Acute Medicine: The Scottish perspective

Essential actions, flow and a touch of realism

@djbeckett
“The Scottish Patient Safety Programme marks Scotland as leader, second to no nation on earth, in its commitment to reducing harm to patients dramatically and continually”

Donald M Berwick, MPP
Former President and CEO
Institute for Healthcare Improvement
Fill rates

**Acute (Internal) Medicine fill rates, Scotland**

Fill rates, A(I)M, 2015

SAM Scotland

- Hosted by RCPE
- Route of entry through SAM UK, initially with no additional cost (regional representation)
- Annual conference (next is December 14th 2018 at FVRH...)

@weeSAMSScotland
Scottish Government

• ‘Acute Physicians play a key role in the Unscheduled Care process and we are keen to see a vibrant and representative SAM Scotland work with us and the other key partners to improve patient and staff experience which are inextricably linked’

Alan Hunter, Director of Performance,
Emergency Access Standard

• The Emergency Department cannot deliver this target alone
• It requires a whole system response to ensure capacity meets demand - by hour of the day and day of the week
• Whole system barometer

Crowding

There is an association between ED crowding and:
• Mortality
• Increased length of stay both in ED and I/P
• Reduced quality of care
• Poor patient experience
• Staff burnout
• Difficulty recruiting and retaining staff
Scotland: weekly, self-reported acute inpatient boarding rates, Nov 2009 to Oct 2014

Proportion of estimated staffed acute inpatient beds reported occupied by boarded patients, %

Notes: (i) interpretation of inpatient boarding definition may vary between Health Boards, hence caution should be taken when interpreting trends; (ii) reported measure changed from Mon census in 2009/10 to bed day usage from 2010/11; (iii) data imputed where required, except for Highland Health Board, for which no consistent data are available; (iv) results are intended for management information only.

Health Board variation 2010/11 onwards: total boarded bed days 2009/10: boarded census at Mon 23.59
Nov 2012 onwards: continuous collection of weekly monitoring submissions

Standardised results

Summary

<table>
<thead>
<tr>
<th>Spell LoS:</th>
<th>Non-boarded, no sitespec boarding</th>
<th>Boarded, site-specified boarding present</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spells</td>
<td>3.2</td>
<td>9.2%</td>
</tr>
<tr>
<td>99% CI</td>
<td>3.1</td>
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<td>Emergency readmission within, of discharge:</td>
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Six Essential Actions Improvement Approach

- Launched in May 2015
- Developed in partnership with the Academy of Royal Colleges, NHSScotland and Scottish Government
- Aims to improve the patient and staff experience of Unscheduled Care
- Delivery of 95% target for all patients to be admitted, discharged or transferred from the Emergency Department within 4 hours.
  - Aiming towards a standard of 98%
  - Ministerial objective
Clinically Focussed Empowered Leadership
Responsive Operational Management
Whole System Escalation
Triumvirate Leadership Team
- Site Director,
- Chief Nurse,
- Chief Doctor

Pathways to reduce attendance, avoid admission and if admission necessary ensure home when ready
Signposting and redirection to appropriate community services

Ensuring Patients Care for at Home

7 Day Services
To reduce variation in access to all services across weekend and out of hours. Includes clinical assessment, diagnostics, and access to Senior Decision Makers. Also support services such as porters, cleaning and transport

Capacity and Patient Flow Realignment

Patient Rather Than Bed Management

Determining and utilising appropriate information and trend data for performance improvement to ensure correct resources are applied to meet demand and system need

Basic Building Blocks

Capacity and Patient Flow Realignment

Daily Dynamic Discharge
Shifting the discharge curve left
Developing a coordinated, multidisciplinary approach to discharge planning encompassing acute and community resources
Improve rate of early in day and weekends

Medical and Surgical Processes
Aligned for Optimal Care

Medical and Surgical Processes
Aligned for Optimal Care

Anytown Royal Infirmary, Assessment Unit: hourly admission and discharge profile,
XRI AU: average hourly inpatient and daycare admissions and discharges, n, by hour of hospital arrival or ward discharge
Source: local unvalidated PMIS extract, taken in ; data have been imputed where required
Note: (i) results are intended for management information only, (ii) records without a recorded discharge time have been excluded

Discharges
Admissions

Scheduled and direct admissions
with XRI AU LoS > 24 hr
Emergency admissions
Total LoS < 4 hr, %
Emergency Admissions
Daily Dynamic Discharge

Creating the Plan
- Dynamic MDT Planning from admission - EDD
- Effective Ward Rounds – management planning
- Daily Communication of Changes
- Dependant tasks considered

Executing the Plan
- Rapid Daily Whiteboard Meetings (sick, discharge, new) x 2 per day
- Ordered ward rounds (sick, discharge, new)
- Non-slip task management
- Check, chase, challenge reinforcement
- In the moment escalation

Discharging when ready
- Following criteria for discharge
- Escalation/expediting of delay causing tasks
- Discharge lounge?

Make sure we align the clinical and therapeutic pathways

How we DDD on Ward 7C

IN THE MORNING:
- At 9am
  We choose:
  - A facilitator, task sheet scribe and ward view updater
  We discuss:
  - Sick patients/safety issues
  - Patients for discharge today and tomorrow
  - Any relevant others (new patients/urgent tasks)
  We agree:
  - Things that need done TODAY, by whom, by when (write on task sheet)
  We summarise:
  - Bed numbers to be seen first
  We finish:
  - By copying the task sheet for each team

IN THE AFTERNOON:
- At 3pm
  We choose:
  - A facilitator, task sheet scribe, ward view updater
  We discuss:
  - Task sheet from this morning
  - Plans for all patients – EDD, tasks etc
  We agree:
  - Any new tasks to be added to today’s sheet (from ward rounds)
  - Any changes to earlier tasks
  - Escalations (preventing/possibly preventing discharge)
  We summarise:
  - What ELSE needs done TODAY
  We finish:
  - Agree to mark task sheet off before leaving/handover to next shift

SIGNED (SCN):  SIGNED (CONSULTANT):
February 2017: 14% improvement in one year

February 2018: 26%
PRE-2PM

17% improvement in one year

46% - Feb 2018

29% - Feb 2017

PRE-3PM

18% improvement in one year

60% - Feb 2018

42% - Feb 2017
Variability Methodology

Use simulation and analysis to identify appropriate capacity to meet scheduled & unscheduled demand

Construct model of improved flow

Improve and monitor standardised clinical processes. Collect data for modelling and benefits

Develop standardised clinical processes to identify natural and artificial variation

Select flow priority based on opportunities to reduce variation identified in analysis

Select redesign recommendation and implement changes e.g. cohort homogenous groups

Benefits Realisation

Analyse data to assess variability in patient flow

Natural Variation

Eliminate / Reduce Artificial Variation

Optimally Manage

ICU Queuing “Puzzle”

Two Medical ICUs with the Same Patients Acuity

5 beds
Average LOS = 2.5 days
Admission rate = 1pt/day

10 beds
Average LOS = 2.5 days
Admission rate = 2pts/day

Do they have the same waiting times to be admitted to these units?
<table>
<thead>
<tr>
<th>1st ICU</th>
<th>2nd ICU</th>
</tr>
</thead>
<tbody>
<tr>
<td>$\hat{T}_w = 0.13$ days</td>
<td>$\hat{T}_w = 0.018$ days</td>
</tr>
</tbody>
</table>

### 1st ICU

- $\lambda, \mu, S$
  - $\lambda = 1, \mu = 1/2.5 = 0.4, S = 5$
  - $p = \lambda / \mu = 2.5$
  - $P(S > s)$ (table) = 0.13
  - $\hat{R} = P(S > s) \cdot p / (S - p) = 0.13 \cdot 2.5 / (5 - 2.5) = 0.13$
  - $\hat{T}_w = \hat{R} / \lambda = 0.13 / 1 = 0.13$ days

### 2nd ICU

- $\lambda, \mu, S$
  - $\lambda = 2, \mu = 1/2.5 = 0.4, S = 10$
  - $p = \lambda / \mu = 5$
  - $P(S > s)$ (table) = 0.036
  - $\hat{R} = P(S > s) \cdot p / (S - p) = 0.036 \cdot 5 / (10 - 5) = 0.036$
  - $\hat{T}_w = \hat{R} / \lambda = 0.036 / 2 = 0.018$ days
Variability:
Daily Number of Surgical Cases

Artificial Variation
Natural Variation

Elective
Urgent
Emergency

Glasgow Royal Infirmary
% of Urgent / Immediate Patients delayed for Emergency Surgery
July-15 to Aug-16

% of Delays
Average Delays
Case Volume
Average Cases

% of Delays
0% 5% 10% 15% 20% 25% 30% 35% 40%

Weeks
20 Jul 21 Aug 25 Sep 29 Oct 2 Dec 6 Jan 3 Feb 7 March 11 April
Number of Cases
0 10 20 30 40 50 60 70 80 90 100 110 120 130 140 150
<table>
<thead>
<tr>
<th>MIB Board of Treatment</th>
<th>[Quarter Ending]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scotland</td>
<td></td>
</tr>
<tr>
<td>Scotland, ex Galloway</td>
<td></td>
</tr>
<tr>
<td>Aberdeen &amp; Orkney</td>
<td></td>
</tr>
<tr>
<td>Borders &amp; Galloway</td>
<td></td>
</tr>
<tr>
<td>Fife</td>
<td></td>
</tr>
<tr>
<td>Forth Valley</td>
<td></td>
</tr>
<tr>
<td>Greater Glasgow &amp; Clyde</td>
<td></td>
</tr>
<tr>
<td>Highland</td>
<td></td>
</tr>
<tr>
<td>Lanarkshire</td>
<td></td>
</tr>
<tr>
<td>Lothian</td>
<td></td>
</tr>
<tr>
<td>North East</td>
<td></td>
</tr>
<tr>
<td>Fife</td>
<td></td>
</tr>
<tr>
<td>Forth Valley</td>
<td></td>
</tr>
</tbody>
</table>

1. **Scotland**: 16,014, 16,116, 16,303, 16,073, 16,894.
2. **Scotland, ex Galloway & Highland**: 13,451, 13,917, 13,767, 13,695, 13,773.
3. **Ayrshire & Arran**: 1,084, 1,125, 1,109, 1,087, 1,081.
4. **Borders**: 236, 249, 236, 249, 246.
5. **Dumfries & Galloway**: 527, 540, 525, 525, 527.
6. **Fife**: 711, 711, 688, 634, 636.
7. **Forth Valley**: 618, 637, 630, 629, 614.
8. **Greater Glasgow & Clyde**: 4,063, 4,065, 3,959, 4,068, 4,089.
9. **Highland**: 875, 888, 877, 888, 888.
10. **Lothian**: 1,531, 1,565, 1,518, 1,538, 1,526.
11. **Lanarkshire**: 2,477, 2,516, 2,459, 2,521, 2,525.
12. **North East**: 44, 47, 48, 46, 48.
13. **Stirling**: 58, 59, 57, 56, 55.
14. **Tayside**: 1,326, 1,421, 1,412, 1,391, 1,387.
15. **Western Isles**: 34, 50, 57, 56, 55.

**Note**: The values are in thousands.
Admissions to FVRH AMU

FVRH compliance with the emergency access standard

80.9% 97.4%
KEEP CALM AND MANAGE VARIABILITY
14. Average AMU LOS by Post-AMU Admitting Unit in Hours with 10th/90th Percentile Error Bars
NHS Forth Valley, [01-Jan-2014 to 30-Jun-2014], All Days
Numbers in parentheses = Total AU admissions to unit
LOS by DOW Of Discharge/ Transfer-out (Based on Actual Move Date)

<table>
<thead>
<tr>
<th>DOW of Discharge/Transfer-out</th>
<th>Average LOS</th>
<th>Median LOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sun (1.70)</td>
<td>6.0</td>
<td>2.0</td>
</tr>
<tr>
<td>Mon (4.34)</td>
<td>5.8</td>
<td>4.3</td>
</tr>
<tr>
<td>Tue (4.54)</td>
<td>4.8</td>
<td>3.0</td>
</tr>
<tr>
<td>Wed (4.57)</td>
<td>9.6</td>
<td>5.7</td>
</tr>
<tr>
<td>Thu (4.16)</td>
<td>4.9</td>
<td>4.2</td>
</tr>
<tr>
<td>Fri (5.18)</td>
<td>7.5</td>
<td>3.0</td>
</tr>
<tr>
<td>Sat (2.00)</td>
<td>4.8</td>
<td>4.8</td>
</tr>
<tr>
<td>Overall (26.33)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Average/ Median LOS (in days)

Note: LOS calculated based on Date & Time

Cardiology transfer criteria
(Patients for cardiology unit only)

Irrespective of age, admitted with type 1 NSTEMI
(typical symptoms of ischemic chest pain lasting
20 minutes or more associated with elevated lab
trapping) with a GRACE score greater than 140 in
whom it would be appropriate to consider
coronary revascularisation and in whom there is
no evidence of ongoing ischaemia or
haemodynamic instability (in which case patients
should be considered for immediate tertiary
referral and if, following this, transfer is not
required, be admitted to HDU).

ADT Criteria

Discharge Criteria Ward B12

NHS

Patient Safety

Drug and operation error

Challenging admission and transfer patients

Sepsis

Infection

Outstanding investigations

Prescribed medications

Delays

Practical and psychological patient needs

Psychosocial Needs

Surgical and medical knowledge

Admission Criteria

Detailed clinical assessment

Social and medical needs

Transport issues
Downstream Ward Median Discharge Times

<table>
<thead>
<tr>
<th>Ward</th>
<th>2014 Median Discharge Time</th>
<th>2015 Median Discharge Time</th>
<th>2016 November</th>
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<tbody>
<tr>
<td>A12</td>
<td>16:00</td>
<td>15:07</td>
<td>14:17</td>
</tr>
<tr>
<td>A31</td>
<td>16:03</td>
<td>15:00</td>
<td>14:47</td>
</tr>
<tr>
<td>B12</td>
<td>16:14</td>
<td>15:38</td>
<td>15:33</td>
</tr>
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<td>B32</td>
<td>16:00</td>
<td>14:34</td>
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Actual Length of Stay (LOS) for Patients Discharged Home without Package of Care (POC)

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3039 annualised bed days saved

*Aggregated LOS based off of performance metrics submitted by FVRH
*Definition changed post-implementation of frailty criteria in March 2016

Overall the general medical wards have seen significant LOS decreases post-implementation of ADT criteria
Sustained improvement
New Temporary Median of 1.16

Provisional reduction of 54%
Most people in Scotland with any long term condition have multiple conditions

Each stop on the Argyll line travelling East represents a drop of 1.7 years in male life expectancy

Life expectancy data refers to 2001-5 and was extracted from the GCPH community health and well-being profiles. Adapted from the SPT travel map by Gerry McCartney.
Public Finances – Fall in Government Expenditure

Realising Realistic Medicine

‘REALISTIC’

1. Having or showing a sensible and practical idea of what can be achieved or expected.
2. Representing things in a way that is accurate and true to life.

By 2025, everyone who provides healthcare in Scotland will demonstrate their professionalism through the approaches, behaviours and attitudes of Realistic Medicine.
Realism in Healthcare

• Doctors generally choose less treatment for themselves than for patients
• Striving to provide relief from disability, illness and death, modern medicine may have overreached itself – is it now causing hidden harm?
• Focus on unwarranted variation in clinical practice and outcomes
• Multiple conditions – management leading to over-complex medical regimes?
• Clinicians have duty to acknowledge powerlessness at times

JJ Gallo et al. Life-sustaining treatments: what do physicians want and do they express their wishes to others?
Value Based Healthcare
Reducing harm and waste

• Harm in healthcare not just missed diagnoses or under-intervention but ‘hidden harm’ exists in over treatment, excessive interventions and medicalising normality.
  – This is far harder to measure.

• Focus on better value care – including ‘the gentle art of doing nothing’
  – This isn’t always in the nature of Acute Physicians...

Over-investigation and over-diagnosis...

Growth in number of Ultrasound, CT and MRI imaging and radiodiagnostic examinations or tests, England, 1995-96 to 2012-13

Steven Hatch
Snowball in a Blizzard
The tricky problem of uncertainty in medicine
CHANGE OUR STYLE TO SHARED DECISION-MAKING?

BUILD A PERSONALISED APPROACH TO CARE?
Doctors and risk

• Managing risk is an inherent part of our role
• There is risk associated with every clinical decision, whether it is to do something or to do nothing
• The importance of positive risk taking – avoidance raises anxiety rather than reduces it
• It is psychologically healthy to stimulate and empower ourselves by taking risks
“Montgomery complements the Realistic Medicine focus of the CMO’s previous annual reports and the international “Choosing Wisely” campaign of the Academy of Medical Royal Colleges in a number of ways. It has renewed the focus on the process of consent, and requires that the emphasis of this is patient focused.”

Emma Cave/Margot Brazier

So...‘Realistic *Acute* Medicine’?

How are we doing?...
Variation between AMUs

- We all know it exists
- It’s very hard to measure
- Poor coding
- Activity data variably recorded
  - Admission vs Attendance vs Ambulatory Care
  - In-patient vs Out-patient
LEM Reid et al (2016). The effectiveness and variation of Acute Medical Units; a systematic review. *IJC* 28; 433-446
There was striking variation between organisations, with no two hospitals operating the same system.

Pathways of care were frequently structured as sets of silos, rather than a smooth stream. Moves between different components of the system resulted in complete discontinuities, with medical work frequently being repeated each time the patient moved location. It is not uncommon for patients to be passed between different medical teams four or five times during a single hospital stay.

The majority of acute medical patients spend all or the first few days of their hospital admission in an acute medical assessment unit (AMU). But in a number of sites the model of medical cover being used on AMUs is creating problems for maintaining continuity of care.

There is a growing emphasis on ambulatory emergency care. However, the level of staffing and support varies significantly between sites.

The degree of involvement by specialists in early patient assessment and management varies considerably. Specialist input is mainly ‘reactive’, responding to requests for a clinical review. There is little specialist input to ambulatory care.

The current model of service, including the configuration of beds, does not match patient need.

Trusts are aware of these issues and are continually experimenting with new approaches and ways of working in an attempt to address them. Some are short term fixes, others are medium and long term solutions. But no trust felt that they had the ‘ideal’ model of care or anything very close to it.

Variation within an AMU

Direct discharge rate from FVRH AMU, per consultant physician 2014-2016

Practising Realistic Acute Medicine is hard...
Recommendation 4: Patients with abnormal liver blood tests should be considered for investigation with a liver aetiology screen irrespective of level and duration of abnormality. Abnormal refers to an analyte which is outside the laboratory reference range (level 2b, grade B).

Recommendation 5: In adults a standard liver aetiology screen should include abdominal ultrasound scan (USS), hepatitis B surface antigen, hepatitis C antibody (with follow-on polymerase chain reaction (PCR) if positive), anti-mitochondrial antibody, anti-smooth muscle antibody, antinuclear antibody, serum immunoglobulins, simultaneous serum ferritin and transferrin saturation. (level 2b, grade C)

However, doctors need support in choosing, with their patients, not to apply evidence based guidelines: the strength of guidelines can make doctors feel unable to deviate from them, driven by feelings of peer pressure, assumed patient demand, concern about litigation and an understandable, emotional need to "do something" in the face of long-term conditions.
Where do we start?

• Hunt out the dogma and the pseudoaxioms
• Look for ‘Must’, ‘All’ and ‘Should’...

All admissions to an Acute Medical Unit need a baseline ECG

All patients with ‘fast AF’ need to be admitted to hospital...AND on a cardiac monitor...

All admissions to an Acute Medical Unit need a set of baseline bloods

All patients with pneumonic consolidation must have follow up CXR

All patients with ‘CT-negative’ thunderclap headache need a lumbar puncture...

All patients admitted to an AMU with an overdose must be reviewed by psychiatry before discharge
‘Right person, right place, right time’

#RightCareEveryTime

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#RightCareEveryTime