

**Health and Social Care Select Committee**  
**Clearing the backlog caused by the pandemic**

**September 2021**

**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 doctors and consultants to A&E departments in the NHS in the UK and other healthcare systems across the world.

**What is the anticipated size of the backlog and pent-up demand from patients for different healthcare services including, for example, elective surgery; mental health services; cancer services; GP services; and more widely across the healthcare system?**

At present, Emergency Departments (EDs) are experiencing unprecedented levels of demand. Performance data published for July 2021 revealed:

- There were 1,431,499 type 1 attendances in July 2021, the **second highest figure on record**.
- The **4-hour target is the lowest on record**, standing at only 67.7%.
- 12 hour waits from Decision to Admit (DTA) waits have increased drastically in July: there were **2215 12+ hour DTA waits, by far the highest figure on record for the summer months**.

Current levels of demand are a result of a number of factors. We have published a detailed explainer on why EDs are currently experiencing high levels of demand which [is available here](#). In summary, patients may be presenting due to:

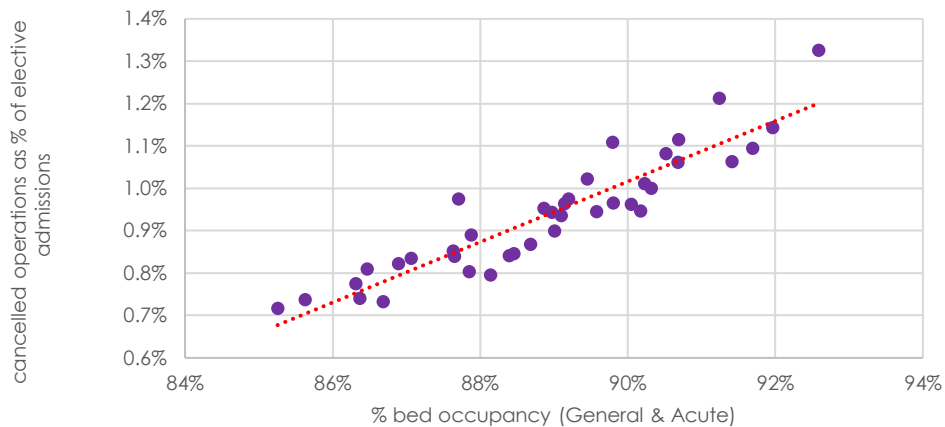
- Delays in seeking healthcare until now due to the pandemic
- Complications from delayed or cancelled procedures
- Higher than average levels of exposure to viral illnesses, especially in children
- High numbers of patients recommended to attend EDs by NHS 111 Phone First services
- Strength of the ED brand in terms of patient access, this may be compounded by lack of face-to-face access to other healthcare provision such as mental health services and General Practitioners

The table below predicts what demand could be like this winter if the same rate of increase that we experienced between June 2019 and June 2021 is replicated across every month this year. This could result in nearly half a million emergency admissions via Type 1 ED by December 2021.

**Table 1: Projected demand in Emergency Departments this winter**

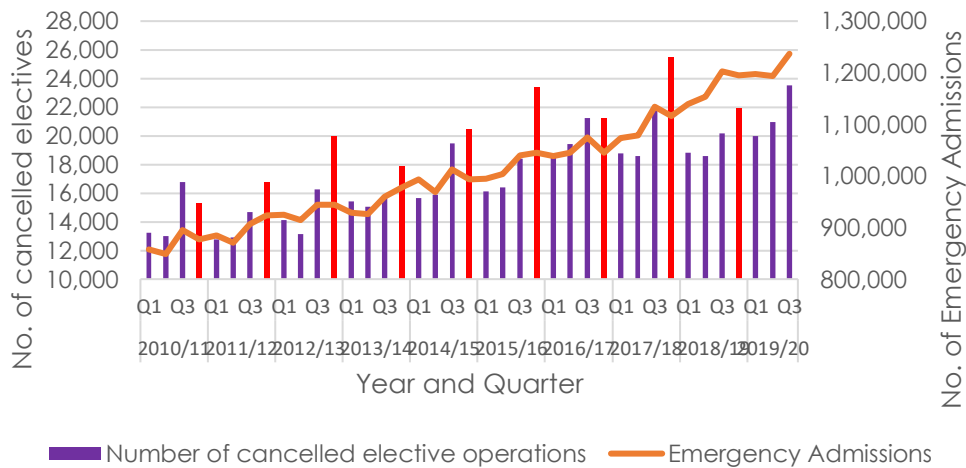
	Attendances, Type 1 Departments - Major A&E	Total Attendances	Emergency Admissions via Type 1 A&E	Total Emergency Admissions
Aug-21	1,425,773	2,177,165	402,117	535,610
Sep-21	1,445,629	2,175,024	399,582	536,290
Oct-21	1,482,065	2,223,721	421,460	569,921
Nov-21	1,471,336	2,195,674	416,831	566,301
Dec-21	1,479,165	2,233,608	424,900	567,555

**Graph 1: General and Acute Bed Occupancy and Cancelled Operations**



The projections and current pressures facing the Urgent and Emergency Care system must be considered within the historic context of winter pressures. Before the pandemic, elective surgery was compromised every winter due to increased emergency demand and a lack of hospital capacity. Crowding and corridor care, which were experienced all year round in many departments, became increasingly dangerous. Graph 1 above demonstrates the relationship between high General & Acute bed occupancy and an increased rate of cancelled elective operations. There is a clear correlation that must not be ignored.

**Graph 2: Accident and Emergency Admissions and Number of Cancelled Elective Operations**



While no period of the year is easy for ED staff, there is undoubtedly a seasonal effect on ED pressures and demand. Graph 2 illustrates that there is, quite predictably, a surge in emergency admissions in Quarter 3 and 4 which correspond to the winter months. This is then followed by a spike in cancelled electives. This trend must now be considered in the current context wherein the scale of the elective backlog is unlike any other year. We argue there is an intrinsic link between emergency and elective care and throughout the summer months we have repeatedly called for emergency demand to be taken into account when considering how to address the elective backlog.

**What capacity is available within the NHS to deal with the current backlog? To what extent are the required resources in place, including the right number of staff with the right skills mix, to address the backlog?**

Staffing in EDs

The table below shows that despite the number of Emergency Medicine consultants increasing at a constant rate, the expansion in consultant numbers is still not happening fast enough to cope with the level of demand growth. This results in continued understaffing in departments. RCEM has previously stated that to staff EDs safely, we should aim for a ratio of 1 Whole Time Equivalent (WTE) consultant per 4,000 annual attendances. Table 2 shows we are nowhere near to achieving that in England.

**Table 2: Attendance and WTE Consultant ratios in England**

Year	Average Number of WTE Consultants	Attendances at Type 1 EDs	Attendances per Consultant	Additional WTE consultants currently required to safely staff EDs
2016/17	1,601	15,262,758	9,533	2,012
2017/18	1,706	15,372,467	9,010	
2018/19	1,824	15,679,999	8,597	
2019/20	1,941	15,810,616	8,145	

Hospital beds

To keep patients safe from Covid, hospitals have been reconfigured, resulting in a loss of beds. The UK has traditionally run its hospitals with relatively few beds per head and this has created exit block. As we begin to recover from the pandemic, we are calling for transparent bed and workforce modelling with a commitment to act on the findings before winter to allow for safe restoration and expansion of bed capacity.

In the first quarter of 2020/21, which coincided with the first wave of the pandemic, the number of available beds decreased drastically by 10,000 in order to comply with Infection Prevention and Control measures. While bed numbers have begun to slowly increase again, hospitals are short of 6,000 beds compared to pre-pandemic levels.

Winter typically represents the most fraught period in terms of pressures on EDs. However, as a consequence of the pandemic, winter 2020/21 saw significantly fewer emergency and elective admissions, and even with a decrease in the number of active beds in the system, bed occupancy dropped compared with earlier winters. This year, rather than calculating the probable number of beds each trust would need to achieve the 85% occupancy threshold, we instead elected to look at the ratio of beds to emergency admissions across the NHS. This method allows us to capture the complexity of the hospital system as it directly accounts for the link between demand (admissions) and capacity (beds).

In the last five years, in England this figure has fluctuated between 11.07 admissions per bed (winter 2015/16) and 12.50 (winter 2018/19). Excluding the most recent winters (both of which saw demand and capacity fall due to the pandemic), we arrive at an average of 11.77 admissions per bed. The number of beds needed to achieve a similar ratio in the 2021/22 winter is contingent on the number of admissions Trusts see. A

range of possibilities exist which depend largely on the medium to long-term effects of Covid-19 on demand, staffing and bed numbers. However, if we assume that demand this coming winter will broadly mirror one of the years between 2017/18 and 2019/20, we can propose a plausible range for the number of additional beds required.

**Table 3: Predicted number of beds required**

With a similar number of admissions this winter as the winter of 2017/18, the NHS will need just over 7,500 additional beds. If demand broadly mirrors that of 2019/20 (which

<b>If Comparable Level of Demand in 21/22</b>	<b>Total Number of Beds Needed</b>	<b>Beds Needed in Addition to Current Stock</b>
<b>17/18</b>	129,900	7,588
<b>18/19</b>	138,100	15,788
<b>19/20</b>	127,300	4,988

saw Covid-19 significantly diminish admissions), just under 5,000 more beds will be needed. If demand rises to the same levels as 2018/19 however, almost 16,000 more beds will be required to keep the bed to admission ratio broadly in line with recent years. Thus far in Summer 2021, attendances, and admissions at type-1 EDs have mirrored the highly pressurised winters pre-Covid. If these pressures do not abate ahead of winter, the number of beds required to manage this level of demand is almost certainly going to be at the higher end of the range proposed above.

### **The wider health and social care system**

**Table 4: OECD data on hospital beds per 1,000 inhabitants, 2020 or latest available**

<b>Country</b>	<b>Beds</b>
United Kingdom	2.4
Canada	2.5
United States	2.8
Italy	3.2
France	5.8
Germany	7.9
Japan	12.8

In the short term, there must be a safe restoration of bed capacity to pre-pandemic levels. However, there must also be a commitment to expand the bed stock in line with our OECD peers in the long term. Table 4 shows that the UK has one of the lowest numbers of hospital beds per 1,000 inhabitants in OECD nations.<sup>1</sup> Only Mexico, Colombia, Chile and Sweden have lower beds per capita in comparison to the UK.

A longer-term restoration of hospital beds cannot happen without addressing the staffing crisis in the NHS. Although the UK fares better in comparison to other OECD nations for doctors per 1,000 inhabitants, there is an urgent need to increase the

<sup>1</sup> OECD (2021), Hospital beds (indicator). doi: 10.1787/0191328e-en (Accessed on 30 July 2021)

numbers of doctors working in the NHS.<sup>2</sup> As the Nightingale initiative during the pandemic revealed, we cannot expand capacity in the NHS if we do not have enough doctors, nurses, and clinicians.

**Table 5: OECD data on doctors per 1,000 inhabitants, 2020 or latest available**

Country	Doctors
Japan	2.5
United States	2.6
Canada	2.8
United Kingdom	3.0
France	3.4
Italy	4.0
Germany	4.5

EDs face the consequences of a failed social care system which does not allow for the timely discharge of vulnerable patients. This often results in patients being cared for in corridors. Any discussion of capacity in the NHS must take into account the challenges facing our social care system. The Government must immediately find cross party consensus on the issue of social care. Solving the crisis in social care will go a long way in easing pressure on hospitals.

**How much financial investment will be needed to tackle the backlog over the short, medium, and long-term; and how should such investment be distributed? To what extent is the financial investment received to date adequate to manage the backlog?**

Over the long term, there must be increased investment in the ED workforce in order to ensure EDs are equipped to manage demand. There has been a historic overreliance on locum ED staff as a way of addressing the shortages in the workforce. In our most recent workforce survey, 69% of Clinical Leads expressed that locum staff were being used to fill permanent posts.

- Over the course of the second wave, locums were used very often to cover both the Higher Specialist Trainee/non-consultant senior decision maker Rota and the junior doctor rotas.
- 20% of Clinical Leads expressed they are not able to comply with the BMA Junior Doctor Contract that stipulates a weekend frequency of no more than 1 in 3. Over half (56%) expressed they could only comply with an increase in locum staff.

It is well evidenced that the use of locum, bank and agency staff is a costly and inefficient way of plugging the workforce shortages. An NHS Benchmarking report published in 2019 found that 21% of ED consultant expenditure is on locums – approximately £56 million per year and 27% of total ED workforce expenditure pays for locum, bank, and agency staff – a cost of £523 million a year. This historic overreliance on locum staff is financially unsustainable for the NHS and must be tackled through a workforce strategy aimed at growing numbers of clinical staff working in EDs.<sup>3</sup>

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<sup>2</sup> OECD (2021), Doctors (indicator). doi: 10.1787/4355e1ec-en (Accessed on 30 July 2021)

<sup>3</sup> NHS Benchmarking (2019) Emergency Department Workforce Benchmarking. Available [here](#).

## **How might the organisation and work of the NHS and care services be reformed in order to effectively deal with the backlog, in the short-term, medium-term, and long-term?**

In the short term there is an urgent need to improve efficiency of hospital services. This means ensuring patients are not admitted unnecessarily and no one remains in hospital longer than they are clinically required to. This can be achieved through improving the availability of Same Day Emergency Care to twelve hours a day seven hours a week as outlined in the NHS Long Term Plan and the Operational and Planning Guidance 2021/22. This will ensure admissions are reserved for only those who need inpatient care.

Additionally, hospital resources such as beds and diagnostic capacity must be used as efficiently as possible. Hospitals should also continue to be vigilant with their Infection Prevention and Control to minimise nosocomial infections and ensure hospital beds remain open.

In the medium to longer term alongside expanding the Emergency Medicine workforce, there is an urgent need to reform the social care system. This in turn will help to improve the efficiency of hospital bed use. Patients are kept in hospital for longer than necessary due to a lack of social care provision. While medically fit to leave, many patients need help to recover in the form of a social care package, which may not be immediately available. This means that their hospital bed is unavailable to the next patient, resulting in Emergency Department crowding. Social care can also help prevent or reduce the need for medical treatment. The current lack of provision means many more patients are ending up at their ED unnecessarily.

## **What positive lessons can be learnt from how healthcare services have been redesigned during the pandemic? How could this support the future work of the NHS and care services?**

As the first wave of covid struck the nations of the UK, EDs were resilient enough to mount a scalable response to the pandemic. To cope with undifferentiated patients presenting to departments, EDs were rapidly reconfigured into streams to separate patients more likely to have COVID-19 from those less likely. EDs expanded into new areas of the hospital, changing the way that staff worked. There was a transformation in cross-specialty working, with an “all hands-on deck” approach, and what had previously seemed like an impossibility was achieved overnight. Inter-specialty communication and camaraderie meant that tackling healthcare pressures was no longer a siloed task. This created an environment in which staff felt able to do their job: caring for patients safely and efficiently.

We outlined the need to retain this way of working in our *COVID-19: Resetting Emergency Care* position statement<sup>4</sup>, emphasising the importance of clinicians from all spheres of practice becoming more involved in the Urgent and Emergency Care pathway so that patients receive joined up, rapid and definitive care within the hospital.

Unfortunately, as we progressed beyond the peak of the first wave of the pandemic, hospitals reverted to their old ways of working. Qualitative responses from our workforce survey revealed that a whole hospital approach to managing the ‘front door’ could help improve wellbeing in departments along with equalising the workload pressure throughout the hospital. Many responses highlighted the role Same

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<sup>4</sup> RCEM (2020) COVID19: Resetting Emergency Department Care Position Statement. Available [here](#).

Day Emergency Care (SDEC) can play in tackling operational pressures and therefore supporting ED staff wellbeing. SDEC is about cross-functional working and helps to improve patient flow in the hospital, creating a more efficient process for both staff and patients.

Additionally, during the first wave we witnessed the creation of surgical hubs and covid light sites within hospitals. They helped to separate elective from emergency services to support vital infection protection and control measures, as well as expand hospital capacity. We support the Royal College of Surgeons of England's call for consolidating covid light sites in each region and expanding surgical hubs as outlined in their New Deal for Surgery report. A separation of elective and emergency services should continue as seasonal and predictable elective cancellations is unfair and unjust to patients.<sup>5</sup>

### **How effective has the 111 call-first system for A&E Departments been? What can be done to improve this?**

The new appointment booking model for EDs, NHS 111 First, was designed to reduce crowding in EDs and improve patient experience by giving the public advice on how to access healthcare during times of urgency. Despite the national roll out of this service, there is no available data on its impact. Additionally, a robust evaluation of the efficacy of this service has not been published. In our Summer to Recover campaign, we called for results for the evaluation to be published in full so we can better understand patient behaviour and the impact on ED presentations.<sup>6</sup>

NHS 111 First data additionally reveals that despite an increase in patients recommended to EDs, there has been a decrease in the percentage of ED patients who are then admitted. In June 2021, the percentage of attendances admitted stood at 27.9%, the lowest since July 2017. This implies that many patients who are presenting at EDs are low acuity, and the reasons why they are attending are due to inaccurate recommendations from 111 or primary care, or dissatisfaction with other services. Data from RCEM's workforce survey carried out in June 2021 found that 50.7% of respondents expressed that NHS 111 First has increased attendances to their EDs, while only 3.6% said that it had decreased attendances. This shows that the service at present is not fit for purpose.<sup>7</sup> We have long argued that the NHS 111 First will not reduce crowding in EDs or add value to the UEC system unless there is an increase in clinical validation of the service.

For NHS 111 First to be effective, there additionally needs to be an increase in the number of alternative services to direct patients to. Emergency Departments have a powerful brand for offering round-the-clock care and as a result of this many patients go to their Emergency Department having tried – and failed – to get timely care and treatment elsewhere, such as their General Practitioner. This has been exacerbated by the continuation of remote consultations during the coronavirus pandemic. Emergency Departments are increasingly providing care for these patients, who may have been better served elsewhere, because access to care is variable across the health service. This is adding to the problem of ED crowding.

Emergency Physicians should not be routinely caring for people who present with predictable complications of specialised care or minor long-term health issues. The

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<sup>5</sup> Royal College of Surgeons of England (2021) A New Deal for Surgery. Available [here](#).

<sup>6</sup> RCEM (2021) Summer to Recover Campaign. Available [here](#).

<sup>7</sup> RCEM (2021) Retain, Recruit, Recover: Our Call for Action to Improve the UEC system. Available [here](#).

best and most cost-effective health care systems in the world are based on a strong primary care system; patients appreciate timely care, ideally with someone who knows their history. For primary care to be effective, capacity needs to match demand.

**What can the Department of Health & Social Care, national bodies and local systems do to facilitate innovation as services evolve to meet emerging challenges?**

In our report *Retain, Recover, Recruit: Our call for action to improve the UEC system*, we called for:

- Additional funding to support inpatient teams to enable more effective Urgent and Emergency Care, including Same Day Emergency Care and Ambulatory Emergency Care. These services improve the quality of care and staff morale, are cost effective, and reduce avoidable admission into hospital.
- A new, actionable, long-term health and social care strategy to enable the delivery of high quality Urgent and Emergency Care.
- Governments to act now to achieve safe staffing levels in EDs. At present, there is a shortfall of 2,000-2,500 Whole Time Equivalent consultants in the UK. Expansion of the workforce is needed to ensure patients are treated by staff who are trained in Emergency Medicine. This must also include an accompanying increase in Allied Health Professionals, SAS doctors, Emergency Nurses, and the faculty to train them.
- Governments to immediately prepare and manage adequate capacity in order to minimise the harm to patients and staff caused by ED crowding and exit block. This will reduce the risk of emergency demand derailing the elective recovery and improve the working conditions of staff in EDs. Ahead of Winter, this must include but is not limited to:
  - Making funding available to local health systems to maintain or expand discharge to assess services so they are available all year round.
  - Expanding clinical validation of Phone First services to ensure patients receive care in the best setting based on their needs.

**To what extent is long-covid contributing to the backlog of healthcare services? How can individuals suffering from long-covid be better supported?**

Long-covid will add additional pressure to the urgent and emergency care system. At present, patients are presenting to EDs with anxiety from covid, symptoms post-covid, symptoms post-prolonged admission and ITU stays post-covid. A study published in the BMJ examining the impact of long covid on emergency admissions found that over a mean follow-up of 140 days, nearly a third of individuals who were discharged from hospital after acute covid-19 were readmitted. Rates of respiratory disease, diabetes and cardiovascular disease were also significantly raised in patients with covid-19.<sup>8</sup> This is an area of additional workload for Emergency Medicine clinicians that should be factored into workforce and service delivery planning on top of current pressures. Additional funding should be provided to support the healthcare service to care for patients living with long covid.

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<sup>8</sup> Ayoubkhani D, Khunti K, Nafilyan V, Maddox T, Humberstone B, Diamond I et al. Post-covid syndrome in individuals admitted to hospital with covid-19: retrospective cohort study BMJ 2021; 372