The Royal College of Emergency Medicine

RCEM Winter Flow Project

Final Report: July 2017

Introduction

In 2015 we launched the 'Winter Flow Project' in an effort to highlight the difficulties facing an NHS struggling with unprecedented financial difficulties and insufficient resources.

The project looked at patient flow within Emergency Departments (EDs) over the winter. It was a great success because of the generosity of its contributors, with over 50 NHS Trusts and Health Boards from across the UK submitting data over a six-month period. These data helped to provide a better understanding of system pressures and four-hour standard performance.

The findings enabled RCEM to broaden the debate around emergency medicine beyond the usual narrow focus on the four-hour standard and meant that providers, commissioners, the national press and governments in each of the countries of the UK were better informed about the challenges faced by staff working on the NHS frontline.

Given the success of the project, the College decided to repeat 'Winter Flow' for 2016/17. As was the case in 2015, each participating Trust/Board has submitted weekly data on attendances, four-hour standard performance, delayed transfers of care and cancelled elective operations. The data together better reflect pressures, constraints and consequences for system performance.

The data is aggregated to ensure the focus of consideration is the wider health care system rather than the performance of individual Trusts/Boards. Over 50 Trusts/Boards encompassing more than 60 separate sites submitted this data on a weekly basis since the beginning of October 2016.

Published on the Friday of each week following data collection, the summary data provided a current overview of 'winter pressures'. The College is grateful to the participants who represent Trusts/Boards of all sizes and geographical locations.

Unlike NHS England datasets, there is no suggestion that our project represents a complete or permanent scrutiny of the healthcare system. Our data includes all four countries of the UK, although the majority of participating sites lie within England. It is a just sample of Trusts/Boards, albeit a large and representative one.

The data has already been of immense value to the College and allows informed comment and analysis rather than just speculation.

The project has now reached its end point for 2017 (26 weeks) and it is therefore timely to present the data and our findings.

Summary of Findings

- Four Hour Standard performance as a whole started at a lower point in 2016-17 than was the case in the previous year.[1]
- The data recorded after Christmas saw a significant improvement in performance yet was still considerably short of the 95% set out in the NHS Constitution,[2]
- Only 4 out of 60 of sites achieved an average of 95% Four Hour Performance over the period, however, 14 sites averaged over 90%.
- Over the course of the project there was a 1.86% increase in the number of acute beds in service. Last year the equivalent figure was 1.9%
- Although this difference may appear small, what this suggests is that the NHS providers participating in the project now have measurably less capacity to cope with surges in demand.
- NHS England figures have shown that while attendances at Type 1 departments actually went down in quarter four of 2016-17 compared with the same quarter of 2015-16;[3] admissions went up,[4] bed numbers went down,[5] and general and acute bed occupancy went up.[6]
- NHS England figures show that, the number of patients waiting more than twelve hours from decision to admit to admission rose from 695 to 1598 in quarter four of 2016-17.[7]
- The overall proportion of acute beds occupied by DTOC patients has averaged 6.6% across Winter Flow contributors. Last year the equivalent figure was 6.1%.
- In short, providers have seen an increasing number of patients who require admission while hospital's capacity to adjust their bed stock to compensate has been diminished, as has the overall bed base.
- In addition, this situation has been made all the more difficult because the number of patients subject to delayed transfers of care has remained a persistent and growing problem.

[1] The 2015-16 project saw Four Hour Standard Performance start out at 90.28% whereas the starting point for 2016-17 was 84.14.%

[2] NHS Constitution

[3] A&E Attendances and Emergency Admissions 2016-17 Type 1 attendances Quarter 4 2015-16 3,818,750, Type 1 attendances Quarter 4 2016-17 3,674,252.

[4] A&E Attendances and Emergency Admissions 2016-17 Type 1 admissions Quarter 4 2015-16 1,045,021, Type 1 admissions Quarter 4 2016-17 1,045,455.

[5] NHS England Bed Availability and Occupancy Data Bed availability Quarter 4 2016-16 131,561, bed availability Quarter 4 2016-17 131,060.

[6] NHS England Bed Availability and Occupancy Data General and acute bed occupancy Quarter 4 2016-16 91.2%, general and acute bed occupancy Quarter 4 2016-17 91.4%.

[7] A&E Attendances and Emergency Admissions 2016-17

60 locations contributed to this project for the full duration. The nation analysis of contributors is as follows:

England	Scotland	Wales	Northern Ireland
50	2	5	3

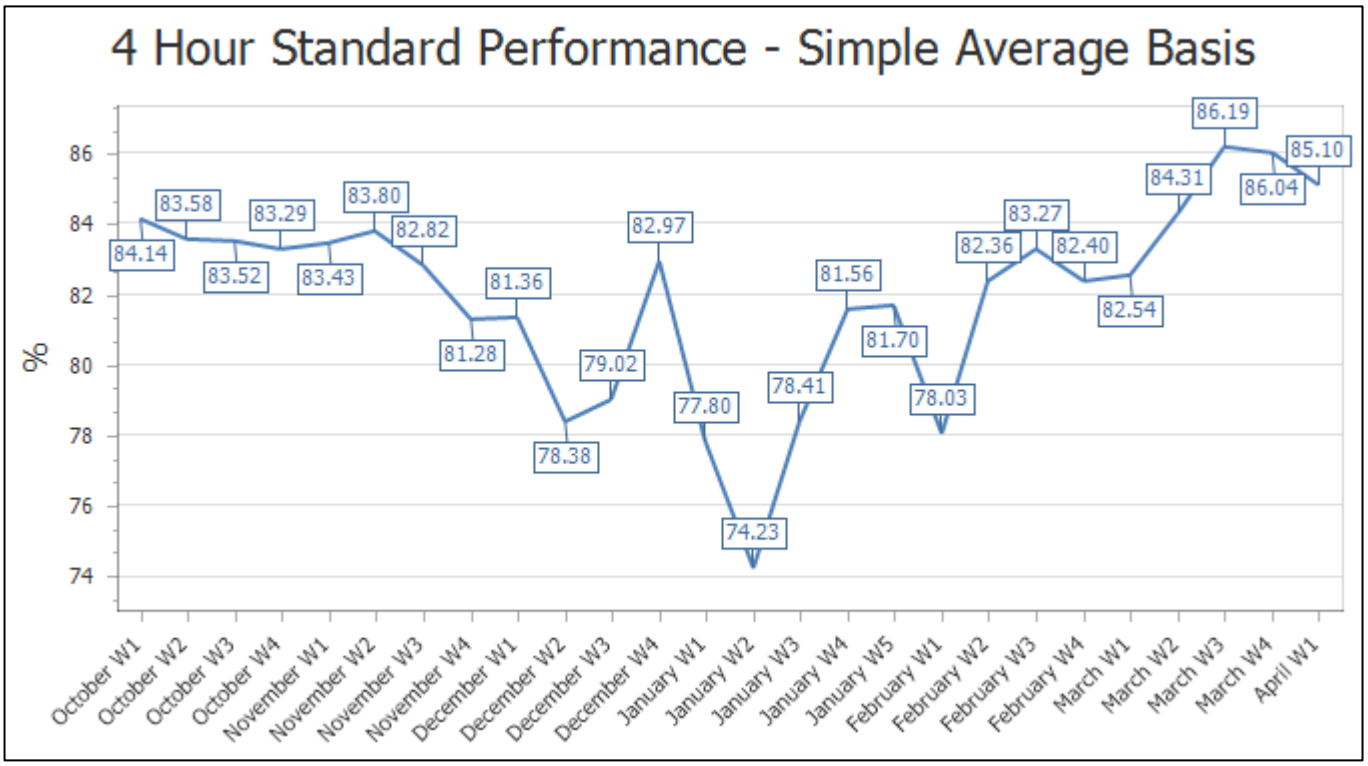
As an indication of size, the bed capacity of each of the contributing sites ranged from 94 to 1849.

The four measures reported on a weekly basis were;

- Four hour performance
- Acute bed stock
- DTOC instances
- Cancelled elective operations

Four Hour Performance Standard

60 sites each contributed 26 consecutive four hour performance scores. The range of performance against the Four Hour Standard was 48.66% to 99.46% with an overall average of 81.98%. The overall weekly trend was as follows:



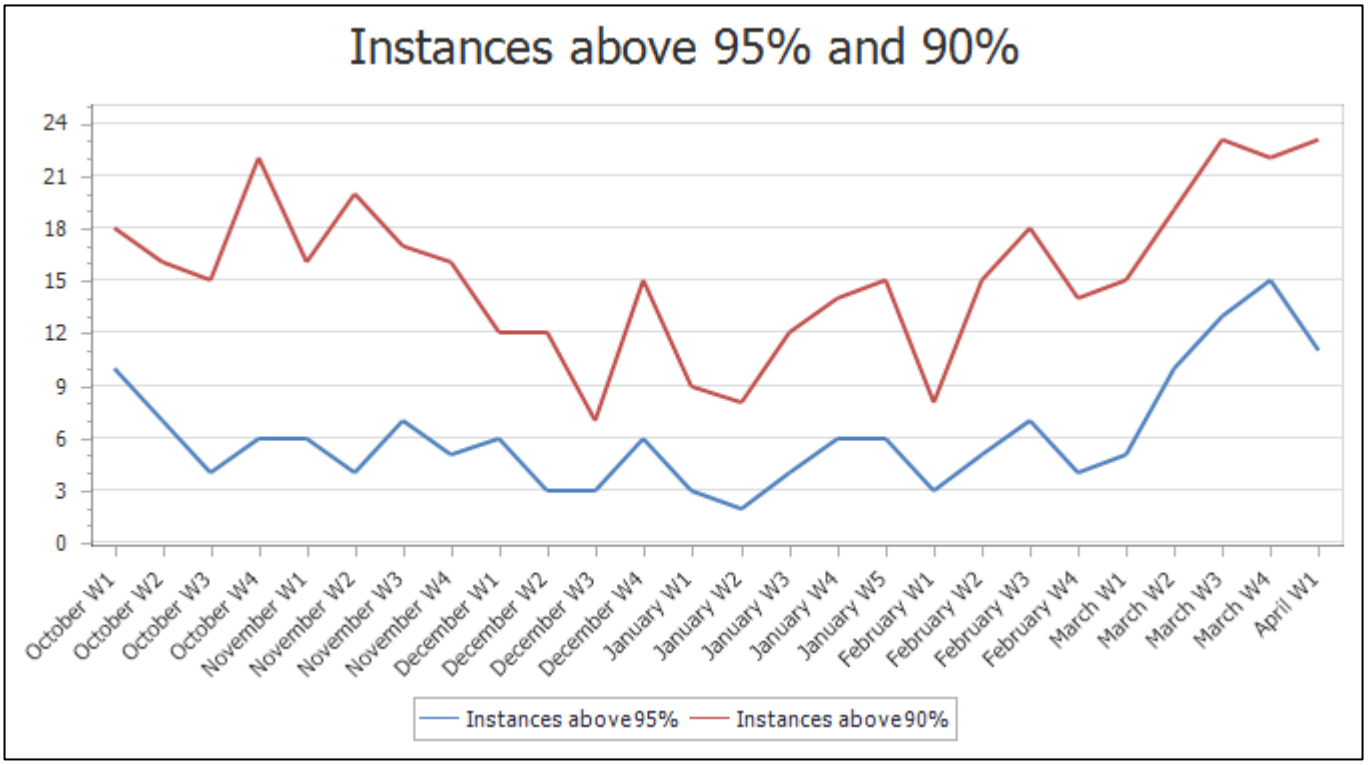
A number of points can be made at this stage. Firstly, although performance as a whole started at a lower point in 2016-17 than was the case in the previous year[8] the data recorded after Christmas saw a significant improvement in performance. This is in contrast to the near constant

[8] The 2015-16 project saw Four Hour Standard Performance start out at 90.28% whereas the starting point for 2016-17 was 84.14.%

deterioration that had been the case in 2015-16. This meant that the 2016-17 project saw performance in week 26 at 85.10% rather than the 83.03% as was the case in 2015-16. Although the cohort of UK wide Trusts and Boards contributing to the project was not identical in both years, the number of contributing NHS providers is broadly comparable.

While this improvement is good news, we are still considerably short of the 95% set out in the NHS Constitution,[9] these figures should not be taken as evidence that the profound challenges facing NHS providers have been resolved. Quite clearly, they have not. Four-hour standard performance has more or less been in steady decline since 2010 and NHS England has not recorded a quarterly performance for Type 1 EDs over 95% since the second quarter of 2012-13.[10]

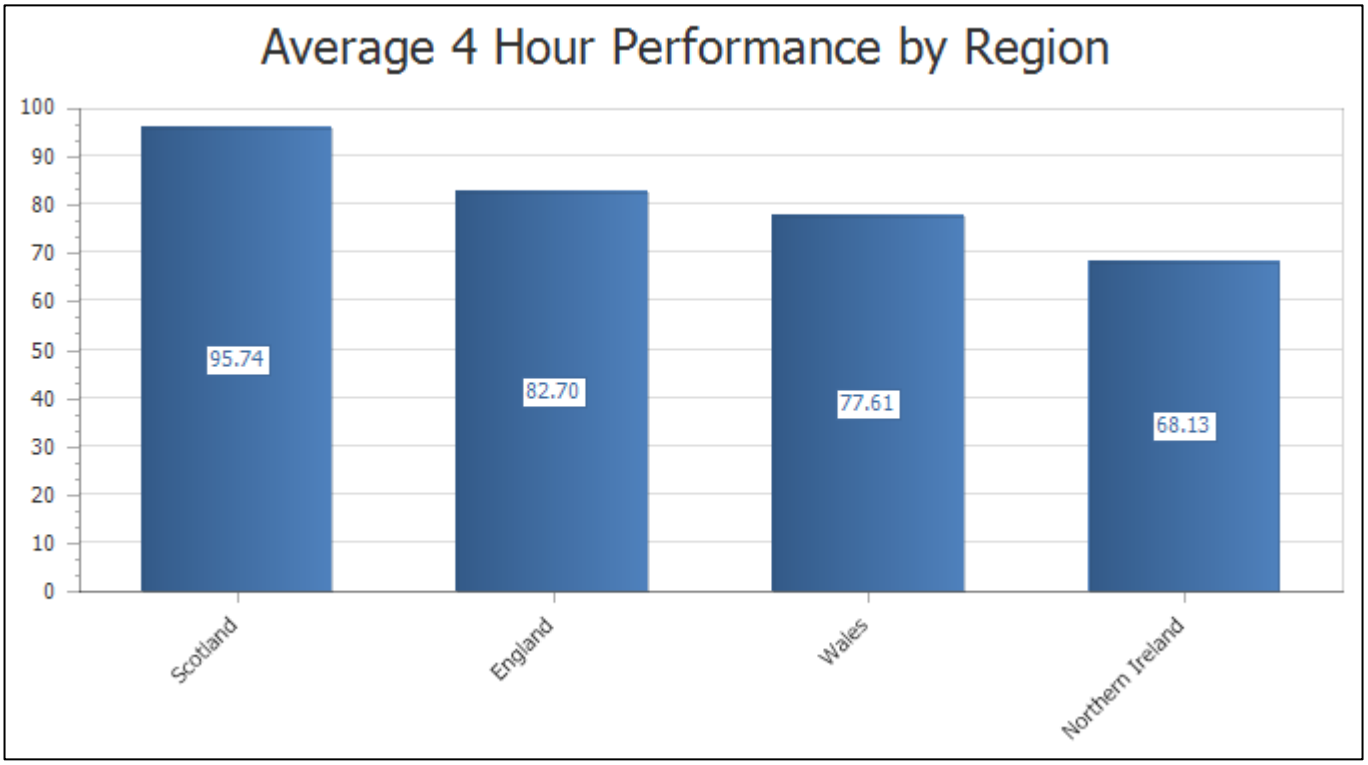
Only four sites achieved an average of 95% Four Hour Performance over the period, however, 14 sites averaged over 90%. The chart below shows the number of locations achieving the 95% target compared to a 90% performance level.



What this means is that this year only 23.33% of contributors have achieved an average of 90% or above over the first three months of the project. Last year the equivalent figure was 44%.

[9] NHS Constitution
[10] NHS England A&E Statistics

Comparison of average performance in England, Wales, Scotland and Northern Ireland



This break down of four-hour performance by region illustrates the extent of variation across the UK nations. It also illustrates the extent to which – with the exception of Scotland – Four Hour Standard performance of 95% remains aspirational at best. It should be noted that contributors in Scotland and Wales received winter pressures money from their respective governments whereas contributors in England and Northern Ireland did not.

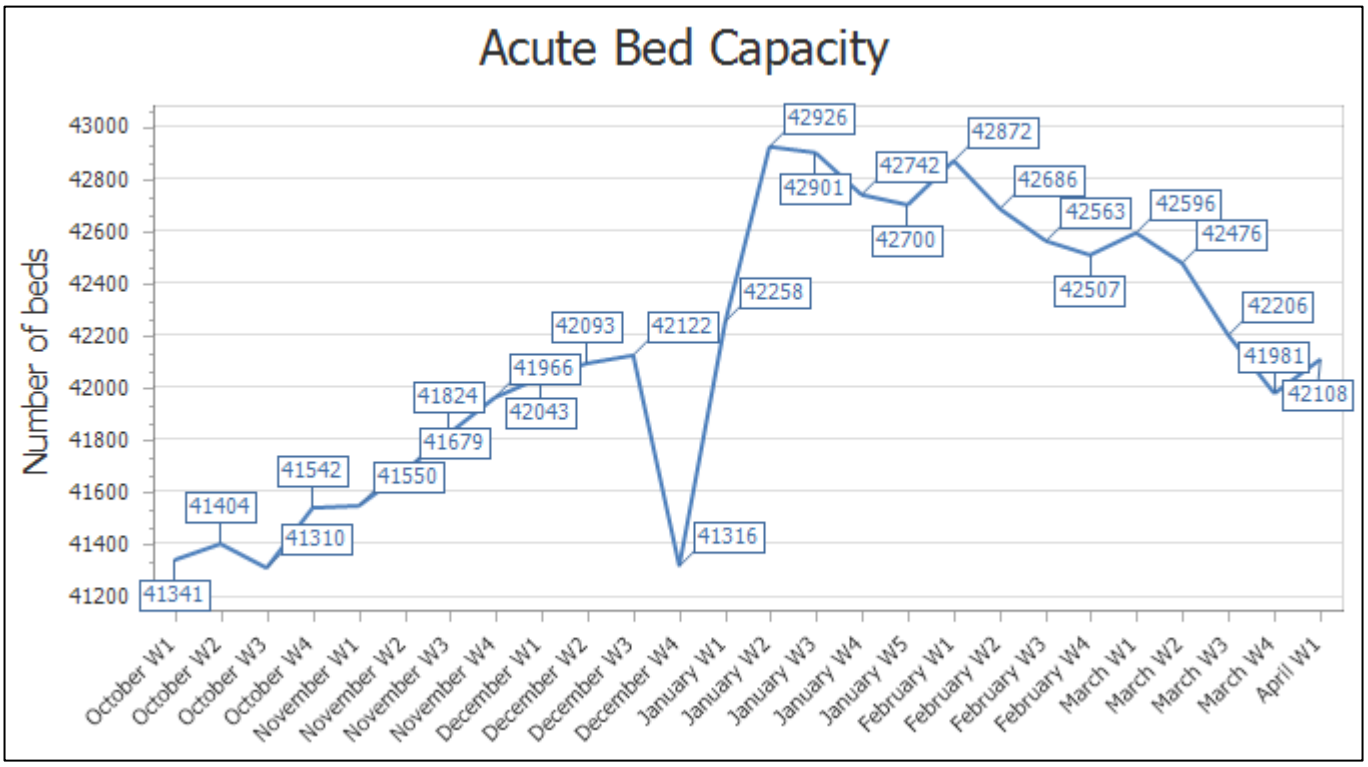
In our interim report, we noted that much of the usual performance differences between England and Wales appeared to have dissipated.[11] However, on the evidence of this data set the disparity between the two nations appears to have reasserted itself. The gap between England and Wales is now around 5% whereas at the project's interim point this was as little as 0.46%.

It is also worth stating that on this evidence, Scotland, England and Northern Ireland all recorded improvements in the Four Hour Standard performance compared with the projects interim point.[12] This goes some way to explain the uplift in overall performance recorded in the latter part of the project.

[11] The Winter Flow Interim Report noted Four Hour Standard performance at 82.65% in England and 82.19% in Wales.
[12] Scotland 0.26% England 0.05% Northern Ireland 1.6%.

Acute Bed Stock

The overall profile of bed stock over the period was as follows:



Active Bed Management

Over the project as a whole 52 of our 60 contributing sites were able to flex their acute bed stock to some extent to meet demand.

The extent to which the individual participating sites flexed their bed stock (minimum to maximum) to meet demand is shown in the table below:

	No flexing	0-5%	5-10%	10-15%	15-20%
Number of Sites	8	10	23	11	8

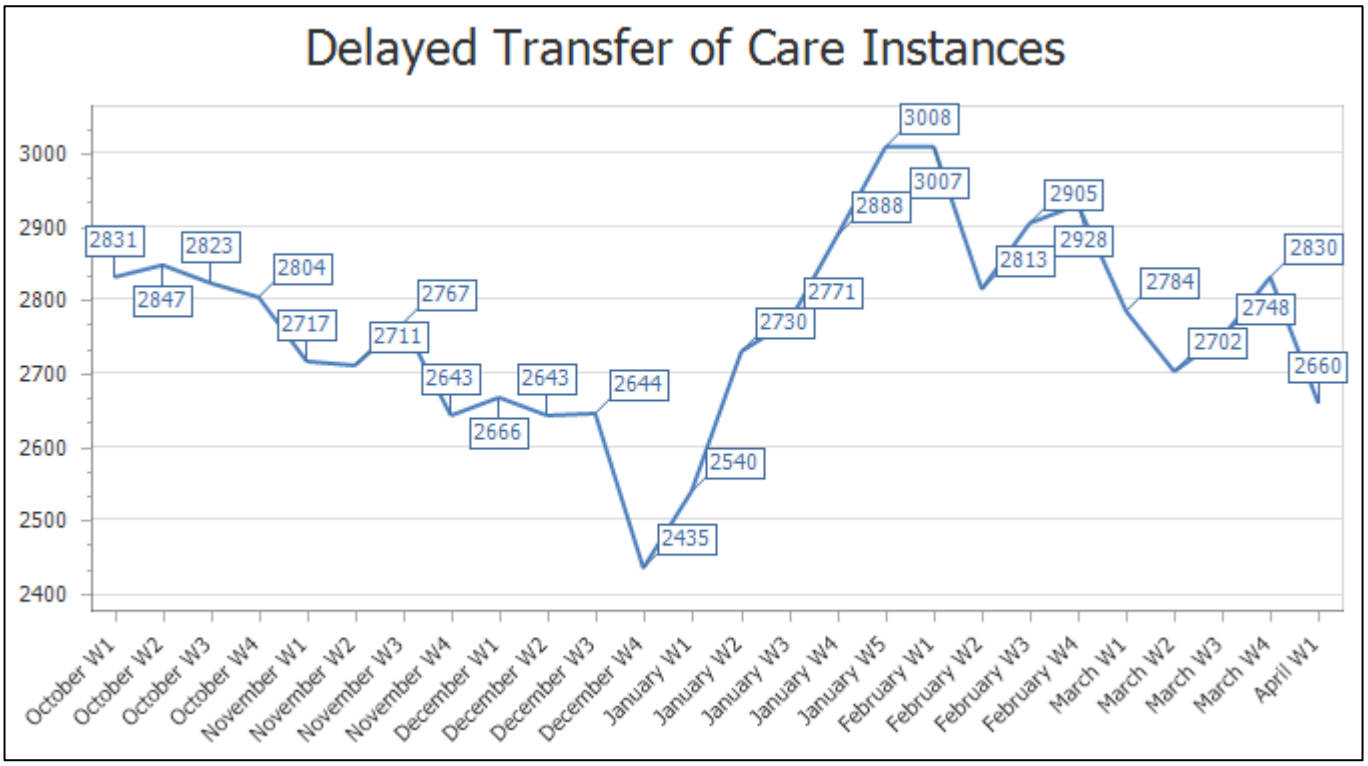
Over the course of the project there was a 1.86% increase in the number of acute beds in service. Last year the equivalent figure was 1.9%. Although this difference may appear small, what this suggests is that the NHS providers participating in the project now have measurably less capacity to cope with surges in demand. What this means for patients is that our hospitals are now even more likely to reach capacity, and those same patients are more likely to find themselves waiting on trollies as a result.

Figures published by NHS England support this analysis. While attendances at Type 1 departments actually went down in quarter four of 2016-17 compared with the same quarter

of 2015-16;[13] admissions went up,[14] bed numbers went down,[15] and general and acute bed occupancy went up.[16] As a result, the number of patients waiting more than twelve hours from decision to admit to admission rose from 695 to 1598 in the same period.[17] This is an increase of 230%.

Delayed Transfer of Care DTOC

The overall proportion of acute beds occupied by DTOC patients has averaged 6.6%. Last year the equivalent figure was 6.1%. This too is borne out by the wide picture. Figures released by NHS England have shown that the numbers of patients subject to DTOC continue their upward trend. In quarter four of 2016-17, 20,560 recorded delays whereas in the same quarter on 2015-16 there were 17,136. This is an increase of 19.98%.[18]



[13] A&E Attendances and Emergency Admissions 2016-17 Type 1 attendances Quarter 4 2015-16 3,818,750, Type 1 attendances Quarter 4 2016-17 3,674,252.
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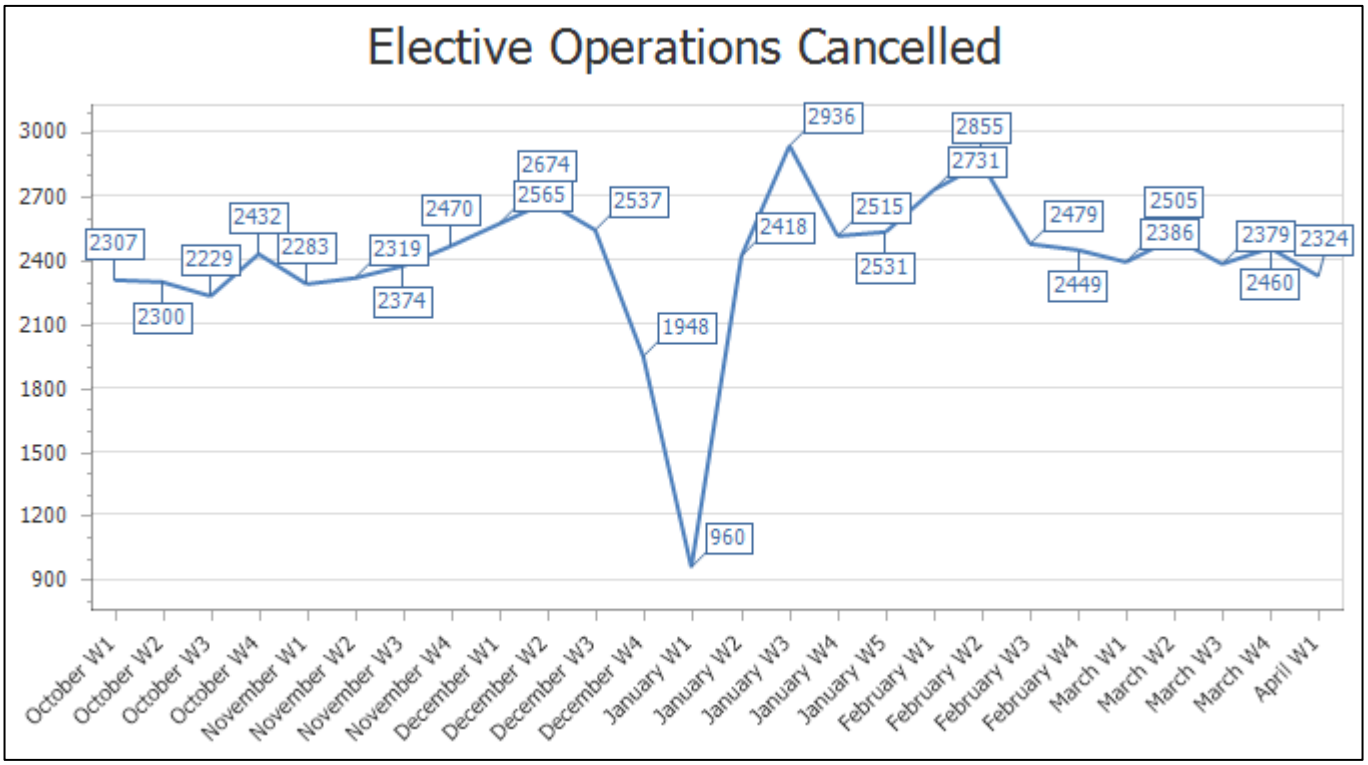
[16] NHS England Bed Availability and Occupancy Data General and acute bed occupancy Quarter 4 2016-16 91.2%, general and acute bed occupancy Quarter 4 2016-17 91.4%.
[17] A&E Attendances and Emergency Admissions 2016-17
[18] Delayed Transfers of Care Data 2016-17

Cancelled Elective Operations

The overall picture of Cancelled Electives was as follows:



Further Analysis

What much of the information presented so far illustrates quite clearly is that Emergency Departments across UK, and the hospitals they work within have had a distinctly challenging winter. Providers have seen an increasing number of patients who require admission while hospital's capacity to adjust their bed stock to compensate has been diminished, as has the overall bed base. In addition, this situation has been made all the more difficult because the number of patients subject to delayed transfers of care has remained a persistent and in some respects a growing problem.

In order to look in more detail at these issues we asked Winter Flow contributors to tell us what were the main constraints on their ability to adjust their bed stock; how, in their opinion, delayed transfers could be improved and what were the main challenges they faced in maintaining Four Hour Standard performance.

There is, as is to be expected, a good deal of variation in these responses. Nonetheless, what they have to say is as clear as it is eye opening. Some talk about the problems of recruiting or retaining sufficient clinical staff – nurses and doctors – as a significant constraint on their ability to provide beds for their patients. Others simply talk about wrestling with financial challenges or state openly that bed occupancy has hovered at or above 95%. As we have pointed out repeatedly throughout the course of this year's Winter Flow Project, such bed occupancy levels are both a logistical problem for the hospitals concerned and place patients at significant risk.

This though is not the whole picture. The providers participating in the project have told us repeatedly that problems in social care provision are impeding bed management and patient flow. Moreover, when asked what could be best done to improve things, the most common answers to this question were the integration of health and social care and the implementation of a 'discharge to assess' model.[19]

While NHS England and others are right to point out that there are places where this approach has been particularly successful[20] this also serves to underline that as the NHS seeks to operate at ever higher rates of bed occupancy we are increasingly asking questions of our social care provision. The ability to answer those questions, and provide Four Hour Standard performance as mandated by the NHS Constitution[21] requires that hospitals and social care providers plan effectively to build 'capacity to deal with the demand faced, rather than the demand that is hoped-for'[22], but it also puts the onus on Governments to give them the resources to make those plans a reality.

[19] NHS England Quick Guide to Discharge to Assess
[20] NHS England Quick Guide to Discharge to Assess & NHS Improvement
[21] NHS Constitution
[22] Transforming urgent and emergency care services in England: Safer, faster, better: good practice in delivering urgent and emergency care

Royal College of Emergency Medicine Manifesto

To enable Emergency Departments to effectively treat patients, emergency care needs the right **Staffing, Systems and Support:**

1. **Staffing**: an increase in the workforce to provide the necessary number of senior decision makers (consultants) to treat patients effectively, safely and in a timely fashion.
2. **Systems**: the elimination of 'exit block' and crowding in Emergency Departments to facilitate delivering quality patient care. Departments need appropriate resources to maintain patient flow through the hospital system whilst also ensuring appropriate care at the right time.
3. **Support**: improving best practice through using support systems and data that can inform the delivery of better patient outcomes.

How this can be achieved

1. **Consultant expansion**: We require an additional 2,200 new consultants in Emergency Medicine in England alone to achieve safe and sustainable staffing levels[23]. Posts must be structured to allow good recruitment, retention and prevent career 'burnout'.
2. **Training**: Emergency Medicine physician training posts should be increased by 250 places per annum for four years.
3. **Hospital beds**: to combat 'exit block' and overcrowding in Emergency Departments more hospital beds are required. We estimate that we have a shortfall of at least 5,065 beds in England alone[24]. In addition better social care provision and community care packages will help maintain flow in the hospital system.
4. **The 'Integrated Emergency Department Front Door'**: The College has produced clear guidance on how to cost effectively support and resource Emergency Departments with other vital care facilities including frailty teams, pharmacists, mental health specialists and GPs for minor illness using an integrated front door model.
5. **Emergency Care Transformation Programme**: To achieve all of the above will require a robust and practical workforce plan that over a four-year period will help reduce the £1.5m being spent each day on locum agency staff.

Our forthcoming strategy to fix emergency medicine will go into further detail of what must be focused on.

[23] Based on 2015-16 attendance figures we have banded EDs groups and then allocated numbers of consultants to deliver a service.

[24] 5,065 extra beds would achieve a safe bed occupancy level of 85%.