



RCEM's response to the AORMC's call for evidence

April 2022

Introduction

As we emerge from Winter 2021/22, Emergency Departments (EDs) have experienced a record-breaking year for poor performance. Given pressures on EDs are no longer seasonal, and exist all year round, RCEM is very concerned about the impact of this on our patients. Patients are being let down as present levels of operational pressure – combined with the cumulative toll of ten years of austerity, poor workforce planning, and the COVID-19 pandemic – are putting them at danger. Alarming, the Government's manifesto commitment to improving waiting times for EDs was downgraded in the Department of Health and Social Care's mandate to the NHS, the aim is now to work towards improving performance 'as conditions allow'.¹ Behind every single metric is a patient and the NHS is currently failing its commitment to provide care to our patients without any unnecessary delay; a key pledge outlined in the NHS Constitution². Although these challenges are great, the problems facing the Urgent and Emergency Care (UEC) system are not insurmountable and there are a number of actions that can be taken now that will alleviate pressures and improve care for our patients in the short and long term.

What is the problem?

The UEC system supports a significant number of patients and a huge variety of medical conditions and social problems, ranging from acute emergencies and trauma to acute mental health crises and the care of homeless, and elderly patients. EDs are by nature dynamic, providing responsive care to those who need it and an essential front-line service. Very few people plan to visit an ED, yet everyone is a potential patient.

There has been an accelerated decline in performance in the last five years, with many metrics from this winter on par with or setting new record lows. Ambulance arrivals and delays stats epitomise this decline, with poor weekly performance over an 18-week period demonstrating a lack of system resilience and capacity to weather winter pressures (see figure 1). This reporting period saw a total of 1,503,065 ambulance arrivals, 6.2% less than in winter 2020/21³. Despite a lower number of patients arriving by ambulance, this winter a total of 324,486 ambulances experienced delays of 30 minutes or more, 89.8% more than the previous year. From 29th November 2021- 3rd April 2022 an average of 21.6% of ambulances were delayed by more than 30 minutes, and an average of 8.9% were delayed by more than 60 minutes. In some cases, vulnerable older people had no choice but to spend all night on the floor at home after falling, waiting for help to come.

1

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1065713/2022-to-2023-nhs-england-mandate.pdf

² <https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england>

³ <https://rcem.ac.uk/data-statistics/#:~:text=Northern%20Ireland-,UEC%20Winter%20Situation%20Report,-A%20Flourish%20data>



Percentage of ambulance handover to hospital delays greater than 30 minutes

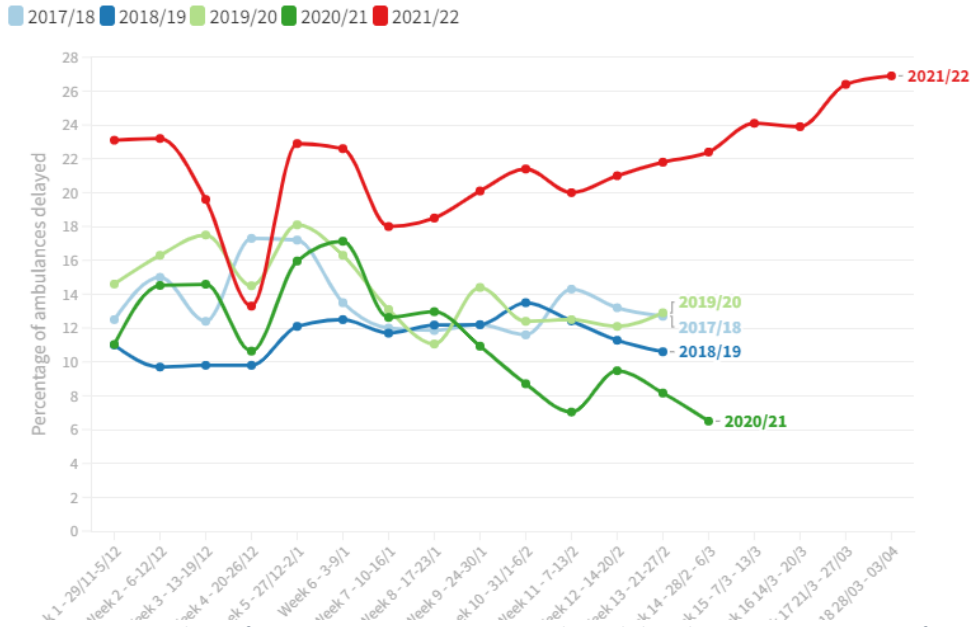


Figure 1 RCEM analysis of UEC Winter Situation Reports showed that this winter an average of 21.6% of ambulances were delayed by 30 minutes or more, the worst performance on record for the metric.

March Performance Figures since 2011

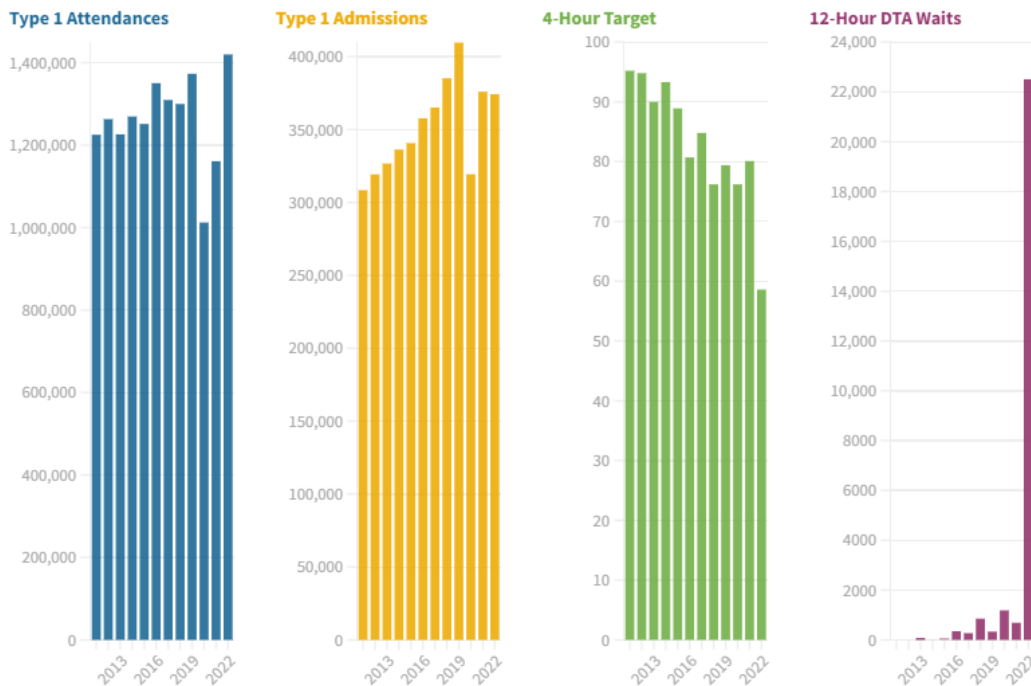


Figure 2 NHSE attendances and admissions data paints a vivid picture of broken system overwhelmed, with no reprieve for ED staff or patients.



This spring there was little to no reprieve for emergency medicine clinicians or patients from the surging pressures and problems typically associated with winter, highlighting the ever-increasing strain on the urgent and emergency care pathway (see figure 2). In the final week of the winter situation reports, ambulance delays hit record-breaking highs as 26.9% of ambulances were delayed by 30 minutes or more and 12.5% of ambulances were delayed by 60 minutes or more (see figure 1). This is by far the worst performance on record for both metrics. Prior to this, the highest percentage of ambulances delayed for 30 mins was 18% in winter 2019/20 and for 60 mins 6.4% in winter 2020/21.

In order to understand the mounting pressure on UEC systems, staff, and patients, the wider health and social care system must be taken into consideration. Whilst the majority of patients that present at an ED are treated and then safely discharged, an average of 28.5% of patients require admission to hospital for further care. Unfortunately, it has become the norm for these patients to experience very long waits. In February 2022, only 60.8% of patients were admitted, transferred, or discharged from an ED within 4 hours from arrival, an all-time record low for the metric. In November 2021, the number of patients that spent 12 hours or more in an ED from the decision to admit to their admission to a ward broke the 10,000-patient barrier for the first time in the metric's history. It has not dropped below the 10,000-patient marker since. The most recent set of performance figures indicate a staggering 22,506 patients waited 12 hours or more from decision to admit to admission⁴. This is an increase of **3171%** when compared to the same month in the previous year. However, we have long argued this metric is misleading and only represents the tip of iceberg in terms of delays to treatment; this metric should be recorded from the moment the patient steps foot into the ED. From November 2021 – March 2022 RCEM's flagship research project Winter Flow recorded 128,183 instances of patients spending 12 hours or more in an ED from their time of arrival, via 40 participating sites⁵. This is a good example of a wicked problem, with multiple causes and requires multiple solutions. The situation before the introduction of the four-hour access standard in 2005 was not dissimilar, 23% of patients stayed over four hours in emergency departments. There is a moral and health economic imperative to reduce long waits in the ambulance service and EDs, as people are harmed by delays in these two services.

Data from RCEM's Snap Survey from March 2022 corroborates the harm these delays cause, revealing the unacceptable length of time patients were waiting for treatment. For the three days prior to being surveyed over half (54.65%) of clinical leads reported stays of 24-48 hours and just under a quarter (23.26%) reported stays in their ED longer than 48 hours⁶. One clinician aptly summarised this, in taking handover from the night team and having to differentiate between "last night's patients" and "last, last night's patients". For patients seeking emergency treatment, this is dangerous and inhumane. In RCEM's December Snap Survey we asked our clinical leads to share with us stories highlighting the impact of long stays and crowding on patients. In response, we received harrowing accounts of patient and clinician experience and safety. Our clinicians shared incidents of patients waiting 11 hours or more in ambulances; of patients discharging themselves as services are so stretched that EDs could not provide better care than what they would receive at home.

⁴ <https://rcem.ac.uk/data-statistics/#:~:text=Northern%2DIreland-,Performance%20Figures,-%E2%80%94>

⁵ <https://rcem.ac.uk/winter-flow-project/>

⁶ RCEM's March 2022 Snap Survey received responses from 86 clinical leads.



It does not matter how efficient emergency medicine clinicians are in providing timely care and treatment to patients, crowding will still occur if patients cannot be admitted to a staffed hospital bed. This was evidenced in January 2022 when we saw record high levels of both staff absences and trolley waits as a percentage of emergency admissions. This problem is further compounded by exit block. Inefficient discharge processes and the lack of integration between social and secondary care means that some patients may be medically fit to leave, they may need help to recover in the form of a social care package. This decreases hospital capacity as it means that the hospital bed is unavailable to the next patient. Good patient flow through the hospital is vital to ensure safe and effective hospital treatment, whatever the journey of the patient.

This winter, average bed occupancy stood at 91.9%, well above the 85% recommendation and 6% higher than the year before. This winter also saw the highest numbers of long stay patients in hospital for 7 days, 14 days and 21 days or more since winter 2017/18, in which performance was so poor that the then Secretary of State launched a national ambition to reduce the number of long stays⁷. A weekly average of 16,570 long stay patients spent 21 days or more in hospital, the highest number since winter 2017/18. Further analysis shows that a weekly average of 6,143 long stay patients in hospital for 21 days or more no longer met the criteria to reside in hospital, equating to 37.1%. An average of only 10.8% of these patients were discharged. In terms of total discharges for this reporting period, a weekly average of 20,560 patients no longer met the criteria to reside in hospital and an average of 57.4% of these patients remained in hospital. This means that on a weekly basis, an average of 11,656 patients remained in hospital that no longer met the criteria to reside.

The consequences of current pressures

An overwhelmed UEC system creates a precarious environment to care for our patients as it is marked by poor access to and a deterioration of quality of care. Being treated quickly in EDs is important for patient experience but also clinical outcomes, long waits have a significant impact on patient morbidity and mortality, as we have demonstrated elsewhere.⁸ We have long argued crowding is undignified and inhumane for patients who are left waiting for treatment in risky circumstances. When crowding occurs inside the hospital, patients waiting in corridors are likely to outnumber those in cubicles. The longest waits are often experienced by the sickest and most vulnerable patients who may be elderly and experiencing distress. Data we have collected through our SNAP surveys reveal that some of these patients have no choice but to wait over a week in the ED to be admitted into hospital.

When EDs become crowded, they are no longer able to accept patients who arrive by ambulance, and the ambulances containing these patients are forced to wait outside. As the above data has shown, the high occurrence of ambulance handover delays is worsening in England. The detrimental effects that crowding can have on patients as a result of crowding is well established, but patients waiting in ambulances are likely to suffer the same harm from their waits as patients receiving care in corridors. Additionally, when ambulances cannot offload patients into the department in a timely manner, they are unable to return to the community where patients may be waiting for emergency care. Two patients are at risk for

⁷ <https://www.england.nhs.uk/urgent-emergency-care/reducing-length-of-stay/>

⁸ https://rcem.ac.uk/wp-content/uploads/2021/11/RCEM_Why_Emergency_Department_Crowding_Matters.pdf

every ambulance unable to offload: the patient in the ambulance and a further patient waiting for an ambulance.

In these conditions, hospital beds become a scarce resource. This can result in cancelled operations, against a backdrop of burgeoning waiting lists for NHS treatments. Our Winter Flow Project recorded over 43,000 cancelled elective operations. Patients experiencing these delays may have to continue to endure chronic pain and some may experience complications, contributing to further emergency demand.

An overwhelmed UEC system places additive strains on emergency care professionals who were already prone to burnout and moral injury prior to the pandemic. Unfortunately, this contributes to the loss of highly skilled emergency care clinicians. An overwhelmed system marked by high levels of crowding may increase the risk of significant adverse events, errors, complaints, and litigation - which come with associated negative effects on staff. In our Retain, Recruit, Recover (2021) report we found that in the next two years, half of respondents are considering reducing their working hours, while just over a quarter are considering taking a career break or sabbatical⁹. When asked what prompted them to make this decision, 32% selected workload pressures and 35% selected burnout. While these clinicians are only considering changing their working patterns, attrition of this nature contributes to shortages of highly skilled emergency medicine clinicians and a vicious cycle can develop as the remaining team suffer from increased stress and hence a greater chance of burnout.

What are the solutions?

- Metrics that promote patient flow and prioritise the care of the most seriously ill and injured patients must be published. Every ED across England is collecting data on the number of patients waiting 12 hours or more from time of arrival. This is a patient centric metric which captures the true extent of long waits in the ED. This data must be published so patients and policymakers can understand the true extent of long waits. Progress must be made towards eliminating 12 hour stays as outlined by NHS England's 2022/23 Priorities and Operational Planning Guidance.
- To eradicate exit block, the health and social care system must be able to support the timely discharge of patients when their hospital care is complete. There is an urgent need to support the social care workforce to ensure it can offer provision that meets the needs of our growing and ageing population.
- The Urgent and Emergency Care System only operates full tilt during the daytime during the week. The alternatives to admission offered by early specialist input into care, and by clinical environments dedicated to same day emergency care or early review in appropriate clinics. This requires service reconfiguration and a change in culture.
- Hospital specialities must prioritise patient flow and work to eliminate delay. Specialty referrals need a rapid response and a management plan that minimises unnecessary admission. This will help us to quickly move patients from ambulances to be managed in safe areas.
- Integrated Care Systems must develop a seven-day range of urgent and emergency provision to which 111 and general practice can direct patients. These services should

⁹ https://res.cloudinary.com/studio-republic/images/v1634809665/Retain_Recruit_Recover/Retain_Recruit_Recover.pdf?i=AA



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include pharmacy, minor injury unit, urgent care unit and out of hours GP services, as well as secondary care services.

- Action must be taken now to secure the future workforce. The Secretary of State's workforce strategy must aim to achieve safe staffing in EDs. At present, there is a shortfall of 2,000-2,500 Whole Time Equivalent consultants in the UK. This gap must be filled with an accompanying increase in ED nurses, AHPs and SAS doctors, and the faculty to train them.
- Staffed bed capacity of hospitals must be restored to pre-pandemic levels at least in order to achieve a desirable ratio of emergency admission to beds. An additional 4500 staffed beds are required across the UK between now and next winter. In the long term, staffed bed capacity must be increased so it is in line with our OECD peers.