Foreword

NCEPOD now operates under the umbrella of the National Patient Safety Agency (NPSA) as an independent confidential enquiry whose main aim is to improve the quality and safety of patient care. Evidence is drawn from the specific areas of hospital activity in England and Wales, both NHS and Private, related to the enquiry in question, and we are very grateful to all those who take part, both advisors, local reporters and those who complete the individual case reporting forms. I would also like to express my sincere thanks to our clinical co-ordinators and all the permanent staff of NCEPOD for the enormous amount of work and enthusiasm which they have put into the production of this report and without which we could not hope to create such detailed analysis and comment upon clinically related hospital activity.

"An Acute Problem?" is the second study related to our enlarged responsibility for including medical cases. It has been designed to link together the provision of critical care facilities with the care of severely ill medical patients throughout our hospitals. The pattern of inpatient care is changing rapidly and NCEPOD's role is to facilitate and inform that change. This study is as much about facilities and resources as about clinical practice and highlights the levels of care appropriate to patient requirements. Although in many cases, overall numbers of hospital inpatient beds are being reduced, the increased complexity of medical care and the expectations of the public mean that there are many more critically ill patients in hospital. In one major teaching hospital in the United States, which now has only 400 inpatient beds, 33% of these are devoted to high dependency and critical care, such are the requirements of patients. However, provision of an appropriate environment for acute care is only part of the story and, as this report highlights, the traditional way in which many consultant physicians work does not involve significant components of acute care. Unlike the surgical on-call team, which often now undertakes no elective work, the medical on-call team tends to divide itself, so that the consultant physician continues with elective outpatient work and is rarely involved in the acute admission process or indeed when the team's patients are deteriorating on the wards. Some physicians certainly have a close interest in acute medicine but the existence of the Medical Admissions Unit with dedicated staff, together with specialisation into other areas of medicine, tends to distance many consultant physicians from acute work. Although available out of hours as the consultant on call, many physicians rely heavily on their junior staff and rarely expect to have to return to hospital out of hours.

As a result, doctors in training are both providing and leading the provision of acute care and to an extent this has extended into the 'Out of Hours Medical Team' and the 'Hospital at Night' projects. This has recently been exacerbated by the changes in working hours following implementation of the European Working Time Directive so that junior doctors, having contributed significantly to out of hours service delivery, are less available for training and, therefore, less experienced and confident than in the past. As a result, in complex cases, there is an inevitable risk that these doctors may provide care which is less than optimal and yet they are unused to seeking advice or supervision, particularly out of hours.

In most hospitals, medical services are severely overstretched and the medical SHOs in particular, have to spread themselves thinly over what is often a significant number of acutely ill patients. Furthermore, the support they receive from their house officers is often small, since, to comply with working hours regulations, the housemen in many hospitals go off duty during the evening, leaving the SHOs to manage on their own for the rest of the night shift. Severely ill patients often exhibit clear signs of clinical deterioration on the wards for some time and although nurses may pick up these simple clinical indicators and call for help, the inevitable delay resulting from SHOs working largely on their own may further delay the instigation of appropriate treatment.

It might appear that the solution is the provision of comprehensive and adequate critical care facilities to allow rapid admission of all sick and deteriorating medical patients. But here again there are problems with

delays in review by the acute care team and subsequent admission to intensive or high dependency care. In many of these cases the delay is related to a lack of critical care beds or staffing shortages, which result in significant numbers of beds actually being closed on a temporary basis. However, even when patients have been admitted, almost 25% are not seen by an intensive care consultant within the first 12 hours of admission, so that the problem of lack of consultant input occurs both in intensive care and in the ward situation.

It has been suggested that one method of addressing many of the above deficiencies would be the comprehensive introduction of intensive care outreach. Many such services are run by intensive care nursing staff and are often not available on a 24 hour basis. Some hospitals do not have an outreach service at all or one that only covers selected patients, particularly postoperative surgical care. Although a Department of Health funded study on outreach is currently occurring, the report is not due until 2007 and even then, if outreach is to provide more immediate care of acutely ill patients, it would need to be fully resourced and staffed and, importantly, have an adequate supply of critical care beds into which the patients could be transferred.

Another proposed solution is the development of acute physicians, and acute medicine is, of course, a recognised medical sub-specialty. Although this may be considered an ideal solution to the above problems, it is undoubtedly a long-term strategy and in the interim we must look for improved ways of managing the problems of acutely ill patients. It is encouraging that the curriculum for Foundation Year training concentrates specifically on the care of the acutely ill patient and that there are many proposals for generic years at the start of run-through specialist training which would contain acute skills, common to both medicine, critical and intensive care, anaesthesia, emergency medicine and radiology.

It is important to acknowledge that acute patient care in today's NHS depends very largely on the hard work and dedication of all grades of staff and that in areas of this report we should emphasise the 90% of patients who receive good care as much as the 10% who do not. In the past, NCEPOD reports have largely concentrated on identifying the reasons for inadequate care, subjecting these to expert analysis and then making recommendations for improvement. This has proved exceedingly effective, for example in the provision of additional "NCEPOD theatres" to cope with the increasing surgical trauma load and in many other areas of pre and postoperative care. It is our hope that by identifying shortcomings in key areas of acute medical care and offering constructive criticism and pragmatic and affordable solutions, NCEPOD will help to do for acute medicine what it has achieved for acute surgery in the past. To some this report may appear critical and uncompromising in its observations but if we are all concerned, as we must be, with improvements to the quality and safety of patient care, armed with these recommendations and working together in a multiprofessional way with Trust management, the improvements which we all strive for can be achieved.

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