'Fixing' emergency care: what does it really need?

The NHS faces an increasing number of demanding challenges linked to fiscal constraint and resource starvation. These challenges seem to be worsening and there is a sense that they are now straining the very fabric of free health care at the point of delivery. Emergency care delivery, especially over the past 6–7 years, has worsened and by association emergency medicine as a specialty has been labelled, inappropriately at times, as being in crisis. Alongside the steady deterioration of the 4-hour emergency care standard, this has frustrated dedicated clinicians who have struggled to deliver safe, timely care in overcrowded emergency departments through no fault of their own.

In this issue a series of articles highlights key challenges in the delivery of safe, effective and efficient emergency care in the UK. More importantly these describe how the specialty of emergency medicine, which celebrated its fiftieth anniversary in 2017, is meeting those challenges and, despite the obstacles, creating a structured solutions-oriented approach for what is needed now and in the future. Indeed, the most recent Royal College of Emergency Medicine (2018a) strategy – *RCEM Vision 2020* – has made progress on a number of fronts. However, a chronic lack of funding continues to compromise the ability of policymakers and providers to plan adequately, resulting in poor system performance and causing increasing attrition of clinical staff who work in the most intense environment in health care.

Our ability to meet these challenges is best considered in three cross cutting themes.

Stabilization

Stabilizing the present chronic downward spiral of care delivery is essential. While the 4-hour emergency care standard has attracted some criticism over the past 15 years, it remains the most resilient and sophisticated metric of overall system performance. There is no other surrogate marker that better describes how pressurised our emergency care systems are nor of the positive impact that occurs when hospitals properly embrace it as a system metric rather than incorrectly considering it as an emergency department target. The steady deterioration of the 4-hour emergency care standard from 97.7% in 2010–11 for type I emergency departments and their systems in England to 76.8% in quarter 4 of 2017–18 has been the most powerful marker of the pressures facing staff (NHS England, 2018a). In Northern Ireland and Wales the emergency care standard dropped to 59.3% in March 2018 (Department of Health, 2018) and 76.9% in 2017–18 (Stats Wales, 2018). Scotland has remained somewhat more resilient at 90.6% during 2017–18 (ISD Scotland, 2018).

Increased crowding is the result in emergency departments. Since 2011–12 in England there has been an 11 831% rise (an increase of 2248 patients) in patients waiting more than 12 hours from a decision to admit to admission into an acute hospital bed (NHS England, 2018b). Crowding leads to increased harm for patients (College of Emergency Medicine, 2014; Boden et al, 2016). Evidence suggests that the actual quality of emergency care for key conditions has also worsened significantly (Royal College of Emergency Medicine, 2018b).

So what are the key factors that have compromised flow? A decrease in the acute inhospital bed base and a resultant increase in acute bed occupancy levels is a major factor. Others include delayed transfer of care of patients who have been medically optimized but are awaiting transfer back into the community. Together these factors have worsened the 'exit block' in emergency departments and been a major contributor to compromising patient care.

This lack of acute bed capacity and flow of patients back into the community tends to worsen during autumn and winter but is now becoming a year-round phenomenon. Nursing shortages have further exacerbated the situation and the lack of resources has led to widespread concern and pressure on government. In July 2018 the Prime Minister announced an increase of £20 billion to help address these issues as part of a wider 10-year plan, but it remains to be seen how this might influence acute care delivery and outcomes.

The design of unscheduled care systems is the other key issue. There has been clear recognition of a need to co-locate services such as mental health, primary care and frailty to meet the needs of patients who do not require emergency care. The College has espoused this for over a decade and it remains a core part of *RCEM Vision 2020*. Systems that have performed well in recent years, or at least not deteriorated as much in terms of the 4-hour emergency care standard, are those which have planned well and delivered these system design solutions.

Workforce

Investing in and valuing the workforce lies at the heart of providing quality health care. Yet, until recently there has been a chronic failure both to plan and recruit an adequate clinical workforce for emergency care and to then find ways to retain that workforce for the long term.

In 2017, the Royal College of Emergency Medicine worked to deliver a unique collaborative strategy in England that will meet present and future demands for emergency departments if implemented well (Health Education England et al, 2017). It addresses three key themes: growing an adequate senior and junior multidisciplinary workforce, reducing attrition during training, and maximizing retention among the older trained workforce. Training numbers for emergency medicine will increase from a baseline of 225/year to 400/year for the next 4 years. Over the next decade this will lead to a steady rise and

Dr Taj Hassan, President, Royal College of Emergency Medicine, London EC4A 1DT (President@rcem.ac.uk; @RCEMpresident)

doubling of the senior workforce in emergency medicine with approximately an additional 2000 consultants. Dedicated programmes to enhance clinical teaching in the emergency department, tailored leadership development programmes for trainees and increasing opportunities for flexible training are being developed as part of the strategy. Additional support for a more multidisciplinary junior clinical workforce is also being created with advanced clinical practitioners and physician associates. Work is ongoing in parallel to develop a similar but tailored strategic approach for each of the devolved nations.

Maximizing retention through better design, including the way in which job plans, are set out is also key. The College has focused on creating sustainable careers for staff in emergency medicine for a number of years – in 2013, it launched *Creating successful, satisfying and sustainable careers in Emergency Medicine* (College of Emergency Medicine, 2013). This work has continued to be built upon and is also described in greater detail in this issue.

Transformation

Change is constant, yet the NHS has been much criticized for being unable to learn the lessons of history. System design solutions progress all too often at glacial speed, translation of technological advances into clinical practice seems even slower and proven therapeutic interventions are not delivered to the 'coal face' consistently or rapidly enough. Managerial teams are often not able to provide time and 'headspace' for clinical staff to combine such strategies into consistent quality improvement programmes that can be easily embedded into clinical practice. There are notable exceptions to this. The development of a national major trauma centre network and the introduction of the 4-hour emergency care standard are excellent examples where positive change has occurred in the UK. Both have led to improvements in care delivery and outcomes, despite having their detractors.

Proper transformation and reconfiguration of emergency care systems requires proper collaboration. The introduction of sustainability and transformation plans in England was an excellent ambition, yet often failed to engage clinicians to provide clinical expertise. In the devolved nations, reconfiguration planning has similarly struggled or been placed on the back burner.

There is potential in the long term to better use the power of technology. In reality, at present too many departments struggle to deliver emergency department information systems that can be regarded as fit for purpose.

All of this requires policymakers to engage and collaborate with clinical experts to produce deliverable strategic frameworks. This must be urgently addressed if we are to transform at pace, deliver on time and use valuable resources to positively impact on patient care.

Conclusions

Emergency medicine has come a long way in its 50 years and is now firmly embedded at the very heart of the NHS. It continues to flourish and expand in a wider system that is struggling badly with increasing demand, complexity and resource limitations. Despite this, emergency physicians have a remarkable resilience, ability to manage change and to care for their patients often in the most adverse conditions. However, policymakers and governments must understand that with this ever-increasing pressure, such care delivery is not sustainable.

Wider system failings must be addressed urgently, with extra funding rather than simple process redesign or 'systems re-engineering'. Clinical workforce frameworks for emergency departments and strategic agreements must be appropriately funded and implemented to cope with present and future demand. Job plans must ensure that clinical staff have time to rest, recover and recuperate so they can work sustainably and be more productive.

These key actions will improve safety and lead to greater consistency in the quality of care and dignity that is provided for patients. **BJHM**

KEY POINTS

- Many emergency care systems in the UK remain in chronic crisis mode primarily because of a failure to adequately fund hospital bed capacity, social care and the emergency department workforce. This is compromising system resilience, is not sustainable and needs urgent action.
- The additional influence of 'winter pressures' further heightens the risks to patient safety and timely clinical care.
- The 4-hour emergency care standard remains a powerful and resilient hospital metric.
- Despite these pressures, the specialty of emergency medicine continues to expand and flourish. Delivering on agreed workforce strategies and engaging clinical emergency medicine experts in transformation planning will be key to meeting future challenges.
- Valuing clinicians and creating sustainable job plans are essential to maximizing satisfaction and productivity, leading to better patient care and outcomes.

Boden DG, Agarwal A, Hussain T et al. Lowering levels of bed occupancy is associated with decreased inhospital mortality and improved performance on the 4-hour target in a UK District General Hospital. Emerg Med J. 2016 Feb;33(2):85–90. https://doi.org/10.1136/emermed-2014-204479

College of Emergency Medicine. 2013. Creating successful, satisfying and sustainable careers in Emergency Medicine. (accessed 29 August 2018) https://www.rcem.ac.uk/docs/Workforce/C--inetpub-wwwroot-medicaCreating%20successful,%20satisfying%20and%20sustainable%20careers%20in%20Emergency%20Medicine_FULL%20REPORT.pdf

College of Emergency Medicine. 2014. Crowding in Emergency Departments. (accessed 29 August 2018) https://www.rcem.ac.uk/docs/Service%20Design%20+%20Delivery/52b.%20RCEM%20Crowding%20Guideline%20(2015).pdf

Department of Health. 2018. Hospital Statistics: Emergency Care 2017/18. (accessed 29 August 2018) https://www.health-ni.gov.uk/publications/hospital-statistics-emergency-care-activity-201718

Health Education England, NHS England, NHS Improvement and Royal College of Emergency Medicine. 2017. Securing the future workforce for emergency departments in England. (accessed 29 August 2018) https://improvement.nhs.uk/documents/1826/Emergency_department_workforce_plan_-_111017_Final.3.pdf

ISD Scotland. 2018. NHS Performs - Weekly Update of Emergency Department Activity and Waiting Time Statistics. (accessed 29 August 2018) http://www.isdscotland.org/Health-Topics/Emergency-Care/Publications/index.asp#2174

NHS England. 2018a. Quarterly Hospital Activity Data, Quarter 4, 2017-18. (accessed 29 August 2018) https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2018/05/QAR-COMM-Web-1718-Q4-46564.xls

NHS England. 2018b. Quarterly Attendances & Emergency Admission monthly statistics, NHS and independent sector organisations in England. (accessed 30 August 2018) https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2018/04/Quarterly-timeseries-March-2018-3XGkJ.xls

Royal College of Emergency Medicine. 2018a. Royal College of Emergency Medicine Vision 2020 – Fixing Emergency Department Staffing, systems and support to deliver excellent patient centred care. (accessed 29 August 2018) https://www.rcem.ac.uk/RCEM/Quality-Policy/Policy/Vision_2020.aspx

Royal College of Emergency Medicine. 2018b. Clinical Audit 2017/18 Fractured neck of femur. National Report. (accessed 29 August 2018) https://www.rcem.ac.uk/docs/QI%20+%20Clinical%20Audit/FNOF%20National%20Report%202017-18.pdf

Stats Wales. 2018. Performance against 4 hour waiting times target by local health board. (accessed 29 August 2018) https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Hospital-Waiting-Times/Accident-and-Emergency/performanceagainst4hourtargetallemergencycarefacilities-by-localhealthboard