PRESS STATEMENT

25 November 2014

STEP Campaign:
Rebuilding the emergency medicine service step by step

The College of Emergency Medicine today launches its STEP campaign in England. The College speaks for doctors and consultants working in A&E departments across the UK and Ireland. We have been calling for action to address the significant challenges facing A&Es, and whilst some progress has been made, there is much work to do to provide a safe and efficient service for our patients.

To rebuild the Emergency Medicine service the College is calling for four steps to be taken:

STEP 1: Safe and sustainable staffing levels must be achieved

STEP 2: Tariffs and funding must be fair and effective

STEP 3: Exit block and overcrowding must be tackled

STEP 4: Primary care facilities must be co-located with A&E services

The College President, Dr Clifford Mann, said:

“This campaign is critical to providing relief and securing the future for A&Es. Our hard working doctors need tangible action to support them to stop the leaching of talent to Australia and New Zealand; patients deserve better access to care with primary care services being co-located with the A&E; ‘exit block’ needs to be a thing of the past; and the funding systems must stop penalising hospitals for treating the acutely ill and injured.”

The College urges Government, politicians and NHS leaders to work together to take the four steps needed to rebuild emergency care. These steps are set out in more detail below:
Staffing - safe and sustainable

The numbers of Emergency Medicine specialist doctors and consultants working in A&E departments remain insufficient to deal with the rising numbers of patients seeking urgent and emergency care.

The College has for many years called for staffing levels to match patient flows. To achieve 7 day coverage of consultants between 8am and midnight this means calling for a minimum of 10 consultants in each Emergency Department, rising to 16 or more in larger units. The College recognises that there is local variability in the size and scope of some Emergency Departments and a one-size fits all approach is not the answer. That is why we will soon be launching some additional toolkits to help with resource planning. However, when we last surveyed our Members and Fellows we found that on average there were only 7.6 consultants per Emergency Department. Whilst the trend is towards improvement, it is not moving ahead fast enough.

The shortages of doctors and consultants are being filled in part by locum doctors. But this wastes in excess of £120m at a time when NHS resources are scarce. Efforts to increase recruitment, with additional training posts being created this year, seem to be having a beneficial effect, yet shortages of trainee doctors remain as not all posts are filled. Until this year we have seen only 50% of trainee posts filled for the previous 3 years. Even now with better recruitment in 2014, there remains a critical shortage of doctors working in A&Es.

Coupled with this is the issue that more doctors and consultants are emigrating to work abroad. Our Members and Fellows tell us that they are being worn down by the relentless workload from understaffed departments. The stress of working in facilities where the desired quality of care is not possible because the team is under-resourced is significant. The cost to the British taxpayer of training doctors who ultimately end up working in Australia alone is around £130m, we estimate.

The College calls for safe and sustainable staffing of A&Es. This means addressing the work/life balance for those working in A&Es, and recognising the demands of all acute specialties through reviewing their terms and conditions.

Failure to address this will result in a haemorrhaging of the acute workforce. Doctors will vote with their feet and exit the specialty.

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Making sure the system is providing adequate funding for Emergency Departments is vital. Whilst the funding systems in each nation within the UK are different, the principle of fair and effective funding should apply to the whole of the UK.

In England the National Tariff Payment System (the national tariff) for the NHS covers national prices, national currencies, national variations, and the rules, principles and methods for local payment arrangements. It is not working effectively. Acute trusts are being penalised for each and every non-elective admission into hospital. Similar issues are seen across the rest of the UK.

The College of Emergency Medicine re-iterates the point it has made repeatedly: current tariffs make provision of urgent and emergency care uneconomical, and create perverse incentives that drive patients towards Emergency Department care, rather than preventing it.

This means in practice that acute trusts lose money on their Emergency Departments and have to subsidise this by increasing the number of elective care operations they undertake. This in turn increases the pressure on hospital capacity, and reduces the numbers of beds available for patients.

The combined effect is to see hospitals operating at full capacity and with under-resourced Emergency Departments.

The College calls for action in the form of an end to the perverse incentives that are producing a dysfunctional system.

The College of Emergency Medicine regards correct and fair implementation of the Payment by Results system in Emergency Medicine using accurate Reference Costs as the quickest, fairest and most logical first step in any payment reform. The practical difficulty in accurately costing Emergency Department reference costs means that a sentinel site approach should be used to determine costs, like the approach used in Australia.

The College of Emergency Medicine believes that Monitor must state as one of its core principles the understanding that acute care and elective care must have equity of funding. Monitor must demonstrate that it understands that the currently accepted notion that elective care will subsidise acute care results in systematic prejudice against acute care that results in direct harm to patients.

In Wales, Scotland and Northern Ireland, although a different payment system is used, the principles of achieving equity of funding remain appropriate for acute care and elective care.
Exit Block

A condition called ‘exit block’ is harming patients: they are put at risk when ‘exit block’ occurs. This happens where you cannot transfer patients from Emergency Departments into a hospital inpatient bed. Exit block is explained in more detail in this video: Exit Block: What it is and why it is dangerous.

Over 500,000 patients a year are affected by exit block. The College of Emergency Medicine says that this is unacceptable.

The College calls on hospital Chief Executives and their Boards to make sure that this issue is on their agenda. To help with tackling this issue the College has issued guidance: Crowding in Emergency Departments, NHS England, Monitor, and the Trust Development Association have all endorsed this in their own winter planning guidance for this coming winter.

We are concerned about patient safety. When the A&E becomes crowded because of Exit Block we know that patients do less well. We know that crowding kills. It is simply not acceptable to let this situation continue which is why we are on a mission to urge hospital Chief Executives and their Boards to make sure they have plans to deal with this issue.
Primary Care Facility - co-located with A&Es

We know that 15% of patients attending Emergency Departments could be treated outside A&E by GPs. We know this from our own research which we published in May 2014.

Rather than blame the patients for attending A&Es, when they may have difficulty accessing other alternatives, we believe a new approach is required. Efforts to encourage patients to seek assistance over the phone or to go elsewhere over the past 15 years have not reduced the flow of people to A&Es. So we believe the issue should be dealt with by positioning services where the patient is attending, by co-locating Primary Care facilities with A&Es.

This approach is supported by NHS Providers (formerly The Foundation Trust Network), the Royal College of Physicians, the Royal College of Surgeons, the NHS Confederation, the Royal College of Paediatrics and Child Health, NHS England and the Department of Health (England).

Co-location will:

1. **Allow patients to be routed to the best place to obtain their care.** Co-location will put more staff at the front line with a better distribution of skills for the wide spectrum of urgent and emergency presentations.

2. **Transfer patients quickly and safely between urgent care and the ED.** Inevitably, there will be people who are in the wrong place; this can be remedied without either patient harm or inconvenience.

3. **Provide Primary Care Out-of-Hours staff with immediate access to facilities such as radiology, pathology and ECG.** This is much cheaper than putting these services on a second site (or even in GPs’ surgeries as sometimes suggested). There is the additional advantage of the proximity of staff who can interpret ECGs and x-rays; immediate reporting by radiologists may also be available. The immediate result from an investigation may guide treatment and sometimes even prevent hospital admission. Sharing facilities in this way also reduces the costs of running an ED. Patient satisfaction is likely to be increased by the ability of GPs to request investigations.

4. **Encourage Primary Care staff and ED staff to share opinions and knowledge.** This may be especially beneficial in the case of returning older people to their own homes with a viable package of care and support, as advised by primary care staff.

5. **Allow other services such as emergency dentistry and frailty units to be co-located on the same site.** This has obvious benefits for both patients and the health economy.
Contact

For further information, or to speak with a media spokesperson for The College of Emergency Medicine, please contact Matt Chorley on +44(0)20 7067 1275 or email matt.chorley@collemergencymed.ac.uk.

About the College of Emergency Medicine

The College of Emergency Medicine is the single authoritative body for Emergency Medicine in the UK. Emergency Medicine is the medical specialty which provides doctors and consultants to (Accident &) Emergency Departments in the NHS in the UK and other healthcare systems across the world.

The College works to ensure high quality care by setting and monitoring standards of care, and providing expert guidance and advice on policy to relevant bodies on matters relating to Emergency Medicine.

The College has over 4500 fellows and members, who are doctors and consultants in emergency departments working in the health services in England, Wales, Scotland and Northern Ireland, Eire and across the world.

The STEP campaign is currently for England only. We are working in Scotland, Wales & Northern Ireland on similar initiatives which will be announced in due course.