Resuscitate, not palliate, emergency care

Emergency care in the UK is in crisis, and stories of long waits, poor care and harm have become commonplace. This situation can no longer be ignored. This article looks at some of the ways in which emergency care can be resuscitated.

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The problems in emergency care are fixable – indeed in the first lockdown and during early parts of industrial action, a combination of increased capacity and cohesive planning between senior clinicians and management led to short-lived but dramatic improvements in care. The public is very aware of the problems in emergency care – polling by the Nuffield Trust (Morris et al, 2023) showed the lowest level of satisfaction with the NHS since 1983. This is likely to attract significant political attention in the run up to the general election (Boyle et al, 2021).

The Royal College of Emergency Medicine (2023) has a public-facing policy campaign, called *Resuscitate Emergency Care*. This is a series of policy recommendations which the College expects any government to enact:

1. Eradicate crowding and corridor care for patients
2. Provide the UK with the emergency medicine workforce it needs to deliver safe care
3. Ensure our NHS can provide equitable care to emergency patients
4. Focus on evidence-based healthcare policies
5. Introduce meaningful and transparent metrics to facilitate performance and better outcomes for patients.

Eradicate crowding and corridor care

In 2022, according to a freedom of information request, nearly 400 000 people spent over 24 hours from their time of arrival in English emergency departments. It is very likely that the patients who endured these long waits were the least able to tolerate this, such as older people and people presenting with mental health crisis. According to a freedom of information request made to NHS England, the average length of stay for a person aged over 80 years in 2022 was 15 hours.

Crowding happens when there is a lack of patient flow – or movement through the health and social care system – resulting in seriously unwell patients being trapped in emergency departments. Hospital occupancy has consistently exceeded the generally accepted 85% threshold, so these patients are often left waiting for care in inappropriate areas such as corridors and trolleys. One of the primary causes of crowding is a lack of hospital beds: since 2010, more than 29 000 beds have been removed despite the increasing complexity of population healthcare needs (Boyle and Chiles, 2022).

A lack of comprehensive social care provision exacerbates this problem. While medically ready to leave the hospital, many vulnerable patients may need help to recover through a social care package. According to unpublished data from NHS England, over 10% of the English acute and general bed base is taken up with people who are ready to leave hospital – this is an expensive way to deliver poor care.

Ambulance queues are a visible and harmful consequence of overcrowding. When emergency departments become crowded, they can no longer accept patients who arrive by ambulance, forcing them to wait outside. The ambulance and crew is unable to return to the community to respond to other medical emergencies. At least two patients are at risk for every ambulance unable to offload: the patient in the ambulance and a further patient waiting for an ambulance. Crowding is dangerous, harmful and undignified for patients (Boyle and Chiles, 2022). There is a growing body of evidence demonstrating that crowding and long waits increase a patient's risk of death after they have left the emergency department (Jones et al, 2022).

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To improve patient flow, UK governments must commit to a significant level of investment in the health and social care system to address the mismatch between the emergency healthcare needs of the population and the capacity of the NHS.

Emergency medicine workforce

Emergency departments across the UK are not safely staffed, and clinicians working within them are stretched thin. For far too long, staff have had to bridge the gap between an under-resourced system and the delivery of the quality of care that patients require. This has severe consequences: many clinicians are having to work less than full time because of the relentless pressure, and for the same reason some leave the specialty, emigrate or retire early. The NHS is struggling to retain its emergency medicine staff, adding more strain to an already pressured workforce. There are many different evidence-based interventions that can improve retention, but delivering care in crowded environments remains a significant reason for staff losses (Daniels, 2023). The ageing workforce and the rise of portfolio careers and less that full time working means that emergency medicine is short of about 120 acute common care stem trainees per year. The Royal College of Emergency Medicine (2023) recommends that there is one emergency medicine consultant per 4000 attendances, but that is some way off.

Emergency medicine clinicians want to care for their patients in a safe environment and timely manner. However, they are often forced to provide care in undignified and often unsafe, distressing conditions while managing an increasingly unsustainable workload. These workforce shortages are felt acutely by patients and the public. Just 18% of respondents surveyed agreed that their local emergency department had enough staff to care for them in a timely way, and only 23% of respondents expressed agreement that their local emergency department had enough staff to care for patients in a safe way (Morris et al, 2023).

Provide equitable care to emergency patients

Emergency departments are often the only point of contact that some patients have with the NHS, including the most vulnerable, such as patients who experience homelessness or are in a mental health crisis. In 2021–22 there were around twice as many attendances to emergency departments in England for the 10% of the population living in the most deprived areas, compared with the least deprived 10% (Scobie and Morris, 2020). The deprivation of a population determines the demand for emergency care, yet research shows that resourcing for emergency care does not follow local health needs (Turner et al, 2022).

In no other part of the healthcare service are patients expected to endure extremely long waits for care, in a dangerous environment where they could potentially experience avoidable harm. Studies suggest that people from deprived backgrounds are more likely to wait longer in emergency departments and receive fewer treatments (Turner et al, 2022), which risks worsening health inequalities in the population. UK governments need to work closely with local systems to ensure that emergency care pathways are designed and resourced to meet the needs of every single patient.

Focus on evidence-based healthcare policies

Doctors rightly expect treatments and diagnostics to have a credible evidence base. Policies from government and health boards can affect people's lives just as much, yet policy evaluation is the exception rather than the rule. The result is that uptake is grudging at best and the unevaluated policies are recycled. Policymakers must understand what works and what does not when implementing new initiatives to tackle long waits, possibly with a quality improvement methodology. Policies should be routinely measured and evaluated, and this evidence used to amend and inform the design of policies.

Metrics for performance and outcomes

Meaningful performance metrics will support the NHS to improve the quality and safety of care. In England, the clarity around the future of the 4-hour access standard – that at least 95%

Key points

- The crisis in emergency care is fixable, but too many people are spending too long in emergency departments.
- Ending dangerous ambulance handover delays and emergency department corridor care requires reducing hospital occupancy to less than 85%. This means both improving social care provision and increasing the number of beds.
- In all four UK nations, the NHS must expand and retain the emergency medicine workforce to achieve a safe patient-to-clinician ratio, with an increase in staff numbers and the faculty to train them.
- Healthcare policies, which affect people's health, must be properly evaluated.
- Metrics and time-based standards must be transparent and meaningful.

of patients attending emergency departments should be admitted, transferred or discharged within 4 hours – is welcome after years of being stuck in a performance vacuum. The standard should not be seen as a emergency department target, but a whole system standard. However, a standard as low as 76% may lead hospitals to preferentially process patients who are not acutely unwell and therefore do not require admission, allowing them to meet the standard. Performance against the 4-hour access standard is in decline in every UK nation; there must be a commitment to resourcing the system to meet this. Furthermore, aggregate reporting (where urgent treatment centre and minor injury unit performance are bundled together with that of major emergency departments) hides long waits and distracts operational attention.

Conclusions

Although the problems in emergency care are daunting, they are not insoluble. Similar problems were happening in the early part of the century and this was improved with political will and investment. The same will be possible if the government is willing to commit to resuscitating emergency care.

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