VIEWS AND REVIEWS

ACUTE PERSPECTIVE

David Oliver: Acutely ill patients on trolleys and beds—why not chairs?

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Activity on the emergency floor of UK hospitals has risen inexorably, even as bed numbers have contracted.¹

Simply being on a trolley in an overcrowded emergency department risks worse outcomes.² Even a bed in a busy acute medical unit can be an unsettling, disorienting experience, especially for older people with frailty or dementia, who already feel snatched from their homes with no notice, minus glasses or a hearing or walking aid.³ The most caring staff can struggle to maintain patients' dignity, privacy, or reassurance.

Beds affect the approach. Shoes off; flimsy, flapping gown on; bedrails applied; medicalised conveyor belt in full swing. Pressure on beds leads to more moves and further exposure to risks.

The King's Fund think tank has concluded that conditions classified as "ambulatory care sensitive" account for about one emergency admission in six, leaving much potential for other approaches.⁴ The proportion of adults with primary care sensitive conditions admitted to hospital after GP referral has fallen steadily over the past decade.⁵ We need systems to ensure that emergency departments aren't seen as the default setting for patients in crisis.

For many patients, we could make more use of same or next day assessments in ambulatory emergency or in acute assessment clinics for older people with frailty.^{6 7} Seeing patients in day clothes, in a setting geared up to keep them away from a hospital bed unless essential, with less of a ticking clock, can be better for them and for clinicians.

Such clinics don't have to be on acute sites. For example, acute frailty clinics in Epping⁸ and Oxfordshire⁹ see many older patients with complex problems in community hospitals, and only about one in four is then referred to hospital. About a quarter of patients seen in more standard acute assessment clinics are described as frail.

These clinics can also divert less frail adults. The Society for Acute Medicine has shown that 14% of all patients treated in acute medical units are already treated in these areas, and about a quarter are defined as frail.¹⁰ Few required admission. Clinics

work best if backed up by direct telephone lines so that referrers can have a clinical conversation with a consultant or nurse practitioner when considering options so appropriate patients can be selected.¹¹

In a functioning system, chairs rather than trolleys could be made the norm unless patients are clearly too sick for clinical needs to be met in that setting or timeframe. This might require different clinical training and behaviours, redeployment of many existing staff, and clinic time and financial flows to divert people away from acute beds.

Acute assessment clinics are no panacea for overcrowded emergency departments, but they may be right for many patients.

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