Royal College of Physicians

The College of Emergency Medicine

sam THE SOCIETY FOR ACUTE MEDICINE

NHS CONFEDERATION

Urgent and emergency care: a prescription for the future

Hospitals are struggling to cope with increasing pressure on urgent and emergency care services. The challenges faced by emergency departments are the most visible sign of pressure across our health system. This statement sets out a 10-point vision for addressing these challenges.

In spring 2013, the Royal College of Physicians (RCP), NHS Confederation, Society for Acute Medicine and College of Emergency Medicine brought together frontline professionals, leaders, policy-makers and innovators in healthcare to consider the future for urgent and emergency care services. The priority areas for action in this statement are the output of those discussions.

Hospital services are one aspect of a continuum of care for patients, involving general practice, social care, mental health services and others. This statement makes it clear that the solutions lie across the health and social care system. Organisations, professionals and policy-makers must work together to revolutionise the way we organise and deliver services for patients and communities.

July 2013

> Pressures on urgent and emergency care services

There are many compounding factors that affect emergency services and emergency care, which includes rising demand and the changing needs of an ageing population.[1] Further challenges include:

- a lack of comprehensive, effective alternatives to hospital admission across seven days
- complex discharge issues
- handover and flow
- recruitment into emergency and acute medicine.

> Ten priorities for action

To address the challenges faced by urgent and emergency care services, we must change the way we deliver and organise care across the whole system. The following priorities are integral to overcoming the pressures on urgent and emergency care services.

1 We must develop effective and simplified alternatives to hospital admission across seven days

Despite the high cost of hospitalisation, the NHS has been slow to develop comprehensive, effective alternatives to hospital admission. This is particularly important for patients with complex needs and chronic illness, and for those attempting to access healthcare services outside normal working hours. A simplified system whereby patients are able to access expert diagnosis and assessment in the setting that is most appropriate to their clinical needs is essential.

Priority: We must ensure that patients have access to expert diagnosis and assessment in different settings, and ensure there is clear information on the services available to them. These services should be centred around, and respond to, both the physical and mental health needs of patients.

2 We must adjust the financial incentives across the system, so that they support effective management of demand for unscheduled care

The NHS payment system includes a marginal rate for emergency admissions, which sees hospitals paid 30% of the tariff price for patients admitted above a baseline for admissions in 2008/09. This marginal rate was introduced to incentivise hospitals to stop rising emergency admissions. However, national data show that admissions have continued to increase since it was introduced. It has not been clear how the remaining 70% of the tariff price has been reinvested back into the healthcare system, and whether it has been spent developing community care to support the system in managing demand.

Priority: Financial incentives in the NHS need to be aligned so that they support the need to manage the demand in unscheduled care. We need to find the resources to invest in primary, community and social care, so they can be developed to be part of the solution to the growing challenge of providing effective urgent and emergency care services. The marginal tariff provides a mechanism to realise this investment. The funds this releases must be invested in a more transparent way in activities that support shared local objectives for improving efficiency and outcomes for patients. This should be driven by the local commissioners and providers who know their systems best and can come together to share risks and benefits appropriately across the whole system.

3 We must focus on supporting patients to leave hospital seven days a week

Effective discharge planning can reduce length of stay and readmission, and is therefore a vital element of emergency care. However, the discharge process is often complex, with some patients requiring a social care assessment, capacity assessment, mental health assessment, best interests assessment and subsequent actions. A safe, supported discharge relies on effective integration of primary, community, secondary and social care services, which should be resourced and available seven days a week.

Priority: Hospital teams should ensure early planning for discharge from hospital, involving a range of healthcare professionals. The use of 'step down' care facilities for patients in need of assessments and supportive care packages, but whose medical needs mean they no longer require an acute hospital bed, should be extended. We must continue the current drive towards seven-day services across and beyond the health service, and improve integration and collaboration between health, social and community care teams.

4 We must organise high-quality consultant-led hospital services across seven days

Consultants have the breadth of experience to recognise diagnoses, take action, investigate appropriately and initiate treatments. Early consultant assessment and intervention ensures that the patient starts on the right pathway of care as soon as possible.

The importance of consultant involvement during the early part of a patient's pathway has been highlighted in a number of reports.[2,3] In emergency and acute medical care settings, this has the potential for immediate improvements in outcome.[4] There are limited statistical data from English hospitals suggesting that the presence of emergency medicine consultants in the emergency department may reduce hospital admissions from between 12 and 25%.[5] Consultant presence on the acute medical unit (AMU) has also been shown to reduce patients' length of hospital stay.[6]

In addition to early review, hospital inpatients should also be reviewed daily by an on-site consultant seven days a week, which could enable immediate discharge or a shortened length of stay.[4] Finally, for this approach to be successful, support services (including diagnostics, treatment, administrative support) should also be available seven days a week to ensure that all the steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken.[4]

Priority: We must reorganise hospital care so that patients have access to consultant-led care regardless of the day of the week. A consultant physician should always be available 'on call' and should be present in the AMU for at least 12 hours a day, seven days a week with no concurrent duties except the delivery of care to acute admissions.[3]

5 We must promote greater collaboration within the hospital and beyond to manage emergency patients

It is increasingly common for patients being admitted to hospital to have a broad range of complex specialty needs. This includes mental health issues which may impact on the patient's physical health, and their ability to cope in their home environment. Effective liaison between emergency departments and mental health services should be in place seven days a week.

Priority: We must promote a collaborative model of care, including early senior decision-making in the emergency department and AMU. Multispecialty teams, with expertise in physical and mental health, should work in a network across the hospital and community to manage patients on an emergency care pathway.

We must ensure that patients have access to expert diagnosis and assessment in different settings, and ensure there is clear information on the services available to them.

6 We must ensure that there is sufficient capacity within the hospital, and the wider system, to meet changing demand

One of the key pressures facing emergency services is managing the increased demand for emergency care within a reducing resource of inpatient beds and deployment of medical staff. The UK has lower numbers of emergency beds than other western healthcare systems.[7]

One of the main causes of delays in ambulance handovers are delays in patient flow through the hospital. This is exacerbated by workforce and demand issues at the 'front door', and insufficient bed capacity within the hospital. The concept of 'flow' is a prerequisite to efficient, safe and effective care of patients in emergency departments and AMUs.

If patients who require further inpatient care cannot be transferred out of an emergency department after their condition has been stabilised, both they and subsequent arrivals may be disadvantaged. We must ensure that staffing levels in the AMU and emergency department match service demands and patient needs, reflecting both the numbers of patients and the times at which they are most likely to attend.

Priority: We must ensure that there is adequate bed and staffing capacity to meet the needs of patients admitted as emergencies. Systems need to be designed to ensure that empty capacity is maintained to enable fluctuations in demand to be safely managed; wherever possible each day should start with some unoccupied beds on the AMU. Likewise, community health and social care capacity, with appropriate support from medical teams, should be increased in order to absorb preventable unscheduled admissions.

7 We must focus on ambulatory ('day case') emergency care where appropriate

Ambulatory emergency care (AEC) is an approach which enables a significant proportion of emergency adult patients to be managed safely and efficiently on the same day thereby avoiding admission to a hospital bed. According to the RCP's Acute Medicine Taskforce, AEC may include diagnosis, observation, treatment and rehabilitation, that is not provided within the traditional hospital bed base or within traditional outpatient services, and that can be provided across the primary/secondary care interface. AEC requires prompt clinical assessment, undertaken by a competent clinical decision maker, and while the healthcare setting may vary, optimal clinical care will often require prompt access to diagnostic support.[8] Effective AEC is part of a whole systems approach that is only achieved by reorganising the working patterns of emergency care, diagnostic services and alternative services.

Priority: Those involved in commissioning and planning emergency care services must focus on AEC where it is appropriate to do so, setting out which patient groups can be better managed without overnight hospital stay. This focus on AEC should relieve some of the pressures on the AMU and emergency department and more widely within the hospital.

8 We must develop a sustainable workforce, fit for the future

Over the past few years it has become increasingly difficult to recruit into acute medicine and emergency medicine, with gaps in training schemes, an increasing reliance on locums, and unfilled consultant posts. This includes three successive years of only 50% fill rates for emergency medicine trainees, resulting in a 'lost cohort' of over 200 potential consultants.[9] In consequence, all UK emergency departments have a significant shortfall in senior trainees which affects service delivery and patient safety on a daily basis.

Priority: We need to ensure that emergency medicine and acute medicine remain attractive career options. It is vital that consultants and trainees have the skills, knowledge and time they need to make clinically appropriate decisions and communicate with patients. Job planning must take into consideration the intensity of workload and the number of hours worked, to ensure the long-term sustainability of a consultant career in these acute specialties.

9 We must show leadership

Following the shocking failures that occurred at Mid Staffordshire NHS Foundation Trust, the Francis Inquiry concluded that a transformation of systems, leadership and culture is needed throughout the NHS.[10] Cultural changes at organisational level are also instrumental to reduce the unscheduled demand for urgent and emergency care services. For example, redesigning the primary–secondary care interface achieved a substantial reduction in A&E admissions of frail elderly patients within the first five years of implementation in the

Southern Health NHS Foundation Trust.[11] Such programmes require partner organisations to incorporate new values and behavioural models, both at clinical staff and managerial level.

Priority: We must further enable leadership development and cultural change within the NHS, through promoting evidence-based decision-making, new organisational values and behaviours, and public transparency.

10 We must focus on public health and preventive health strategies

The effects of lifestyle choices, including alcohol, smoking and obesity, on public health and well-being have exacerbated pressures on urgent and emergency care services, with serious financial implications. For example, the cost to treat preventable diseases associated with behavioural factors is estimated at £17.9 billion each year – equivalent to approximately a fifth of the NHS budget.[12] They have also led to an increase in some long-term conditions, such as diabetes, which is expected to double in the UK by 2025.[13] A focus on public health and preventive health strategies, tailored to local needs at community level, will therefore be essential for a system-wide approach to urgent and emergency care services. Significant initiatives led by both NHS providers and commissioners have already strengthened early intervention efforts in areas such as psychiatric liaison, alcohol and falls prevention. Further expansion of such services, aiming to take a whole person and community approach to improving health, is essential.

Priority: We must support early intervention and preventative strategies where extra investment on community and preventive health is required; specifically, the future payment mechanism should be designed to support coordination of these services.

References

1 Department of Health. *Timesseries A&E attendance data*. London: 2011.

2 Royal College of Physicians. *Acute care toolkit 2: high-quality acute care*. London: RCP, 2011. www.rcplondon.ac.uk/sites/default/files/acute-care-toolkit-2-high-quality-acute-care.pdf [accessed 27 June 2013].

3 Royal College of Physicians. *Acute care toolkit 4: delivering a 12-hour, 7-day consultant presence on the acute medical unit*. London: RCP, 2012. www.rcplondon.ac.uk/sites/default/files/documents/acute-care-toolkit-4.pdf [accessed 27 June 2013].

4 Academy of Medical Royal Colleges. *Seven day consultant present care*. London: AoMRC, 2012. www.aomrc.org.uk/projects/seven-day-working.html [accessed 27 June 2013].

5 College of Emergency Medicine. *Emergency medical consultants: workforce recommendation*. London: College of Emergency Medicine, 2010.

6 McNeill G, Brahmbhatt D, Prevost A, Trepte N. What is the effect of a consultant presence in an acute medical unit? *Clinical Medicine* 2009:3:214-8.

7 Royal College of Physicians. *Hospitals on the edge? The time for action*. London: RCP, 2012. www.rcplondon.ac.uk/sites/default/files/documents/hospitals-on-the-edge-report.pdf [accessed 27 June 2013].

8 Royal College of Physicians. *Acute medical care: The right person, in the right setting – the first time*. London: RCP, 2007. www.rcplondon.ac.uk/sites/default/files/documents/acute_medical_care_final_for_web.pdf [accessed 26 June 2013].

9 College of Emergency Medicine. *Emergency medicine taskforce interim report*. London: CEM, 2012. www.collemergencymed.ac.uk/Public/Latest%20News/default.asp [Accessed 26 June 2013].

10 Francis Inquiry. *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. London: Stationery office, 2013. www.midstaffspublicinquiry.com/report [accessed 26 June 2013].

11 Southern Health NHS Foundation Trust. *Integrated community and mental health services*. Hampshire.

12 The Health and Social Care Information Centre. *Statistics on alcohol: England* and *Statistics on smoking: England*. London: 2012; and Government Office for Science. *Tackling obesities: future choices*. London: 2012.

13 Diabetes UK. *State of the nation 2012, England*. London: Diabetes UK, 2012. www.diabetes.org.uk/Documents/Reports/State-of-the-Nation-2012.pdf [accessed on 26 June 2013].

Join the debate

You can join the debate on how we overcome the challenges facing urgent and emergency care by:

- visiting the online forum: **www.rcplondon.ac.uk/forum**
- emailing suggestions and examples of innovative practice to: **policy@rcplondon.ac.uk**

This statement is the catalyst for discussions with national policy-makers, those involved in the design and delivery of urgent and emergency care services, patients and other key stakeholders from across health and social care.

It will be used to inform the national debate, including NHS England's 2013 review of urgent and emergency care (www.england.nhs.uk/uec-england).

> Royal College of Physicians www.rcplondon.ac.uk

The Royal College of Physicians (RCP) plays a leading role in the delivery of high-quality patient care by setting standards of medical practice and promoting clinical excellence. We provide physicians across 30 medical specialties with education, training and support. As an independent body representing over 28,500 fellows and members worldwide, we advise and work with government, the public, patients and other professions to improve health and healthcare.

The RCP's Future Hospital Commission was set up to review medical care for hospital patients, and covers many of the areas in this statement. The Commission reports in September 2013. For further information, visit: www.rcplondon.ac.uk/futurehospital

> NHS Confederation www.nhsconfed.org

The NHS Confederation is the membership body that speaks for the full range of organisations that commission and provide NHS services. It brings together the views of each and every part of the healthcare system, to provide a unique, strong voice for the whole of the NHS.

Our Hospitals Forum aims to identify the most important issues for hospital service providers. Our Urgent and Emergency Care Forum represents the whole healthcare system on issues relating to the delivery of urgent and emergency care. Both forums influence national policy and raise the public and service profile of existing good practice. For further information, contact: viviana.olivetto@nhsconfed.org

Examples of innovation in urgent and emergency care are available on the NHS Confederation website at: www.nhsconfed.org/Networks/Urgent-and-Emergency-Care-Forum/Pages/Innovation-in-urgent-and-emergency-care.aspx (new users will need to register). To find out more about the projects listed, or to add your project details, email: chiara.vivaldi@nhsconfed.org

> The College of Emergency Medicine www.collemergencymed.ac.uk

The College of Emergency Medicine supports, informs and champions the emergency medical needs of the population, so that the healthcare system provides care of the highest standard with compassion, respect and fairness, in appropriate and sustainable healthcare systems. We are responsible for setting standards of training in emergency medicine. We work to ensure high quality care by setting and monitoring standards, and providing expert guidance and advice on matters relating to emergency medicine.

> The Society for Acute Medicine www.acutemedicine.org.uk

The Society for Acute Medicine (SAM) is the national representative body for staff caring for medical patients in the acute hospital setting. We have over 1,000 members, the majority of whom are doctors specialising or training in acute medicine. We promote the education of medical, nursing and paramedical staff in acute medicine, promote acute care models that improve the management of patients, and share good practice.

Royal College of Physicians | The College of Emergency Medicine | sam THE SOCIETY FOR ACUTE MEDICINE | NHS CONFEDERATION