients who would otherwise be admitted to hospital, improving exit block and flow from the ED. SDEC remains well positioned to support UEC recovery by reducing both corridor care and the number of patients facing waits in the Emergency Department of more than 12 hours - associated with worse patient outcomes and increased mortality. Additionally, it can support reducing Acute Medical Unit (AMU) length of stay by facilitating rapid investigation and management with follow up where needed.

SDEC is a rich environment for training, including the valuable skill of providing rapid and safe appropriate investigation and management of patients with complex needs without an overnight hospital stay.

The recommendations in this statement aim to reinforce and complement the recent joint guidance from Society for Acute Medicine (SAM) and Royal College of Emergency Medicine[2] explicitly acknowledging these principles, outlining what medical SDEC is and, as importantly, isn't.

Despite the intense pressure on urgent and emergency care services, which Acute Medicine is committed to improve, it remains imperative that patients are seen by the right person, in the right place at the right time. Failure to do this can cause harm to the patient, both by misdiagnosis and over investigation and over-diagnosis, which can cause harm to the patient and considerable disruption to services.

We believe that a medical SDEC should be 'pulling' appropriate patients into SDEC. Namely these are patients with an acute medical need, who would benefit from seeing an Acute Physician and may otherwise have a high probability of admission. This requires appropriate triage and a brief initial clinical assessment as the patients are often complex with significant comorbidities.

At the point of a streaming or redirection decision, there is rarely enough information to make a sound clinical judgement around suitability for SDEC, and this may lead to the wrong patients being sent into our services. This can prevent medical SDEC being able to serve its core purpose of reducing medical admissions resulting in increased bed occupancy, poor flow, and worse patient experience. This short term 'win' of moving patients from the ED inevitably worsens the overall hospital situation.

SDEC should be consistently available and never bedded; latest SAM data shows 44% of medical SDECs were bedded overnight[3]. This profoundly reduces the potential numbers of patients seen, and rather than making hospitals safer, leads to a subsequent worsening of the hospital position over the following days. An intermittent service loses the faith of those referring into it as well as those working within it.

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***Recommendation 1:*** *Patient selection to medical SDEC should have agreed processes with clinical leadership from the acute medical team.*

***Recommendation 2:*** *Appropriate diagnostics should be arranged before transfer to SDEC when required. The system should support appropriate patients being moved from ED in an efficient and expeditious manner.*

***Recommendation 3:*** *Medical SDEC should not be used for patients are more appropriately managed by other services, including the ED, Urgent Treatment Centres (UTCs) and primary and community care.*

***Recommendation 4:*** *The management of complex patients within SDEC frequently requires a further patient review (in person or virtually) in the subsequent few days. This should be recognised as good practice when it is part of ongoing acute care*.*

***Recommendation 5:*** *Appropriate resources for workforce, physical capacity and access to diagnostics and therapeutics are required to minimise wait times and provide an optimal patient experience. This needs to be frequently assessed and evaluated.*

***Recommendation 6:*** *There should be 'zero tolerance' of bedding in medical SDEC, supported at Executive and senior leadership level**. To facilitate flow, downstream patient admission from SDEC must have the same priority as those in the ED, no patient should remain on the unit for longer than 8 hours.*

SAM continues to work with the Royal College of Emergency Medicine, Royal College of Physicians, and other stakeholders to drive and deliver high quality innovative services. We are committed to returning to the standards of care we all strive to provide.

We ask for a pause and a reset, as currently the deal does not provide a level playing field considering how high the stakes are regarding patient outcomes, staff and patient satisfaction, flow, and value for money.

**The Emergency Care Data Set (ECDS) recognises each attendance equally and is coded as Type 5 activity and the whole spell is coded as an Extended Care Episode or Type 6 activity.*

*** If SDEC is bedded it must be de-escalated with patient flow being restored within 2 hours of opening.*

**References**


1 Society for Acute Medicine Benchmarking Audit (SAMBA). SAMBA23 National report, available at https://www.acutemedicine.org.uk/blog/2024/01/10/samba23-national-report/. Accessed 20th April 2024

2 Joint statement RCEM and SAM regarding SDEC. Available at https://rcem.ac.uk/joint-statement-rcem-and-sam-regarding-same-day-emergency-care-sdec/. Accessed 20th April 2024

3 Personal communication from SAM research SITREP analysis Feb 24


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