Letters to the editor

OVERVIEW

Please submit letters for the editor's consideration within 6 weeks of publication of the *Future Hospital Journal*. Letters should ideally be limited to 350 words, and sent by email to FHJ@rcplondon.ac.uk.

Characterising the acute medical take

Editor – It is always interesting to read about other hospitals' medical take and the similarity to your own hospital's workload (Robbins *et al, FHJ* June 2014 pp. 28–32). However, the authors missed an opportunity to compare their results to others when they suggested little information examined the acute medical take as a whole and instead literature focused on disease entities or appropriateness of scoring systems in isolation. Readers with an interest in acute medicine may like to be directed to the following studies.

The Society of Acute Medicine's work with its national 'A Day in the Life of the AMU' Audits started in 2012 and describes the compliance with clinical quality indicators for acute medical units, disease-specific conditions, patient flow and outcomes.[1]

St James Hospital in Dublin has interrogated their databases and produced reports describing the acute medical take in several ways – regarding generating severity assessment scores with biochemical data (serum sodium, potassium, urea, albumin, red cell distribution and white blood cell) with a median length of stay of 4.5 days and 30 day mortality of 3.9% in 2010; the weekend and weekday case mix and illness severity; and readmission trends and mortality.[2–4]

Chelsea and Westminster Hospital have described the severity of presentations with their local Chelsea Early Warning Score and the National Early Warning Score (median score on their assessment unit 0 and 1 respectively).[5] York Hospital has described the case mix that presents in their acute medical take with 16,000 admission episodes (cardiovascular, respiratory and falls being the top 3 presentations, median age 71 years) and Edinburgh Royal Infirmary has described the medical take in terms of presenting symptoms, referral patterns/source and multi-disciplinary interventions.[6,7] ■

ANDREW THOMPSON
Consultant in acute medicine
Musgrove Park Hospital Taunton

References

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Community and acute care

Editor – I had the pleasure of reading Nigel Edwards' article regarding the Future Hospital Commission in the June issue of the *Future Hospital Journal* (*FHJ* June 2014 pp. 13–15).

I am a retired consultant geriatrician, with 33 years of experience as consultant across both community and acute services. Before my retirement, my geriatrician colleagues and I had acute on-call work as well as community hospital responsibilities looking after rehabilitation patients. This arrangement worked well until the community hospital was taken over by the CHC. They were unable to fill the consultant posts in the community, and so combined posts in acute and community hospitals were created in the relevant specialities. The community physicians continued to provide a similar service to that which we previously provided. Since retirement, I have worked in a community hospital in Surrey as a part time consultant in elderly care.

My experience on both 'sides of the fence' has informed my belief that an artificial barrier between community and acute hospitals is not good for the service or for the patients, and I would agree with Nigel Edwards' comment that the same consultants should look after the patient in both acute and rehab wards, treating their care as one episode. If we have responsibilities on both sides, we tend to select the appropriate patients for either further care and investigation in the acute hospital or rehabilitation in the community services, and avoid using the community hospital as a 'dumping ground'. This also reduces transfers and the associated discontinuity of care and disorientation for the patient. We unfortunately have enough fragmentation of services within the acute wards.

I would also urge policymakers to see what is available in the community now. We need to strengthen community hospitals, GP practices and community nursing care before sending the patient out of the acute hospital to community care, as we all know what happened to mental health services. If we fail to do this, transferring patients to community care might free up more acute beds, but these will be filled up by failed discharges.

As an experienced physician, I would caution against jumping on the 'community care' band wagon. It may sound