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ADVANCING SURGICAL STANDARDS

Acute and emergency care: prescribing the remedy

Urgent and emergency care services face profound pressures that are most obviously experienced by patients and clinicians working in emergency departments and acute admission wards. This policy paper sets out 13 recommendations to address these challenges and to build safer, more effective and efficient urgent and emergency care services for all patients.

The 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. The recommendations of this key summit are clear, concise and constructive. No plans for emergency care should be developed without consideration of these consensus recommendations.

Clifford Mann

Dr Clifford Mann, President
The College of Emergency Medicine

The recommendations set out in this report were informed by discussions that took place at a round-table event in spring 2014. The event, co-organised by the College of Emergency Medicine, the Royal College of Physicians, the Royal College of Surgeons, the Royal College of Paediatrics and Child Health and the NHS Confederation, 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.

Whilst the emergency department may be the primary focus of public attention for urgent care, it represents only part of the urgent and emergency care system. Acute hospital services, general practice, mental health services, and community and social care are the other core components of the system. This policy paper identifies the key recommendations across all the components of urgent and emergency care that must be addressed if we are to avoid an annual crisis response and build a resilient system that is fit for purpose.

Challenges for urgent and emergency care

Currently the challenges faced by urgent and emergency services overwhelm the capacity of the system. In consequence the delivery of quality care is compromised. Key contributors to this phenomenon are rising acuity levels and a lack of accessible and effective alternatives to the emergency department. Further barriers include:

- > complex discharge requirements and community integration
- > emergency department crowding and patient flow into the hospital
- > staff recruitment and retention in acute care specialties
- > recognising and meeting the needs of specific patient groups, including frail older people, individuals with mental health conditions, homeless people, adolescents, infants, drug and alcohol users, and patients entering a final illness.

Building system resilience

Emergency care must be delivered 24 hours a day, 7 days a week, 365 days a year for all patients in need. System pressures can occur at any time and the system must be robust enough to withstand such pressures without compromising the delivery of care. The following recommendations must be implemented to ensure a resilient system that is fit for purpose.

For each recommendation, the main drivers are highlighted according to whether they operate at local or national level. Although a degree of shared responsibility invariably exists, this must not be a barrier to action or an excuse for delay.

This report is accompanied by a recommendations statement specifically referenced to the health and social care systems of England, Northern Ireland, Scotland and Wales.

Key:

- L** Local recommendations
- N** National recommendations

Access and alternatives

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

The entire urgent care needs of the population cannot be delivered within the same framework and resources as emergency care. It is not appropriate for accident and emergency to be regarded as 'anything and everything' or for the emergency department to be 'everyone's default'.¹

It is unreasonable to expect patients to determine whether their symptoms reflect serious illness or more minor conditions. Co-location enables patients to be streamed following a triage assessment. This also enables collaborative working including sharing of diagnostic facilities, reduces duplication of administrative tasks and permits patients to be easily re-triaged should further assessment require so.²

2 N 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.³⁻⁵

Examples of best practice include:

- > stroke patients being transferred directly to stroke units
- > medical patients who have been assessed by a GP being taken directly to the medical admissions unit
- > elderly patients with multiple comorbidities undergoing investigation by multidisciplinary teams, not necessarily within the setting of the emergency department
- > patients with post-operative complications being returned to surgical services
- > patients suffering from falls being assessed first by ambulance falls services
- > GP-to-consultant advice lines
- > easy access to urgent clinics.

Such best practice must be complemented by agreed and implemented guidelines for the management of patients on acute medical and surgical units, mindful of the need for many such patients to receive cross-specialty care.

Skill mix / case mix

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

In line with recommendations made in Shape of Training, Medical Royal Colleges should promote the development of core common competencies by all doctors in training.⁶ Emergency department experience is an invaluable asset.⁶ This will create a medical workforce with the interspecialty skills necessary to meet the clinical challenges of the future.

4 L 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.

This is the most reliable way to deliver safe, effective and efficient care.^{7,8} It should include acute physicians, acute paediatricians, GPs, emergency care physicians, geriatricians and psychiatrists. Early senior review has substantial proven benefits, including mortality reduction, lower admission rates, early safe discharge, reduced lengths of stay and more appropriate use of investigations.

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

Where an emergency department does not have on-site back-up from particular specialties, there should be robust networks of care and emergency referral pathways. NHS provider organisations should implement the recommendations of the Berwick report.⁹

6 L At times of peak activity, the system must have the capacity to deploy or make use of extra senior staff.¹⁰

If escalation procedures are a frequent occurrence, for example weekly, this is evidence of poor staffing models. Inadequate capacity exacerbates exit block and this in turn increases mortality for all patients.

Integration and communities

7 N Community and social care must be coordinated effectively and delivered 7 days a week to support urgent and emergency care services.^{3,11,12}

This requires investment in the infrastructure of community care and a change in culture to remove many of the current procedural obstacles. The aim should be to facilitate the safe discharge and timely transfer of care of patients from the hospital to their own home or usual place of residence. This requires direct daily communication between the hospital and social care services, and integrated care planned in advance.

Delivering care to the homeless and to patients with alcohol and substance abuse problems are exemplar projects in which best practice models have delivered proven benefits.

8 L 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. The physical, mental and social needs of adults and children with acute or long-term mental health conditions are better met when psychiatric liaison services are easily accessible to staff working in the emergency department and acute medical units.¹³ Best practice models for psychiatric liaison services should be adopted across the NHS.

Delivering care to the homeless and to patients with alcohol and substance abuse problems are exemplar projects in which best practice models have delivered proven benefits.

All emergency departments must have timely access to a paediatrician with safeguarding skills and experience.¹⁴

Seven-day service

9 **N** The delivery of a seven-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.¹¹ This will require additional resources.

This will enable equity of outcomes for all patients. Nevertheless, this will require sustainable staff rotas that encourage recruitment and retention.¹⁵ Urgent and emergency care services must also develop and implement credible plans to meet predictable surges in demand, such as on bank holidays and when GP services close. If implemented properly, seven-day services can empower hospitals to return patients home sooner, reduce crowding and improve efficiency.

Health services are judged on two key components: the ability to deliver elective care and the ability to deliver urgent and emergency care. Neither should compromise the other.

Urgent and emergency care services must also develop and implement credible plans to meet predictable surges in demand, such as on bank holidays and when GP services close.

Funding / fair reward

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


Funding structures currently penalise all acute care services and ensure that they are a loss-making activity for hospitals.¹ This condemns the system to be reactive, owing to a poverty of resources. Proactive behaviours are the hallmark of properly managed and sustainable systems. Though the 4 hour target is useful, it has insufficient drivers in place to eliminate exit block and has perverse effects. Targets must be aligned to support clinically relevant outcomes and the system reconfigured to better share ownership of risk and reward, thereby encouraging collaboration and innovation.

11 **N** Delivering 24/7 services requires new contractual arrangements that enable an equitable work–life balance.

Fairness and sustainability should underpin all staff contracts. Current contracts lack the mechanisms necessary to ensure that acute care specialists have a fair work–life balance. This issue has been recognised by the Secretary of State, the Department of Health, the NHS Confederation and the British Medical Association.^{16–18}

If locum doctors are required to ease workforce shortages, then such locums should be rewarded with longer fixed-term contracts.

Training time is essential for equipping the medical workforce with the skills to handle system pressures. Trusts must also support staff suffering from ‘burnout’ due to current pressures.



‘There’s no such thing as ‘out-of-hours’ for my condition. I just want the right care for me, in the right place, at the right time.’

Patient representative

Key:

L Local recommendations

N National recommendations

Information technology (IT)

12 **L** 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.

Proper use of data can allow hospitals and acute care systems to predict with reasonable accuracy times of peak pressures using a calendar and system dashboards. This should inform capacity planning for medical staffing, bed planning, transport and diagnostics. The workforce should be able to access medical and safeguarding records promptly to ensure safe and efficient care. The IT infrastructure must also allow rapid notification of urgent and emergency care services to GPs, social care and children's services.

Current data are often of poor quality and certainly cannot be used with confidence to provide an accurate reflection of urgent and emergency care throughout the UK.

Proper use of data can allow hospitals and acute care systems to predict with reasonable accuracy times of peak pressures using a calendar and system dashboards.

13 **N** If configured properly with significant clinical involvement and advice, NHS 111, NHS 24, NHS Direct and equivalent telephone advice services can help to reduce the pressures on the urgent and emergency care system.

Telehealth staff should be able to access the medical records of patients, such as those found in the summary care record, and should be supplied with an electronic directory of all healthcare services. They should be able, with senior clinical support, to make appointments with primary care teams in cases where such a course of action is most clinically appropriate.

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Summary of recommendations

Access and alternatives	1 L	Every emergency department should have a co-located primary care out-of-hours facility
	2 N	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
Skill mix / case mix	3 N	All trainee doctors on acute specialty programmes should rotate through the emergency department
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Integration and communities	7 N	Community and social care must be coordinated effectively and delivered 7 days a week to support urgent and emergency care services
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Funding / fair reward	10 N	The funding and targets systems for emergency department attendances and acute admissions are unfit for purpose and require urgent change
	11 N	Delivering 24/7 services requires new contractual arrangements that enable an equitable work-life balance
Information technology	12 L	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
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