



RCEM Scotland's steps to **rebuilding**  
emergency medicine

# The RCEM Scotland

## STEP campaign

The Royal College of Emergency Medicine (RCEM) is calling for action to address the significant challenges facing Scotland's Emergency Departments (EDs), and whilst some important progress has been made, much work remains to be done to provide the safe and quality service that our patients require, and to which we aspire.

**To rebuild the Emergency Medicine service the College is calling for four steps to be taken:**

- Step 1:** Safe and sustainable staffing levels must be achieved
- Step 2:** Terms, working conditions, and funding, must be fair and effective
- Step 3:** Exit block and overcrowding must be tackled
- Step 4:** Primary care facilities must be co-located with ED services

**The College urges The Scottish Government, politicians and NHS leaders to work together to take the four steps needed to rebuild emergency care. These steps are set out in more detail below.**



## Staffing: safe and sustainable



The number of Emergency Medicine (EM) consultants, specialist doctors and trainee doctors working in Scottish EDs remains insufficient to deal with the rising demand from patients seeking urgent and emergency care.

For many years, The Royal College of Emergency Medicine has called for staffing levels to match patient flows. To achieve 7 day coverage of EM consultants between 8am and midnight requires a minimum of 10 whole time equivalent (WTE) consultants in each ED, rising to 16 or more in larger units. The College recognises that there is local variability in the size and scope of some EDs and a one-size fits all approach is not the answer. That is why we will soon be launching some additional toolkits to help with resource planning.

In recent years, EM consultant recruitment in Scotland has increased from 121 to over 190 WTE. This has had positive effects on extended clinical cover and patient care, staff morale and recruitment. However, this is still short of the workforce target of 230 WTE consultants agreed by the College with the Scottish Government in 2012, a figure which aims to provide trained specialist EM consultant presence on the clinical "shop-floor" for 16 hours a day, 365 days a year, in every Scottish EDs as they are currently configured.

Recruitment to Higher Specialist Training posts continues to face challenges with a fill rate of only 61%. At entry-level for core EM training in 2015, however, competitive recruitment fill rates reached 100%. It is evident that at stages during their training programmes, our trainee doctors are exiting the specialty in significant numbers.

As a result, the Middle Grade tier of EM doctors has all but disappeared in many Scottish EDs.

This shortage of doctors and consultants is being filled in part by locum doctors. This wastes precious funds at a time when NHS resources are scarce.

Coupled with this is the real and current issue that more doctors and consultants are emigrating to work abroad. Our Members and Fellows tell us that they are being worn down by the relentless workload in understaffed and crowded EDs. There is a significant resultant clinical and professional dissatisfaction as a consequence of working in facilities where the desired quality of care is difficult to deliver because the team is under-resourced. We estimate that the cost to the taxpayer of training doctors who ultimately end up working in Australia alone is around £130m.

The College calls for safe and sustainable staffing of Scotland's EDs. This means addressing the life-career fit for those working in our EDs, and recognising the demands of all acute specialties through reviewing their terms and working conditions.

More must be done to retain and value our trainees. Without them we will not be able to staff the consultant posts of the future.

Failure to address this will result in continued and accelerated haemorrhage of the acute workforce. Doctors will vote with their feet and exit the specialty, or the country.



## Terms, Working Conditions, & Funding - Fair & Effective



The current system for funding EDs in Scotland is inadequate for effective resourcing of the service.

Through block funding to Health Boards, EDs are allocated specific funds which resource their services. Many departments are fundamentally under resourced to deliver all aspects of the service which providers and patients expect of them. ED medical and nursing staff in particular, are under pressure to deliver hospital and system targets, which are increasingly poorly linked to the level of resource they receive, and the services they are asked to provide. Funding can also fail to take into appropriate account the resources required to deliver new services, innovation, research and medical training. This mismatch can result in Scottish EDs being an unattractive environment in which to work, for doctors of all grades.

The current annual and irregular allocation of non-recurrent funding payments exacerbates the inadequacies of this system. Reliance upon finances released during winter results in departments being able to fund only short-term projects to cope with pressures. This results in a reactionary system of handling service pressures. This occurs despite awareness that winter can be a most challenging time for hospitals. The ability to plan for system pressures, in both the medium and the long term, is severely constrained if funds continue to be allocated via non-recurrent measures.

Furthermore, the inconsistency of funding arrangements extends to the amount of money spent on expensive locum staff. Whilst locums are at times necessary to fill short-term gaps, long term over-reliance on locums inhibits the development of a sustainable and appropriately-staffed service. The College believes that this money could be allocated to improve the working conditions of ED doctors. By doing so, the need for locums is minimised.

The College calls for the Scottish Government and Health Boards to undertake an evaluation of the appropriate level of resourcing for EDs. We urge the Scottish Government to avoid the sporadic payments which are allocated to handle winter pressures, and instead to include these funds and those for locums in the share of block funding allocated to departments. This would allow available funds to be spent more intelligently on long-term planning for pressures of demand, workforce, training and service innovation.

Resourcing EDs appropriately will ensure that the service operates effectively, is valued by patients, and that the working environment for ED doctors is improved.



## Exit block: eliminated



A condition called 'exit block' is harming patients: they are put at risk when 'exit block' occurs. This happens when patients cannot be timeously transferred from EDs and admitted into a hospital inpatient bed. Exit block is explained in more detail in the RCEM video: **Exit Block: What it is and why it is dangerous.**

Over 500,000 patients a year in the UK are affected by exit block. This in turn accounts for 500 avoidable deaths. The College calls on Scottish Health Boards and their Chief Executives to make sure that this issue is on their agenda.

We are concerned about patient safety. When the ED becomes crowded as a consequence of exit block, we know that patients do less well. We know that crowding kills. It is simply not acceptable to let this situation continue which is why we are on a mission to urge hospital Chief Executives and their Boards to make sure they have plans to deal with this issue.

Of secondary importance but of greater long term risk is the effect of exit block on staff. Working in overcrowded departments, where care is constantly impaired as a consequence, saps morale and is a key cause of burn-out and poor retention of staff.

Consequently, more emergency medicine doctors are referred to professional counselling services than those from any other medical workforce.

Safe and sustainable staffing of EDs will require contractual changes to promote and ensure retention of staff. Failure to address this problem will ensure doctors continue to vote with their feet and exit the specialty or emigrate.

To help with tackling this issue the College has issued the guidance: **Crowding In Emergency Departments.**

## Primary care facilities: co-located



We know that 15% of patients attending EDs could be treated more appropriately outwith the ED by GPs. This was confirmed by our own research, 'The CEM Sentinel Sites Survey' published in May 2014.

Rather than blame patients for attending EDs when they have difficulty accessing other more appropriate alternatives, we believe a new approach is required. Over the past 15 years, efforts to encourage patients to seek assistance over the phone or to go elsewhere have not reduced the flow of people to EDs. The College believes the issue should be dealt with by positioning services where patients attend, by co-locating Primary Care facilities with EDs.

### Co-location will:

- 1. Allow patients to be routed to the best place to obtain their care.** Co-location will put more staff at the front line with a better distribution of skills for the wide spectrum of urgent and emergency presentations.
- 2. Transfer patients quickly and safely between Primary Care, and the ED.** Inevitably, there will be people who are in the wrong place; this can be remedied quickly without either patient harm or inconvenience.
- 3. Provide Primary Care Out-of-Hours staff with immediate access to facilities such as radiology, pathology and ECG.** This is much cheaper than putting these services on a second site (or even in GPs' surgeries as sometimes suggested). There is the additional advantage of the proximity of staff who can interpret ECGs and x-rays; immediate reporting by radiologists may also be available. The immediate result of an investigation may guide treatment plans, and prevent hospital admission. Sharing facilities in this way also reduces the costs of running an ED. Patient satisfaction is likely to be increased if GPs have immediate access to diagnostic and other investigations.
- 4. Encourage Primary Care staff and ED staff to share opinions and knowledge.** This may be especially beneficial in cases of older people returning to their own homes with a viable package of care and support, as advised by Primary Care staff.
- 5. Allow other services such as emergency dentistry and frailty units to be co-located on the same site.** This has obvious benefits for both patients and the health economy.



## The Royal College of Emergency Medicine in Scotland.

The Royal College of Emergency Medicine is the membership body for accident and emergency doctors. It was established to advance education and research in Emergency Medicine. The College works to ensure high quality clinical care by setting and monitoring standards, and by providing expert guidance and advice on policy to relevant bodies on matters relating to Emergency Medicine.

In Scotland, The Royal College of Emergency Medicine is represented through the National Board for Scotland, led by the Vice President for Scotland. The Board is responsible for all matters of interest relating to the practice of emergency medicine in Scotland. The Board actively engages with the Scottish Government, all political parties and health stakeholders to promote emergency medicine.

If you would like to discuss any of the issues raised within the RCEM Scotland STEP campaign or to meet with a representative of the RCEM Scotland, please contact Ben Walker, Policy and Public Affairs Manager, at [ben.walker@rcem.ac.uk](mailto:ben.walker@rcem.ac.uk)

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