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Acute Medicine

Guest Editorial

Ambulatory Care:
Turning Urgent and
Emergency Care
inside out

R Rowland & D Lasserson

Emergency departments are under year-round pressure, driven by high hospital bed occupancy and compounded by increasing attendances and admissions.¹ In 2023, 1.5 million people waited 12 hours or more for a bed.² Long waits are associated with increased mortality and there is a disproportionate impact on people living in more deprived areas.^{3,4} Addressing this problem begins with unity of purpose and vision, such that we all view emergency department performance as our responsibility, whatever our place in the healthcare system.

Ambulatory care pathways are key strategies for delivering safe and effective urgent and emergency care, whilst avoiding unnecessary hospital admissions. In this edition of *Acute Medicine*, Teh *et al.* describe the development of a specialist cardiology ambulatory care hub, and estimate that admission was avoided in 91 patients over a 4 week period.⁵ They turned the timeline for specialist assessment inside out. In traditional models of hospital flow, people presenting with suspected cardiovascular disease would see a series of ‘generalists’ before receiving a specialist cardiology assessment. Teh *et al.*’s model of specialist inreach into emergency department, and primary care calls being directed to a consultant cardiologist, reduces the separation and duplication between specialists and generalists.⁶ This is an example of increasing our productivity, by working

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smarter and reducing waste, rather than working harder and faster.⁷ At the heart of models like this is a change in mindset.

The term ambulatory care is a broad one and refers to a spectrum of different generalist or specialist care pathways which do not involve an overnight hospital stay, from single or multiple hospital visits to 'hospital at home' models.⁸ Using ambulatory strategies to bring meaningful improvement to urgent and emergency care is a complex process. Successful change involves making the uncomfortable journey inwards as well as outwards; aligning vision, shifting culture and attending to leadership behaviours.^{9,10} The most effective ambulatory pathways, as with all healthcare models, will be evidence based, adapted to fit the context and underpinned by a culture of continuous improvement. Improvement methodologies need to be data-driven, with statistical process chart tracking, and multidisciplinary, engaging both people who have experienced the service and staff who are delivering the service. Similarly, stakeholder participation in research will enhance the quality and applicability of data. Outcomes typically measured include bed days saved, mortality and readmission rates. Further work is required to develop validated and reliable tools for measuring patient reported outcomes for research and service improvement.¹¹

How should we approach risk in specialist rather than generalist led acute ambulatory care models? There are many nuances to the management of risk and perceptions of acceptable risk vary between individual clinicians, patients, context and prediction tools.⁸ As well as further

work into the development of validated risk prediction tools to aid with decision making, we could learn from other disciplines, such as finance, mental health and social care where the concepts of 'managing risk' and 'positive risk taking' are more familiar.¹² Similarly, our palliative care colleagues discuss 'uncertain recovery' with patients and this is applicable to people living with multiple medical conditions.¹³ Involving patients and caregivers in the management of risk requires us to develop expertise in hosting shared decision-making conversations.

What next for acute ambulatory care? Specific conditions which account for the highest or increasing rates of emergency admissions, and could be targeted by dedicated ambulatory pathways, such as described by Teh *et al.*, include falls, non-specific chest pain, non-specific abdominal pain, cellulitis, COPD and acute mental health crisis.¹⁴ We also need ambulatory pathways where people with undifferentiated acute illness can be managed. There is an argument for managing people as ambulant unless they meet the 'criteria to reside', such that ambulatory care led by 'acute generalists', rather than hospital admission, becomes the default pathway for acute medical illness.¹⁵

There is an urgent need to reduce the harm that is caused by delays to assessment and admission in our emergency departments. This is a national, system-wide problem and the greatest impact is felt by the most vulnerable. Within this crisis is an opportunity to take the next steps in developing and improving standardized, evidence-based models for acute ambulatory care.

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