The Royal College of Emergency Medicine

In 2014 four Medical Royal Colleges produced 13 recommendations to improve urgent and emergency care entitled:

'Acute and emergency care – prescribing the remedy'

This survey by the Royal College of Emergency Medicine looks at what happened next…

Ignoring the prescription?

February 2015

Foreword

This report represents a comprehensive assessment of the impact or otherwise of the recommendations published last summer, 'Acute and emergency care - prescribing the remedy'.

These recommendations were collectively and uniquely endorsed by the Royal College of Surgeons, the Royal College of Physicians, the Royal College of Paediatrics and Child Health and the College of Emergency Medicine. They were welcomed by the NHS Confederation.

There is no point in making recommendations if they are not acted upon. As the winter of 2014/15 draws to a close it is timely to make assessment of the extent to which the recommendations have been adopted.

The findings make sobering reading. In almost all cases a majority of commissioners, providers and systems have not acted upon the collective recommendations of the aforementioned medical royal colleges or the endorsement of the NHS Confederation.

Additionally we sought to determine the impact in England of the £700 million allocated by the Department of Health to Local Resilience Groups to relieve the pressures on the acute care system. Our survey demonstrates that a derisory proportion of 'targeted' funds have been assigned to emergency departments.

As a consequence of 'ignoring the prescription' and failure to invest available funds in proven, frontline strategies it cannot be a coincidence that the NHS has faced the four of the most challenging months ever, during which there have been unacceptable levels of system performance with directly harmful effects on patients and frontline staff.

Dr Clifford Mann, FCEM FRCP
President of the Royal College of Emergency Medicine

Executive summary

1. Less than half of EDs in the UK have fully implemented co-located primary care out-of-hours facilities. A third have no co-located primary care facility at all.

2. More than half of EDs across the UK are able to undertake some best practice models enabling specific patient groups (e.g. stroke, post-op complications, readmissions) patients to bypass the ED. However a third have no such processes and in many cases the implementation is not fully realised.

3. Two thirds of UK EDs do not currently have trainee doctors on acute specialty programmes rotating through the department as standard practice.

4. A third of hospitals do not have senior clinical decision-makers deployed routinely for prompt assessment of all new patients in all their acute admission units.

5. Less than a third of departments have an appropriate skill mix and workforce in place to deal with their patient volumes and casemix.

6. More than half of departments are not assisted by senior decision makers from in-patient teams at times of peak activity. In only 10% of EDs is this routine practice.

7. In two thirds of departments there is no effective direct access to community teams 7 days per week.

8. In 40% of EDs there are no on-site community teams.

9. More than 80% of EDs are not supported by fully functioning 7 day services. This deficit is due to lack of senior clinicians or lack of full diagnostic support or lack of access to specialists.

10. Only 3% of acute trusts and CCGs have reformed the current funding mechanisms for ED attendances and acute admissions. More than 80% are still obliged to operate an ED and acute admission tariff that is widely accepted as unfit for purpose.

11. Only 4% of acute trusts have introduced innovative terms and conditions that support equitable work/life balance for EM clinicians.

12. Almost 90% of EDs do not have adequate IT infrastructures in place to provide reliable data of their urgent and emergency care system.

13. Two thirds of EDs report inadequate integration with telephone triage services properly supported by trained clinicians.

14. £700 million was allocated by the government for emergency care in England this winter and a derisory 1% (£6, 685, 000) was spent directly on emergency department services.

Introduction

The Royal College of Emergency Medicine is committed to ensuring that emergency care in the UK and Ireland is delivered to a high standard in a system that is safe for patients and sustainable for clinicians.

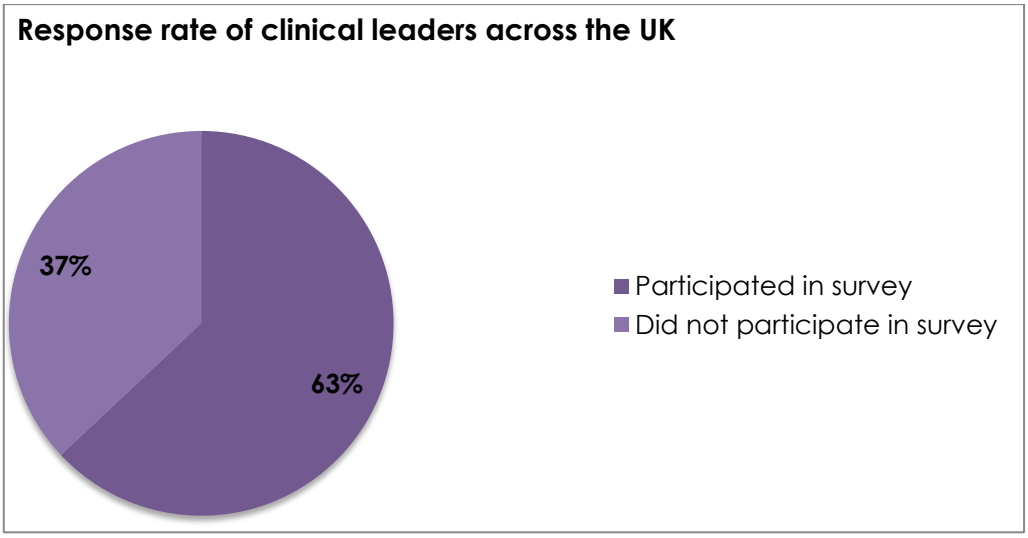
In July 2014 the College, in conjunction with the Royal College of Physicians, the Royal College of Surgeons and the Royal College of Paediatrics and Child Health published a recommendations report 'Acute and emergency care: prescribing the remedy' to address the profound pressures facing urgent and emergency care services in England.

The recommendations of this report were informed by discussions that took place at a round-table event in spring 2014. The event brought together key policymakers, opinion-formers and leaders in acute healthcare to review how greater resilience can be built into urgent and emergency care services.

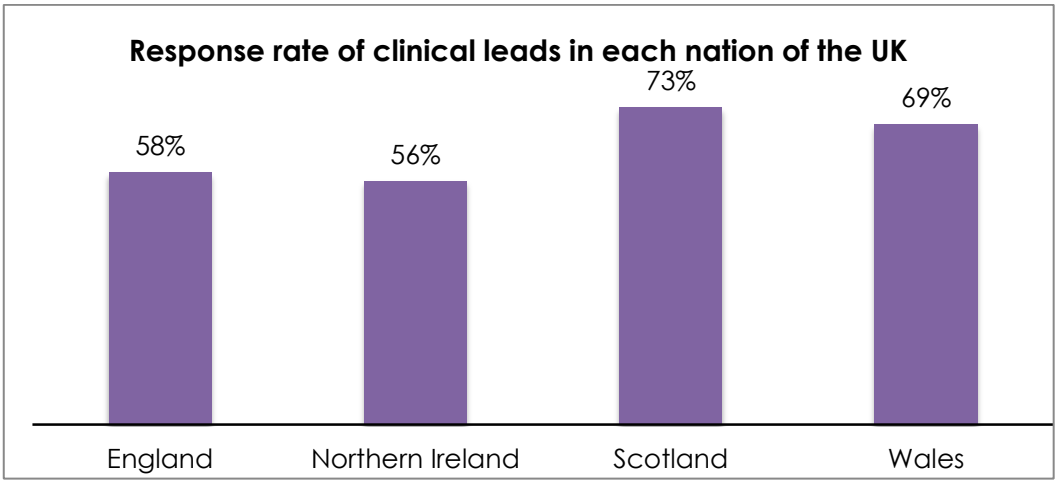
In January 2015 the College surveyed clinical leaders in emergency medicine (EM) across the UK to gather evidence on the extent to which the recommendations of this report had been implemented in emergency departments (EDs) across the four nations of the UK. The results of the survey are presented in this paper.

Methodology

In January 2015 the College invited the clinical lead from each of the 225 EDs across the UK to participate in a web-based survey based on the 13 recommendations set out in the 'Acute and emergency care: prescribing the remedy' paper. Participants were asked if these recommendations were currently implemented in their locality and to provide an answer of 'yes, 'no', 'partially', 'not at all' or 'I don't know'. In addition to this, clinical leads from England were asked what proportion of the additional £700 million government winter pressure funding of 2014 had been spent in their ED.
As demonstrated in the chart below, a total of 142 clinical leaders in the UK completed this survey which is an overall response rate of 63%.



The chart below illustrates the response rate of clinical leads attributable to each of the nations in the UK. It is clear from this that there was a high response rate from each nation so we can be confident that our findings are representative of the entire UK urgent and emergency care system.

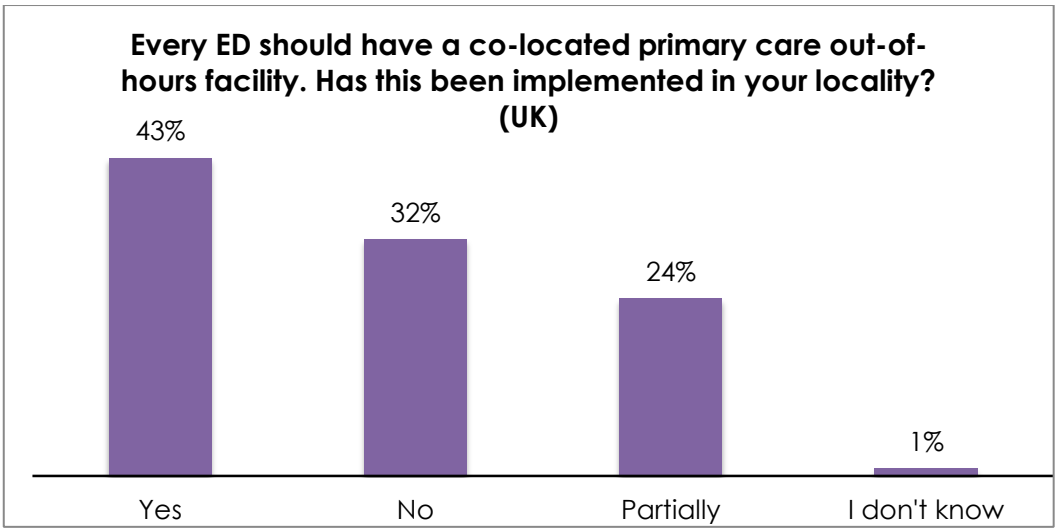


Participants also had the opportunity to leave further comments on the recommendations and their experiences of working in EDs over this winter period. A substantial proportion (53%) of consultants in the UK took this opportunity and the findings are presented at the end of this paper in the 'further information' section.

Results

Recommendation 1:
Every emergency department should have a co-located primary care out-of-hours facility.

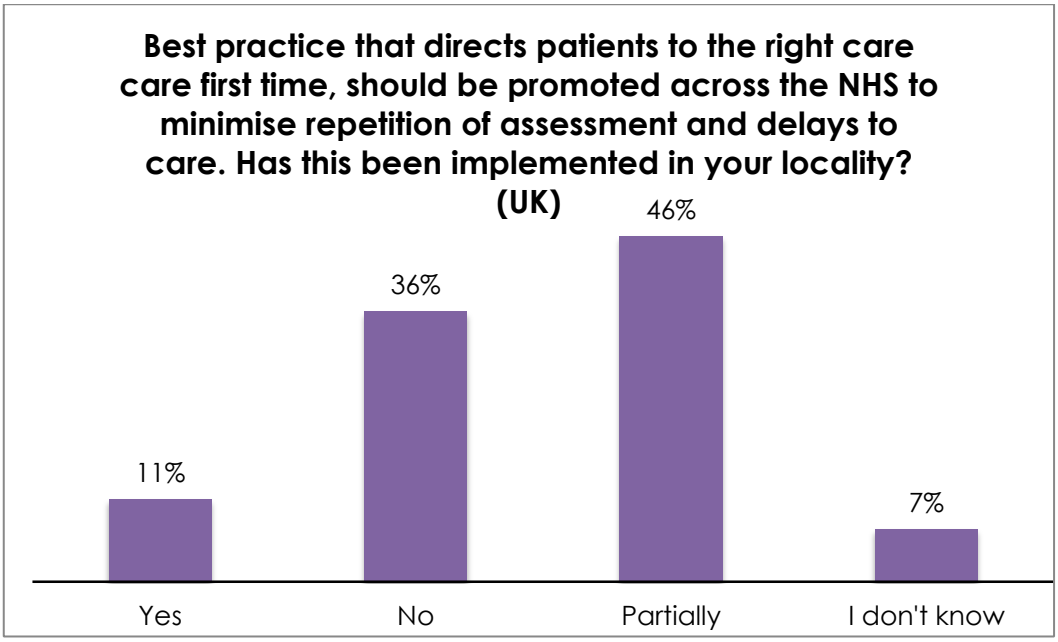
The College recommends that co-location of primary care is provided at every ED to ensure patients requiring urgent primary care are assessed and managed appropriately. This enables collaborative working amongst professionals and reduces duplication of administrative tasks and patient assessment, increasing the efficiency of ED services.



Fewer than half of hospitals/commissioners have fully implemented this service. A third have no service at all. Failure to implement this service results in increased pressure on ED departments and compromises patient care.

Recommendation 2:
Best practice that directs patients to the right care, first time, should be promoted across the NHS so as to minimise repetition of assessment, delays to care and unnecessary duplication of effort.

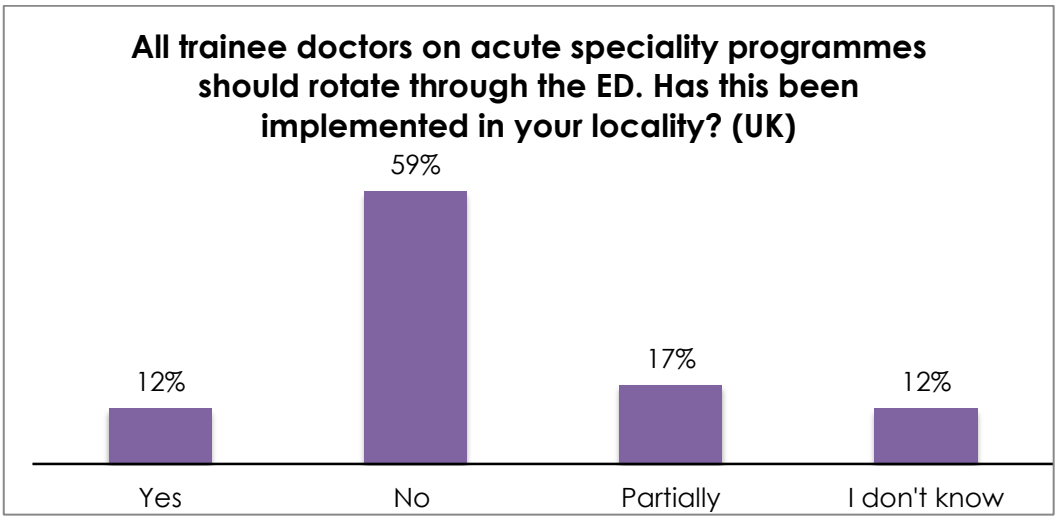
Best practice models of care are well established and include for example, stroke patients being transferred directly to stroke units, easy access to urgent clinics, GP-to-consultant advice lines or elderly patients with multiple comorbidities undergoing investigation by multidisciplinary teams, not necessarily within the setting of the emergency department. The College believes this practice is essential in order to ensure patients receive the most appropriate care. Only 11% (15) EDs surveyed across the UK have fully adopted this practice.



Considering the large number of patients that present at EDs with long-term conditions, post-surgical complications and elderly care needs, it is essential that ED staff can move such patients quickly to the most appropriate facility, bypassing the ED or minimising the time spent their.

Recommendation 3:
All trainee doctors on acute specialty programmes should rotate through the emergency department.

The College strongly believes that ED experience is an invaluable asset to the entire medical workforce and that by developing a core of common competencies ensures that all medical professionals have the skills that are needed to meet clinical demands. This should be promoted by the Medical Royal Colleges.

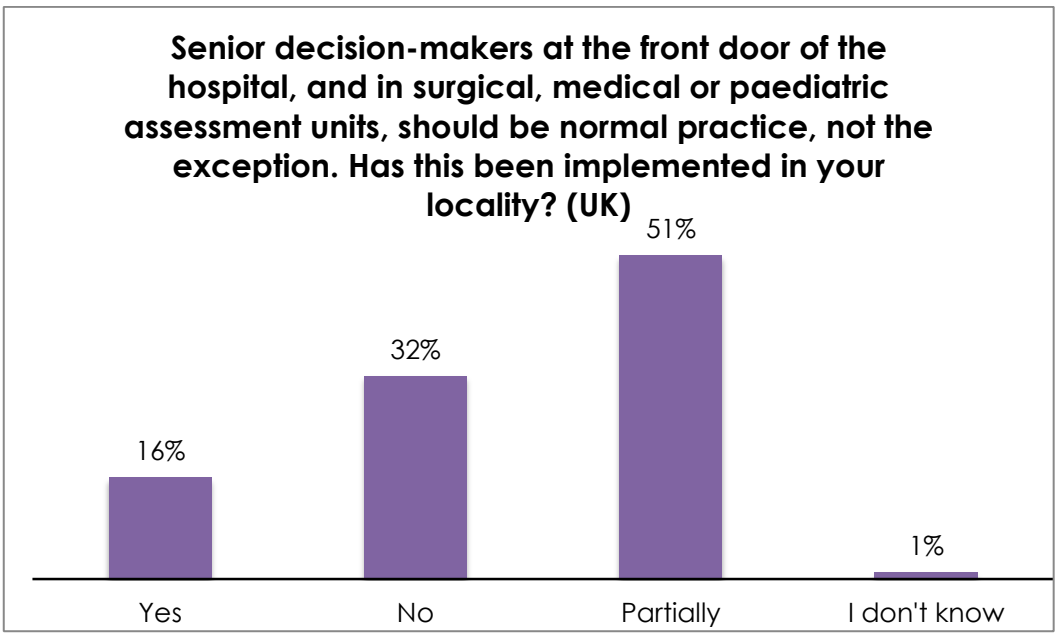


Despite the widespread consensus of the value of this practice, such training rotations are absent from almost two thirds of UK Emergency Departments. Failure to fully implement this model will

significantly impact on the ability of the medical workforce to meet the clinical challenges of the future.

Recommendation 4:
Senior decision-makers at the front door of the hospital, and in surgical, medical or paediatric assessment units, should be normal practice, not the exception.

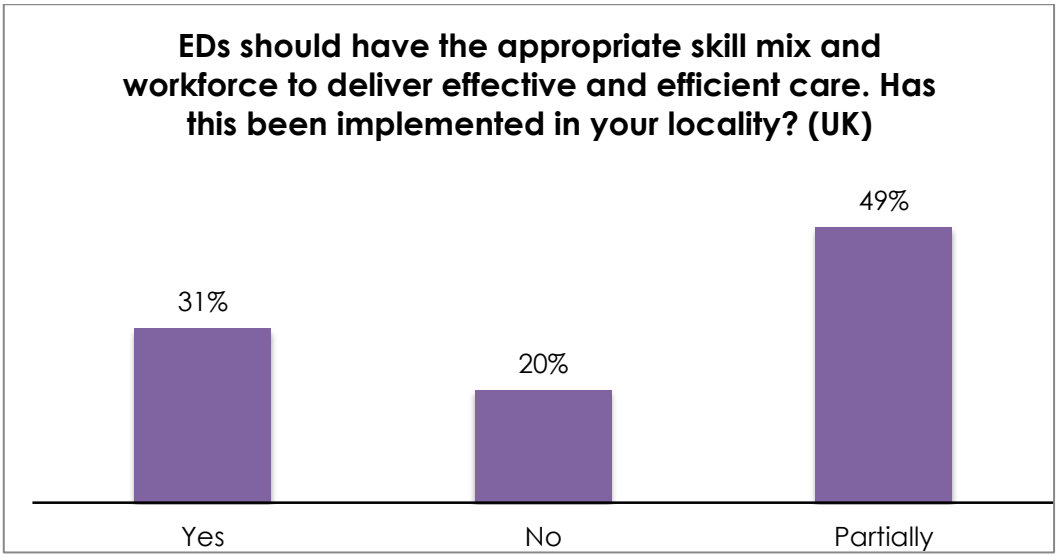
The College endorses this service model as the most reliable way to deliver safe, effective and efficient care to all patients presenting at emergency departments. This should include acute physicians, acute paediatricians, emergency care physicians, geriatricians and psychiatrists.



More than two thirds of hospitals and acute admitting units have addressed this issue though fewer than one in five have done so fully. Whilst partial implementation is a positive step, all acute admission departments must strive to provide this service as normal practice to ensure patients reap the benefits. These benefits include mortality reduction, lower admission rates, early and safe discharge, reduced lengths of stay and more appropriate use of investigations.

Recommendation 5:
Emergency departments should have the appropriate skill mix and workforce to deliver safe, effective and efficient care.

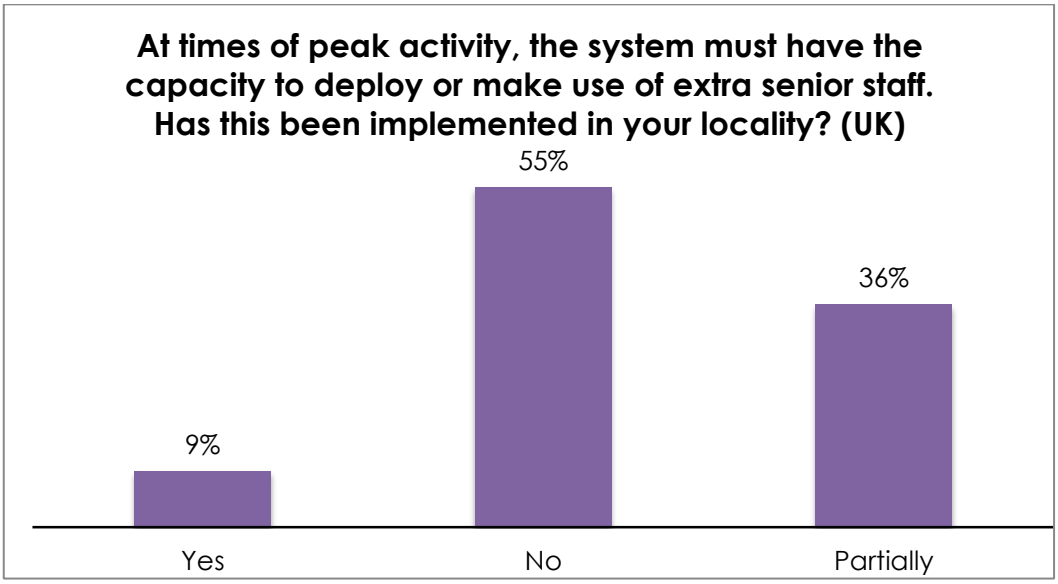
It is self-evident that emergency departments must be staffed adequately both in terms of number and skill mix if they are to be able to care for patients safely. Where specialist staff are lacking robust networks of care and emergency referral pathways must be in existence as recommended by the Keogh report.



Patient safety is paramount in delivering urgent and emergency care services and therefore it is concerning to see that less than a third of departments have the appropriate staffing to deal with their current casemix.

Recommendation 6:
At times of peak activity, the system must have the capacity to deploy or make use of extra senior staff from within the hospital

This should be standard practice in all EDs to protect patients from avoidable harm and maintain a safe department. Exit block is an unacceptable phenomenon that has characterised the problems in emergency departments this winter. Whilst eradication of exit block must be the aim, the effects on patients can be mitigated by the attendance of relevant specialists from in-patient teams.

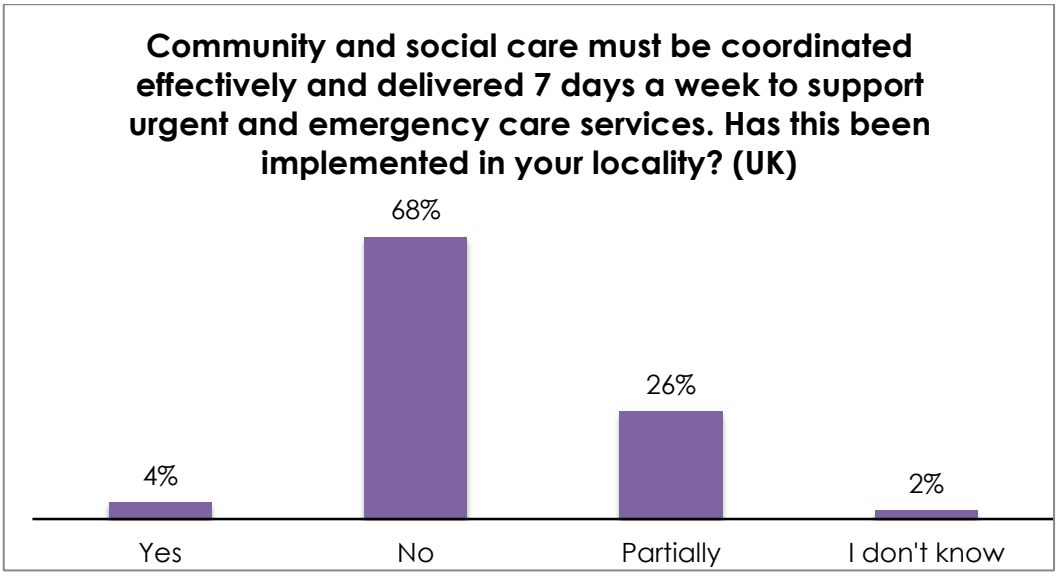


Fewer than one in ten departments have fully adopted this practice and more than half have no such mechanism in place to better respond to peaks in patient volumes and acuity.

Recommendation 7:
Community and social care must be coordinated effectively and delivered 7 days a week to support urgent and emergency care services.

Integrating community and social care teams with the urgent and emergency care system is essential to removing many of the barriers to 'time and place' appropriate patient care. An ageing population, coupled with a rise in the number of people living with long-term conditions such as dementia and diabetes is increasing the pressure on EDs and therefore the need to deliver joined-up care.

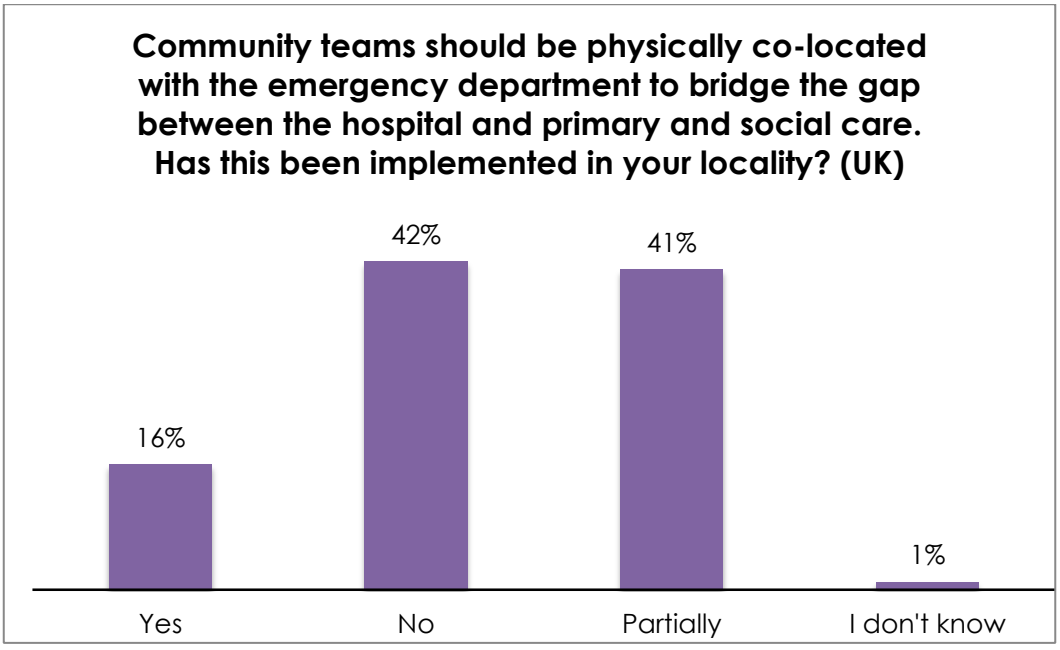
The College urges health and social care services to work together to provide better support at home and earlier treatment in the community to prevent people needing emergency care in hospital. This requires investment in the infrastructure of community care and a change in culture to remove many of the current procedural obstacles. The College advocates the use of community and social care teams 7 days per week to facilitate the safe discharge and timely transfer of care of patients from the hospital to their own home or usual place of residence.



Over two thirds of UK EDs do not have access to community and social care teams 7 days per week. Fewer than one in twenty have full 7 day integration.

Recommendation 8:
Community teams should be physically co-located with the emergency department to bridge the gap between the hospital and primary and social care, and to support vulnerable patients.

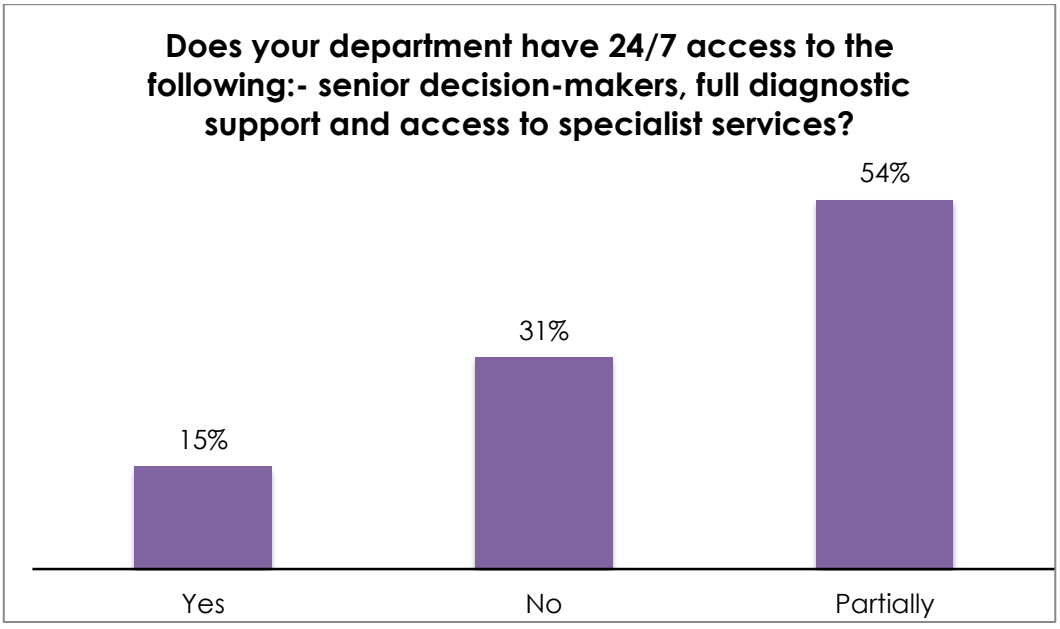
Co-located teams should include primary care practitioners, social workers and mental health professionals. There are best practice models of this type of care in existence across the NHS. For example, psychiatric liaison services easily accessible to staff working in EDs enable the physical, mental and social needs of patients with acute or long-term mental health conditions to be better cared for.



Almost half of EDs have no access to on-site community teams.

Recommendation 9:
The delivery of a 7 day service in the NHS must ensure that emergency medicine services are delivered 24/7, with senior decision makers and full diagnostic support available 24 hours a day, including appropriate access to specialist services. This will require additional resources.

Patients need the NHS every day and there is a wealth of evidence which shows that the limited availability of services at evenings and weekends can have a detrimental impact on outcomes for patients including, but not limited to, increased mortality.



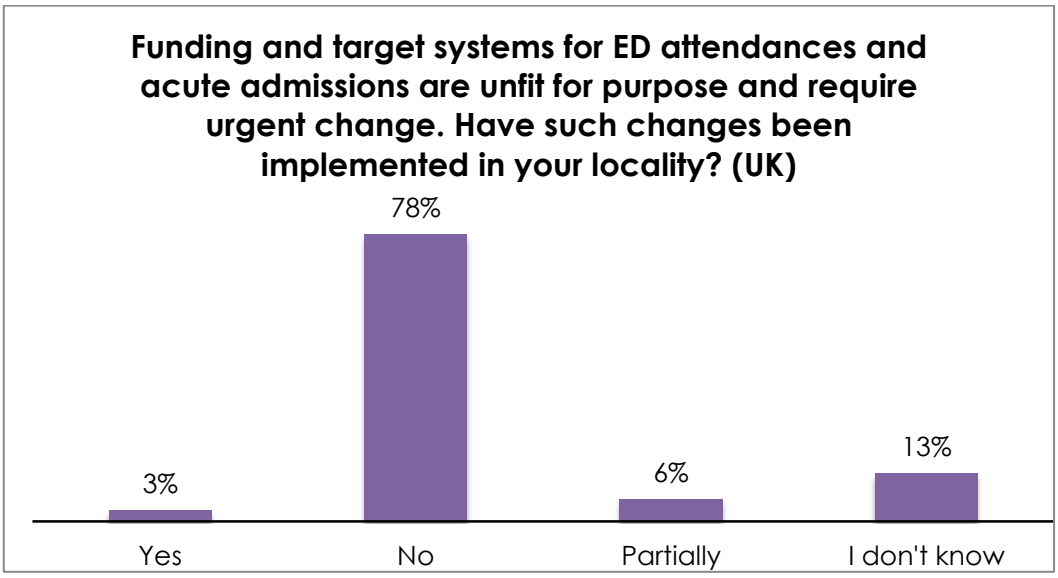
85% of EDs are not supported by fully functioning 7 day services. This deficit is due to lack of senior clinicians or lack of full diagnostic support or lack of access to specialists.

Recommendation 10:
The funding and targets systems for emergency department attendances and acute admissions are unfit for purpose and require urgent change.

The current funding system for urgent and emergency care services is unfit for purpose and penalises all acute care services. As it stands, the funding measures in place ensure that EDs act as a loss-making activity to Trusts. The College believes that there must be equity between elective care and urgent and emergency care.

The four hour standard requires 95% of patients to be discharged, admitted or transferred within 4 hours of presenting to the ED. NHS England has reported the highest ever number of breaches of the four hour standard during the winter of 2014/15 and this in turn has been associated with high levels of exit block - a problem that is growing substantially across all nations in the UK.

Exit block, a hospital acquired condition, has a number of negative consequences for patients. These include increased mortality, delays to time critical interventions, increased risk of adverse events, decreased patient satisfaction and increased staff stress and burnout. Over 500,000 patients a year are affected by exit block with an estimated mortality of more than 500 patients per year.



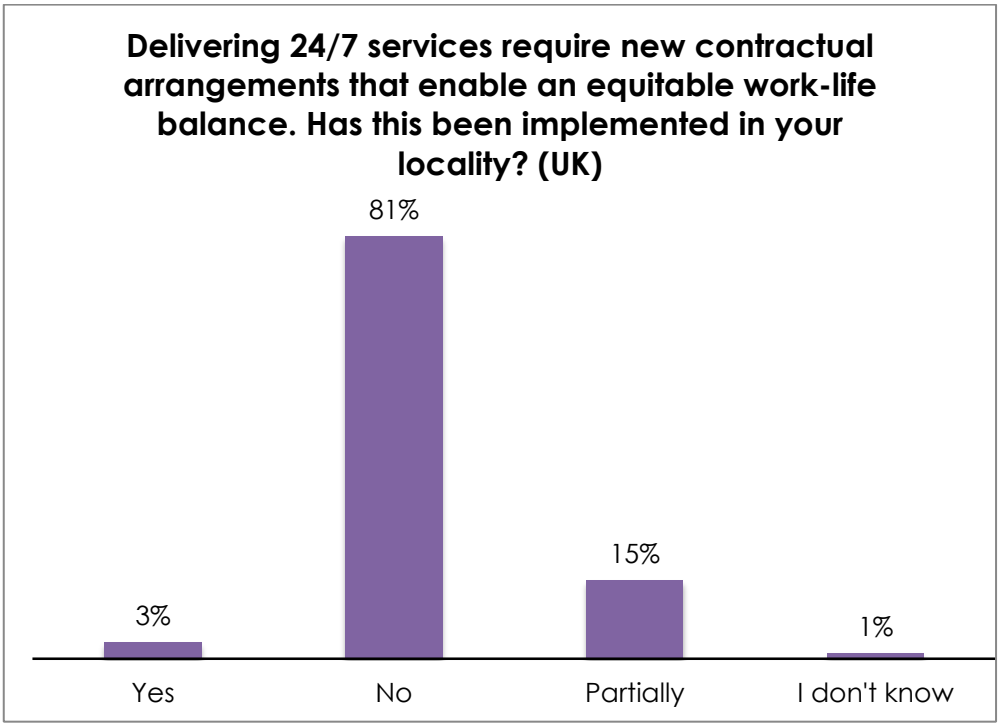
Almost 80% of departments are still funded using a mechanism that is unfit for purpose. A small number of providers have been able to adopt more equitable systems. The College welcomes the announcement by Monitor of a proposed change in the marginal tariff from 30% to 70% and will expect the money derived from this to be invested in resources and processes to eradicate exit block.

Recommendation 11:
Delivering 24/7 services require new contractual arrangements that enable an equitable work-life balance.

There is recognition from senior health professionals and stakeholders including the Secretary of State for Health, the Department of Health, the British Medical Association (BMA) and the NHS Confederation that current contracts for doctors lack the mechanisms necessary to ensure that acute care specialists have a fair work-life balance. Work is currently ongoing in England and Northern Ireland to review and improve contracts and we hope that this process will also take place in Wales and Scotland.

The College strongly believes that fairness and sustainability should underpin all staff contracts and that this is a key component to addressing the current workforce shortages in the UK.

Senior medical staff working in EDs across the UK are under enormous pressure to manage demand and complexity of workload, the effects of which can lead to stress, burnout and other health problems, all of which have been highlighted in our report *Stretched to the limit* (2013).

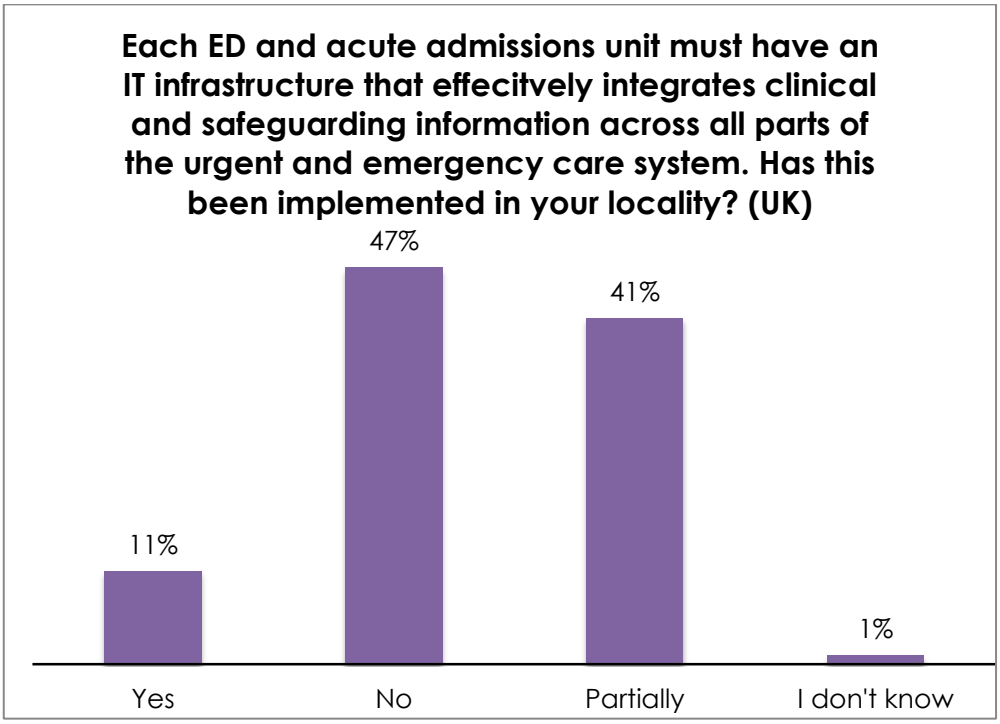


81% of acute trusts have made no amendments to standard terms and conditions for doctors. The College accepts that such arrangements can only be widespread and sustainable if they are part of a national contract framework.

Recommendation 12:
It is essential that each emergency department and acute admissions unit has an IT infrastructure that effectively integrates clinical and safeguarding information across all parts of the urgent and emergency care system.

IT infrastructure is essential in order to optimise care to patients in an efficient and effective manner. Good systems provide reliable data, enabling departments to predict with reasonable accuracy casemix and volumes. This allows trusts to effectively plan staffing levels, bed capacity, transport and diagnostics. Such IT systems also enable easy access to patient records, improve treatment times and increase patient satisfaction.

Currently, data is woefully inadequate and inaccurate and does not provide a true description of urgent and emergency care throughout the UK; poor planning is an inevitable consequence.



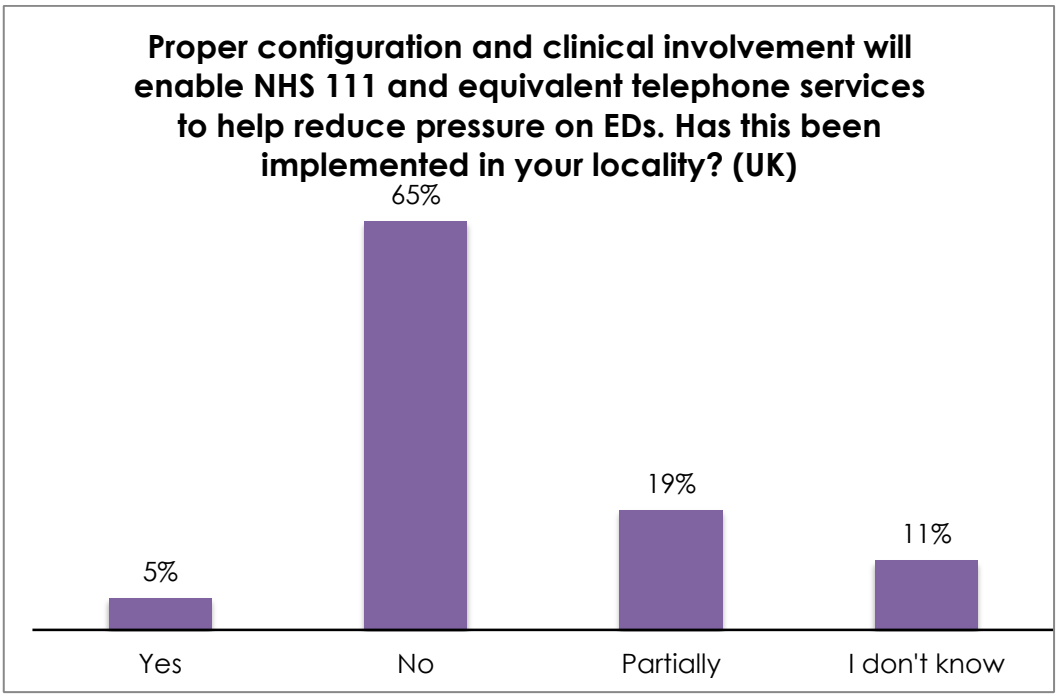
47% of EDs surveyed do not have adequate IT infrastructures in place that can provide reliable data regarding their urgent and emergency care system. Only one in ten units have confidence in the reliability and scope of the data they collect.

Recommendation 13:
If configured properly with significant clinical involvement and advice, NHS 111 and equivalent telephone advice services can help to reduce the pressure on the urgent and emergency care system.

The College believes that if these services are configured correctly they will significantly reduce pressure on the urgent and emergency care system. This mirrors a key commitment of the Keogh Review of Urgent and Emergency Care. However, in 2014 in England the number of ED attendances has increased by 450,000. There has been a similar increase in the number of patients referred to emergency departments by NHS 111.

NHS 111 relies on non-clinical staff guiding callers through standardised algorithms. These staff do not have the experience or authority to advise alternatives to the dispositions determined by these algorithms. More importantly the disparity in dispositions to the ED between weekdays and weekends highlights that the Directory of Services used by NHS 111 is substantially constrained at weekends. In consequence people attend, or are advised to attend the ED, not because it is the best option but because it is the only option.

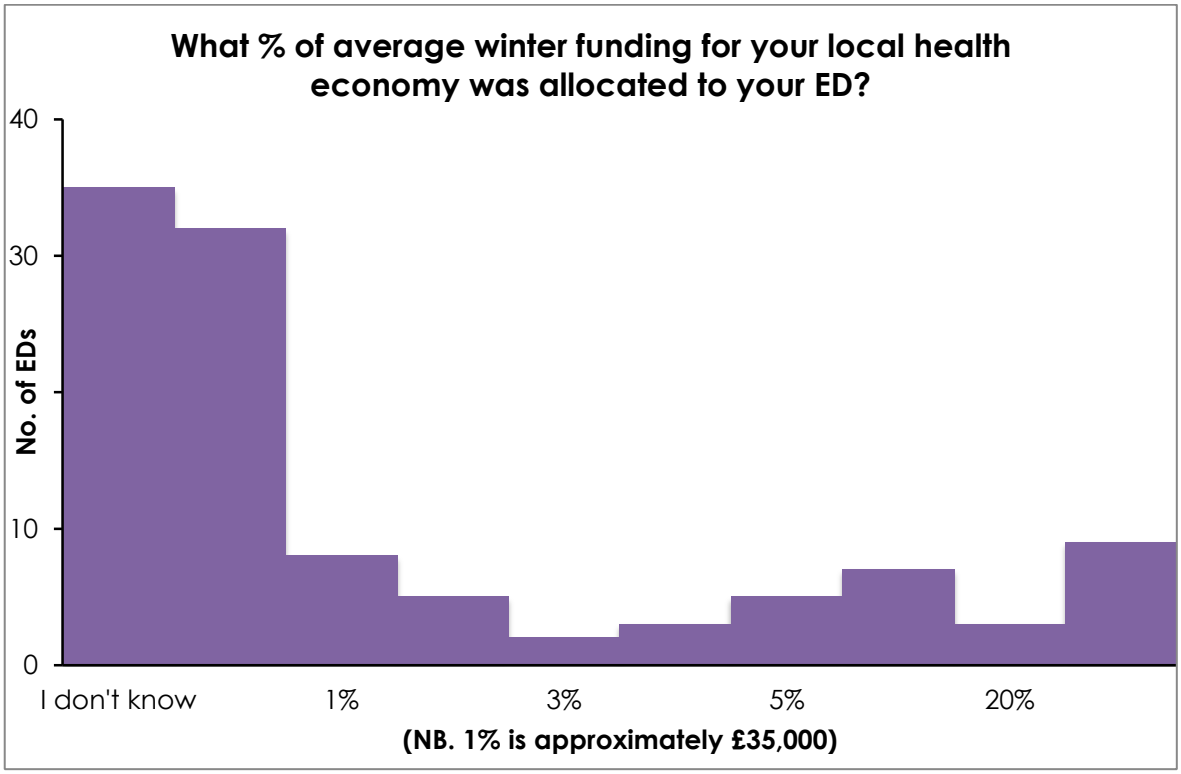
In order for telephone health advice systems to work effectively it is essential that staff have access to patient records and a substantial number of patient encounters will require the input of experienced clinicians. Many more services must be provided 7 days per week to avoid A&E acting as an 'Anything and Everything' default.



Most respondents indicated that such arrangements are not in place; they clearly should be.

Government winter funding on urgent and emergency care 2014 (England only)

In England in 2014, the government allocated £700 million to support urgent and emergency care services over the winter period. This equates to approximately £3.5 million for an average-sized health economy. Respondents were asked what percentage of this money had been allocated to their ED? 100 senior ED consultants in England answered this question.



When this additional money was announced by the Secretary of State for Health Secretary, it was made clear that this was to be used to boost frontline NHS services to ensure strong performance throughout the winter months. The results of this survey show that this has not been the case across much of England. Based on the findings of the survey of the **£700 million that was allocated by the government for emergency care this winter just 1% (£6,685,000) ended up directly in emergency departments.** It is clear that most of the additional money has been diverted into schemes that have self-evidently failed to reduce attendances or admissions.

Many senior clinicians (35 clinical leads) stated that they did not know what percentage of funding, if any, had been allocated to their ED and a further 23 said that they had received none of it. This demonstrates that over half of EDs in England were not directly supported at all, contrary to the anticipated purpose of the funding.

There were mixed reviews about how this money had been spent but overall clinicians felt that it was not spent in an efficient way that would lead to long-term improvements in the delivery of urgent and emergency care services. There is cause for concern as a number stated that this funding had been *"incorporated into the trust's financial bottom line"* or *"used to offset an increase in expenditure in July as part of a 4hr recovery plan"*. This suggests that as a result of

financial constraints and imminent deficits, trusts have been forced to use allocated winter money to pay off their debts.

In addition to this a number of consultants said that high cost, inefficient spending was continuing in their departments either as a result of failed CCG pilots/ initiatives or locum spending to cover shifts. As one respondent illustrates *"a lot of money has had to be spent on locums and bank staff because no one wants to work in the ED when it is bursting at the seams!"*.

A small proportion of departments said that this money was spent effectively over the winter period for example being used to open extra beds in the hospital to improve flow through the ED and extra staffing, including *"employing a very good pharmacist in ED scheme which I would choose to have long term."*

Nine consultants stated that their ED did not directly receive winter funding but their Trust did and *"investment has been made in other services in attempt to improve flow through ED, with the consent of ED"*.

Further supporting information

Respondents of this survey were asked to provide additional feedback on the recommendations and any further comments or experience they have had working in EDs during this winter period 2014/15. 53% of respondents answered this question.

The general feeling was that the EM workforce, across all grades are under immense pressure to deliver a high standard of care to patients. Senior staff explained that the current working conditions are unsustainable and are having a serious impact on their stress levels, home life, and ability to think clearly and rationally working for prolonged periods in a high intensity environment. Some stated that staff of all grades are often working longer hours and sometimes unpaid.

Additionally, consultants said that the pressures experienced during the winter are predictable and therefore robust plans should be in place at an early stage. However some noted that these pressures are often unrelenting and continue throughout the year.

There were four general themes to emerge from the additional evidence participants were asked to provide. These include staffing, tariffs and terms, exit block and primary care services.

Staffing

A substantial number of respondents said that the biggest issue for them is a lack of senior staffing in the ED. Their departments have inadequate staffing levels, in particular middle-grade staffing, both in terms of numbers and seniority. Consultant numbers are lower than recommended and in addition to this many are heavily reliant on locums of variable quality and experience to cover shifts. One consultant described this practice as "*haemorrhaging cash on agency staff and it feels like there is little light at the end of the tunnel on this one.*" Deficiencies in the registrar rota and the inability to find locums to cover weekend shifts in particular have resulted in consultants working on what should be their weekends off to fill gaps.

The current winter pressures have meant that a number of EM physicians have had to cancel their non-clinical duties to the detriment of clinical quality and governance.

Tariffs and terms and conditions

There is a consensus amongst senior EM physicians that the current tariffs, terms and conditions for doctors warrant immediate attention to ensure that the urgent and emergency care system is sustainable for both patients and staff. Recurring problems will not disappear and more funding will not address this issue "*without a fundamental change in the system.*" Many stated that the funding of EDs does not fully reflect the care provided and needs to be overhauled as a matter of urgency.

Retention of staff was also identified as a major issue that needs to be addressed through terms and conditions as described by one consultant "*continuously losing experienced staff to other specialities, locum agencies and moving abroad- there is an urgent need to improve pay and conditions in order to retain staff of all grades.*"

Exit block

The majority of consultants discussed Exit block as the "primary problem" facing their emergency department and described the winter period as characterised by "crippling exit block" resulting in overcrowding in the ED because of lengthy bed waits. Some respondents described significantly inadequate patient flow within the hospital as making patient care very difficult, resulting in *"intolerable and unsustainable pressures amongst staff, both nursing and medical."*

A major issue identified by consultants is the inability to refer patients directly to acute specialty units. There is a feeling of disengagement between the ED and other specialties across the hospital system which often results in poor patient experience and long waits in the ED. Patients breaching due to inadequate ED capacity and poor flow has a significant impact on both patients and staff.

Primary care services

The majority of consultants surveyed said that patients' inability to access primary care services when they need them, particularly during out-of-hours is placing a huge strain on the urgent and emergency care system. This is widely evident with elderly patients, a number of whom are directed to the ED from their care home. One consultant described *"vulnerable elderly patients, many with severe dementia, are sent to the ED by 999 ambulance instead of phoning for advice first…primary care has a responsibility here to facilitate 'best decision' for individual patients, I would welcome a 'call don't send first' facility to best meet the needs of the patient."*

There is a consensus amongst senior EM consultants surveyed that primary care presentation to the ED must be redirected to more appropriate services in order to protect emergency resources. Consultants agreed that the most effective way to reduce pressure on urgent and emergency services is to invest more in social and mental health systems and co-locate primary care out of hours services.

Conclusion

It may not surprise too many people that the thirteen recommendations of 'Acute and emergency care - prescribing the remedy' have been incompletely implemented. The scale of the shortfall in many cases is however striking.

Nevertheless, there are hospitals and systems that can be cited as examples of best practice for every one of the thirteen recommendations. This report is not primarily intended to be critical. Rather its purpose is to restate what must be done and demonstrate that it is already happening in some parts of the NHS.

Our original recommendations acknowledged that there were resource implications for many of them, though more effective and efficient acute and emergency care would in turn save money. It is clear that much of the additional resource of £700 million allocated by the government has been diverted into schemes that have self-evidently failed to reduce attendances or admissions, or used to reinforce balance sheets.

Money must be spent strategically on proven schemes and those charged with the stewardship of additional monies for acute and emergency care must expect to be held to account.

References

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