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Royal College of Emergency Medicine Scotland's response to the Health, Social Care and Sport Committee inquiry into winter preparedness and planning within health and social care

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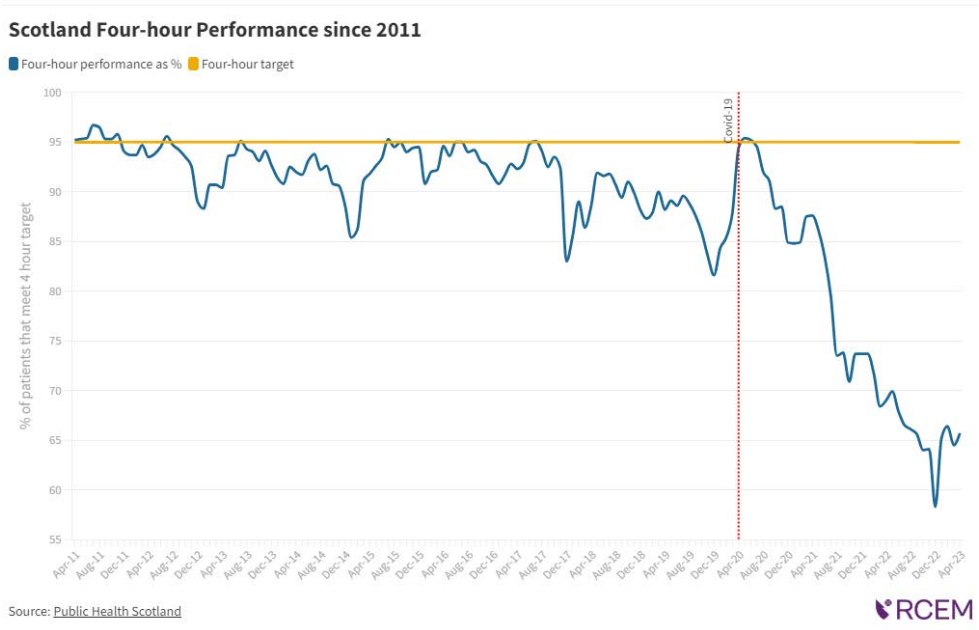
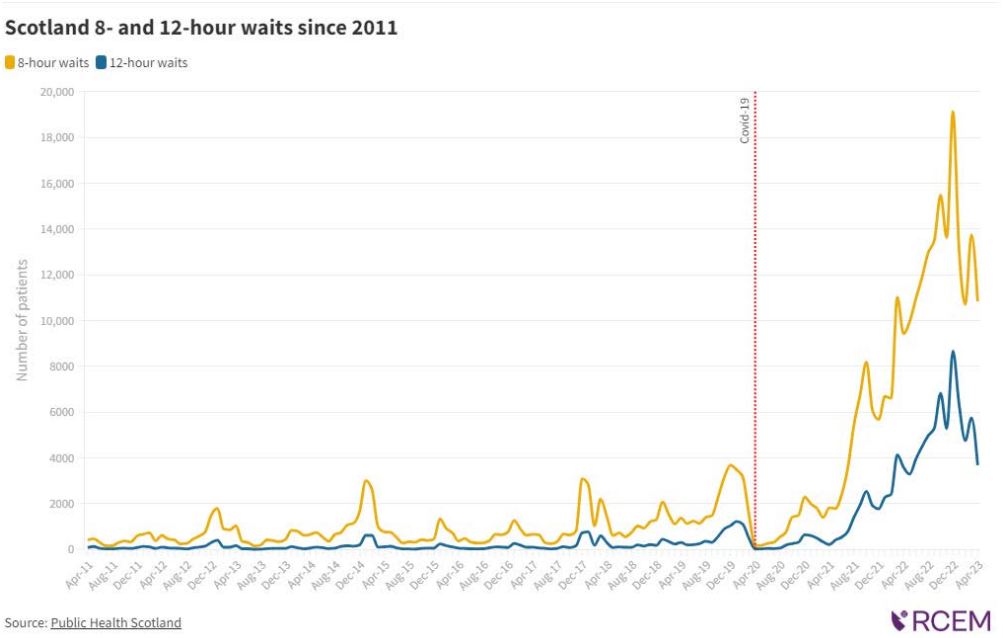
About the Royal College of Emergency Medicine:

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 clinicians, doctors, and consultants to Accident & Emergency departments (EDs) in the NHS in the UK and other healthcare systems across the world. Our response refers only to Emergency Medicine in Scotland or areas that directly affect Emergency Medicine.

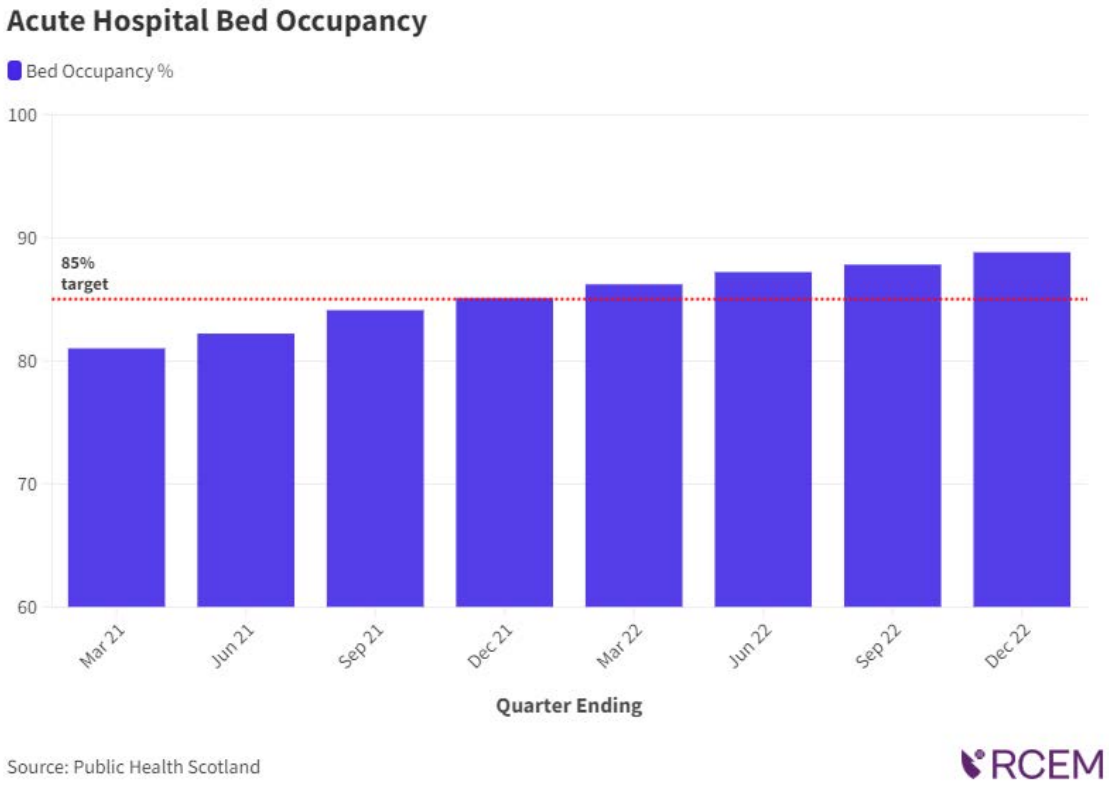
1. How effective were government actions to support winter resilience across health and care systems last year?

Performance data highlights that EDs in Scotland were not well prepared or equipped for winter pressures. Last winter was the worst on record for 4-, 8-, and 12-hour performance. In December 2022, only 58.3% of patients were seen within four-hours from time of arrival. 19,131 patients waited more than 8-hours from time of arrival and 8,658 patients waited more than 12-hours from time of arrival. No patient should ever wait more than 12-hours in an ED. The Getting it Right First Time (GIRFT) Emergency Medicine report finds a direct link between longer waits in EDs and increased mortality, therefore long waits are deadly for patients. Data in the GIRFT Emergency Medicine report showed an increase in the Standardised Mortality Ratio (SMR) associated with ED delays beyond 5-6 hours from time of arrival.





Along with poor performance, we saw a precipitous collapse of emergency care standards and safety, various health boards declaring capacity related major incidents and requests by clinicians to do the same. It is not only inhumane and undignified for patients, but also dangerous. Studies show that patient mortality increases when there are long delays to admission and when hospitals are full.



Despite making a commitment in the NHS Recovery Plan to release 150 beds per day in NHS Scotland, we have seen little improvement in occupancy and available bed stock. As the above graph shows, the average occupancy across Scotland was nearly 90% in the

most recently recorded quarter, according to Public Health Scotland. Occupancy levels have exceeded the safe 85% level for the last four recorded quarters. Indeed, the period March 2021 and before was unusually low due to Covid. Above 85% occupancy is becoming the norm and Scotland is consistently hitting just under 90%.

Evidence suggests that hospitals operate most effectively when their occupancy levels do not exceed 85%, allowing for extra capacity to handle sudden increases in demand. A 2022 study of hospitals in NHS England found that higher occupancy leads to higher mortality. A 5 percentage-point increase in bed occupancy is associated with a 1.1% increase in overall mortality and a 3.1% increase in surgical mortality. Some boards in Scotland are reporting to be over 100% occupied in recent months, with patients being treated in corridors and for long periods in ambulances queues outside EDs. Without planning we will see a similar collapse of the system in winter 2023-24. Between 2011 and 2019, there was a loss of 1,500 beds across Scotland.

This high occupancy not only has impact in the ED, it also means that some paramedics are spending an entire shift in an ambulance queue outside of an ED, unable to get back into the community to handle the next urgent call. Increasing numbers of patients are stuck at various points in the healthcare system. The problem of crowding is no longer hidden within the ED, it is spreading to other areas such as ambulances, and hospitals are at crisis point. We need to increase capacity and improve patient flow through the hospital so that we can keep patients and staff safe this coming winter.

2. What additional priorities should inform actions to support winter resilience across our health and care system this year?

Crucially, we need a winter plan months before winter comes. Planning last year was not carried out enough in advance, and therefore EDs were not equipped to deal with pressures. We need an action plan for this winter formulated now and to begin implementing agreed solutions as soon as possible. Fixes need to come across the whole patient journey; from ambulatory care to care in the community, preferably as early in the summer as is possible. We need resilient and robust backups of the staffing base to bolster under resourced departments especially in times of crisis. All this needs to be done in close consultation with royal colleges and experts across the NHS.

Our Five Priorities for UK Governments published in January are a useful guide of solutions to prioritise. They will help prevent future winter crises in EDs and form a plan for Emergency Care. Here we set them out and add Scotland specific recommendations:

1. Eradicate overcrowding and corridor care for patients:

To bring bed occupancy down to the optimum 85% level in Scotland, we have calculated that there needs to be an increase of the acute bed stock in the Scottish hospitals by 448 staffed beds. We realise that this is costly, therefore we would like to work with the Government to figure out exactly what is needed to deliver an increase in beds. Whether it be an increase in UK capital budget, or a reduction in spend elsewhere. The Government should also explore where this money could come from if not available within the current budget. We set out how we came to this ask in our recent UK-wide Beds Briefing.

An expansion of social care capacity is required to allow for quicker discharge from hospitals to the community. There needs to be improvements to flow navigation with a full range of referral in flow centres. On the issue of ambulance handover delays, we joint published an options appraisal with the College of Paramedics which serves to inform those with operational responsibility for ambulance handovers. Here we have prioritised options from

the ideal option of improving the system to the unacceptable least ideal option of holding patients in corridors. Essentially however, the ultimate solution is increasing beds and flow through and out of the hospital by improving social care.

2. Provide the UK with the Emergency Medicine workforce it needs to deliver safe care:

We need to prioritise a fully costed workforce plan with future building to improve recruitment and retention of ED clinicians. Addressing working conditions for those in our EDs to improve retention of trained and experienced staff- still recruiting well but not keeping people in the specialty and in NHS Scotland. There are four doctors for every ED trainee place. However, the attrition rate from ST1 to consultant is 33%. This needs to change; we need a plan for keeping doctors from trainee to consultant so that EDs are staffed sufficiently. Indeed, this year we there is a lack of uptake of trainees which will significantly affect our winter response. We commissioned a report on improving retention, which we will explore in section 7 of this response.

3. Ensure our NHS can provide equitable care to emergency patients:

Any plan should ensure that no group receive disadvantaged care. A 2022 study found that patients from deprived backgrounds are more likely to wait longer in EDs, receive fewer treatments, are less likely to be admitted as an inpatient, and are more likely to die shortly after visiting an ED. We also see longer waits and worse access to sufficient care for the elderly – an Aberdeen University study found that patients over-85 were more likely to have breached the four-hour target that younger patients– and an RCEM study from 2022 found that patients suffering from mental health were twice as likely to wait longer in EDs across Britain that other patients. This needs to be addressed in any winter planning.

4. Focus on evidence-based interventions to tackle overcrowding:

Any plan should be sufficiently measured and evaluated to ensure the best policies for preventing future crises. We would be happy to assist in the development of policies and potential interventions aimed at improved performance.

A blanket approach does not work. A tailored and evidence approach for each board is required. An example of this is the introduction of NHS 24 to manage demand. Sometimes works but does not work across the board. Data after the trial period did not seem effective. Not enough clinical involvement after trial period.

5. Introduce meaningful and transparent metrics to facilitate performance and better outcomes for patients:

Public Health Scotland should continue publishing regular performance data. Public bed occupancy data (number of available and occupied beds) should be published monthly to allow for clear and regular assessment of bed stock in Scottish hospitals.

Capacity and system flow

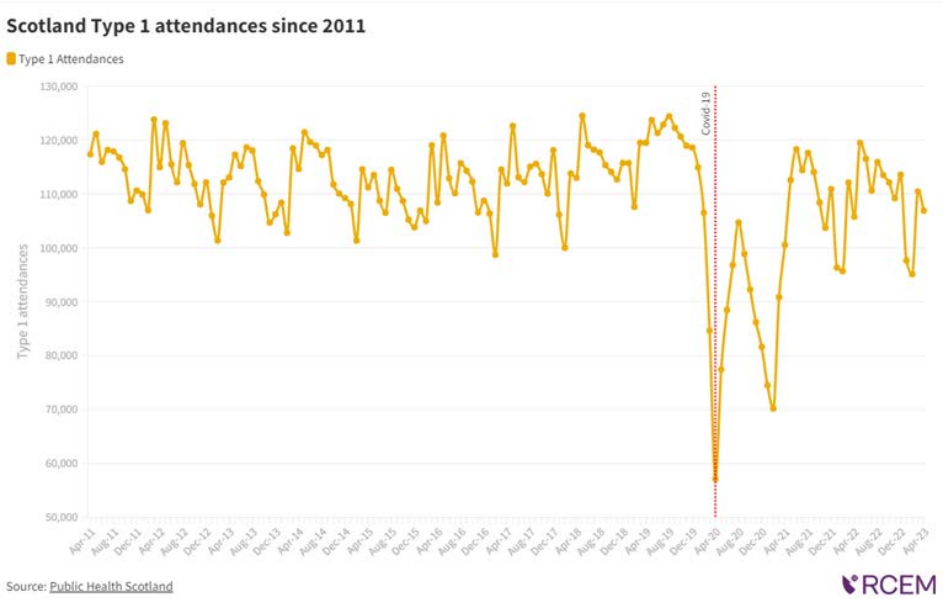
3. What were the key factors limiting capacity and delivery in the NHS and social care last winter?

As discussed above, a lack of beds, lack of flow through hospitals, a huge number of delayed discharges, and workforce issue are all factors limiting capacity and delivery in the NHS across the care pathway.

4. Was the flow through the NHS and social care adequately maintained last year?

Flow into EDs and out of the hospital was not adequately maintained. Winter 2022/23 saw the highest average number of beds occupied due to delayed discharges per day since current guidance came into place in 2016. The graph above shows delayed discharge data since May 2021. Between November 2022 and February 2023, the average number of beds occupied per day due to delayed discharges was 1,877 (a 15.7% increase on the period November 2021 to February 2022) and there was a total of 225,270 days spent in hospital by people whose discharge was delayed (a 15.8% increase on the period November 2021 to February 2022). There is a significant lack of social care packages in the community. Many people in hospital beds who are medically fit to leave are unable to do so until social care becomes available.

5. How can capacity be maximised to meet demand, and maintain integrated health and social care services, throughout the coming autumn and winter?



An increase in beds and improved social care packages as stated in previous questions is vital. As the graph above shows, minus covid-19 years, ED demand has not risen and has in fact decreased somewhat over the past decade, we have lower ED attendance numbers, but we have higher acute bed occupancy rates and long waits as set out previously. We need more beds and improved social care to protect the system.

Workforce and staff wellbeing

6. What factors affected the wellbeing of those providing health and social care support, including both paid and unpaid carers, over the 2022-23 autumn and winter periods?

There is immense pressure on staff in emergency departments across Scotland. The poor performance that leads to overcrowding in EDs is hugely detrimental for staff well-being. Emergency department crowding and corridor-care places huge amounts of pressure on staff. Placing responsibility on them to treat patients beyond the 4-hour mark also negatively affects staff morale and well-being, EDs are not designed, and staff are not equipped, for care beyond 4 hours since admission. As stated, risk of patient mortality increases the longer they wait.

7. What should be done this year to ensure staff wellbeing, and ensure those providing support (in all settings) are able to continue to do so?

Delivery of our suggestions to improve winter resilience would go a long way to ensuring greater staff well-being: increasing beds, improving workforce, and improving social care. We have also commissioned a recommendation for retention and workforce well-being in emergency care which makes four key suggestions: firstly, creating an environment to thrive in by improving staff ratios, improving access to hot foot, and protecting study time; secondly, cultivating a better culture by encouraging a culture of care and shared responsibility in hospitals, clarifying lines of accountability, and nurturing growth; thirdly, a tailored pathway of care from ED to staff support; fourthly, enhancing leadership in emergency departments.

ED clinicians deal with patient emergencies and are therefore in their nature going to be an intense environment. However, implementing necessary changes to EDs to ensure adherence to the above recommendations and reducing unnecessary extra stresses for clinicians will go a long way to improving staff well-being and retaining ED staff beyond their training years.

Outcomes

8. Were patient outcomes affected last winter, either positively or negatively?

Patient outcomes were affected negatively last winter. Long waits and high occupancy are strongly related to higher patient mortality. Using NHSE's GIRFT associated mortality calculation, we calculate that between November 2022 and February 2023 there were 438 deaths at or before 30 days associated with long waits between 8 and 12 hours in hospitals. This is the most 8-12 hour associated deaths since these measures began. This is not including mortality for waits over 12 hours.

9. What recommendations would you make to ensure services best support vulnerable communities and achieve positive outcomes this year?

All the above will be vital to supporting vulnerable communities such as the elderly, those suffering with mental illness, and people from deprived communities. On the beds ask, we would need to assess which EDs require more beds. These are more likely to be EDs in vulnerable communities. Poor communities tend to be further from an ED and are more likely to present out of hours – when EDs are poorly staffed. Providing alternatives for these communities is vital, some have nowhere else to go except an ED to receive care.

Indeed, we know that elderly patients and mental health patients all experience the longest waits and have the poorest outcomes in EDs. Improving community care and access to EDs as well as alternative services for these patients and ensuring that they feel welcome to attend EDs is vital.