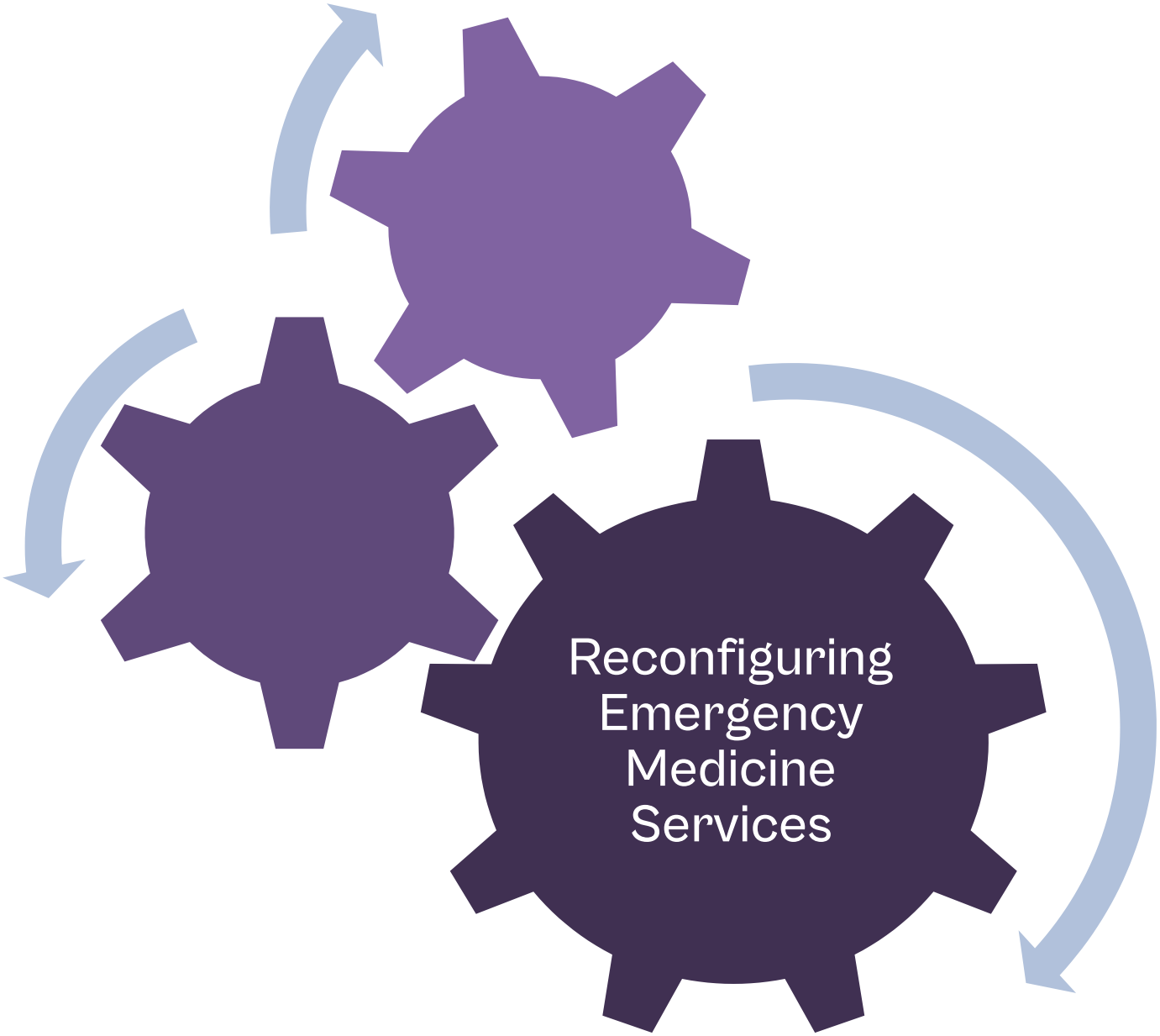
Royal College of Emergency Medicine



Safe Efficient Effective Care

Service Design and Delivery

RCEM guidance on reconfiguring Emergency Services

Summary

1. Reconfiguration of emergency medicine services should always have patient care at its heart. Perceived cost efficiencies may be illusory.
2. Basing reconfiguration decisions around planned reductions in demand for urgent and emergency care, or around hoped-for effects of redirection strategies, is not recommended.
3. Workforce shortages are a poor justification for service reconfiguration. The solution for this is investment in the workforce.
4. Increased transport times resulting from reconfiguration will have a disproportionate effect in rural areas, and on vulnerable patient groups. They also impact upon ambulance services and can create problems relating to discharge and repatriation.
5. Most EDs are already crowded. Actively deciding to increase attendances into crowded EDs will harm patients. This will be made worse if bed closures are also planned in the same systems.
6. Whilst there are strong arguments for centralising some specialised capability, local EDs must retain basic capability to treat time critical problems and manage common injury and illness.
7. Emergency Departments can become too big to work effectively.
8. The consequences of closing or reconfiguring EDs on other co-dependant hospital and community services should be modelled carefully. Resources should be allocated to track progress.

Context

The Royal College of Emergency Medicine receives requests for advice from people and organisations in areas where there are plans to reconfigure or downgrade emergency departments and to centralise services at a larger site. Decisions in each case will be influenced by complex and varying local factors beyond the scope of this document. It is expected that the number of these requests will increase in the context of the NHSE's current Sustainability and Transformation Plans (STPs).

Wherever reconfiguration of services is planned the following issues must be considered and addressed. Any proposals should be predicated on a proper risk assessment of these key issues which should be published for consultation.

Reconfiguring for the right reasons

Any reconfiguration proposal must start by considering the needs of the communities served. The key issue is the impact on patients and patient care at the site from which services will be removed or reduced. Secondary, though important,

are the consequences for services at sites that would be required to absorb the diverted patient flows. The additional stress on local primary care and ambulance systems must also be considered.

The College recognises that recruitment and retention of staff is often cited as a relevant factor. However, this is commonly a consequence of historical poor planning and resourcing; in itself it is poor justification for service reconfiguration. It is the view of the College that the emergency medicine workforce should be developed in a sustainable way to enable the facilities required by the population to be properly staffed.

Demand predictions

1. Basing reconfiguration decisions on planned reductions in either ED demand or the hospital acute bed base is fraught with hazard.
    a. The College is aware of many examples of flawed national and local predictions underpinning arguments for change.
    b. The College is not aware of systems which have successfully reversed current ED demand patterns. These typically demonstrate rising demand for both physical and mental health problems. The former is characterised by more elderly, complex and sick patients presenting to EDs.
2. Basing reconfiguration decisions on assumptions about the "primary care" workload of EDs, and the ability of local primary care services to absorb this perceived workload, is not recommended.

Travel

1. Relocating services has a disproportionate effect on the very young, the very old, patients with mental health issues and those with chronic illness or reduced mobility.
2. Relocation also has a greater impact on poorer socioeconomic groups through difficulties with transport.
3. The likelihood of transportation difficulties will be higher in rural areas.
4. Increased travel times are associated with worse outcomes for some patient groups with time-critical illnesses[1].
5. The increased demands on ambulance services brought about by longer transport times are seldom properly modelled.
6. Similarly, repatriation issues are often ignored. Patients in hospitals at a distance from their homes may be harder to discharge and so increase hospital occupancy rates.

1. The relationship between distance to hospital and patient mortality in emergencies: an observational study Emergency Medicine Journal. 2007 Sep; 24(9): 665–668.

Staffing and resources

1. Short-term staffing shortages cannot be a rationale for permanent reconfigurations. Longer term patient outcomes will be compromised.
2. Moving resource / capacity issues does not solve them. The necessary increased capital and revenue expenditures at the receiving site(s) are seldom properly modelled.
3. The King's Fund have demonstrated that the cost efficiencies associated with such reconfigurations are largely illusory[2].

ED crowding

1. The most significant immediate cause of crowding in EDs is lack of inpatient capacity, followed by rising demand and acuity, and inadequate staffing
2. Systems planning to close beds should be mindful of the potential effects on ED crowding, which is associated with patient harm and death. This will be particularly pertinent in systems where there are plans to close beds in the same trusts that are expecting increases in ED attendances.

Capability

1. There is a strong argument for centralising capability for some key presentations such as major trauma, acute myocardial infarction, stroke or vascular surgery. This should always be undertaken as part of a networked approach to care.
2. Local EDs should maintain core basic capability to serve the needs of the local population, to treat time-critical problems and to manage most common conditions.

Sufficient size

1. Emergency departments in the UK are substantially larger than international comparators - even small UK departments are relatively large in relation to European, American and Australasian departments.
2. Departments can be too big to be efficient, as well as too small. This is particularly the case if the supporting infrastructure, or downstream capacity, is inadequate.

2. The reconfiguration of clinical services. What is the evidence? The King's Fund 2014

Unintended consequences/ self-fulfilling consequences

There is an inherent unintended consequence of rendering other services at the same site non-viable. Limiting the case-mix and case-load means reconfiguration may exacerbate recruitment and retention issues in non-EM services such that a self- fulfilling, non-viability scenario is created.

RCEM May 2022

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