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Small Emergency Medicine Departments – New way of working

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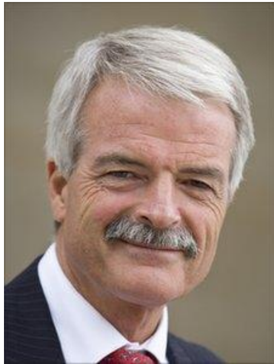
Preface



Many aspects of the NHS's operations need now to be reviewed in the light of the Covid experience. It demonstrated just how adaptable and agile this great organisation can be.

We must not revert to old habits once the threat recedes. We must lose nothing of the learning of the last year, and we must be willing to take on new ideas and approaches that will work better for our staff - especially our junior staff who we must do everything to retain and support - and our patients.

To that end, I commend strongly the ideas in this paper for serious consideration.

Sir Malcolm Grant

Former Chair of NHSE (2011-2018)

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1. Executive Summary

One of the priority measures that has been adopted across NHS England/Improvement (NHSE/I) to address the failure to meet the 4-hour performance of Emergency Departments during the last decade, is to **close or downgrade small Emergency Departments** (ED) across the country. This paper proposes a new way of working to support the continued use of small EDs, improve the timeliness and quality of patient care, and address medical staffing shortages. The underpinning principle of the proposal is achievable change, developed and proposed by front-line clinicians.

The need for change is driven by a wide range of factors including:

- An increasing and ageing UK population trend
- Continuing increase in ED attendances
- An increase in emergency hospital admissions via ED
- Failure to meet the 4-hour ED performance target
- Shortage of specialist medical staff in the EDs and Medical Registrar Jobs becoming unattractive
- Emergency department closures due to various factors (staffing, quality and financial issues)
- Perceived inadequacy of Quality patient care
- High quality junior medical staff training requirements
- Financial (Use of Locums)

Current practices lead to duplication of junior doctor work, delays in Consultant review and decision making, reduced flow of patients out of EDs and a stressed and unhappy staff in EDs and medical wards.

Proposal summary

The proposed way of working is to deploy middle and junior grade doctors belonging to medicine and other specialities in ED while being on call. They will work alongside the ED staff as an Integrated Team using standardised multidisciplinary medical records and all admission processes will be done at the same time in ED.

Proposal Benefits

This proposal brings both tangible and intangible benefits via improved performance in

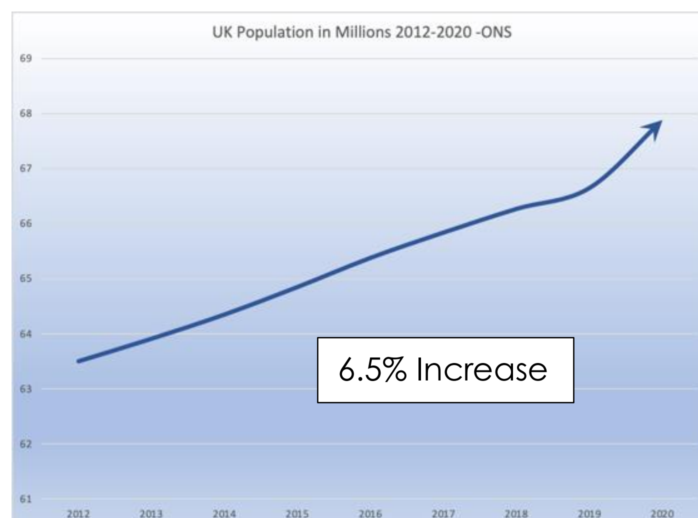
- Emergency Departments,
- Ambulance handover time
- Patient Safety,
- Patient and Relatives Experience,
- Junior Doctors' Learning,
- Staff Training,
- Staff Morale and
- Financial sustainability.

Overall, there will be harmonisation of staff utilisation across departments that balances the current peaks and troughs in staffing requirements.

2. Background

The NHS needs to constantly evolve, not only because of current demand, but also to ensure it is ready to meet future challenges of the 21st century. The country faces extraordinary health pressures from a rapidly growing and ageing population (Figure 1), NHS workforce shortages, changing lifestyle and likelihood of worsening health inequalities. This is further compounded by a looming economic recession due to COVID-19. It is evident to all that a "*New Normal*" within the NHS is urgently required.

FIGURE 1: UK POPULATION FROM 2012 TO EARLY 2020



Source Office of National Statistics

There is much speculation about how quickly we shall return to normal after the COVID-19 pandemic. Even with the introduction of vaccines, there is likely to be a continued need for social distancing, new methods for health provision and a review of global economics. Many novel health service reconfigurations have been rapidly introduced during the COVID-19 crisis to facilitate new working practices between specialities, to create extra capacity, to allow working from home and to reallocate staff between specialities[1].

Even at a time of crisis, the NHS has a responsibility to optimise its ***performance*** to meet existing and proposed national targets and to provide best value for tax-payers money. It is imperative that NHS funded organisations optimise ***efficient*** ways of working across all departments. One of the key national performance targets in England is the 4-hour Emergency Department (ED) performance target. Very few Trusts were able to achieve this target prior to the crisis created by COVID-19. Currently this performance target has been imposed on the ED department alone whereas, in reality, a multitude of factors from other departments drive the flow of ED patients. We support the NHS England-Transformation of urgent & emergency care paper[2] to reshape the future by looking at how to improve the ED performance in a holistic manner alongside the safety reshaping that has been required due to COVID-19.

Current Practice in Emergency Departments

Current practices dictate that patients who present to the Emergency Department are initially seen by an Emergency Medicine junior doctor, discussed with a senior doctor, and then are referred to the appropriate in-patient speciality team, most commonly the medical team.

Once referred, they are seen again by a junior doctor in Acute Medicine, clerked, discussed with a senior doctor (usually a Specialist Registrar), and then seen by an Acute Medicine or On-call consultant during a post-take ward round

This results in duplication of junior doctors clerking the patient from the ED and medical teams. It also leads to delays in patients being seen by the medical consultant, who can make decisions regarding admission or discharge.

Often, acute medical junior doctors are spending more and more time clerking patients in ED, instead of being on the Acute Medical Unit or on the wards looking after their patients.

These delays and duplications result in reduced flow of patients out of the emergency department and lead to stressed and unhappy staff in both the ED and Acute Medicine notwithstanding the issues with only F1 level Junior Doctors covering the wards out of hours.

Current ways of working are impacting on the experience of both patients and staff and leading to dissatisfaction for:

1. The ED team – who are unable to deliver emergency medicine best practice
2. The Medicine on call team – who are required to 'split' their time and focus between several clinical areas
3. Patients – who are not being seen in a timely manner
4. The NHS Trust Board – who are not able to meet national performance standards
5. F1 Junior Doctors covering the wards – who are receiving a poor training experience with limited supervision.

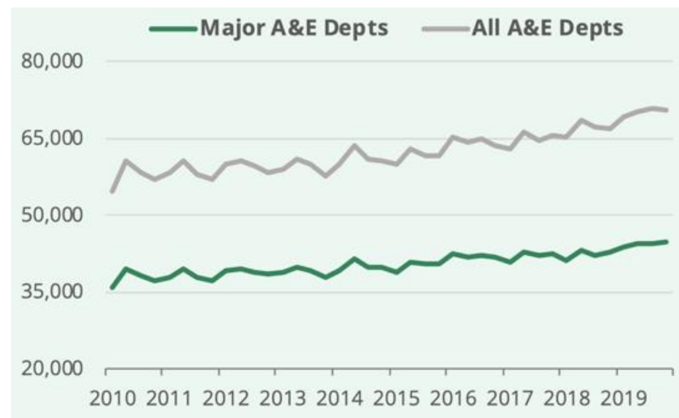
Challenges for Emergency departments

1. Increase in A&E attendances

A major focus of pressure on the NHS over the last twenty years has been a rise in ED attendances and emergency admissions to hospital; this will continue into the future unless we address this issue.

Based on statistical data (Figure 2), there has been a +10.6% increase in Major ED attendances in the last 5 years against a +14.5% increase in attendances to All types of ED.

FIGURE 2 : AVERAGE QUARTERLY NUMBER OF ED ATTENDANCES SINCE 2010

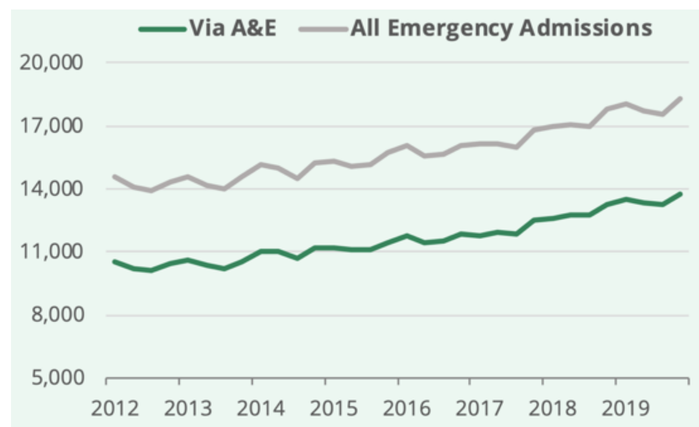


Source: NHS key statistics (House of Commons, Feb 2020) (3)

2. Increase in emergency hospital admissions via A&E

There has been a +19.6% increase in all emergency admissions as compared to +22.7% increase via ED alone, in the last 5 years (figure 3). This percentage increase of admissions requires sufficient numbers of ED senior clinical staff to validate and authorise these admissions. An increasing burden of ill-health, associated with an ageing population, only explains a proportion of this increase in emergency admissions.

FIGURE 3 : EMERGENCY HOSPITAL ADMISSIONS

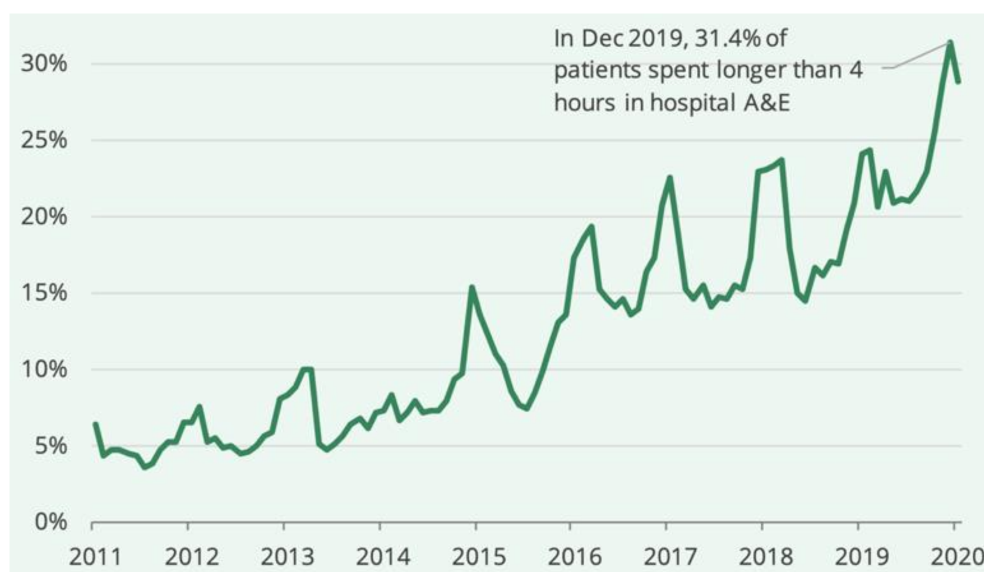


Source: NHS key statistics (House of Commons, Feb 2020) (3)

3. Four-hour waits in hospital ED

There has been a +31.4% increase in more than 4-hour minimum waiting hours prior to admissions (figure 4).

FIGURE 4 : FOUR-HOUR WAITS IN HOSPITAL ED (TYPE 1 EMERGENCY)



Source: NHS key statistics (House of Commons, Feb 2020) [3]

4. Staffing

Clinical staffing levels within an ED are driven by standards set by the Royal College of Emergency Medicine and Deaneries. Due to significant medical staff shortages many specialist ED clinicians are employed via Locum Agencies creating financial pressures which are often resolved by closure or downgrading of EDs. Reduction in junior doctors' hours cannot be met in the short term by employing new doctors because they are not available. Medical staff take a long time to train to work within NHS standards, even for those who are clinically experienced in other countries.

We need to strike a balance between trying to manage the patient volume without compromising on desirable clinical outcomes (GIRFT-Getting It Right First Time) whilst providing services for communities that are safe, robust, affordable, adequately staffed to perform at national level quality standards and with flexibility in their delivery to ensure that the process is running efficiently compared with the risk of no local service. Therefore with ED medical staff recruitment so precarious consideration as to whether

EDs should or can be solely staffed by dedicated and experienced ED specialists is needed.

5. Adoption of new models and centralisation of ED services.

New models of care and staffing have been introduced to Emergency Departments, these include:

- Introduction of Ambulatory Emergency Care (AEC) in various guises
- Emergency Nurse Practitioners (ENPs) and Advanced care Practitioners (ACPs)
- Rapid rise in the number of ED consultants
- General Practitioners in EDs supporting integration of primary and community services

These models have not managed to fully address the issues relating to emergency and urgent care. These challenges have become the driver for change leading to the centralisation of ED services, under the umbrella of system Sustainability and Transformation Plans (STPs) with the **closure** or **downgrading** of small EDs (defined as seeing less than 60,000 attendances per annum[4]); many of these are rural and isolated and identified as being at risk due to financial and/or clinical issues. Centralisation of EDs has polarised communities, caused confusion within front-line professions and has often been perceived as "hospital closure or down-grading". Clinical Commissioning Groups and NHS trusts feel that they are doing their best to deliver modern responsive hospitals, given their financial and service constraints, but somehow the core purpose of smaller hospitals within the issue of centralisation has been lost.

ED STP plans are currently proposing the downgrading or closure of up to 24 EDs in England[5]. STPs rely on the assumption that large numbers of patients can be kept out of hospital and cared for in the community or will attend urgent care centres with minor conditions[6]. Centralisation of EDs and closure of smaller EDs, without adequate alternatives being in place, has been criticised within and one

independent commission has called for a halt to the programme pending an immediate financial assessment by the National Audit Office and an equality impact assessment[7]. Some commentators and clinicians have even suggested that, if we continue this programme of closures, based on a false narrative of quality, then we would end up with a single, massive hospital in central London for all of England, reducing the argument to the level of absurdity.

Impact on Service Users

1. Economically Deprived Areas

Office for National Statistics data shows that the risk of EDs being downgraded directly correlates with levels of deprivation. It is in the areas with denser population, highest levels of poverty and disease which burdens the respective hospital services steering them to be downgraded. This leaves the most vulnerable residents who are least able to afford to travel to have to go the furthest for hospital treatment, while the sites that are destined to remain as major acute hospitals are in less deprived areas e.g. St. Mary's, Chelsea and Westminster, West Middlesex, Northwick Park and Hillingdon Hospitals[7].

As well as having the poorest patients, the outer north west London boroughs also have the highest population and a higher proportion of elderly patients. Before the closure of Central Middlesex and Hammersmith EDs, the performance of Type 1 EDs across North West London hospitals met NHSE/I's 4hour operational standard between 78% and 95% of the time during the winter months. Immediately following the ED closures these figures fell to between 60% and 80% - in other words up to 40% of patients needing serious emergency treatment had to wait more than four hours to be assessed and admitted into an appropriate bed. Whilst most hospitals recovered from this low level of performance, Northwick Park Hospital did not and has subsequently experienced a summer crisis as well as a

winter one. This story bears a stark resemblance to what has been happening in other areas.

2. Geriatric Emergency Medicine

The ever-growing proportion of elderly patients leads to its own challenges that are compounded by closing smaller ED's. This has been recognised by many trusts who have invested in the care of this patient group with higher care needs, less physiological reserves and unlikely to make their own way to the hospital in genuine emergencies.

One such example is Norfolk and Norwich University Hospital that has created a separate Older Persons Emergency Department, staffed by emergency physicians, geriatricians, and emergency & elderly care nurses[8].

Winners of the BMJ Awards for Emergency Care 2018, Heartlands HECTOR project[9] highlighted a different approach, bringing geriatricians and ortho-geriatricians down to the ED. This was combined with front-door elderly care access, a medical day hospital for elderly patients, and frailty admissions unit.

3. Geographically Remote Locations

Closure of EDs in geographically remote locations leads to dilemmas for service users, particularly overnight and at weekends. A 90-year-old in a remote rural village location, waking with chest pain in the night, may well choose to wait until daytime hours to seek local help rather than face the longer journey to a centralised ED. Failure to seek early treatment may impact on their ability to recover from or even survive the event.

With the closure of small rural EDs the department performance statistics will see an improvement, but these statistics do not capture any adverse health impact on service users or excess deaths. Even

if the patient calls 999 there are significant factors like ambulance availability, travel time, and overload/burden on centralised EDs due to the downgrade of the local small EDs.

Risks to Small Emergency Departments

Small EDs are invariably in geographically isolated areas, serving small communities who value and require the services of a local ED.

However, medical staff, both senior and junior are more difficult to recruit for these EDs and consequently there is much reliance on locum doctors, who are itinerant and costly. In addition, the substantive and locum staff may not always have the desired competence or experience. This leads to:

- Questionable referrals to on-call teams
- Resultant reassessments
- Unnecessary admissions
- Inefficient use of staff and resources.

External overseeing agencies (Care Quality Commission, General Medical Council, Deaneries, Medical Colleges, and Health Education England) apply the same level of scrutiny, expectations, and standards as they do to the more central, larger, and better funded EDs. This practice appears to be unrealistic, unattainable, and perhaps not appropriate for a service unit for a local hospital.

Smaller EDs are disproportionately affected by all of the issues discussed in this section and, therefore, require a bespoke approach to providing safe, effective and efficient care for their population.

3. A new way of delivering care

Many NHS staff and service users would agree that the majority of 'traditional' ED activity can and should be delivered in local hospitals. We should not be in any doubt that it can only be sustained in those local hospitals by redesign. NHSE/I have to reconsider the approach of 'one size fits all' to systems and instead allow flexibility to local hospitals in their method of delivering emergency care. This means creating a whole new system approach to urgent care based on our general principle of delivering care as locally as possible.

We believe that to meet the challenges and to deliver on the key requirements described above will require a shift in the way we deliver emergency health care in England. This will require new ways of working, new thinking and a new culture in the NHS – one of shared responsibility and engagement of front-line staff in service improvement. We need all the specialities in secondary care to realise that they are inter-dependant. Action in one part of the system has an impact elsewhere. And we need the partners and stakeholders to understand that we all need to change – permanently and not just for the sake of change.

What an emergency service requires now is the idea of better deployment of medical staff in secondary care, working as a single, holistic system whilst allowing the small cohort of emergency specialists to concentrate on what they excel. The central task for the professionals working in the system is to determine the level and speed of response required for a patient and then direct that person to the team which is best equipped to deal with the problem.

The NHS England consultation on "Transforming Urgent & Emergency Care", December 2020[2] proposes replacing the 4 hour ED target with a bundle of 10 indicators which include timely Ambulance Handovers in ED, timely Initial Assessments in ED, shorter length of stays in ED and Alternative Centres of Care for appropriate clinical conditions to improve patient flow. These are all addressed by the Proposal below.

4. Proposal

Small EDs and Hospitals are there to provide a wanted service to their local community and the various health organisations and regulators (e.g., General Medical Council, Care Quality Commission, Health Education England, Medical Colleges and Deaneries) should do all they can to support this, including allowing junior doctors across different specialties to integrate with ED and work as a team when on-call to avoid duplication.

This proposal acknowledges that small EDs should not see major trauma or specific time critical conditions, such as strokes and ST elevated Myocardial Infarction. However the majority of smaller ED's workload is medical, surgical or paediatric in nature with the majority of admissions being medical. Minor illnesses and the 'walking wounded' being managed by Enhanced Nurse and Advanced Care Practitioners.

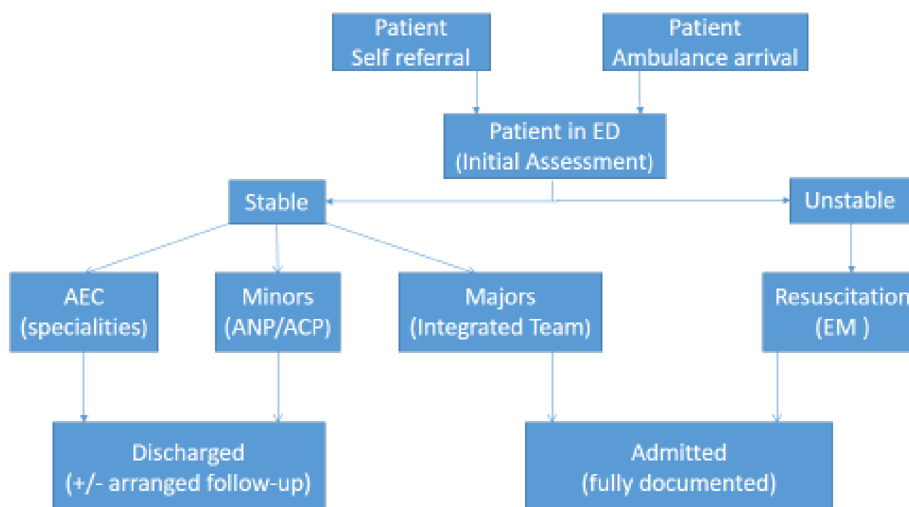
In addition evidence suggests that a significant proportion of patients presenting to ED, especially walk-ins have minor illnesses which could be managed in primary care; however due to workforce crises in Primary Care, they often present to hospital. This is where an AEC (Ambulatory Emergency Care centre), staffed by ANPs, GPs (if available), medical and surgical juniors (not those designated on-call) supported and supervised by speciality consultants could be optimally used. Referrals to an AEC could be guided by the Amb score[10] triage tool.

We propose:

1. That the middle and junior doctors responsible for specialty admissions (especially medical) are based in the ED, having been freed of all elective duties whist on-call.
2. That they work alongside the EM junior medical staff as an Integrated Team[11] using standardised multidisciplinary medical records.
3. These Integrated Teams would work mostly in the Majors area of the ED but the middle grade specialists would be available for advice elsewhere in the ED.
4. That upon arrival patients will be Initially Assessed and then directed to Minors (walking wounded or ill), Majors (requiring a trolley or seriously ill), Resuscitation (requiring immediate care and stabilisation) or AEC (those with specialist conditions requiring more extensive and definitive management but not needing resuscitation)
5. Those patients requiring admission would be fully assessed by the junior doctor (no matter the base speciality of that junior doctor) of the Integrated Team, reviewed by the middle grade doctor of the appropriate specialty who will decide and advise accordingly. Following which the patient will be admitted to the appropriate specialty ward with the medical records, care plan and drug charts completed.
6. Once in a ward the on-going care would be from the Hospital at Night teams for out of hours admissions and by the speciality teams otherwise.
7. Junior doctors in such Trusts should be made aware of such working arrangements and indeed it may be an attraction to such juniors as they are likely to gain a greater range of medical experience with deeper understanding of ill and worried well patients.

8. Individual Trusts will have to decide who their "junior and middle" speciality grades are according to their staffing structures, but the junior would be expected to see any majors patient in time (or severity) order whilst the middle grade must be able to make specialist decisions and give advice.

FIGURE 5: PROPOSED PROCESS FOR PATIENT FLOW



This proposal would address the following,

1. ED medical staffing difficulties: by amalgamating the current ED staff with the on-call specialty medical staff the ED workload should be manageable without the need for EM locums and thus potentially offer financial savings.

2. Quality and timeliness of care: The specialty middle grades within ED would significantly improve the quality of care by working as "reviewers" (rather than additional clerking-in doctors), providing faster decisions (both for discharge or admission), and reducing unnecessary investigations whilst being available to provide advice

for resuscitation and appropriate triage direct to Ambulatory Emergency Care or Same Day Emergency Care units[12]

3. The duplication of clerking (aided by a single medical record), opinions and investigations would be significantly reduced resulting in less stress and anxiety for the patient and family. This would also release junior doctor time by approximately 10 hours (for 10 ED referrals) per 12-hour shift which could be redirected to learning and supporting the F1 on the ward.

4. Improve the educational experience for junior doctors of all specialities of managing the very ill and recognising those who may be managed as an outpatient in an OP Clinic, Same Day Emergency Care centre, Urgent Treatment Centre or AEC.

5. Early Senior advice which would be sought from the most appropriate and available person who is within the ED.

6. Time spent by the patient in ED by avoiding duplication, delayed decisions and excessive investigations. This will help to decongest ED.

7 Reduce ambulance handover times by having the ED space following the decongestion of ED.

5.Discussion

There could not be a more appropriate time to offer a different narrative which is based on using scarce and high-end clinical resources more efficiently. This is the moment, then, for all of us to transform the NHS, bringing in new thinking with a series of low-cost innovative solutions, which will provide a framework to deliver safe, quick and sustainable health care for the future. Rather than focusing on centralising Emergency Departments, by closing or downgrading small hospitals that does not help patients who cannot afford to travel long distances, we would prefer to build on this wealth of clinical resource to improve efficiency via STEP changes within the current infrastructure to achieve effective integration between clinical and managerial disciplines, alongside engagement with the cohort of public governors.

During times of limited financial and medical staff resources, it is important that systems are efficient by avoiding duplication, making earlier decisions, starting prompt treatment and by reducing unnecessary investigations. This is in line with the joint recommendations on Rebuilding the NHS Improving medical pathways for acute care[13] from the Royal College of Physicians, the Royal College of General Practitioners, the Royal College of Emergency Medicine, and the Society for Acute Medicine

The closures of small hospitals are the result of the relentless pursuit of so-called efficiency and quality compounded by the workforce crisis, poor recruitment and retention of middle grade staff and non-delivery of the NHS 4hour emergency standard. What is needed is to look in depth at some of the issues relating to small hospitals. There is indeed data supporting centralisation of certain highly specialised services, but most care can be delivered safely locally.

A review of the effects of centralisation of emergency services in North East England[14] emphasised that one of the main attributes of the scheme was "early specialist review". We believe that our

proposal provides a very early specialist review which therefore does not require the centralisation of these services and closure or downgrading of the smaller ED.

The following limitations to the analysis within the report are acknowledged:

- Effect of the lack of specialised services in remote settings.
- Influence on performance and decision delays due to diagnostic services.
- Impact on performance due to delay of ambulance response times.
- Effect of reduction in qualified General Practitioners & Nurses during the last decade.
- Consequence of delays due to home care and transfers.

6. Summary

The report has been commissioned to challenge the rationale for centralisation of ED services, and the Closure of small EDs. These small EDs (defined as seeing less than 60,000 attendances per annum) were identified to be at risk due to financial and/or clinical issues.

Many of these services are in a geographically isolated area. The report also emphasises the importance of these ED services to the community and the NHS as a whole system. Actions aimed at improving ED performance to date have not prevented system failures, nor have they led to improvement of the overall 4-hour ED performance across the board. The report proposes process improvements and solutions to optimise the utilisation of clinical staffing to work within the budget and performance targets.

This proposal is designed to ensure the continued presence of small EDs by a novel way of allocating medical staff and improving processes which should also improve finances. By reallocating the on-call inpatient specialty teams to work in ED during their shift alongside the ED staff, Trusts would provide a multidisciplinary medical team to manage all the emergency patients (self or community referred) with expertise and efficiency and so improve quality and reduce costs.

This proposal builds on the lessons and actions learned during the COVID-19 pandemic and anticipates the future requirements identified in NHS England's – Transforming Urgent and Emergency Care document. It uses medical staff more efficiently, provides quality care and improves the learning experience and job satisfaction of junior doctors. This model of integrating the ED and on-call Speciality teams, in our opinion, would also help in managing the rising demand for ED services in these small Trusts enabling personalised care locally in deprived communities.

We are grateful for the contributions of the following specialists:

Dr Minesh Khasu

Dr Jaspal Dua

Dr Kurien John

Prof Derek Bell

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Our vision is an efficient, effective, equitable NHS.

Our NHS Our Concern is offering a different narrative based on proposing solutions involving front line staff and aimed at avoiding wastage.

Our aim is to provide quality care within finite resources.

We are promoting a new narrative towards a change in culture, which promotes the role of frontline staff in generating ideas and driving actions.

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