RCEM
Royal College of Emergency Medicine

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Summary of the Royal College of Emergency Medicine's Emergency Care Crisis Summit

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 clinicians, doctors and consultants to A&E departments (EDs) in the NHS in the UK and other healthcare systems across the world.

Context
The crisis facing the emergency care system is unacceptable and requires immediate political attention. This 'Call to Action' style event highlighted the need for long term action in order to ensure the NHS is equipped to provide timely care to all patients who need emergency care. The aim of the event was to build political will to address problems that will take more than an election cycle to fix. The panel discussion highlighted the pressures on staff and patients across the entire emergency care pathway and focussed on potential solutions.

The event took place on Tuesday 28th March in the House of Lords and was kindly sponsored by Baroness Merron.

Chair: Dr Adrian Boyle, President of the Royal College of Emergency Medicine

Panellists:

- Wes Streeting MP, Shadow Secretary of State for Health and Social Care
- Lord Allan of Hallam, Liberal Democrat Lords Spokesperson (Health)
- Anita Charlesworth, Director of Research and the REAL Centre, Health Foundation
- Dr Camilla Kingdon, President of Royal College of Paediatrics and Child Health
- Dr Tim Cooksley, President of the Society for Acute Medicine
- John Martin, President of the College of Paramedics
- Professor Adam Gordon, President of the British Geriatrics Society
- Becky Goddard-Hill, an ED patient

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Opening discussion

Adrian Boyle opened the event, introduced the panel and thanked Baroness Merron for kindly hosting the Crisis Summit. Dr Boyle began by talking attendees through the grave situation emergency care is in. He gave a powerful anecdote about his shift the night before wherein 75 people were waiting to be seen with only 40 cubicles, 33 of which had people waiting for admission. The longest of waits was 35 hours. Long waits such as these are now not uncommon. In 2022 1.6 million patients spent more than 12 hours from their time of arrival in an emergency department (ED). 60% of those were over 60 years old – it is sadly often the elderly and most vulnerable that have the worst experiences in EDs. Dr Boyle lists the major issues facing the specialty, namely the retention of staff, ambulance handover delays, crowding and exit block. However, he emphasised that all these issues have a solution and are fixable. The five priorities laid out in the RCEM Resuscitate Emergency Care Campaign outlines what should be focussed on:

- Eradicating overcrowding and corridor care for patients.
- Providing the UK with the Emergency Medicine workforce it needs to deliver safe care.
- Ensuring our NHS can provide equitable care to emergency patients.
- Focus on evidence-based interventions to tackle overcrowding.
- Introduce meaningful and transparent metrics to facilitate performance and better outcomes for patients.

The Patient Experience

Panellists, including a patient, spoke of their first-hand experiences with the emergency care system and how the pressures it is facing mean patients are receiving sub-optimal care. Becky Goddard-Hill described her 24 hours in a department waiting for admission on a trolley side by side with other patients. Her husband waited next to her on the floor. Staff tried their best, but without sufficient resources, they struggled to meet the demand. Her poor experience meant that when Becky fell acutely ill a few months later, she was reluctant to seek care and her conditioned worsened.

John Martin spoke of the immense strain paramedics are under. Over the Christmas period the average wait time for a response to chest pain (Category 2 call) was over an hour even though it should be no more than 18 minutes. Mr Martin has witnessed first-hand how delayed response times can lead to poor outcomes for patients and even death. Furthermore, high sickness and higher than average suicide rates are now commonplace in the paramedic profession.

Dr Cooksley reflects on how on crowded departments are impacting cancer patients. Due to fear of contracting an illness, those undergoing chemotherapy are understandably reluctant to access care via an ED. He describes how a patient who was experiencing a high fever following chemo could not reach her chemo specialist and was advised to visit her ED. She followed the advice, however, on arrival the department was so crowded she had no choice but to wait sat on the floor. Feeling anxious about the proximity to sick patients also waiting, she decided to leave. Her fever persisted and because of the delay to her care, she was no longer eligible for Same Day Emergency Care and was later admitted for four days. This was an avoidable admission had this patient had timely access to safe care.

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Professor Gordon shared a story of a patient who had no previous memory problems. When she came into the department, she was fully oriented. By the time she finally had her brain scan at 3am, she had become violent and confused. While her brain scan and blood test were normal her confusion was exacerbated by the bright lights, with no windows and crowded environment. Sat on a chair for hours her mobility deteriorated, and she therefore needed she need a rehabilitation bed but the was a seven day wait. By day two, she had fallen, and Professor Gordon saw her once again in hospital.

Dr Kingdon told a story about a 9-month-old baby who had developed a high fever. With no GP appointments available, they called NHS 111. After 40 minutes the call was disconnected due to a lack of available call handlers. Failing other options, they decided to go to an ED. They were seen after seven hours, waiting amongst other sick children. The child was seen and had a mild viral infection that did not need an ED, but of course, the parents weren't to know. The risk in such a scenario is that the baby had now been in a crowded waiting room, inevitably near children who may have had something more sinister.

Wes Streeting started by asking the attendees how many of them had had a bad experience in the last six months, or knew someone who had, in an ED. Most people in the room raised their hand. Wes Streeting then shared a story about two people in his immediate family who had recently had poor experiences with the emergency care service due to pressures and delays. He added that people are feeling like they can't rely on the NHS anymore when they are in an emergency situation for the first time in history, and the data would show this to be true too. He feels inaction and delayed action has made this worse and the priority must be to reduce demand to increase access to primary care. Releasing winter discharge funding in the middle of winter will not suffice.

Anita Charlesworth explained that the Health Foundation have been working with Ipsos on polling. The most recent results from November show that two thirds of the population think that the standards of care have got worse and anxiety around the standards of care are rising not falling after the pandemic. People want the service that we have got to be resourced. A significant part of that is needing more staff, safe emergency care and access to planned care. Adrian Boyle agreed that cash injections are frequently spent on short term staffing and locum. We must strive to get to a situation where the government had a long term vision.

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Long Term Vision

The panel considered the implications of short termism in health policy. The need for a long-term vision for the future of emergency care was discussed, along with recommendations and solutions to help the NHS recover from the crisis.

Adrian asked the panellists what they believe to be the three long-term solutions:

- Mr Martin listed workforce and retention, as lots of people want to become paramedics but hard to hold onto them given the intensity of the work and high moral injury. Additionally, investing paramedics working outside a hospital, as lots can be done to avoid admission. Safely treating patients in the community and facilitating rapid pathways to other services should be a priority,
- Dr Cooksley spoke of the need to reduce the occupancy. When hospitals are operating at 92% capacity as they currently are they become terribly inefficient. Digital innovation should also be a key focus.
- Professor Gordon flagged that the system is not designed well to deal with frailty, we must ensure systems are in place to help this cohort of patients. Furthermore, rehabilitation has been underinvested for far too long.
- Dr Kingdon added that invest in the primary emergency care interface is paramount. We must empower parents and increase clinical involvement in NHS 111. A recent pilot recently using paediatricians in 111 had a really rewarding impact. Secondly, mental health problems for children are on the rise and there is no capacity to deal with them in a confidential and dignified way.
- Finally, Ms Charlesworth adds that we are experiencing a rapidly ageing population and have reached a tipping point. We have not planned for the anticipated - there are not enough hospital beds and not enough staff. We need different and better models of care, higher quality, that aren't an alternative to bolstering capacity. We need to invest and reform.

Reflecting on the panellists' comments Adrian added that reducing crowding was RCEM's priority. We welcome the return of focus to the 4-hour target. While it is certainly a crude metric, it should not be replaced until an evidence-based alternative, that is good for the patient, is proposed. We should be routinely evaluating what has worked and what hasn't.

Lord Allan of Hallam concurred with the comments made. He shared that the key areas of focus should be beds, buildings, and staffing, including social care staff. Critically on staffing action must be taken quickly, and Mr Streeting echoed this message adding the need to reduce the prevalence of preventable disease.

Q&A with the audience

The audience were given the opportunity to ask questions to the panel.

Questions were focussed on prevention and public health, and ensuring solutions have the long-term health and wellbeing of the country in mind built on a strong primary care system. Over the last decade compared to the other 14 big EU countries the UK would have spent 33bn pounds more on healthcare if we were matching their investment.

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Ms Charlesworth summarises the sentiments of the panel. Underfunding, the pandemic, and a rapidly ageing population have resulted in current pressures. We need to see integration across health and social care and putting preventive care at the heart. This means a serious commitment of 5 years of rebuilding the foundations of our health service again, and pumping investment into preventive care. 9 in 10 people are committed to the principles of the NHS. It has to be appropriately resourced.

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