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NHS Ayrshire & Arran

Unscheduled care

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This monthly current awareness bulletin aims to highlight relevant reports and peer-reviewed literature in emergency and unscheduled care. The bulletin focuses on efforts to improve patient flow, reduce waiting times and alternative care models.

If you require specific information, please contact us via email.

References

Bowers, S. P., et al. (2025) **'Use of Unscheduled Care in the Last Year of Life for People with Multiple Long-Term Health Conditions: A Retrospective Cohort Study of 299,361 Decedents.'** ***Bjgp Open***

BACKGROUND: People living with and dying from multiple long-term health conditions are high users of healthcare services. Unscheduled care, the unplanned use of healthcare services, rises dramatically in the last year of life, likely reflecting unmet needs. **AIM**: To characterise Scotland-based decedents with multiple long-term health conditions in their last year of life and explore the relationship between characteristics and unscheduled care usage over that year. **DESIGN & SETTING**: Retrospective cohort study of all individuals who died in Scotland between 01/01/2017 and 31/12/2021. **METHOD**: Data were linked across routine NHS Scotland datasets. Associations between sociodemographic factors, multiple long-term health conditions and unscheduled care usage in the last year of life were explored through binary logistic regression. **RESULTS**: 299 361 individuals died in Scotland between 01/01/2017 and 31/12/2021 - 136 953 (45.63%) had two or more long-term health conditions leading into their last year of life. More decedents with multiple long-term health conditions (97.1%) used unscheduled care compared to those without (95.6%). When adjusted for sociodemographic factors, those with multiple long-term health conditions were more likely to use unscheduled care (adjusted Odds Ratio 1.51, 95%Confidence Interval 1.45-1.57). **CONCLUSION**:

People dying with multiple long-term health conditions have particularly high use of unscheduled care in the last year of life, likely reflecting unmet need. Anticipating and addressing these needs, through usual care providers, could reduce avoidable use of unscheduled care.

Cheng S.F., et al. (2025) 'Transforming Surgical Care: The Launch of the UK's First Surgical Virtual Ward for Acute and Elective Patients.' ***Surgical Endoscopy*** **(pagination), Date of Publication: 2025.**

Introduction: The increasing demand on healthcare services, coupled with financial pressures and the need to optimise patient outcomes, has driven the exploration of innovative care models. This abstract outlines the launch of a surgical virtual ward in the United Kingdom. The virtual ward aims to provide continuous care for surgical patients following hospital discharge, allowing them to recover effectively at home under remote monitoring. This new approach aims to reduce hospital readmissions, and lower healthcare costs.

Method(s): The virtual ward uses advanced wearable devices and remote monitoring systems to continuously track patients' vital signs 24 h a day. This allows healthcare providers to detect early signs of clinical deterioration and intervene promptly. Secure video consultations are used to visually assess patients, including monitoring wounds for signs of infection or poor healing. The primary objectives of the virtual ward are to reduce the length of hospital stays, promote faster recovery by managing complications early, and reduce healthcare costs through remote care.

Result(s): From January 2024-February 2025, a total of 46 patients were enrolled to the surgical virtual ward. Early outcomes demonstrate the feasibility and effectiveness of this model. The financial impact has been substantial; with an average hospital bed costing 589 per day, the virtual ward has saved approximately 91,295 in bed costs alone, underscoring the cost-efficiency of the approach.

Conclusion(s): The surgical virtual ward initiative represents a significant shift in the delivery of surgical care, offering patients the benefits of home-based recovery while maintaining high levels of clinical oversight. The model not only alleviates pressure on hospital resources but also enhances patient satisfaction and provides a cost-effective solution for healthcare systems. As the program expands, it is expected to set new standards for surgical care, with the potential to redefine patient-centred, technologically advanced healthcare in the UK.

Deutsch V.S., et al. (2025) 'Psychiatric Diagnoses in Prehospital Emergency Care and Sociodemographic Characteristics of the Incident Location at the District Level.' ***Prehospital and Disaster Medicine 40*****(4), 214–223.**

BACKGROUND: The aim of this study was to analyze the prevalence of psychiatric

symptoms in prehospital emergency care and the characteristics of this patient group as well as the association with deprivation in the district, self-assessment of health status, and the frequency of emergency calls due to or accompanied by psychiatric diagnoses.
METHOD(S): A retrospective cross-sectional study descriptively and analytically evaluated all ground-based Emergency Medical Service and rescue service incidents dispatched by the Integrated Regional Control Center (IRLS) in the period from January 1, 2021 through December 31, 2021. In addition to the clinical parameters and the demographic data of the patients, the sociodemographic characteristics of the incident location at the district level, unemployment rate, net equivalent household income, and the proportion of single-person households, as well as personal assessment of mental health and overall well-being, were included in the study.
RESULT(S): A total of 68,345 deployment protocols were examined. Of these, 6.4% were emergency incidents due to or involving psychiatric diagnoses. Emergency physician (EP) involvement in these operations was 56.1%. RM Andersen's Behavioral Model of Health Services Use (1968) was used as a theoretical reference model for the description, analysis, and explanation of the use of health-related care. The analyses showed that interventions due to or involving psychiatric diagnoses without emergency doctor alerts were more frequent in urban districts with a high proportion of single-person households and a high net equivalized houshold income.
CONCLUSION(S): The accumulation in individual city districts and the factors identified by Andersen point to opportunities to target preventive measures to avoid emergencies involving psychiatric diagnoses in order to use limited resources efficiently.

Dilip M., et al. (2025) **'Load Leveling as a Strategy to Enhance Emergency Department Throughput.'** ***American Journal of Emergency Medicine 98*, 207–212.**
Study objectives: Emergency Department (ED) crowding is recognized as a national crisis. Load-leveling is the process of transferring patients between campuses in the same hospital system for admission to redistribute patient capacity. Our study evaluates the impact of this load-leveling on ED throughput from the transferred patient perspective and on ED operations to evaluate operational benefits and drawbacks.
Method(s): We performed a retrospective observational study on two EDs in a single health system. These EDs see more than 140,000 visits annually in the same city. Patients were categorized as transferred to the other campus or admitted to the same campus. Primary outcomes focused on the patients who were load-leveled, examining their boarding times and the effect of load-leveling on their inpatient length-of-stay. Secondary outcomes focused on ED throughput.
Result(s): A total of 42,046 admissions were included. Of these, 5520 (13.1 %) were

load-leveled for admission, while the remaining 36,526 (86.9 %) were kept at the same campus. Load-leveled patients had shorter boarding times by 7.8 h (95 % CI -8.35, -7.31) but no significant difference in inpatient length-of-stay. Load-leveling also reduced door-to-room times and the risk of leaving without being seen, without significant changes in boarding time.
Conclusion(s): Load-leveling decreases the boarding times and creates capacity for new patients to be seen. As boarding times continue to climb nationally, load-leveling can be a tool for hospital systems to improve patient throughput.

Edmunds K., et al. (2025) **'Enhancing the Psychiatric Emergency Department Triage Process to Optimize Patient Care.'** ***Journal of Emergency Nursing*** **(pagination), Date of Publication: 2025.**
Introduction: Emergency departments have seen a steady increase in patients presenting with mental health and substance use disorders, leading to overcrowding, prolonged length of stay, patients leaving without being seen, and diminished staff satisfaction. To address these issues, a behavioral health psychiatric emergency department redesigned its triage process to include a fast-track protocol for low-complexity patients, eliminate treatment redundancies, and incorporate a provider in triage to improve patient outcomes and staff satisfaction.
Method(s): Using the Plan-Do-Study-Act methodology, a revised triage process was implemented to streamline workflows and reduce waste. Time metrics from pre- and postintervention periods were compared.
Result(s): Reductions were observed in all phases of the ED encounter. The median total length of stay decreased by 110 minutes (38% reduction; P<.001). Time from rooming to provider was reduced from 98 to 43 minutes (56% reduction; P<.001), and the median time from arrival to provider was halved, from 152 to 76 minutes (52% reduction; P<.001). The leaving without being seen rate dropped from 10.5% to 6.3% (40% reduction; P<.001).
Discussion(s): The findings suggest that a fast-track triage system, combined with provider in triage, can improve length of stay, reduce leaving without being seen, and enhance staff satisfaction. This model could be beneficial for other emergency departments managing patients with behavioral health concerns.

Eikendal T., et al. (2025) **'Perceptions of Workload in Emergency Care in the Netherlands and how to Influence this: A Qualitative Study.'** ***BMC Emergency Medicine 25*****(1) (pagination), Article Number: 178. Date of Publication: 01 Dec 2025.**
Background: Adequate staffing and manageable workloads are crucial for high-quality emergency care. However, high perceived workloads in the emergency department (ED) threaten both. Increased demand and staff shortages intensify these issues and cause crowding. Understanding healthcare workers' perspectives

on workload is essential for effective policymaking and maintaining a durable workforce. The objective of this study was to explore the current perceived workload of ED professionals, and their vision on how to influence it and to understand the healthcare worker's perspective on proposed healthcare reforms in the Netherlands.
Method(s): Qualitive study using semi-structured interviews with 33 healthcare professionals (ED physicians, physician assistants and nurses) working in a university medical center, and three general hospitals from March-July 2023. The interviews were audio-recorded and transcribed verbatim. The interview transcripts were coded. An inductive content analysis was performed, where codes were assigned to the transcripts and adjusted. Codes were then sorted into themes on causes of workload, consequences and proposed solutions for reducing the workload.
Result(s): Emergency department professionals identified increasing patient inflow, barriers to patient throughput and output, and staff shortages as key workload causes. Consequences included increased time, mental and psychological demands, leading to stress and reduced job satisfaction. A well-coordinated team and having social interaction with colleagues is seen as a key part of the profession by ED-professionals. Next to that, training and development opportunities contribute to job satisfaction. Proposed solutions involved public education, improved care coordination, technological innovations, and enhanced collaboration within and among hospitals to improve efficiency and job satisfaction, and to reduce perceived workload pressure.
Conclusion(s): Addressing perceived workload is crucial for maintaining quality and accessibility of care. Dutch ED professionals face a high workload leading to stress and lower job satisfaction. To ensure successful changes, adequate preconditions and engaging healthcare professionals in decision-making are crucial. In future research, a stronger focus on effective work habits and processes, including provider satisfaction and workplace well-being, is necessary.

Hart J., et al. (2025) **'Development and Implementation of a New Process to Improve Safety of Urgent Direct Admissions.'** ***Hospital Pediatrics*** **(pagination), Date of Publication: 10 Se 2025.**
BACKGROUND: Direct admission can help reduce emergency department crowding, improve patient satisfaction, and decrease costs, yet there is opportunity to improve standardized processes to do so safely and efficiently. We designed and implemented a new process for urgent direct admission (UDA) at our children's hospital with the SMART (specific, measurable, achievable, relevant, time-bound) aim to increase the number of UDAs between transfer to an intensive care unit (ICU) within 12 hours from direct admission by 50% in 12 months.
METHOD(S): We compared unanticipated ICU transfers within 12 hours of admission (outcome) before and after implementing a standardized UDA process.

Process measures included number of UDA orders and admissions; balancing measures included rapid response calls within 12 hours of admission.
RESULT(S): A total of 2950 UDA orders were placed postimplementation. The average number of UDA admissions between ICU transfers increased from 41.4 to 162.6. Referring clinicians found the process easy to use and preferable to the previous system.
CONCLUSION(S): Implementation of a standardized UDA process improved patient safety and efficiency by increasing UDA use and reducing ICU transfers. Key components of the process included the following: clinical criteria for UDA, an electronic health record order including clinical decision support, automatic notification to admissions management, streamlined communication across the patient placement department, the referring clinician, and the family, and a quality metrics dashboard.

Ingielewicz A., et al. (2025) **'Triage and Hospitalization Outcomes in the Geriatric Population of an Emergency Department: A Retrospective Cohort Study Comparing the Manchester Triage System and the Emergency Severity Index.'** ***Plos One 20*****(9 September) (pagination), Article Number: e0332304. Date of Publication: 01 Se 2025.**

Introduction Elderly patients in emergency departments (EDs) are at increased risk due to nonspecific symptoms, multimorbidity, and elevated mortality. This study compared the predictive performance of the Manchester Triage System (MTS) and the Emergency Severity Index (ESI) for hospitalization and critical outcomes in geriatric patients and analyzed symptom patterns by age and clinical course. Methods This retrospective study included all patients aged >=18 years admitted to a tertiary ED in northern Poland between January and June 2021. Each patient was concurrently assessed using both MTS and ESI. Data collected included triage level, age group (18-64, 65-79, >= 80), sex, mode of arrival, presenting symptoms, and outcomes including hospitalization and ten predefined critical events (e.g., sepsis, admission, urgent surgery). Logistic regression was used to assess associations. Results Among 1,063 patients, 475 (44.7%) were aged >=65. Patients aged 18-64 most commonly presented with abdominal pain or polytrauma, while geriatric patients more frequently reported dyspnea, weakness, and altered mental status. Dyspnea was nearly twice as common in patients >=80. Weakness (OR = 1.67) and abdominal pain (OR = 1.64) were significantly associated with hospitalization. Hospitalization and critical events were more likely in older adults (OR = 2.03 for ages 65-79; OR = 3.74 for >=80). In both systems, higher triage urgency was independently associated with greater risk (MTS: OR = 0.51; ESI: OR = 0.43). ESI showed stronger alignment with physiological deterioration and predicted complications such as ICU admission and sepsis more consistently than MTS.Conclusions MTS and ESI show limited sensitivity in older patients, particularly

with nonspecific presentations. ESI provided better discrimination of clinical urgency. Findings support revising triage systems to account for age, atypical symptoms, and geriatric vulnerability.

Janerka C., et al. (2025) 'Co-Design of a Framework for Person-Centred Care at Emergency Department Triage and Waiting Room.' ***Health Expectations : An International Journal of Public Participation in Health Care and Health Policy 28*(5), e70442.**
INTRODUCTION: Patients presenting to an emergency department (ED) are typically assessed by a triage nurse and often required to wait for further assessment and care. Ongoing issues of ED overcrowding and prolonged wait times can impact the processes and patients' experiences. A person-centred approach is recommended. This study aimed to develop a person-centred care framework for use in the ED triage and waiting room.
METHOD(S): The multi-phase research involved a synergistic partnership-based fully integrated mixed-methods approach based on person-centred care principles. Framework development followed target population-centred and partnership-based processes of conception, planning and designing. A consumer group was actively involved throughout. Data collection involved two literature reviews, a patient survey and triage nurse survey. Findings were synthesised through focus group sessions and the framework was developed during a collaborative workshop.
RESULT(S): A total of 225 patients and 176 triage nurses responded to the respective surveys. Patients reported the need for better communication, efficiencies and comfort in the waiting room. Nurses identified barriers to person-centred care, such as workloads, poor environment and long wait times. Strategies for overcoming barriers included enhanced communication, addition of waiting room staff and family involvement. Focus groups recommendations were synthesised as support for staff, systems and processes, environment and facilities, communication and information, and individual care needs, forming the framework elements/components. Practical micro, meso and macro level interventions were also recommended.
CONCLUSION(S): The newly developed framework can now be applied to ED triage settings and inform person-centred interventions.

Machida A., et al. (2025) 'Association between Transitional Care in Acute Care Hospitals and Ambulatory Care Sensitive Condition-Related Readmission.' ***Age and Ageing 54*(9) (pagination), Article Number: afaf247. Date of Publication: 01 Se 2025.**

Background Little is known about how ambulatory care sensitive condition (ACSC)-related readmissions can be reduced in acute care settings. Objective This study examined the association between transitional care for hospitalised older patients with ACSC and ACSC-related readmissions. Methods This retrospective observational cohort study included patients aged 65 years and older admitted with ACSC as the primary diagnosis from 1 April 2022 to 31 January 2023, using linked data from the Diagnosis Procedure Combination and the medical functions of the hospital beds database. The primary outcomes were cumulative readmissions within 1-7, 1-14, 1-21, 1-30 and 1-60 days, analysed using inverse probability treatment weighting regression models. Results Among 85 582 patients from 711 hospitals, 39 916 (46.6%) were female, with a median age of 82 years (interquartile range: 75-88); 57 127 (66.8%) patients received transitional care. The overall readmission rates were 2.9%, 6.0%, 8.7%, 11.4% and 17.5% among total hospitalisations within 7, 14, 21, 30 and 60 days, respectively. Overall, transitional care was associated with reduced odds of ACSC-related readmission, with odds ratios ranging from 0.72 (95% CI: 0.65-0.78) within 7 days to 0.91 (95% CI: 0.87-0.95) within 60 days. The association between transitional care and readmission varied by ACSC category. In chronic ACSC, the association was strongest for 7-day readmission, followed by a downward trend. In acute and vaccine-preventable ACSC, the association was strongest for 7-day readmission but levelled off after 21 days. Conclusions Transitional care in acute care hospitals may be associated with a reduced risk of early readmissions due to ACSC when older patients are hospitalised.

Stocker M.D., et al. (2025) **'Improving Door-to-ECG Time at a Quaternary Care Emergency Department.'** ***Joint Commission Journal on Quality and Patient Safety*** **(pagination), Date of Publication: 2025.**
Background: Timely diagnosis of ST-segment elevation myocardial infarction (STEMI) in the emergency department (ED) is dependent on electrocardiogram (ECG) completion. The American Heart Association recommends ECG testing within 10 minutes of arrival for patients with symptoms concerning for acute coronary syndrome. The authors aimed to increase the percentage of patients with door-to-ECG (DTE) times of 75%.
Method(s): We initiated a quality improvement project at an academic, quaternary care ED in June 2022. Patients included were adults (age > 30 years) who presented as walk-ins to ED triage with chest pain and received a cardiac troponin order. The primary measure was the percentage of patients with an ECG completed within 10 minutes of registration. Secondary measures included mean DTE time and mean time to STEMI activation. Statistical process control charts were used to analyze intervention impact.
Result(s): Successful completion of ECGs within 10 minutes increased from 53.7%

to 80.0% despite rising patient volumes. Three separate centerline shifts were associated with three interventions: (1) physical relocation of a pivot nurse to identify patients on arrival and dedicated space for rapid ECG acquisition; (2) staff education and recognition of high performers; (3) increased waiting room monitoring staff. DTE time was monitored for one year with no additional interventions, and the centerline decreased to 71.3%.
Conclusion(s): The authors used rapid Plan-Do-Study-Act (PDSA) cycle changes to improve DTE within 10 minutes to > 80% before declining to 71.3% during the maintenance phase. Modification of nursing roles and positions, staff education, recognition of high performers, and increased staffing were drivers of improvement. These improvements are translatable to other departments seeking to improve DTE metrics and may be largely sustained without active surveillance or additional interventions.

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