Royal College of Emergency Medicine

Patron: HRH The Princess Royal

7-9 Breams Buildings
London
EC4A 1DT

Tel +44 (0)207 404 1999
Fax +44 (0)207 067 1267
www.rcem.ac.uk

RCEM Statement on the Comprehensive Spending Review 2020

September 2020

About the Royal College of Emergency Medicine

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

Introduction

A strong Urgent and Emergency Care system underpins a strong National Health Service. Due to years of underinvestment and financial austerity imposed on the NHS, Emergency Departments – by providing a round-the-clock consultant-led service to all – now play a crucial role in mitigating the weaknesses and sustaining other parts of the healthcare service.

Unfortunately, this has contributed to unsustainable and unsafe overcrowding and corridor care in Emergency Departments. This is incompatible with safe care in a world where we must manage the risk of COVID-19 alongside providing Urgent and Emergency Care. Our Emergency Departments work effectively to maximise returns on public investment, and in recent years Emergency Department staff have had to do more with less. Any cuts to funding would be counterintuitive for the long-term health of the country and the Prime Minister's levelling up agenda. The pandemic has exposed persistent levels of inequalities in health across the UK; the Government must use this opportunity to invest and build a resilient, world-class health and social care system by growing the Emergency Medicine workforce, increasing the number of staffed beds in hospitals, and investing in preventative, primary and community care.

Declining Emergency Department performance

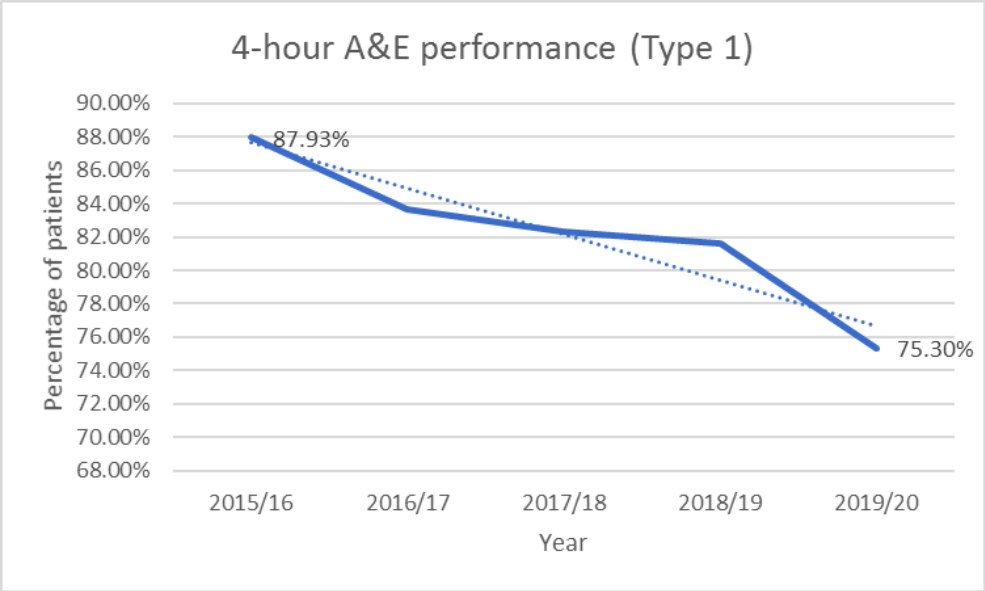
Before the pandemic, Emergency Departments across the UK were operating at maximum capacity. The number of attendances has increased every year, yet the physical size of hospitals and departments has not increased accordingly. Most Emergency Departments before the coronavirus pandemic were stretched beyond the capacity they were designed and resourced to manage at any one time.

The four-hour target was introduced in 2004; it refers to the operational standard that at least 95% of patients should be admitted, transferred, or discharged within four hours. Despite this pledge, the standard has not been met in England, since July 2015,

and the last time it was met over a full year was in 2013/14. The target has not been met at Type 1 A&E departments since June 2013 and has not been above 95% annually since 2010/11.

The standard acts somewhat like the canary in the coal mine – it is a crude target, yet it calls attention to failures in other parts of the system. Emergency Departments have constant interactions with other parts of the hospital, for example, to request diagnostic tests and to transfer patients. Emergency Department performance is therefore dependent on processes and capacity in other hospital departments, as well as other parts of the health and social care system. High levels of hospital bed occupancy, delays in transferring patients out of hospital, and staff shortages throughout the Urgent and Emergency Care system have all had an impact on Emergency Department waiting times.

Graph 1 – Percentage of patients admitted, transferred, or discharged within four hours 2015/16 to 2019/20

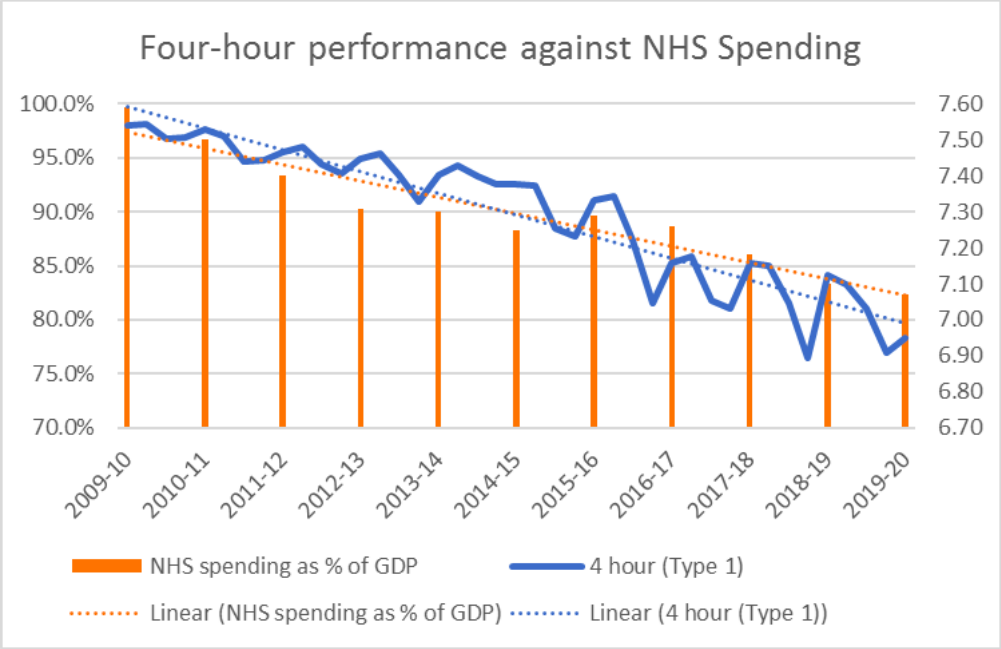


Source: NHS England, A&E Attendances and Emergency Admissions 2019-20[1]

Graph 1 above illustrates four-hour performance in major departments in England over the last five years. The clear decline in performance is not due to a lack of trying but rather a sustained period of financial austerity and chronic staffing pressures. Staff are still being expected to aim for a target that is ultimately no longer achievable given the increase in number of attendances, rise in admissions and fewer hospital beds.

Graph 2 – four-hour performance against NHS spending

[1] NHS England (2020) A&E Attendances and Emergency Admissions 2019-20. Available here.



Source: NHS England, A&E Attendances and Emergency Admissions 2019-20[2]

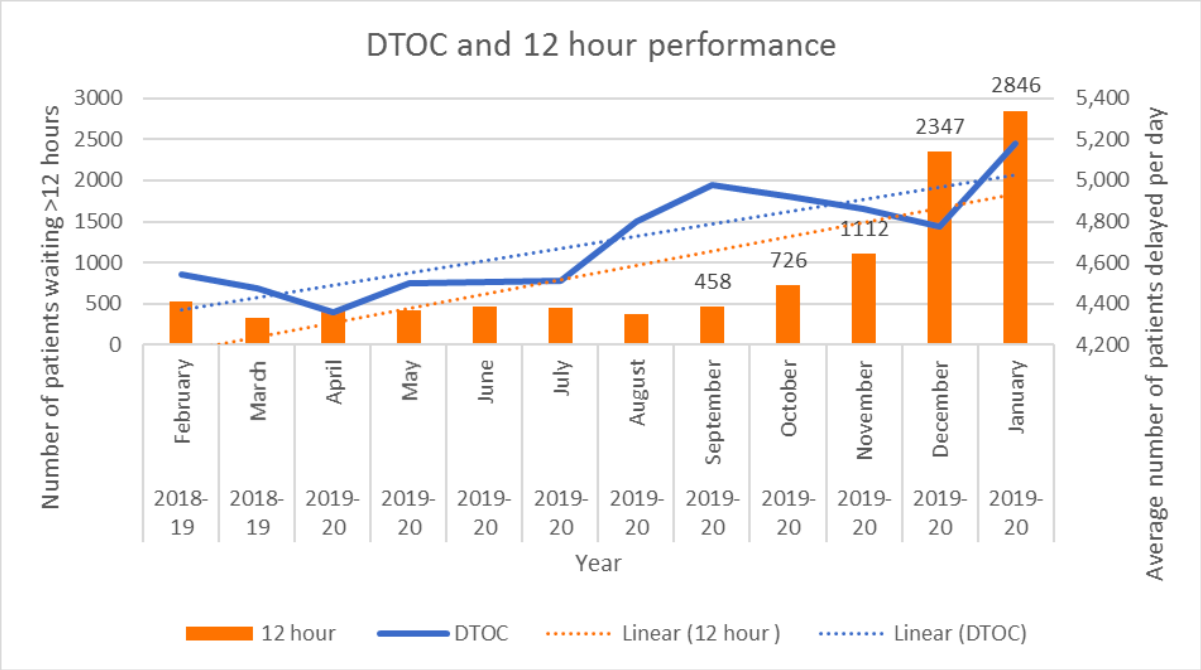
In terms of growth as a percentage of GDP, the 11-year period since 2009/10 is the lowest since the first decade of the NHS. Graph 2 demonstrates the relationship between funding and Emergency Department performance. As NHS spending as a percentage of GDP decreases, the ability for Emergency Departments to achieve the four-hour target also decreases. This is because increased funding allows us to grow the workforce, restore bed numbers, and ensure that the system is adequately equipped to meet demand. Admissions have gone up on average by 3.48% per year in the last 10 years while spending in real terms has only increased on average by 2%. The performance of our Urgent and Emergency Care system is therefore dependent on increased investment.

Crowding and Delayed Transfers of Care

Crowding is the dangerous side effect of deteriorating Emergency Department performance. It is one of the greatest challenges facing Emergency Departments, the result of which has meant that trolley waits and "corridor care" have unfortunately become common practice. This can be upsetting and stressful for both patients and staff. Crowding is most commonly the result of high hospital bed occupancy, driven partly by Delayed Transfers of Care (DToC). Failures in other parts of the health and social care system mean that though a patient may be ready to move on from the Emergency Department, they cannot be put into a hospital bed and end up waiting in the Emergency Departments until a bed is available. This also prevents social distancing and increases risk of patients acquiring infectious diseases in the Emergency Department.

[2] NHS England (2020) A&E Attendances and Emergency Admissions 2019-20. Available here.

Graph 3 - Delayed transfers of care and 12-hour performance (12 months pre-COVID)



Source: NHS England, Delayed Transfers of Care[3] and NHS Digital, Hospital Accident and Emergency Activity.[4]

Graph 3 demonstrates how DToCs can have an impact on long waits. In England, 12-hour waits are measured from the decision to admit. This differs from the other Devolved Nations, where the clock starts from the patients' arrival. Nevertheless, the data in Graph 3 show the dramatic increase in 12-hour waits in the months leading up to the coronavirus pandemic. To rectify this Emergency Departments must be free of crowding to avoid the nosocomial spread of COVID-19 and to ensure hospitals can discharge people promptly when their medical care is complete.

Emergency Department capacity

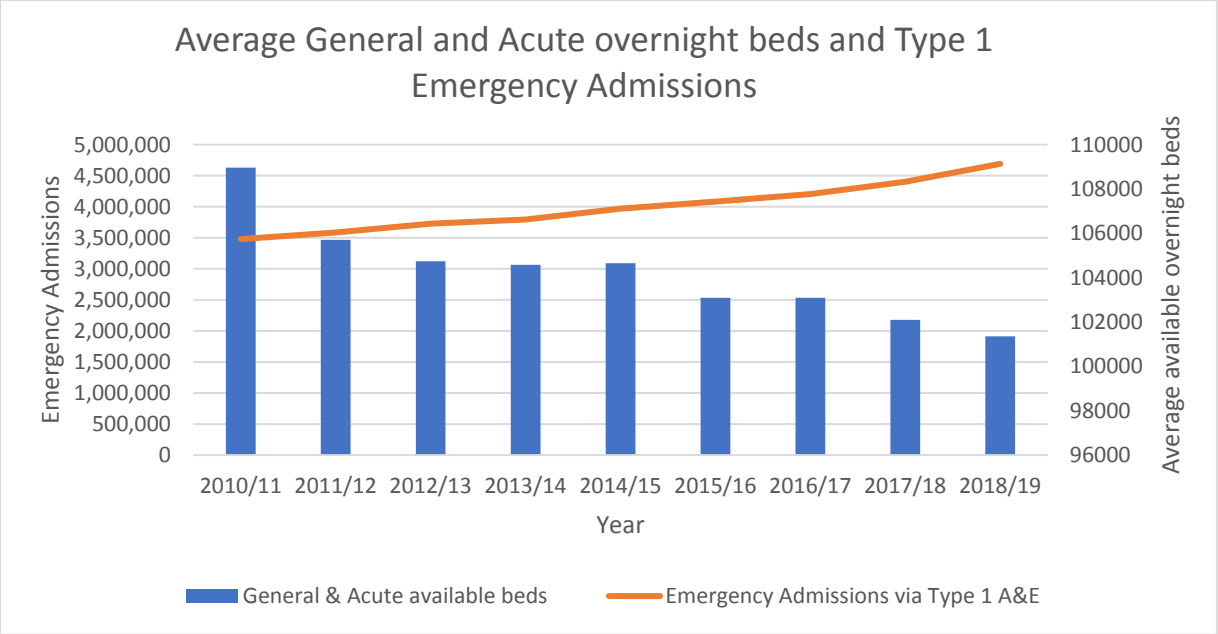
Hospital beds in NHS England

The number of available beds is an important measure of hospital capacity as most hospital-based medicine requires a use of a bed. Hospital beds rely on staff and equipment to deliver care, so most references to available beds refer to beds that can be adequately staffed and resourced. Ensuring there is adequate bed capacity

[3] NHS England (2020), Delayed Transfers of Care. Available here.
[4] NHS England (2020) Hospital Accident and Emergency Activity. Available here.

– with additional beds available to meet surges in demand – is fundamental to improving patient outcomes.

Graph 4 Average overnight beds for General and Acute specialities and Type 1 Emergency Admissions

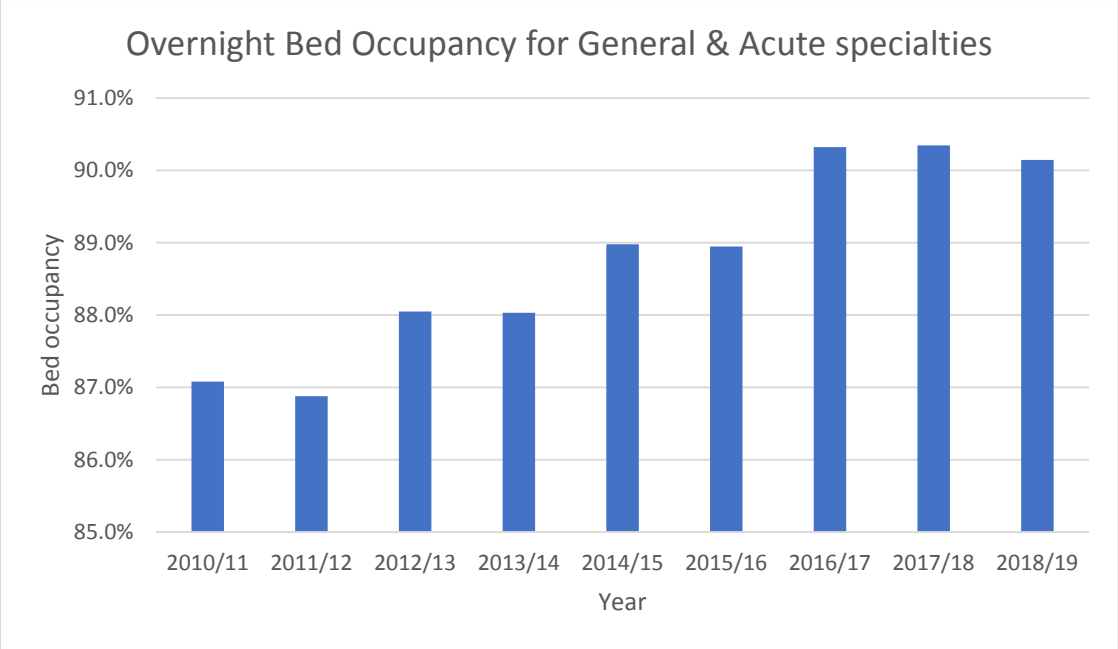


Source: NHS England, Bed Availability and Occupancy Data – Overnight.[5]

Graph 4 shows that although the average number of available General and Acute beds has significantly decreased since 2010/11 and has not kept up pace with rising Emergency Admissions. From 2015/16 to 2018/2019 an average of 1,738 overnight beds were removed from General and Acute specialties, representing a decrease of 1.69% whereas attendances to Type 1 Emergency Departments increased by 4.81% and more concerningly, Emergency Admissions to Type 1 Emergency Departments increased by 14.9%. As the growth in Emergency Admissions has not been met with a growth in staffed hospital beds, hospitals in England now have stubbornly high and dangerous bed occupancy rates. Graph 5 shows how bed occupancy has increased overtime for General and Acute specialities.

Graph 5 – Overnight bed occupancy for General and Acute specialities 2010/2011 to 2019/2020

[5] NHS England (2020) Bed Availability and Occupancy Data – Overnight. Available here.



Source: NHS England, Bed Availability and Occupancy Data – Overnight.[6]

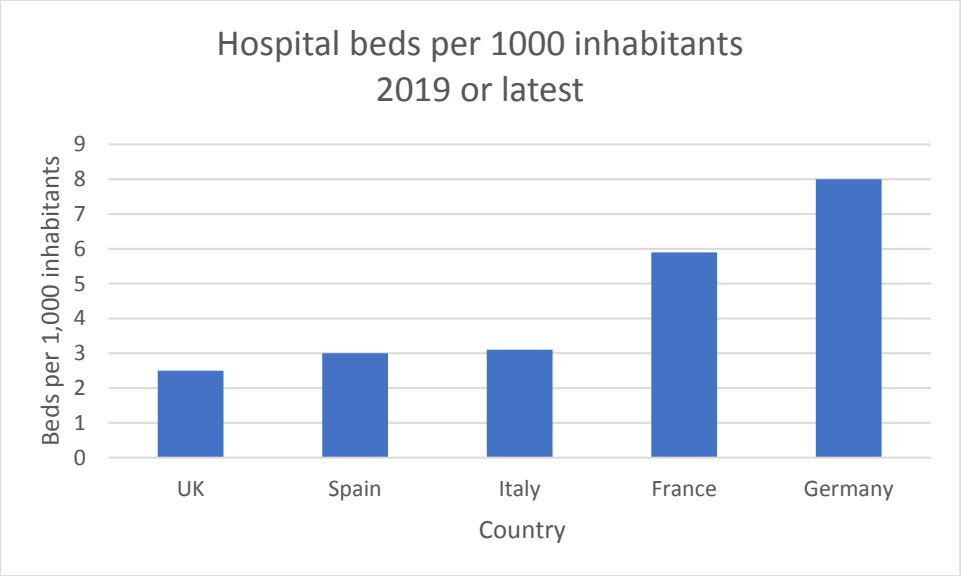
RCEM supports 85% as the recommended safe level of occupancy as it allows hospitals to be able to cope with surges in demand. High bed occupancy results in patients being cared for in corridors as there are not enough beds to admit them to. This is inhumane and undignified for patients and puts a lot of pressure on staff. Addressing the shortage of staffed beds in hospitals would improve outcomes for patients.

International bed comparisons

The OECD collates data on hospital beds[7] across member states, which provides a measure of the resources available for delivering services to patients in hospitals. It is useful to compare the trends in bed availability in the UK with other comparable health systems.

[6] NHS England (2020) Bed Availability and Occupancy Data – Overnight. Available here.
[7] https://data.oecd.org/healtheqt/hospital-beds.htm

Graph 6 Hospital beds per 1,000 inhabitants



Source: OECD, Hospital beds.[8]

There has been a general trend of reducing hospital beds across OECD nations, which is consistent with the trend in the UK. However, from the available data we can see that the UK has fewer beds per 1000 inhabitants than other comparable health systems.

Number of beds required to improve outcomes in Emergency Care

Analysis of NHS figures carried out by RCEM suggest that in order to keep bed occupancy at a safe level, and ensure patient flow in Emergency Departments, approximately 9,000 additional staffed beds will be needed this winter.

The calculation of 9,000 beds is based on the number of beds required to move to 85% bed occupancy in General and Acute wards and includes an additional 10% headroom in order to help maintain infection control. The calculation is based on actual and required bed numbers for Q4 2018-19.

The figure assumes that the 10,000 beds removed from the system during the peak of the pandemic (Q4 2019/20) will be available again this winter. If they are not, the NHS in England is likely to be short by over 19,000 beds.

The Treasury should provide funding for 9,000 additional staffed beds to be available in the General and Acute specialities this Winter and ensure future bed calculations are based on the 85% bed occupancy target.

Investing in our Emergency Medicine workforce

Patients depend on acute care delivered in our Emergency Departments. We are the frontline of the NHS. An appropriate Emergency Department workforce is the most important factor for providing safe, effective, high-quality emergency care in a timely, cost-effective, and sustainable manner. This requires a balanced team of nurses,

[8] OECD (2020) Hospital beds. Available here.

doctors, allied health professionals and support staff, with appropriate knowledge and skills.

Emergency Departments cannot deliver safe care if they are not adequately staffed. The NHS is facing a workforce crisis and EDs have insufficient resources to meet the minimum number of Consultants/senior decision makers required per 100,000 attendances. RCEM advises that there should be one Emergency Medicine Consultant per 4000 attendances. As such, an additional **2500 WTE** Emergency Medicine Consultants are needed by 2025 to address the shortage. Furthermore, the Conservative Party manifesto pledged to recruit 50,000 more nurses to be working in the NHS by 2024/25 with the March Budget reconfirming the Government's commitment to a significant funding package to improve the recruitment, training, and retention of nurses. Emergency medicine needs **4000 WTE** Emergency Nurses by 2024/25 to reach adequate staffing numbers to deliver safe care. A shortage of Paediatric Emergency Nurses is a common cause of Emergency Department safety concerns flagged by the Care Quality Commission. Numbers entering EM training places must be increased which will address the deficits in WTE trainees caused by increased flexibility in training in the short term and Consultant shortages in the longer term.

While we welcomed the focus on staff wellbeing and developing compassionate leadership cultures in the People Plan, we were disappointed that it failed to deliver a long-term workforce strategy with a commitment to recruiting additional staff. Understaffing means our existing workforce suffers from burnout – arguably more so than other specialties – which leads to many staff leaving the specialty.

The NHS is currently experiencing significant and high-profile support; we must build on this urgently by funding a nationally coordinated programme of ethical international recruitment for Emergency Medicine nurses and doctors, focussing on attracting clinicians from nations with comparable training and health systems. The UK is one of the best places to study and practice Medicine. To keep competitive advantage and strengthen the UK's place in the world, international qualified doctors and nurses should be offered fast-track entry, reduced visa fees and dedicated support to come to the UK with their families.

The Treasury should fund an additional 2500 WTE Emergency Medicine Consultants by 2025, deliver the 50,000 nurses commitment outlined by the Conservative Party manifesto by 2024/25 as Emergency Medicine requires 4000 WTE Emergency Nurses by this time to reach adequate staffing numbers to deliver safe care.

New Urgent and Emergency Care pathways

NHS England is transforming the Urgent and Emergency Care pathway. NHS 111 services will be the 'front door' for Urgent and Emergency Care to avoid unnecessary visits to Emergency Departments this winter. This model of care is aimed at ensuring people get the right care at the appropriate place; allowing Emergency Departments to manage attendances at Emergency Departments whilst offering care in a COVID-19 endemic world.

This change in the Urgent and Emergency Care pathway is consistent with several policy initiatives on reducing reliance on hospital-based care. One of the reasons for

shifting care outside of the hospital is the higher cost of hospital-based care. It is important to highlight that the evidence on efficiency of shifting the location of care is very mixed.[9]

Tackling crowding in Emergency Departments

Although we welcome the introduction of new Urgent and Emergency Care pathways, we caution that this will not eliminate crowding in Emergency Departments. Effective redirection of lower acuity patients to appropriate services elsewhere may help reduce demand on services by an estimated 5%.

Prior research shows that interventions to reduce unplanned hospital admissions struggle to manage demand.[10] It is important to stress that implementation of new initiatives can take time, and transformation of the urgent and emergency care pathway will require investment in alternatives alongside primary and community care services. There should be time factored in for providing existing levels of emergency care whilst alternatives are being set up.

Managing demand will not reduce crowding in Emergency Departments. Around 32% of patients who attend Emergency Departments are discharged after receiving advice and guidance only and 9% are discharge without requiring treatment.[11] As demonstrated in the sections above, increased pressures on Emergency Departments is more closely linked with increasing numbers of emergency admissions to hospitals and reduced bed and staffing capacity, rather than managing attendances to Emergency Departments.

Investing in primary care

> Effective implementation of this pathway is highly reliant on building capacity in primary care. The Government's ambition of making 50 million more appointments available per year in GP surgeries by 2024/25 and recruiting 6,000 more GPs and trainees alongside 6,000 more primary care professionals will contribute towards building capacity outside of emergency care.

Investing in community care

The Health and Social care systems are inextricably weaved together meaning that a holistic approach must be taken when seeking to reduce crowing in EDs. For example, an increase in council funding is a crucial means of ensuring that people do not end up in the emergency department unnecessarily. The most vulnerable in society use EDs at a higher rate than the rest of the population; strong, well-funded community care can go some way in reducing avoidable attendances. The Government's pledge to pump £1 billion extra of funding every year for more social care provision, better infrastructure, technology and facilities is welcomed - however, it will not address future demand and the workforce crisis faced by the social care

[9] Imison C, Curry N, Holder H, Castle-Clarke S, Nimmons D, Appleby J, Thorlby R and Lombardo S (2017), Shifting the balance of care: great expectations. Research report. Nuffield Trust. Available here.
[10] Purdy S, Paranjothy S, Huntley A, Thomas R, Mann M, Huws D, Brindle P, Elwyn G (2012). Interventions to reduce unplanned hospital admission: a series of systematic reviews [online]. Cardiff University website. Available at: http://orca.cf.ac.uk/93110/
[11] NHS Digital (2020) Hospital statistics: A&E Activity. Available here.

sector. The Health Foundation estimates that at least £3.9 billion must be invested in adult social care in England by 2023/4 in order to meet future demand and provide additional funding to increase the pay of the adult social care workforce.[12]

Investing in mental health

During the first wave of the coronavirus pandemic we saw a decrease in attendance for all patients including mental health patients, however from local data available us, mental health attendances have returned roughly to their pre-COVID level. Mental health patients are more likely to attend Emergency Departments and up to five times more likely to be admitted than the rest of the population. As such, investment into increasing the number of mental health beds in acute settings must be included in the £2.3 billion in real terms per year by 2023/24 promised in the NHS Long Term Plan. Child and Adolescent Mental Health Services (CAMHS) are also stretched; capacity for CAHMS must be increased to provide support for young people.

Liaison psychiatry teams play a crucial role in the parallel assessment of mental health patients that attend Emergency Department who might also need medical care. Due to a lack of mental health staff, liaison staff are stretched thin, as many of them also staff alternative units. Additional Liaison staff are needed to ensure that they are posted in 70% of Emergency Departments by 2023. This will support the Government's ambition of establishing parity between mental and physical health, alongside promoting the integration of care. Expansion of Liaison Psychiatry must go hand-in-hand with prevention and alternative services such as community support schemes and good telephone triage.

The Treasury should invest at least £3.9 billion in social care by 2023/4; expand the number of mental health beds available in acute settings along with expanding liaison psychiatry teams; and deliver on the Government's promise of providing additional GP appointments by recruiting more General Practitioners and primary care professionals.

Five-year funding deal

In 2018 the NHS received a multiyear funding settlement, confirming an increase in funding of an average 3.4% a year in real terms over the next five years. Whilst this reflects a substantial increase since the years of financial austerity, this is still below the 3.7% average increases in budget since the NHS was established. This is not enough to allow the NHS Emergency Departments to address growing demand and restore capacity.

RCEM agrees with NHS Providers, Institute for Fiscal Studies, and The Health Foundation that at least an average increase of 4% is required per year in real terms in order to improve the Urgent and Emergency Care system.[13]

The Treasury should adjust the NHS multiyear funding settlement to reflect the increased pressures placed on the healthcare service. At the very least, the NHS

[12] The Health Foundation (2020) Social Care Funding Gap. Available here.

[13] NHS Providers (2020) Parliamentary Briefing: NHS Funding Bill. Available here; Institute for Fiscal Studies (2018). Securing the future: funding health and social care to the 2030s. Available here.

budget should increase by an average of 4% per year in real terms over the next five years.

Capital investment

In line with the Conservative Government's manifesto promises to upgrade hospitals, we welcomed additional funding this winter to improve Emergency Department facilities. This will help Emergency Departments to expand capacity and ensure they are physically fit for purpose as we move into the winter months in which they will be contending with both COVID19 and flu.

However, although this funding will provide temporary relief this winter, it falls short of addressing the scale of the maintenance backlog in the NHS.

A multi-year capital plan is still required to address this backlog, expand, and physically redesign and rebuild Emergency Departments, so they can meet demands placed on them.

The Treasury should use this Comprehensive Spending Review as an opportunity to introduce a multi-year capital plan to physically design and rebuild Emergency Departments.

Health inequalities and the Government's 'levelling up' agenda

The coronavirus pandemic has exposed stark levels of inequalities in society. Although health inequalities were widening before the pandemic, the economic challenge ahead of us will exacerbate and entrench these inequalities. Investment in the health and social care service must therefore form a fundamental part of the Government's levelling up agenda. Indeed, the Health and Social Care Act 2012 made reducing health inequalities in access and outcomes an explicit duty for the Secretary of State for Health.

We do not underestimate the role Emergency Departments play in addressing health inequalities. The most deprived communities use Emergency Department services significantly more than the least deprived. There were more than twice as many attendances to Emergency Departments in England for the 10% of the population living in the most deprived areas (3.1 million), compared with the least deprived 10% (1.5 million) in 2018-19.[14] In addition, more deprived *children and young people* are more likely to go to Emergency Departments than the least deprived.[15]

A study in the BMJ showed that after controlling for demographic and health factors, not being in employment and living in poor quality housing increase the likelihood of attending Emergency Departments.[16] The Treasury should be mindful of

[14] NHS Digital (2019) A&E attendances twice as high for people in the most deprived areas as in the least deprived. Available here.
[15] Nuffield Trust (2017) Admissions of inequality: emergency hospital use for children and young people. Available here.
[16] Giebel C, McIntyre JC, Daras K, et al. What are the social predictors of accident and emergency attendance in disadvantaged neighbourhoods? Results from a cross-sectional household health survey in the north west of England. BMJ Open 2019.

the impact of their economic decisions on an already very stretched Emergency Care system.

Analysis carried out by the Institute for Public Policy Research found that since 2014/15 there has been an estimated £850 million decline in net public health expenditure in England with drug and alcohol services most severely affected by these cuts.[17] When preventative public health services are cut the burden of health often shifts on to Emergency Departments. For example, in 2018/19 there were 358,000 admissions to hospital where the main reason was alcohol, representing a 6% increase from the previous year.[18]

If the Government wants to meet its own manifesto commitment to extending healthy life expectancy by five years by 2035 then these cuts to vital public health services must be reversed. The return on investment for public health is high[19] and some suggest that spending through public health is up to four times as cost-effective as NHS spending.[20] It is evident that lack of investment in public health only shifts the demand for care to other – and more costly – parts of the healthcare service, such as Emergency Departments.

The Treasury should increase the Public Health Grant allocations to Councils. Long term investment in local public health is required to reduce pressures on Emergency Departments and reduce health inequalities.

[17] IPPR (2019) Hitting the poorest worst? How public health cuts have been experienced in England's most deprived communities. Available here.
[18] NHS Digital (2020) Statistics on Alcohol. England. Available here.
[19] WHO (2014) The case for investing in public health. Available here.
[20] Centre for Health Economics (2019) Is an ounce of prevention worth a pound of cure? Estimates of the impact of English public health grant on mortality and morbidity. Available here.