NHS CONFEDERATION

briefing

September 2013 Issue 268

Emergency care: an accident waiting to happen?

Key points

- NHS leaders are clear – rising numbers of frail older people with long-term conditions are the most significant cause of growing pressures on urgent and emergency care.
- Unless urgent action is taken to address these pressures, patient safety could be endangered, waiting times increased and a domino effect triggered, pushing some NHS organisations into financial failure.
- Many NHS organisations have implemented innovative schemes to tackle the pressures but bold action is needed at a national level to safeguard the future of emergency care.
- To tackle rising demand, we need more investment in primary and community care, a national campaign to explain the alternatives to A&E and wholesale reform of incentives in the NHS.

Emergency departments are the most recognisable part of any hospital. The inherent drama of emergency care often graces our TV screens, and for many people emergency departments are their only experience of NHS acute care. They are greatly valued in local communities as a reliable and easy way of accessing care when it is most needed, which is why they have been the focus of intense scrutiny over the last six months.

This *Briefing* aims to debunk some of the myths around A&E care and provides a snapshot of what our members are experiencing across the country. Our findings are based on a survey of 125 senior NHS leaders and an analysis of national data. Respondents to our survey included NHS chief executives, commissioners, chairs, medical directors and chief nursing officers. They have shed light on the causes of A&E pressures and put forward potential solutions.

What happens in emergency care is crucial for patients and the NHS as a whole – and it is our job to give voice to those experiencing what is happening on the front line. This is their contribution to the debate.

The current picture

The Health Select Committee recently said the system will be unable to resolve the problems in emergency care if it continues to 'fly blind'.[1] That is why gaining insight from our members is crucial to this debate.

National statistics show that emergency admissions have increased by 51 per cent in the past decade[2], but that acuity in the needs of patients has risen sharply. This is demonstrated by the fact we have seen a 26 per cent rise in admissions

'Members were clear the biggest cause of pressures on local A&E services is the rising number of frail older people with multiple long-term conditions'

among the 85-plus age group over four years.[3] Indeed, members were clear the biggest cause of pressures on local A&E services is the rising number of frail older people with multiple long-term conditions (see Figure 1).

How patients move through the health service is also a huge concern for our members. Difficulty in discharge often results from a lack of available, more appropriate care outside of the hospital. There is a particular problem with the lack of social care places, given the current pressures on local authority budgets. It is clear that problems with discharge put further pressure on already stretched services and are distressing for patients.

Working under pressure

Others cite the difficulties of recruiting middle-grade medical staff as a factor in overstretched emergency departments. As one member told us when asked if they could identify any other pressures on emergency care:

"There are not enough qualified consultant staff to provide 24-hour cover in our A&E. Workforce planning and protection of professional status need to be addressed."

This reflects a general trend among our members to highlight workforce issues such as skill mix as areas that need more attention in emergency departments.

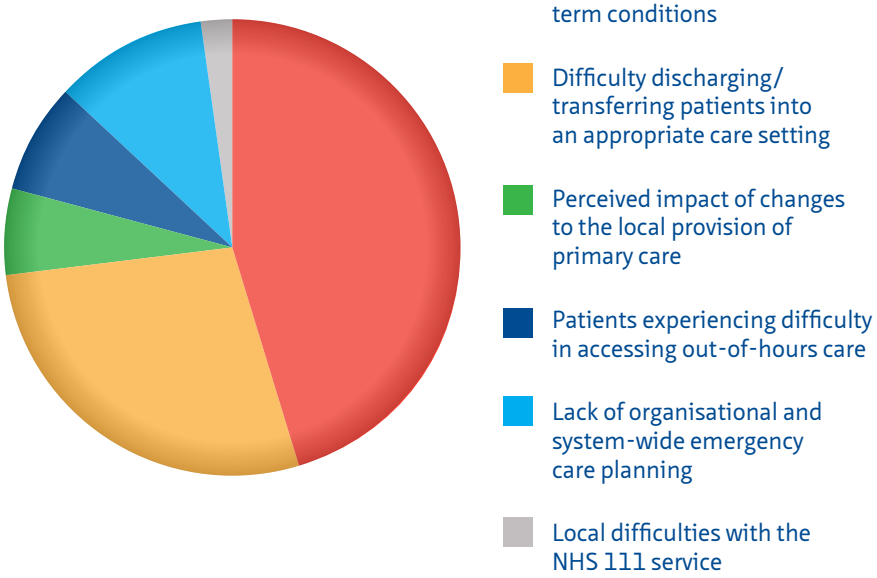
Figures show this is not only about a shortage of trained staff nationally, but problems with the recruitment and retention of emergency clinicians in some areas. This can particularly be the case for small or rural hospitals, resulting in expensive locum cover. At a time when the NHS faces a significant financial challenge this is concerning. College of Emergency Medicine figures show that emergency departments are spending an average of £600,000 each on locum doctors – a total of £120 million a year.[4] Yet the number of consultants with an A&E specialty has risen substantially in the past decade – with 1,230 consultants working in England in 2012[5] compared to 511 in 2002.

A system approaching breaking point?

Despite some media reports, our members tell us local difficulties with NHS 111 services or a perceived lack of organisation and system-wide emergency care planning have not played a core role in the problems being felt in emergency care.

We believe this is because members are more concerned with the ability of community, social care and primary care services in their local area to cope with demand. That is not to say an effective 111 service cannot play an important role in helping to improve access for patients to

Figure 1. What respondents think are the biggest causes of local A&E pressures



urgent and emergency care – and we need to give it a chance to improve. Clearly the problems faced by 111, particularly the need for improved clinical input in call handling, will need to be resolved for confidence to be restored. We also suggest that it would be sensible to make 999 and 111 co-terminus, so that no one falls through the gaps.

Making sense of the public debate

Our survey reveals no one part of the system is to blame for the increased pressure – and therefore any solution must be multi-faceted. A number of members cited the unhelpful nature of the current A&E debate, and said:

> *"The continued negative press publicity about primary care is unhelpful. This is combined with politicians continually driving up public expectations, which are often unreasonable and cannot be delivered."*

Our members have been clear the conversation needs to move away from the blame game, and instead focus on practical and helpful solutions that impact on the entire health and care system.

There is also a wider point to be made about the need to have an honest conversation with the public about the reconfiguration of services. Our members are clear the whole system needs an overhaul if it is to deal with the ever-changing health and care needs of future populations:

Our members tell us...

- The rising number of frail older people with long-term conditions is the main cause of current pressures on A&E services.
- NHS 111 is not often the cause of pressures on A&E.
- The likely impact on patients of these increased pressures could be lower patient safety, higher mortality and demoralised, exhausted staff.
- A third of respondents say they are unlikely or very unlikely to meet the four-hour waiting standard for this quarter (July-September).
- More than half of respondents don't think they will meet the four-hour waiting standard over the coming winter.
- Further investment in primary and community care would have the biggest impact on relieving pressures on A&E.
- Local health economies should be informed of winter pressure funding decisions much earlier.
- A public-facing campaign is needed to highlight the alternatives to emergency departments.

> *"The social care system is still largely available only 4.5/5 days a week with limited support at weekend and out of hours. Bank holidays, particularly Christmas and new year, normally see a lesser service. A&E continues to be the point of default. The whole primary, community and social care system seems unable to respond in a timely way to activity surges."*

If A&E is to stop becoming the default, then more resources need to be channelled into community and social care. This might mean some emergency departments closing, or hospital beds removed and investment increased to ensure people do not have to be treated in hospital in the first place. Either way, the NHS has a responsibility to engage in a meaningful way with the public[6] and develop potential service changes in partnership with local communities.

What will happen this winter?

With only three months to go until Christmas, the NHS is already gearing itself up for a difficult winter. Last year's long cold snap placed a huge amount of strain on emergency care units across the country – and we are concerned this year will be just as difficult for patients and NHS staff alike. Indeed, in the last 12 months hospitals across the country have only met the 95 per cent four-hour standard for Type One A&Es a mere eight weeks out of the past 47.[7]

> *"The four-hour target is a leading indicator of how well the overall emergency care system is working – removing it risks reducing focus, resulting in increased waiting times that are bad for patients."*

'Unless urgent action is taken to resolve A&E pressures we risk triggering a domino effect, pushing a number of NHS organisations over the cliff edge and into financial failure'

The majority of respondents (65.1 per cent) believe they are likely or very likely to meet the four-hour waiting time standard for A&E this quarter (July-September). But they are less confident about the next quarter, with under half (45.7 per cent) saying their organisation was likely or very likely to hit the same target (see Figure 2). Indeed, compared to last winter, the overwhelming majority of respondents believe A&E pressures will increase this winter. More than one in five believe this increase will be dramatic – a sign that action is needed now to meet the impending crisis.

"In seeking efficiencies to meet reduced income levels, trusts have shut beds and increased occupancy to 90 per cent. There is precious little slack in the system."

A prolonged period of cold, a rapid increase in the acuity of patients presenting in A&Es or a lengthy norovirus season would be all it would take to bring many departments to breaking point.

What is the likely impact of A&E pressures...

... on patients?

Our members believe failure to tackle these issues could have a severe impact on patients. One of the starkest findings of our survey was that NHS leaders are seriously concerned about the impact of these pressures on patient safety and mortality. Many say the consequences of rising demand could be:

- a significant increase in cancelled elective surgery
- longer waiting times for patients
- less time for staff to discuss treatment plans with patients
- serious safety issues, including increased mortality.

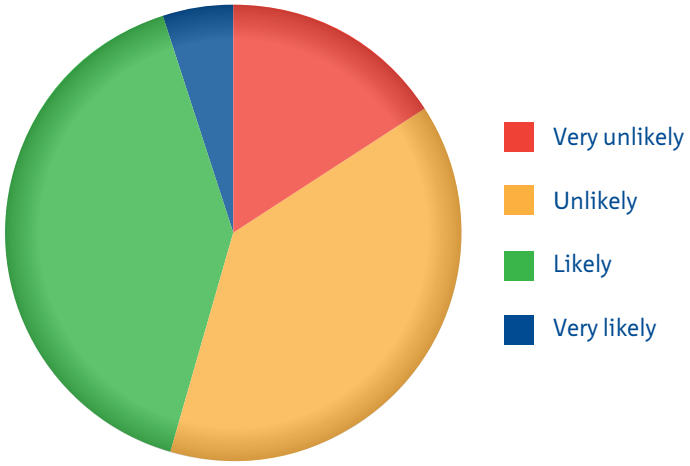
... on NHS organisations?

The impact of a struggling A&E stretches far wider than that one department. The respondents to our survey, many of them chief executives and chairs of large trusts, are clear the organisational consequences could be a high probability of serious incidents, failed targets, potential sanctions by regulators, intense media scrutiny and a loss of reputation. Crucially, our members are very clear about the significant financial impact of rising pressures on urgent and emergency care. The NHS is already facing a grave financial challenge. Unless urgent action is taken to resolve A&E pressures we risk triggering a domino effect, pushing a number of NHS organisations over the cliff edge and into financial failure.

... on staff?

The impact of increased A&E pressures on staff will be hard to ignore. Our research revealed sickness absence rates could rise, emergency departments could be populated by "burnt out doctors", and that exhausted staff are more likely to make mistakes. This will make it even harder to recruit and retain good quality clinical staff. One member told us that he has

Figure 2. Respondents' views on the likelihood of their organisation meeting the 95 per cent four-hour A&E waiting standard in the next quarter



so far only managed to fill six of his organisation's 22 registrar posts. Another said that "the pressure is also down to a lack of suitably qualified doctors and consultants".

The solution does not rest in paying emergency care clinicians more, as rightly noted by the Health Select Committee[8], but neither does it necessarily mean recruiting more emergency medicine specialists. What it does mean is making sure the right people are recruited into A&E departments, not least generalist clinicians who can help ensure people with multiple, long-term conditions receive the care they need. But this alone will not solve the issue. As one paramedic in the south east told us:

"CEOs are literally in tears, trying to solve the problem of moving patients out of hospital and into the community. The system just breaks under the pressure on some nights – and then we don't have a single spare bed free for miles."

We need to encourage stronger links between primary care and A&E, as well as better formal and informal communication channels between social workers, paramedics, GPs and the consultants in emergency departments. A longer-term effort to relieve A&E pressures will only succeed if each and every one of these workforces have the resources they need to provide sustainable cover for the whole of their local population.

What local successes have we seen?

Despite the plethora of negative stories in the media, many of our members have established their own innovative schemes to ease A&E pressures. They include:

- increasing the number of senior decision-makers 'at the door' of A&E to help improve the flow of patients through the emergency department and to avoid double referrals[9]
- introducing geriatrician liaison services, where geriatric specialists are placed in A&E departments
- placing GPs in acute settings such as A&E departments or ambulance control rooms to help with discharge and patient flow issues
- launching 'home before lunch' campaigns to reduce delayed discharges and help free up beds
- doing more outreach work in the community and assessing people at home to reduce the number of emergency admissions, particularly among the elderly
- extending the availability of consultants on the shop floor, seven days a week and introducing onsite bed managers 24/7.

We have recently established an urgent and emergency care forum. It will be publishing a report early next year to look in more detail at some of the innovative solutions being implemented by our members to improve patient care and ease A&E pressures.

The solutions

Our members know what they are doing when it comes to identifying solutions to the problem in their local area. But they cannot do this alone. And they certainly cannot lift the pressures if the rest of the system is crumbling around them. So, while the recent government announcement of £500 million extra funding over two years for struggling A&Es was welcome[10], it will not address the long-term root causes of the issue on its own. Announcements like this also provoke concern among some members that only sticking plaster solutions are being put forward, rather than solutions that focus on the long-term challenges ahead.

The NHS needs to use clear, accessible language to help raise public awareness about the pressures on the service and ensure transparency. It is also important that patients and the public are actively engaged by the NHS when urgent and emergency care services are being redesigned by their local health service. Our members have made it plain[11] that the sector, NHS England and the Department of Health all need to do more to educate the public on how the emergency care system works, how they can best access care and when an emergency really is an emergency.

"Patients don't have the confidence in out-of-hours services and have the perception that A&E is a more efficient place for them to be seen."

We asked our members what solutions they would find most helpful in assisting their organisation to ease A&E pressures. From Figure 3 it is clear they want a decision on winter pressure funding allocations much earlier in the year – so they can better plan and prepare for the forthcoming surge in attendances. For instance, one foundation trust chief executive told us they only received their winter pressure funding in February this year, having asked for it in the summer of the previous year.

It would therefore be more helpful if, at the start of the financial allocation cycle, local commissioners were given a clear steer on what winter pressure funding they are likely to receive. This would allow them to ask the local health economy to work up plans on how best to use this money to help ease pressures. By the time the winter funding is received, the local health system would know where it will be spent and why.

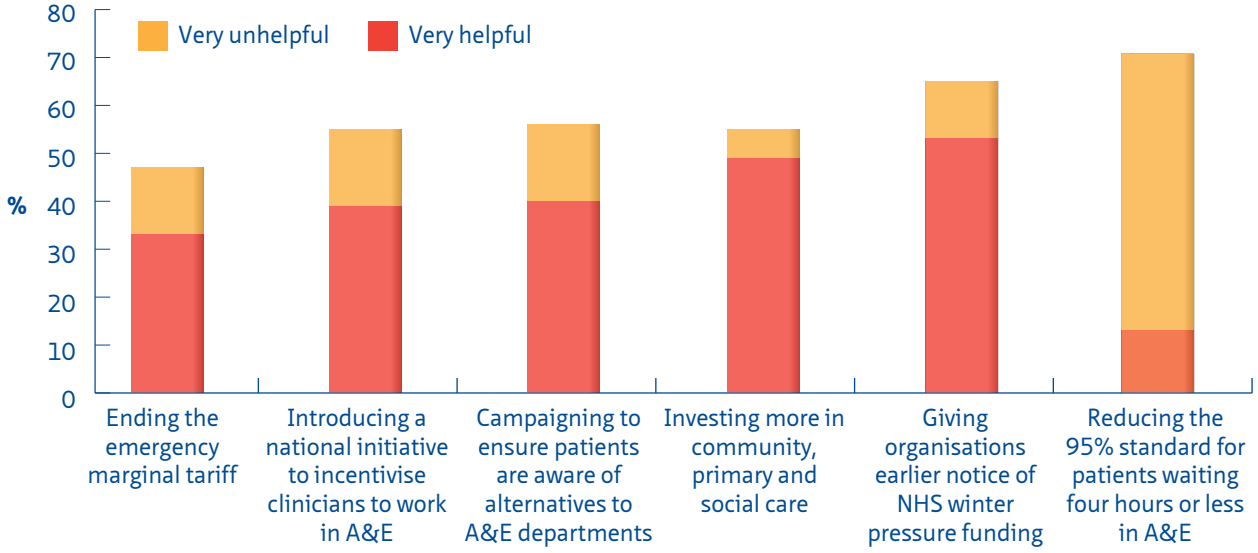
Our members also have concerns about the way in which NHS organisations are paid for their urgent and emergency care activity. The 30 per cent marginal tariff for emergency work, which sees trusts paid only 30 per cent of the cost for work above 2009 levels of activity, was introduced to tackle rising demand – an intention we welcomed. However, it is clear the tariff has not been successful at reducing demand and our members feel the tariff is no longer workable in its current form.[12] This is why 82 per cent of our respondents believe ending the emergency marginal tariff would be helpful or very helpful in easing A&E pressures. We have put forward an alternative suggestion to Monitor and NHS England, which focuses on trying to use the marginal rate to achieve the outcomes we want.[13]

Ultimately, we need a payment system that helps to encourage better joint working, more focus on intervention and greater investment in community services, all of which would relieve A&E pressures.

That said, investing more and more in the acute sector will not solve this problem. What we need is a wholesale reform of incentives in the health service. Our members are clear that payment systems have often been developed in an ad hoc way to 'plug gaps' across the system – and this cannot continue. They are therefore calling for the tariff reform currently being carried out by Monitor and NHS England to incentivise joint working, prevention and early intervention.

Our members are equally clear the A&E crisis will only be resolved if there is genuine and sustainable investment into community, primary and social care – and fast. This would require political courage from those holding the purse strings, but members strongly believe this would help to prevent the impending crisis in A&E. Only by taking bold action now will we safeguard emergency patient care for the future.

Figure 3. Respondents' views on what might help ease A&E pressures in their organisation



Our recommendations

- A decision on **winter pressure funding** allocations should be communicated much earlier in the year – to allow time for different parts of the system to plan and prepare.
- In addition to the local campaigns many trusts carry out, a **national public campaign** on the alternatives to A&E should be launched by NHS England.
- There needs to be **more senior staff and consultants** present in A&E at evenings and weekends if the pressures on the workforce and the potential risk to patients are to be reduced.
- Monitor, NHS England and local commissioners need to develop **alternative payment systems** to the emergency marginal tariff, which include effective incentives for improving the quality of care, so that NHS organisations are fairly rewarded for their A&E work.
- The Department of Health and Health Education England should launch a **national initiative** to incentivise clinicians to work in A&E as soon as possible, so that senior decision-makers are placed at the heart of emergency care.
- More detailed work should be carried out to understand the **impact of pressured A&E** departments on staff morale and productivity.

References

1. *Urgent and emergency services*. Health Select Committee, 2013
2. www.theyworkforyou.com
3. ibid
4. *Struggling A&Es spend £120m on 'army of locums'*. Daily Telegraph, 13/08/13
5. HC Deb, 04/07/13, c795W
6. *Changing care, improving quality: Reframing the debate on reconfiguration*. NHS Confederation, National Voices and the Academy of Medical Royal Colleges, 2013
7. *A&E waiting times and activity*. NHS England (weekly sit rep statistics at time of writing)
8. Health Select Committee, op. cit
9. Geddes, L: 'Solving an age-old problem', *New Scientist*, 17/08/2013
10. *A&E wards to be given £500m bailout in bid to avert crisis*. Guardian, 08/08/13
11. Campaign to ensure patients are aware of alternatives to A&E departments was deemed a very helpful or helpful solution by 82 per cent of NHS Confederation members
12. Health Select Committee, op. cit
13. NHS Confederation response to the emergency admissions marginal rate review, June 2013

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