The Royal College of Emergency Medicine is the single authoritative body for Emergency Medicine in the UK. The Royal 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.

**Question:** Why does the NHS finds it necessary to continue to implement specific plans to cope with winter pressure when it is well established that seasonal change will alter the nature of demand?

1. In 2015, the Royal College of Emergency Medicine endorsed ‘Safer, Faster, Better’ published by NHS England. This offered ‘good practice in delivering urgent and emergency care’ and was, in our view, a constructive step forward.

2. This document put forward a number of principles, ‘to improve safety and flow, and help reduce unwarranted variation and manage demand’. The first of those principles states:

   “**Emergency departments (EDs) should be resourced to practice an advanced model of care where the focus is on safe and effective assessment, treatment and onward care. While it is essential to manage demand on EDs, this should not detract from building capacity to deal with the demand faced, rather than the demand that is hoped-for.**”

3. It is our view that the NHS finds it necessary to implement specific winter planning because – despite this advice – we continue to resource emergency departments for demand that is hoped for instead of the demands that we actually face.

4. For example, ‘The Keogh Urgent and Emergency Care Review’ has been progressing since 2013. Much of its attention has been directed at reducing patient demand on A&E departments.

5. This is commendable, though the College is of the opinion that the gains realisable from such a strategy are limited. The UK already has a relatively low usage of emergency departments when measured as visits per annum per capita.

6. Nevertheless, the pressures on emergency departments in terms of attendances and admissions have risen consistently over the last ten years\(^1\). To expect this trend to reverse at a time when the population is both aging and rising will condemn the system to further failure.

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7. Since 2010-11 attendances have increased by 1,031,164 (7.4%) but admissions have increased by 603,063 (17.34%). Not only does this demonstrate that redirection strategies have largely failed, it also indicates that they are seeking to address the wrong problem. The growth in admissions is more than double the growth in attendances. We are not dealing with ‘more of the same’. The casemix has shown a significant rise in the proportion of patients whose care cannot be delivered outwith the acute hospital setting.

8. The increase in attendances in the last 5 years is equivalent to the workload of 10 medium sized departments in England alone – none of which have been built. Moreover, during the last 5 years the number of beds available for admission of acutely ill and injured patients has continued to fall and we now have the lowest number of beds per capita in Europe and England has the lowest number within the UK.²

² NHS England Average Daily Available and Occupied Beds Timeseries
9. Since 2010-11 the total number of beds has decreased by 8.91% (12,875) and the number of general and acute beds has declined by 6.44% (7,127). The combination of increased demand and diminished physical capacity has led to a predictable increase in rates of bed occupancy. Since 2010-11 general and acute bed occupancy has increased from 86.3% to 91.2%. This is the figure recorded at midnight – daytime occupancy rates frequently exceed 100% in many hospitals. Such occupancy levels mean there is no surge capacity, rendering hospitals hostage to fortune.

10. These problems have been exacerbated by the difficulty of recruiting and retaining adequate number of staff in A&E departments. The table given below show the number of emergency physicians (FTE) working in the NHS in England, as recorded by the Health and Social Care Information Centre (HSCIC)

<table>
<thead>
<tr>
<th>Staff Grade</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>FTE Change</th>
<th>Percentage Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident &amp; Emergency Consultants (FTE)</td>
<td>1,013</td>
<td>1,100</td>
<td>1,230</td>
<td>1,320</td>
<td>1,425</td>
<td>1,483</td>
<td>470</td>
<td>46.40</td>
</tr>
<tr>
<td>A&amp;E Registrars</td>
<td>2064</td>
<td>2166</td>
<td>2185</td>
<td>2256</td>
<td>2376</td>
<td>2359</td>
<td>295</td>
<td>14.29</td>
</tr>
<tr>
<td>A&amp;E Senior House Officers</td>
<td>124</td>
<td>119</td>
<td>98</td>
<td>111</td>
<td>104</td>
<td>79</td>
<td>-45</td>
<td>-36.29</td>
</tr>
<tr>
<td>Foundation Year 2</td>
<td>1104</td>
<td>1086</td>
<td>1086</td>
<td>1088</td>
<td>1144</td>
<td>1156</td>
<td>52</td>
<td>4.71</td>
</tr>
<tr>
<td>House Officer and Foundation Year 1</td>
<td>200</td>
<td>206</td>
<td>192</td>
<td>205</td>
<td>209</td>
<td>223</td>
<td>23</td>
<td>11.50</td>
</tr>
</tbody>
</table>

11. These figures indicate a growth in the workforce but the ratio of patients to ED medical staff is stark. Currently there is 1 A&E consultant for every 11,000 attendances. No other country developed operating emergency medicine departments has so few senior decision makers.

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3 Health and Social Care Information Centre NHS Workforce Statistics
12. There are 176 type 1 Emergency Departments in England. Currently there are insufficient consultants in post to provide even one on duty in every department for even 16 hours per day.

13. Had staffing levels been adequate⁴ and kept pace with admissions⁵ by 2015-16 there would have been 2516 EM consultants in the NHS in England c.f. 1483. Had the workforce as a whole grown at a similar rate there would now be 8,074 doctors working in our emergency departments rather than, as now, 5300.

14. In the wake of the Francis Report, Trusts have frequently complained about the difficulty of recruiting sufficient numbers of consultants, a situation which can only have been made worse by the significant number of NHS trained professionals who have chosen to work in other countries⁶. Over 600 senior emergency medicine doctors trained in the UK now work in Australia. All of this contributes to an increased risk of attrition and burnout for those EM staff who remain in the UK⁷.

15. The rise in admissions coupled with a reduced bed stock creates a phenomenon of ‘Exit Block’. This occurs when a patient requiring admission cannot be moved to an appropriate ward in a timely fashion. Since 2013-14 the number of patients waiting over 4 hours has increased by 131% and the number of patients waiting over 12 hours has increased by 323%⁸.

16. These trends provide both cause and effect with respect to A&E department capacity. Reduced flow through the emergency department impedes the accommodation of new attendances. In turn all aspects of A&E performance deteriorate including ambulance off-load times.

17. Exit block is proven to be associated with both significant morbidity and mortality. The latter has been estimated at 3000 patients per year in the UK⁹.

18. Paradoxically exit block is associated with a greater number of patients admitted to ‘any bed’ rather than an ‘appropriate bed’. In turn this leads to greater lengths of stay, reducing the available bed stock and perniciously increasing the frequency and severity of exit block.

19. NHS England itself stated in their report ‘Safer, Faster, Better’ published in 2015 that ‘ED crowding adversely affects every measure of quality and safety for patients & staff.’ And went on to explain that ‘The main causes of ED crowding include surges in demand and lack of access to beds in the hospital system due to poor patient flow and high hospital occupancy rates’.

20. The preceding data and analysis describe the pressures and constraints that are non-seasonal. The winter period is atypical in that although overall ED attendances per day are lower in winter than summer, the reverse is true of admissions. In particular respiratory admissions almost double in December and January.¹⁰

21. Set in the context of more patients, more admissions and fewer acute beds it is hardly surprising that performance against the 4 hr standard has fallen. Indeed it is perhaps more

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⁴ Royal College of Emergency Medicine The Way Ahead.
⁵ See above 17.34% growth in admissions.
⁶ Royal College of Emergency Medicine Why Does Winter in A&E get Worse Every Year
⁷ Royal College of Emergency Medicine Stretched to the Limit
⁸ NHS England Annual A&E Activity and Emergency Admissions statistics, NHS and independent sector organisations in England
⁹ Royal College of Emergency Medicine Why Does Winter in A&E get Worse Every Year
¹⁰ Royal College of Emergency Medicine Why Does Winter in A&E get Worse Every Year
surprising it has not fallen further. The seasonal demand of winter merely highlights the lack of surge capacity endemic within understaffed and under-resourced departments and the aforementioned bed pressures.

22. The Nuffield Trust have published data showing that to achieve the occupancy rates within A&E that were seen ten years ago we would need to have built 30 major new A&E units. They conclude ‘It is a huge achievement that a decade of increased activity has been accommodated by increasing efficiency within A&E departments’\textsuperscript{11}

**Question:** What steps need to be taken to ensure that A&E departments are able to cope with the pressure they will face in the coming winter?

23. Given these trends, and the demonstrable inability of redirection or re-education strategies to alleviate these pressures, it is our opinion that the co-location of key out of hours urgent care services would significantly decongest emergency departments.

24. A co-located model – in which key components of urgent health care are physically and functionally co-located and integrated would allow the alignment of behaviours with resources. In turn this would promote collaborative working and better focus service provision according to patient need. Such a model is already partially implemented in some places and has had considerable successes. For example, the Blackpool ‘Reception Point Project’ showed an 18% deflection rate away from emergency care\textsuperscript{12}.

25. The College’s own data is even more compelling\textsuperscript{13}. Our Sentinel Sites study published in 2014 shows that more than a third of attendances could be managed without input from an EM doctor\textsuperscript{14}. As such, it is quite certain that a significant proportion of patients attending an A&E department could be managed at least as well if not better by other services/staff.

26. There any many theories as to why the NHS struggles each winter, the Health Select Committee\textsuperscript{15} recognised this in 2013 when they stated ‘the system cannot accurately analyse the cause of the problem, still less resolve it, if it continues to ‘fly blind’. More accurate information about the causes of rising service pressures is not simply a management convenience; it is fundamental to the delivery of high quality care’. The College has been leading a project to develop a new data standard to address this, the Emergency Care Data Set, and would appreciate the Health Select Committee’s ongoing support regarding its implementation.

27. A&E has become ‘Anything and Everything’ in the out of hours period, a function it is not resourced to deliver. The lack of other services for urgent care needs leads to clinically improbable spikes in attendances at weekends and bank holidays. Establishing an A&E hub model of service provision would ensure that up to a third of patients (almost 5 million per year) were seen by more appropriate providers/services thereby decongesting the emergency department and improving the care delivered to those most in need of ED clinicians.

28. This model is endorsed by the following key stakeholders; the Royal College of General Practitioners, the Royal College of Psychiatrists, the Patients Association, the Royal Pharmaceutical Society and the British Geriatric Society.

\textsuperscript{11} Nuffield Trust *What’s Behind the A&E ‘Crisis’*
\textsuperscript{12} NHS Pathways Reception Point [http://systems.hsic.gov.uk/pathways/blackpool](http://systems.hsic.gov.uk/pathways/blackpool)
\textsuperscript{13} Royal College of Emergency Medicine *The Drive for Quality*
\textsuperscript{14} Royal College of Emergency Medicine *Sentinel Sites: Better Data Better Planning*
\textsuperscript{15} Health Select Committee *Urgent and Emergency Services*
29. The Nuffield Trust has shown that 84% of A&E attendances are by people who live within 7.5 miles of a major A&E department.\textsuperscript{16} That is why the College believes that providing such a hub of services within easy travelling distance of most of the population is both effective and efficient. For those not within easy travelling distances non-urban urgent care centres could provide all but hospital based services.

30. Under shared locally agreed governance, the co-location of the Out of Hours Primary Care Team, Community Pharmacy, Out of Hours Mental Health Team, Frailty Team and the Emergency Department would provide patient services more appropriate to case-mix and skill mix than the current arrangements. This is not to argue for new services but for the co-location of existing services around the point that patients attend: the A&E department.

31. The endorsement of the British Geriatric Society is particularly important given the rapid changes in the elderly demographic within the UK. The trend data demonstrate that the number of people over 85 years of age will grow by almost 90k per year for the next 20 years\textsuperscript{17}. Compared to 2010 there are an additional 130,000 people aged over 85 alive today.\textsuperscript{18}

32. In-reach frailty services based upon a Comprehensive Geriatric Assessment are proven to reduce admissions and length of stay and must be regarded as an essential component of 21\textsuperscript{st} century acute services. The care of this section of our population more than any other will determine the success or otherwise of the acute care system. Currently the probability of admission is directly correlated with age. It is imperative that this default option is challenged.

33. However it is vital to recognise that meeting this challenge will require a multi-disciplinary approach with skilled and expert teams working together, as the burden of illness carried by this elderly cohort is substantial.

34. It is also important that we recognise that the provision of financial resources has a role to play in tackling these issues. Tariffs have led to chronic underfunding of acute care in general and emergency care in particular. The current system has also created perverse activity incentives. The 30% marginal tariff for acute admissions guaranteed acute services in hospitals were dependent upon cross subsidies from elective care. This meant that any arguments for increasing acute care capacity were subordinated to the delivery of more elective services.

35. This failure to align incomes with activity only changed with the uplift of the tariff to 70% when it became clear that bed occupancy rates in England were so high that elective activity and hence income had become compromised. Regrettably this revision was too little too late.

36. Within the A&E department itself tariffs are also ill conceived. Those patients requiring least intervention, investigation or treatment are remunerated at a rate that enables services to be maintained. However the maximum tariff for the most seriously ill or injured is less than £250. This ensures that treating the very patients emergency departments are established to treat is a loss-making endeavour for a hospital.

37. Poor systems of reimbursement for acute care have led to almost two decades of underfunding. We are currently reaping both the capital and revenue consequences with

\textsuperscript{16} Nuffield Trust: \textit{Focus On: Distance from home to emergency care}

\textsuperscript{17} NHS Confederation \textit{Key Statistics on the NHS}

\textsuperscript{18} ONS \textit{Mid-Year Population Estimates 2015}
A&E departments designed and built for far fewer attendances and woefully understaffed much of the time.

38. Were this situation associated with significant cost savings an independent scrutineer might adjudge the constraints and consequences as worthwhile. However the costs of supporting this overstretched system are considerable. Examining just the locum costs for A&E doctors (i.e. excluding all other medical locums and nursing agency costs) demonstrates a weekly spend of £3 million. The average annual running cost of a medium sized emergency department is £8.5 million. It is therefore a matter of simple arithmetic that if invested rather than spent we could actually run an additional 17 medium sized A&E departments per year and still save money.

39. As stated above, in 2015 we welcomed the publication NHS England’s ‘Safer, Faster, Better’, and endorsed all of the conclusions:

- Emergency departments (EDs) should be fully resourced to practice an advanced model of care where the focus is on safe & effective assessment, treatment and onward care.
- Whilst it is essential to manage demand on EDs, this should not detract from building capacity to deal with the demand faced, rather than the demand that is hoped-for.
- ED crowding adversely affects every measure of quality and safety for patients & staff.
- The main causes of ED crowding include surges in demand and lack of access to beds in the hospital system due to poor patient flow and high hospital occupancy rates.
- EDs should be staffed so that capacity meets variation in demand NOT average demand.
- Performance against the 4-hour standard is a useful proxy measure of crowding.

Conclusion

40. Admissions via Type 1 A&Es have risen annually by an average of 110,000 since 2005. This rise is set to continue.\textsuperscript{19}

41. There are too few senior medical staff in A&E departments to deliver effective and efficient care. The attrition rate from UK training programmes has wasted our most valuable resource. We must ensure the work environment and shift patterns promote rather than discourage staff retention.

42. Planning must especially address the need to cope with rising numbers of attendances by the frail elderly – with complex interactions between health and social care and long term co-morbidities.

43. Provision of co-located services within an A&E hub to decongest emergency departments will deliver a successful strategy that is patient centred, affordable, efficient and effective.

44. Correct funding of emergency care is essential as the cross subsidy model has failed.

\textit{August 2016}

\textsuperscript{19} NHS England \textit{Annual A&E Activity and Emergency Admissions statistics, NHS and independent sector organisations in England}