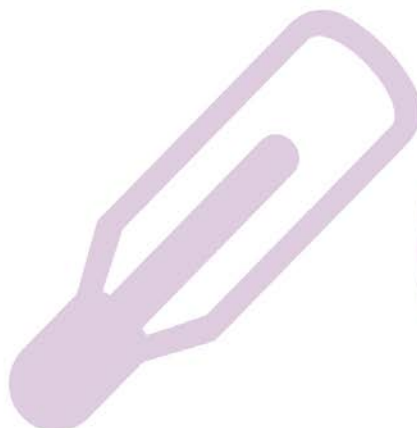




The Royal College of  
Emergency Medicine

# RCEM Winter Flow Project

Interim Report: 24th February 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 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 have 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 provide 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 the half-way point and it is therefore timely to summarise the data and our findings.

58 locations contributed to this project for the full duration. The national distribution of contributors is as follows:

England	Scotland	Wales	Northern Ireland
50	2	3	3

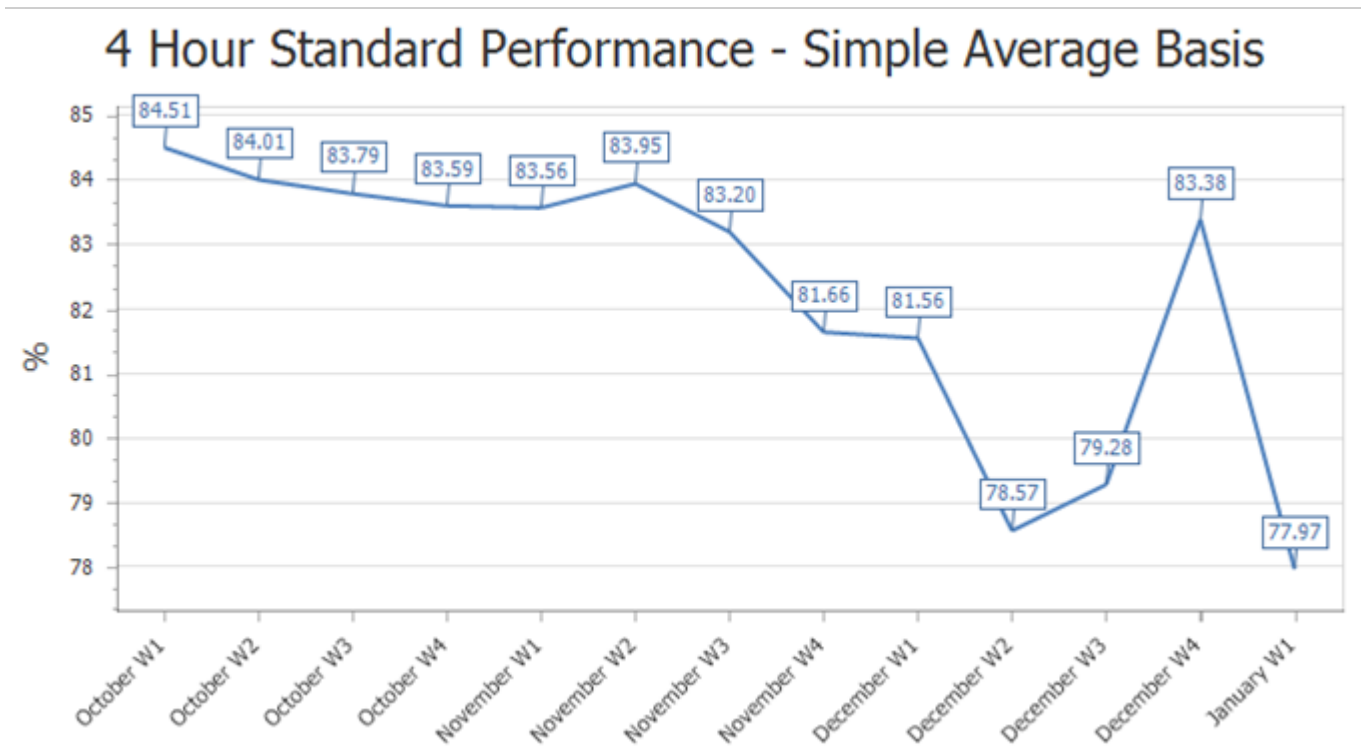
As an indication of size, the bed capacity of each of the contributing sites ranged from 94 to 1801.

The four measures reported on a weekly basis were:

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

### Performance against the Four-Hour Standard

58 sites each contributed 13 consecutive four-hour performance scores. The range of performance against the four-hour standard was 60.68% to 97.93% with an overall average of 82.23%. The overall weekly trend was as follows:



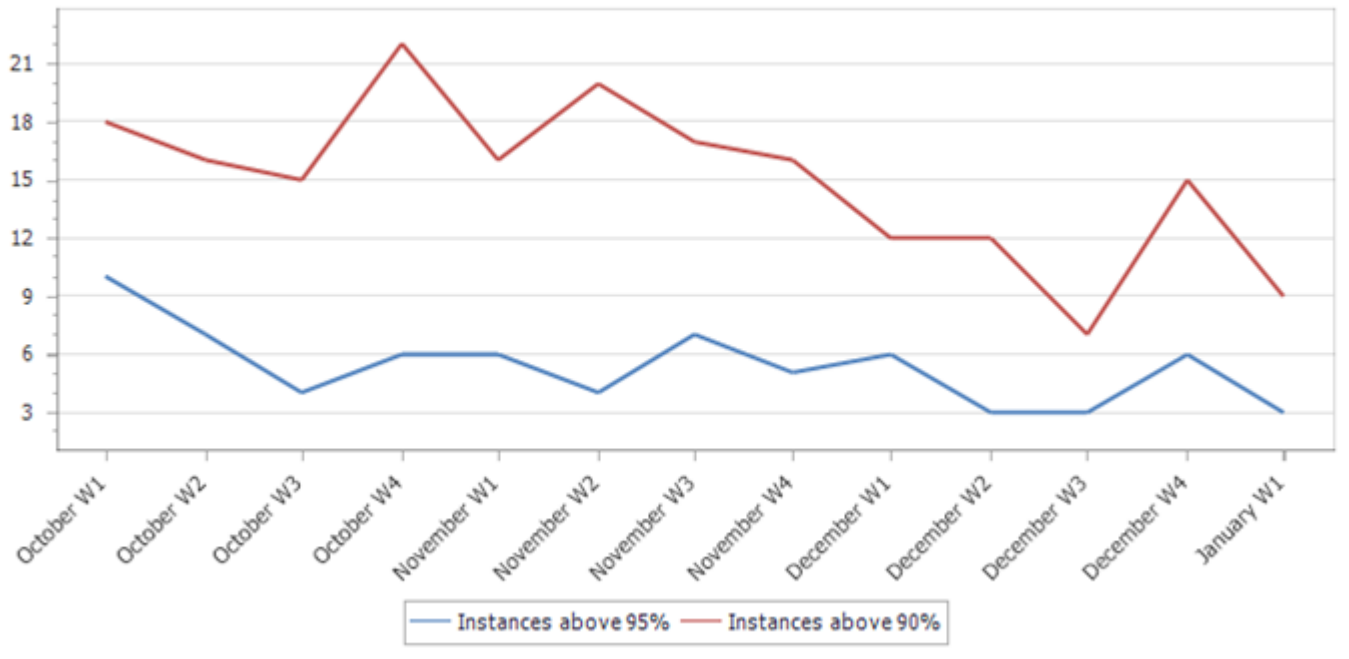
There are several additional points that should be made at this stage. Firstly, despite the expected – albeit brief – improvement in the week of Christmas, performance has already dipped significantly below the lowest performance seen in the duration of the project last year.<sup>1</sup> Secondly, last year’s data showed steady improvement throughout December

<sup>1</sup> The lowest recorded overall performance for last year’s Winter Flow Project was 81.99%  
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whereas this year, improvement did not become evident until the third week. Finally, at this point last year, the range of overall weekly performance was between 90.35% and 85.83%, a range of 4.52 percentage points. The same figures for this year are 84.51% and 77.97%, a range of 6.54 percentage points. As such, performance has both started lower and fallen further than was the case last year.

Only two of the sites achieved an average of 95% four-hour performance over the period. However, 13 sites averaged over 90%.

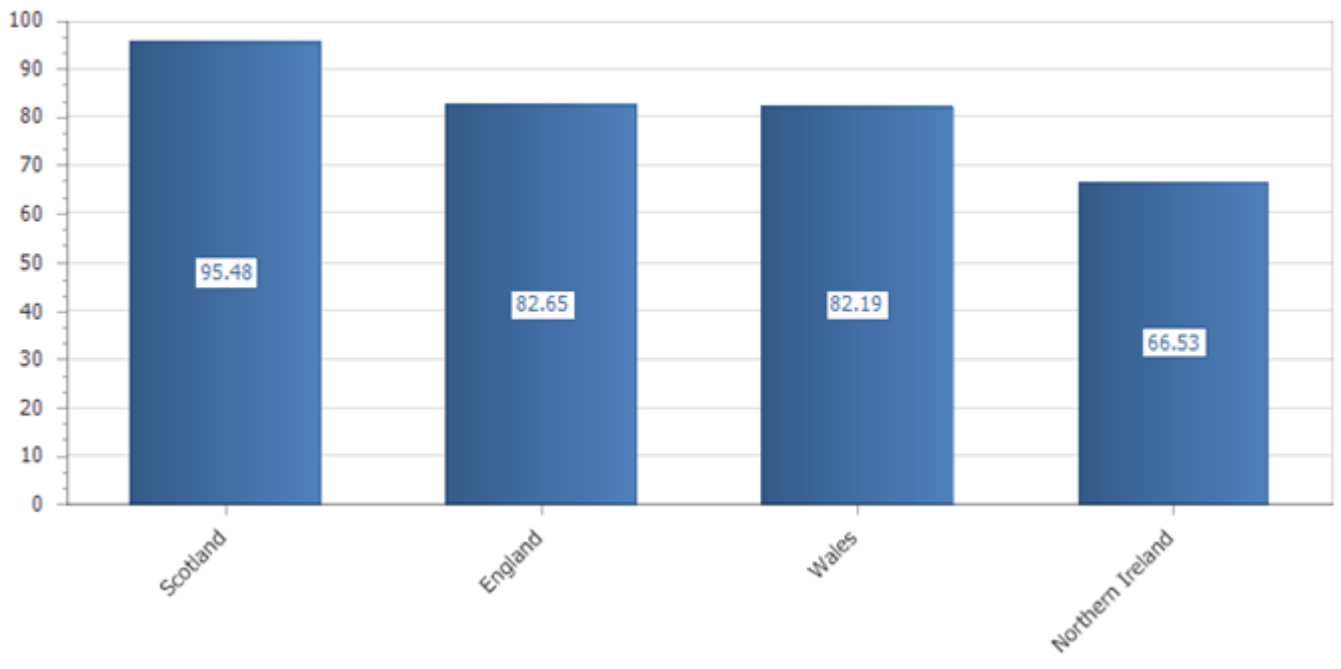
### Instances above 95% and 90%



What this means is that this year only 22.41% of contributors have achieved an average of 90% or above over the first three months of the project. Last year the equivalent figure was 50%.

Comparison of three-month average performance in England, Wales, Scotland and Northern Ireland:

### Average 4 Hour Performance by Region

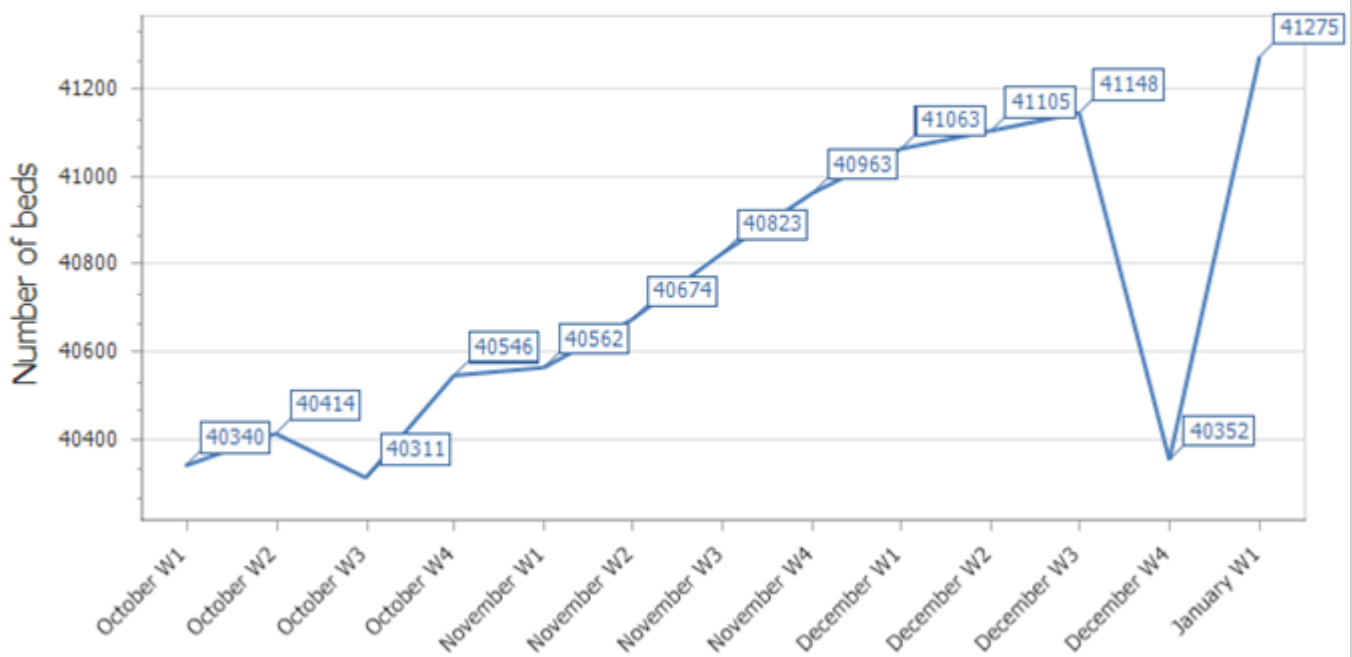


This break down of four-hour performance by region illustrates that in much of the UK performance remains challenging. It should be noted that contributors in Scotland and Wales received winter pressures money from their respective governments whereas contributors in England and Northern Ireland did not. Moreover, much of the prior difference in performance between England and Wales has apparently disappeared.

### Acute Bed Stock

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

### Acute Bed Capacity



## Active Bed Management

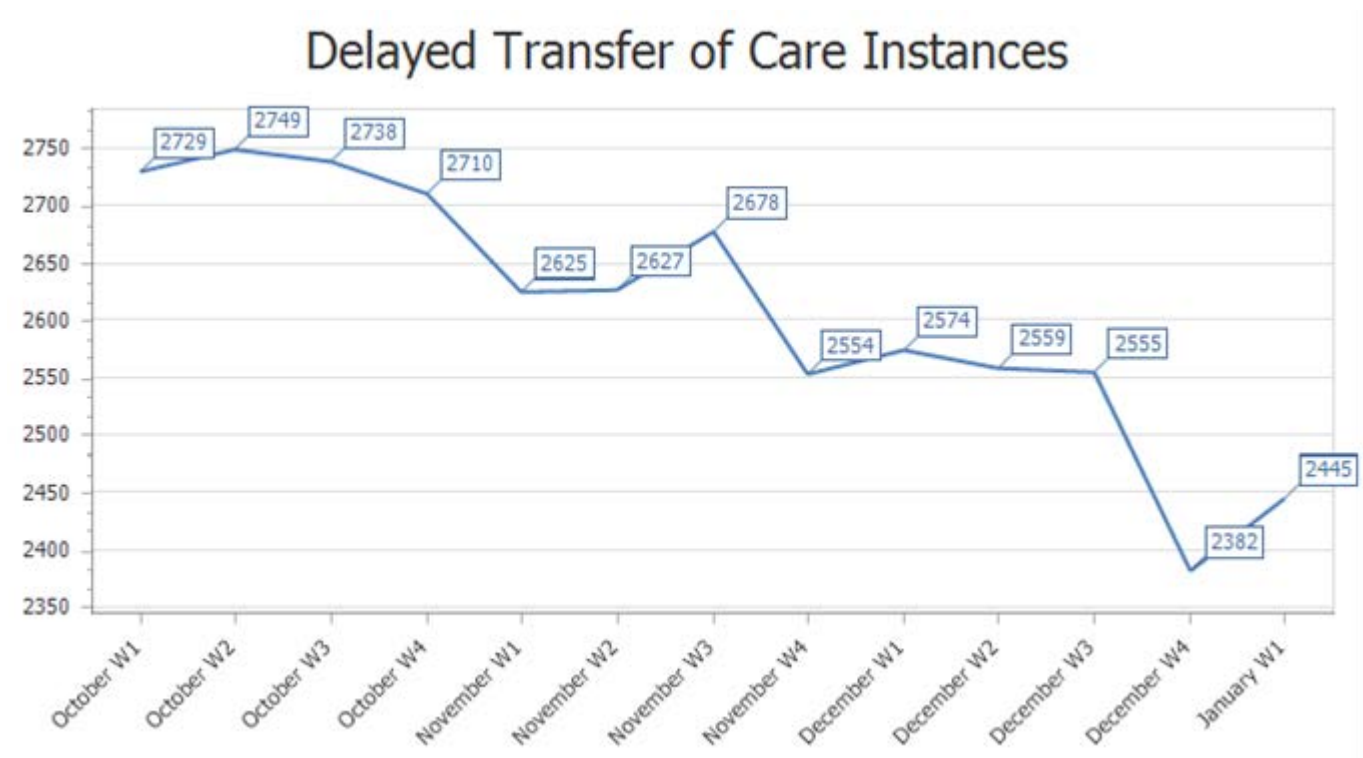
50 of the project's 58 contributors flexed their bed stock over the first three months of the project. In total there was a 2.32% increase in the number of acute beds in service.

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	17	21	7	5

## Graph of Delayed Transfers of Care (DTOCs)

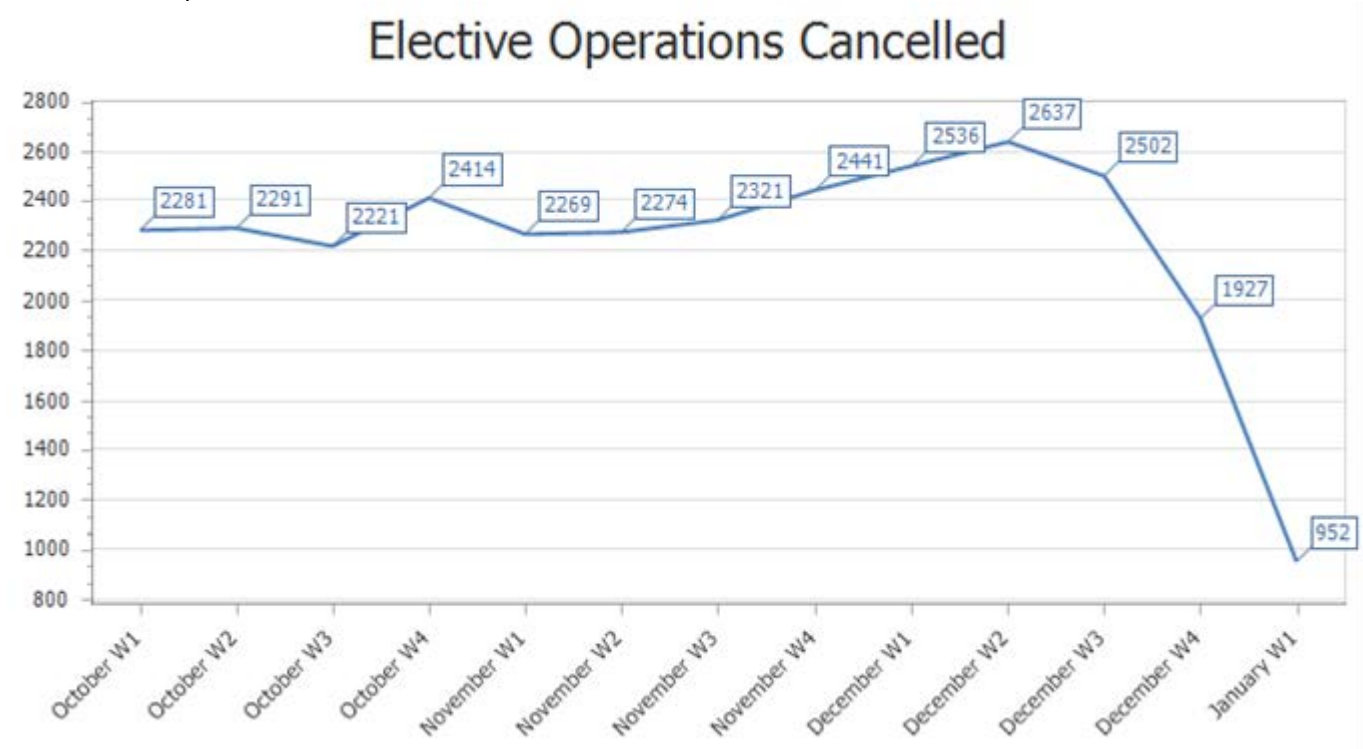
The overall picture of delayed transfer of care was as follows:



The overall proportion of acute beds occupied by DTOC patients has averaged 6.4%.

## Cancelled Elective Operations

The overall picture of Cancelled Electives was as follows:



## Further Analysis

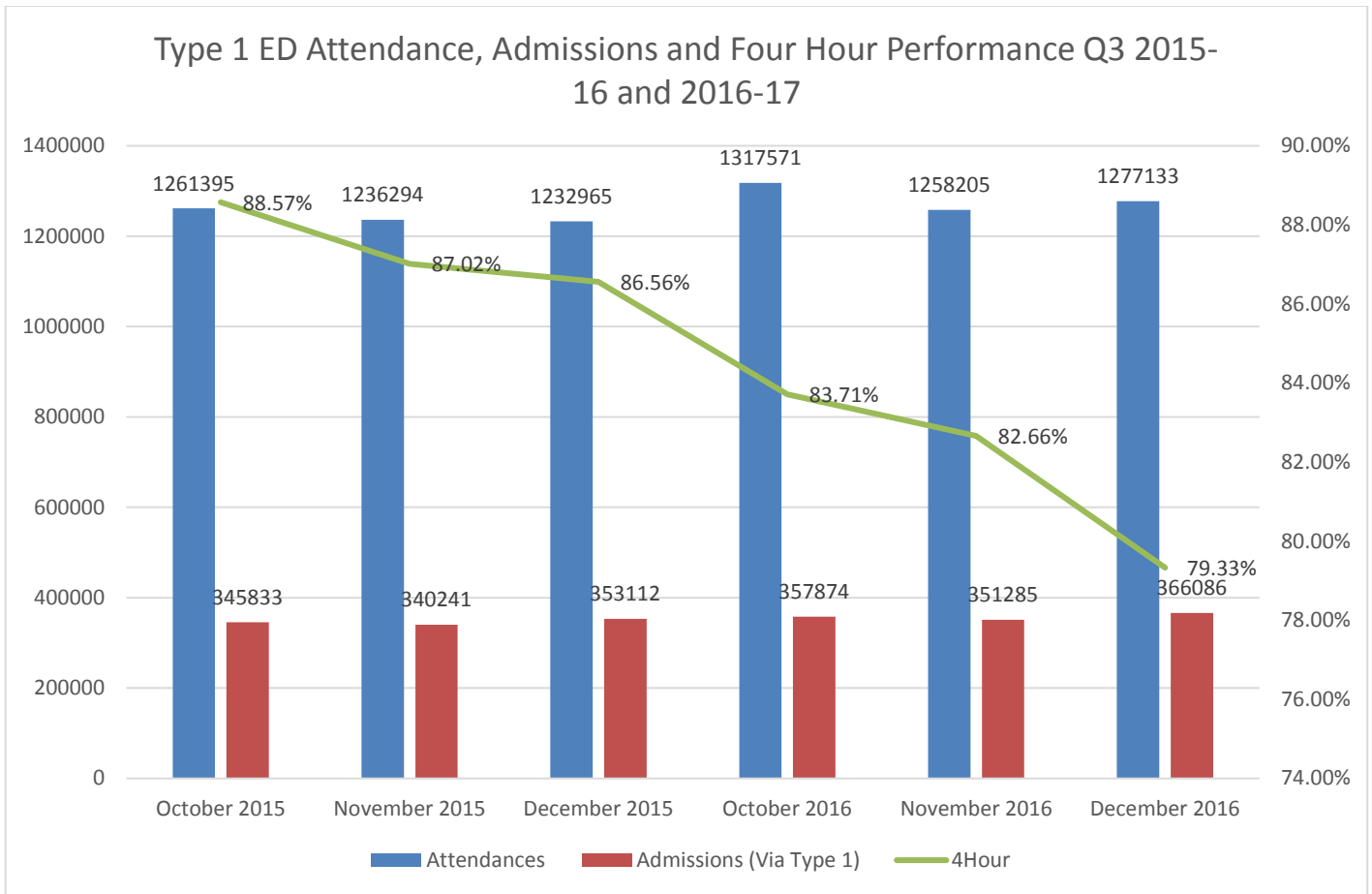
The information collected throughout the course of the Winter Flow Project is important for a number of reasons. For example, it is intended to allow the Royal College and others to comment on ED performance using data which is published more contemporaneously than many of the datasets released by NHS England. It is also intended to broaden the debate around emergency medicine by pointing out that four-hour standard performance is affected by other factors which impact the availability of hospital beds.

While there are significant difficulties in presenting this point in a single chart, considered on the level of individual contributors, the data collected so far illustrates this quite clearly. Those Trusts/Boards who are more able to manage their bed provision through flexing their bed stock and minimising the number of patients subject to Delayed Transfers of Care, also tend to have lower percentages of cancelled elective operations and better four-hour standard performance.

This is why – on the face of it – the data presented so far presents something of a conundrum. As we have seen, providers throughout the UK have had some considerable success in reducing the number of patients subject to Delayed Transfers of Care. In fact, at 6.4%, DTOCs as a percentage of acute beds are no higher than was recorded by last year's Winter Flow Project at the same point. Yet despite this, four-hour standard performance has both started lower and fallen further than it did last year. So why is this?

Part of the answer is the demands being made of hospitals in terms of the number and complexity of patients that they are called upon to treat. Although patient complexity is not easily reflected in official figures, the attendance and admissions data from NHS England

for October, November and December 2015 and 2016 is given below, alongside four hour standard performance.



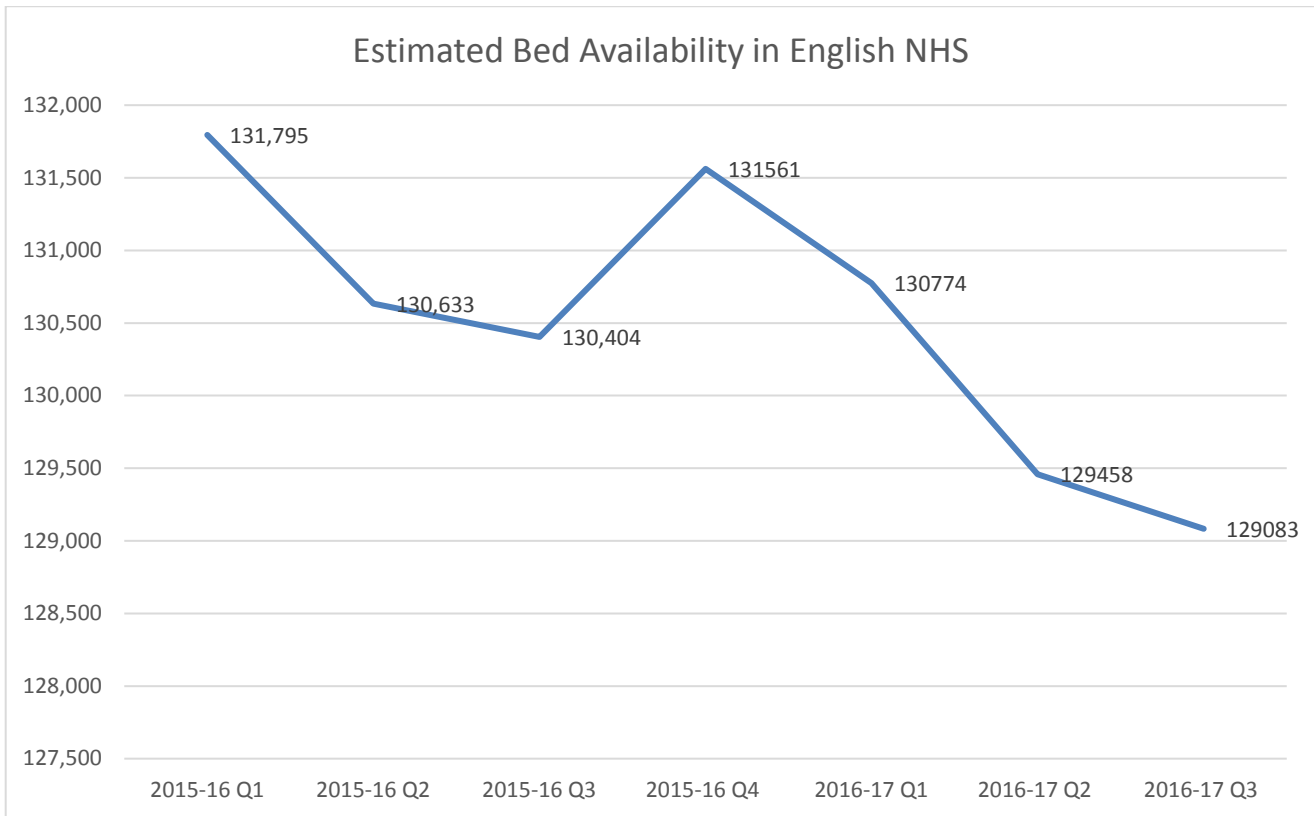
What this shows is that when compared with the same period last year attendances have increased by 3.28% while admissions have risen by 3.47%.<sup>2</sup>

As was the case last year, this project has well documented the efforts of providers to flex their acute bed stock in response to demand. What we have not shown is whether they were in fact starting from a smaller bed base than was the case the previous year. Here too, NHS England data on overnight bed availability suggests an answer.<sup>3</sup>

<sup>2</sup> [NHS England ED Attendances and Admissions](#)

<sup>3</sup> [NHS England Overnight Bed Availability](#)





This data shows two things. Firstly, at the end of quarter two, there were 129,458 beds in the NHS in England - down from 130,633 the previous year. This is a fall of 1,175 or 0.89%. As such, providers did indeed start from a lower starting point than had been the case in the previous year. Secondly, the number of beds recorded for quarter three in 2016 has fallen further to 129,083. This is a drop of 0.29% compared with 0.18% in the same quarter last year and represents the loss of 375 beds.

What this means is that despite bed occupancy rates well in excess of those considered safe for patients,<sup>4</sup> faced with the competing priorities of increased demand for services and unprecedented financial pressure,<sup>5</sup> providers have cut their cloth accordingly. The consequences of this situation have been rates of bed occupancy at or near 95% (when measured as usual at midnight<sup>6</sup>) and crowded Emergency Departments with ambulances queueing for long periods to transfer their patients to hospital care. It has thus become increasingly difficult for Emergency Departments to treat and admit patients within four hours and to ensure that they receive safe and timely care.

<sup>4</sup> [BMJ](#)

<sup>5</sup> [National Audit Office](#)

<sup>6</sup> [NHS England Winter Sit Rep Data](#) This data is considered to be an underestimate because of the relatively low activity level at that time of night.