Rebuilding and advancing emergency medicine

Last year I wrote an editorial in this journal (Mann, 2014) to accompany six articles, authored by leading emergency medicine physicians, highlighting matters most relevant to UK emergency medicine and accident and emergency departments. One year on and a progress report is required to record success and highlight issues yet to be fully addressed.

I must of course begin by recording the defining event of 4 February this year, when we received news from the Cabinet Office that our application for permission to be known as the Royal College of Emergency Medicine had been granted. We thus became the first 21st century medical royal college.

This was a great morale boost and reflects the remarkable endeavours of frontline clinicians in UK emergency departments over many years. Although a change in name does not change the circumstances in which the college finds itself, it has emboldened our campaign to 'rebuild emergency medicine'.

In November 2014 we launched the Royal College of Emergency Medicine STEP campaign. This had four domains: Sustainable staffing, Tariff and term reform, Exit block eradication and Primary care co-location.

Sustainable staffing

The issue of sustainable staffing is particularly current given the recent media reports of the sums expended on locum cover. In the 3 years from 2012–14 £500 million (Royal College of Emergency Medicine, 2015a) has been spent employing emergency department locums. This equates to £3 million per week. To place this in context the total cost of an average accident and emergency department is about £6 million per year. The need to address the underlying causes of staff shortages and the ruinous costs associated with forced short-term staffing solutions is financially imperative. The solution lies with reforming both tariffs for hospitals and terms of employment for emergency medicine doctors.

Tariff and term reform

In England, hospitals are paid by a tariff system. The current tariffs ensure that acute care is a loss-making exercise. In consequence, investment in accident and emergency staffing has failed to keep pace with service demands. Employed staff are expected to cope with ever more work. Last year alone attendances rose by almost 400 000 patients. Currently there is one emergency medicine consultant for every 11 000 accident and emergency attendances.

Many have concluded that accident and emergency in the UK is an unattractive long-term career; in the last 4 years over 600 senior emergency medicine doctors have resigned – a number equivalent to a third of our current workforce.

Were we to provide staff with working conditions and rotas that enabled a sustainable work–life pattern we would retain the workforce we have trained. Paradoxically underfunding has led directly to excessive expenditure.

NHS England and Monitor have proposed a new tariff structure, the details of which have yet to be finalized. It remains to be seen if the new mechanisms will provide a level playing field for acute care. Similarly the effect of current contract negotiations on recruitment and retention in emergency medicine have yet to be realized. It is self evident, however, that current terms and conditions have not served practitioners of acute care well and in consequence patient services have been stretched ever more thinly, creating fragile rotas and skeleton staffing.

Exit block eradication

Exit block has become a well-recognized term, describing the phenomenon of patients unable to be admitted into the hospital from the emergency department because of a lack of available beds. The college has produced guidance on ways to tackle this and commissioned several short films to highlight the causes and effects (Royal College of Emergency Medicine, 2015b). A key reason for last winter's worst ever performance as measured by the 4-hour standard was a sharp increase in the number of patients unable to be discharged from hospital. These delayed discharges were often for reasons other than the need for ongoing medical care. NHS England (2015a) reported that delayed transfers of care rose by over 100% last Christmas when compared to the same period 5 years ago.

The 4-hour standard is a vital tool to maintain focus on flow through the emergency department. Monitor (2015) recently described it as a 'sophisticated measure of complex interactions within the whole of a local health and care system'.

Importantly the 4-hour standard is a proxy measure of crowding which itself is known to increase morbidity and mortality (Boden et al, 2015). However, too often poor performance against this metric is reported as 'accident and emergency department failure'. As the college demonstrated in our Sentinel Sites study, published in this journal last year (Moulton et al, 2014), the best way to refute erroneous statements is to collect and analyse the data and publish the evidence to better inform the debate. This year the College Winter Flow project will collate data from 70 acute trusts across the UK. Each week the college will report the aggregated data items of 4-hour standard performance, cancelled elective operations and delayed transfers of care. The linkage of these metrics will better reflect the causes and consequences of bed availability.

Primary care co-location

Primary care co-location is a key component of the college's campaign to decon-

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gest emergency departments. Currently there is a huge disparity between what accident and emergency departments were established to provide, what they are commissioned to deliver, and what they are staffed to undertake when compared to the volumes and case-mix of patients that actually attend. The 'emergency' component has been subsumed by the expectation that accident and emergency is the default facility for 'any and every' out-of-hours care need.

Perhaps paradoxically the college believes that the answer to this challenge is to broaden the range of services associated with the accident and emergency 'brand' yet simultaneously recognizing that emergency medicine, while a specialty of considerable range, is but a subset of the totality of urgent care work.

Other essential components of 'accident and emergency' are out-of-hours primary care for urgent conditions, community pharmacy services, community mental health teams, links to palliative care teams and district nursing teams – all essential services but not emergency medicine. Support for this model has been forthcoming from a wide variety of organizations including Monitor, The Patients Association, the Royal College of Psychiatrists, and the Royal College of General Practitioners.

The STEP campaign

The STEP campaign has delivered clarity of purpose and a shared agenda. Launched last year it was reinforced in June by the publication of the Royal College of Emergency Medicine fact sheet (2015c) – which itself was published in Parliament with support from the Secretary of State for Health and the Chair of the Commons Select Committee for Health. Details of the Royal College of Emergency Medicine STEP campaign can be found on our website with specific refinements for each of the UK nations (Royal College of Emergency Medicine, 2015d).

At first sight it might appear that sustainable staffing and tariff and term reform are staff focussed whereas exit block eradication and primary care co-location are patient focussed. However, the reverse is equally true. Were departments properly staffed and fairly funded, patients would receive better and more timely care. Similarly were exit block to be eradicated and primary care services co-located the working environment would be transformed and with it the work experience of all accident and emergency employees.

Many of the issues addressed by the STEP campaign are included in the recent NHS England (2015b) guidance 'Safer, Faster, Better'. This renewed focus on the challenges facing accident and emergency departments must be the catalyst to rebuild and advance emergency medicine.

Conclusions

The college continues to pursue the aims for which it was granted a royal charter; the advancement of emergency care in the UK. The STEP campaign is work in progress but 2015 has seen a remarkable move from symptom recognition to a widespread recognition of the aetiology of the current challenges and agreement on treatment. BJHM

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KEY POINTS

- The Royal College of Emergency Medicine has launched the STEP campaign to rebuild and advance UK emergency medicine.
- Sustainable staffing levels with funding reform of hospitals and practitioners are key tasks for the Department of Health and arm's length bodies.
- Eliminating exit block and the provision of other urgent care services alongside the emergency department to create an accident and emergency hub are key tasks for commissioners and providers.
- The College has garnered widespread agreement and endorsement of these issues and published guidance on how they can be delivered.

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