## Health, social care and sport committee - Winter Planning 2018-19

## Written evidence submitted on the behalf of the RCEM Wales (September 2018)

**The Royal College of Emergency Medicine Wales (RCEM Wales) is the single authoritative body for Emergency Medicine in Wales. RCEM Wales works to ensure high quality care by setting and monitoring standards of care and providing expert guidance and advice on policy to relevant bodies on matters relating to Emergency Medicine.**

---

**Views on the oral evidence session.**

**1.** Despite the best efforts of clinical staff, winter 2017-18 saw poor patient experiences, record breaking 12-hour waits, crowding and Exit Block in Welsh emergency departments (EDs). For many emergency care staff, working in these busy and crowded environments was stressful, demoralising and sometimes overwhelming. And for patients, safety was often compromised as well as their dignity.[1]

**2.** At the oral evidence session held on 19 July 2018, many Health Boards expressed a degree of confidence that their plans will deliver better outcomes and experiences for patients this upcoming winter. Last years' poor performance, some explained, was in part due to a severe flu outbreak, low vaccination uptake figures, extreme weather conditions and the acuity of frail elderly patients.[2]

**3.** Yet, RCEM Wales takes the view that performance has been deteriorating for several years, despite influenza, challenging weather conditions and the ageing population – all of which are predicted annually. The main reasons for this continued deterioration are insufficient capacity to match demand, staffing shortages and deficient social care resources.

**4.** Some of these issues were raised by witnesses at the evidence session, including workforce shortages which were seen by a majority as detrimental to performance and safety. One Health Board commented: "there are some specialties where we can't get additional staff. That's one of the big impingements to delivery on a day-to-day basis, let alone the winter".[3]

**5.** It was also apparent that locum cover is increasingly being relied on to fill rota gaps, despite the expense:

"You can have all the money but if the posts are not there – even from an agency perspective – so, our contingency plans can often be based on the use of agency to include off-contract agency. If they then don't fill, we're left with the gap".[4]

**6.** There is also evidence that many Health Boards are relying on the goodwill of staff – which is arguably waning - to work overtime:

---

[1] RCEM, Welsh EDs are severely stretched this winter (January 2018) and Patients in Welsh EDs increasingly put in harm's way (February 2018)
[2] Health, Social Care & Sport Committee, Evidence session on winter resilience plans, 2018-19 (19/07/18), please see, for example, paragraph two, 10, 93 in the transcript
[3] Ibid. Paragraph 83 and 255
[4] Ibid. Paragraph 105

"We put on extra capacity and extra staff to deal with [four-day weekends]. The problem we have is that lots of that is often based on overtime and on goodwill of staff, to get people to work additional hours – we have lots of vacancies".[5]

**7.** And where Health Boards acknowledged that extra capacity, in terms of hospital beds, is required to deal with demand and flow issues, other options are sort due to workforce deficits and budget constraints:

"All of our hospitals pretty much operate at capacity on a daily basis, and, even if there were additional moneys to open additional capacity, we wouldn't have the nurses and doctors and therapy staff available to put that on".[6]

**8.** Therefore, the majority of winter resilience plans – and the Welsh Government's transformation plans - focus on prevention, redirection and short-term solutions rather than long-term planning to solve the perpetual capacity and demand issues.

**9.** It is important to note that some areas of good practice were highlighted in the oral evidence. This includes shared learning from previous years, earlier resilience planning and integrated initiatives with social care providers. The fact that Health Boards are required to formally submit plans to the Welsh Government in September 2018 is positive and will hopefully help to improve accountability. It was particularly encouraging that one Health Board considered extra beds for the safety of patients:

"We regularly put additional beds on wards, so we are reviewing the risk on wards – it is a low-level boarding. So, I've made the decision personally that, if the risk is in the emergency department, and it is too high, then we need to consider how we 'board' a patient safely".[7]

**10.** Nevertheless, the College is of the opinion that NHS Wales will not see great improvements in performance and patient experiences for the foreseeable future unless workforce, capacity and social care resources are increased in the long-term. We would like to see more commitments by Health Boards to increase bed numbers and fill vital workforce vacancies.

**Question 1. In your view, how well prepared and equipped do you feel the Welsh NHS is to cope with the forthcoming winter, and where are any pressure points likely to be?**

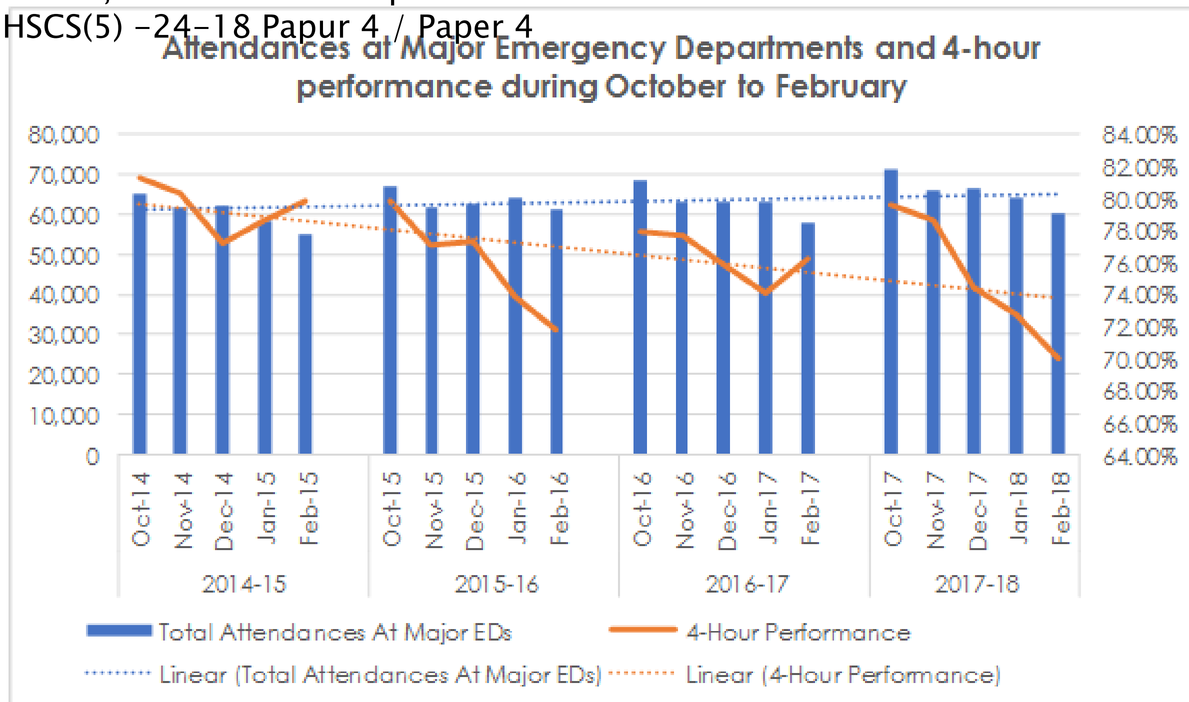
**11.** When asked about how it felt to work in an emergency department last winter and what their perceptions are on the forthcoming winter, many of our Members and Fellows commented that the situation feels worse than previous years, that they believe emergency care is in a state of crisis and that they do not have confidence that this winter will be any better.

**12.** National data – in terms of the gradual increase of demand coupled with the decline in performance – shows that these responses are justified.

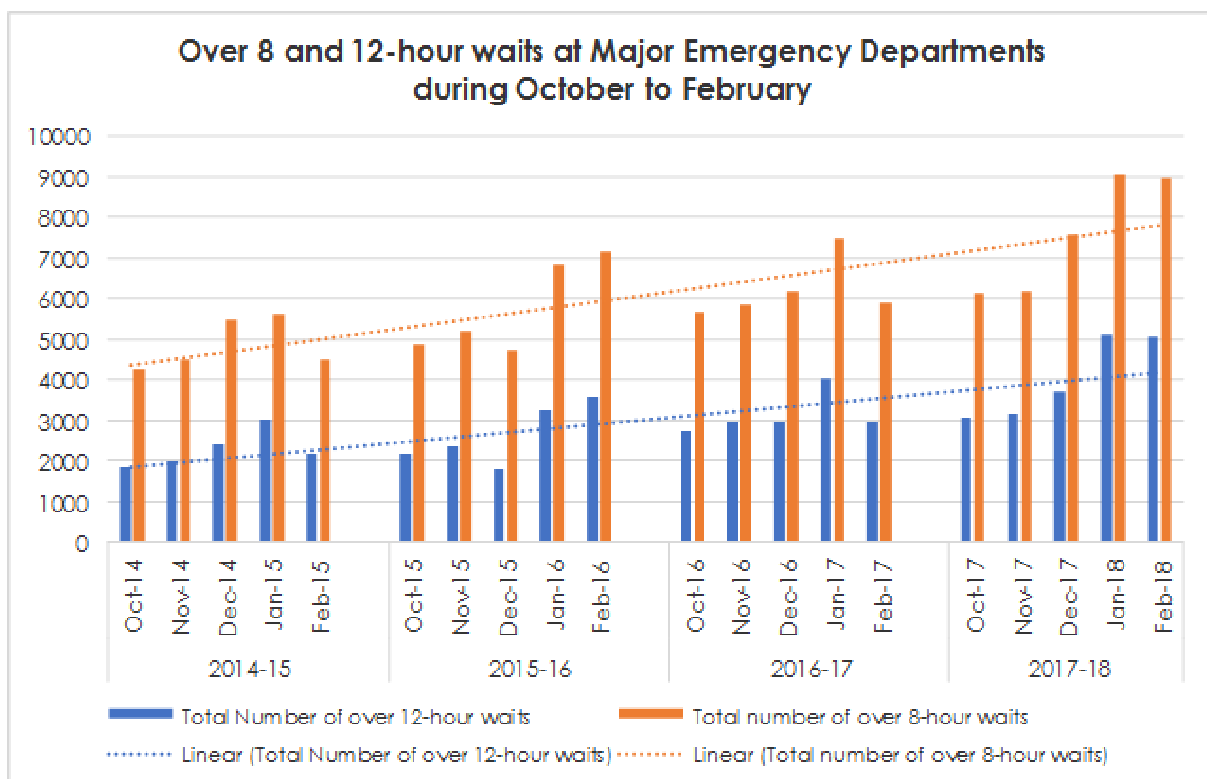
**13.** There were 1,030,045 attendances at Welsh emergency departments in 2017-18. This in an increase of 4.8% when compared to 2010-11 and is equivalent to the annual workload of one District General emergency department. In the same timeframe, average four-hour performance at Major departments has deteriorated from an average of 85.8% (2010-11) to 76.9% (2017-18). [8] The graph presented overleaf demonstrates this trend over the winter period.[9]

---

[5] Health, Social Care & Sport Committee, Evidence session on winter resilience plans, 2018-19 (19/07/18), paragraph 102
[6] Ibid. Paragraph 97
[7] Ibid. Paragraph 35
[8] Stats Wales, Performance against 4 hour waiting times target
[9] Ibid.




**14.** When we look at eight and 12-hour performance data, the picture is equally concerning.[10] January 2018 saw the highest number of 12-hour waits on record[11] and in December 2017 only 78.9% of patients spent less than four hours in all emergency care facilities from arrival until admission, transfer or discharge - the lowest performance since March 2016.[12]




**15.** As it is widely acknowledged, longer waits in emergency departments can lead to negative patient outcomes and even avoidable fatalities and are due to congestion in hospital wards[13] and insufficient social care provision in the community.

---

[10] Stats Wales, Performance against 8 and 12 hour waiting times target
[11] Welsh Government, NHS Activity & Performance Summary: December 2017/January 2018 (Feb 2018)
[12] Welsh Government, NHS Activity & Performance Summary: November/December 2017 (Jan 2018)
[13] Nuffield Trust, Understanding patient flow in hospitals (Oct 2016)

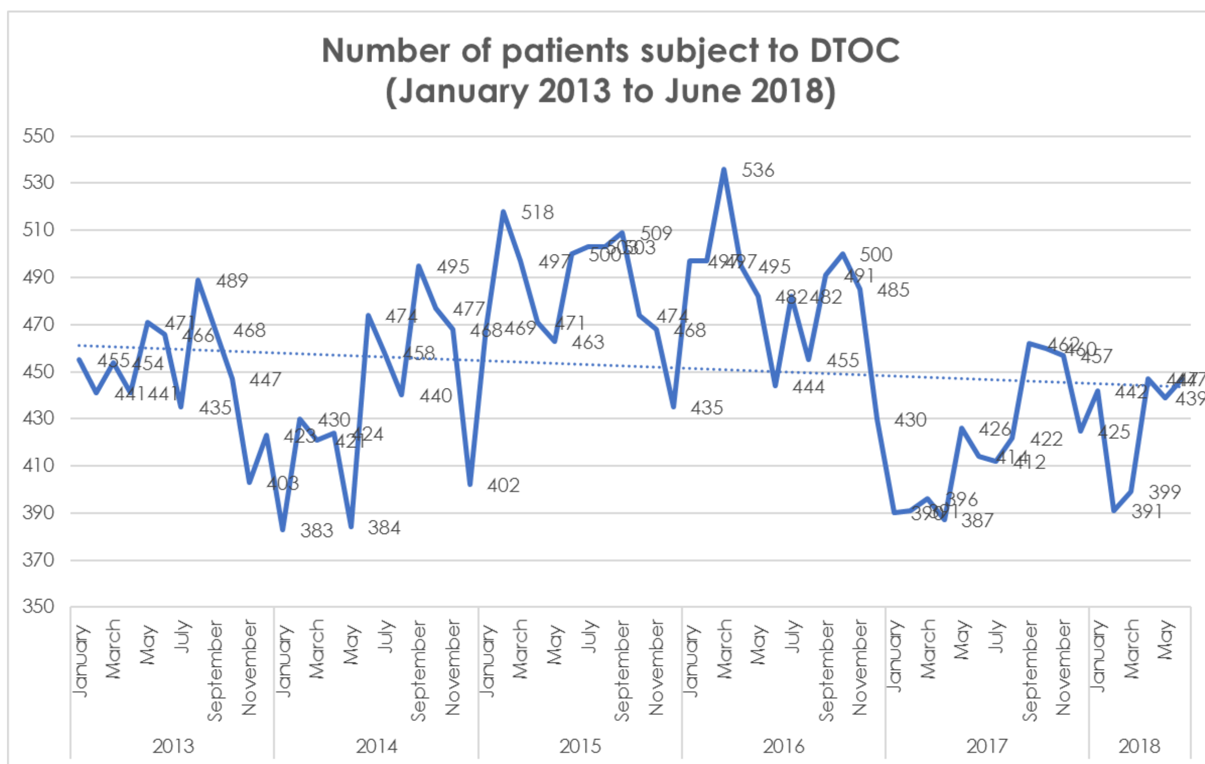
**16.** If these trends continue - and currently there is no substantial evidence to suggest otherwise - it is arguable that patient safety will continue to be compromised. NHS Wales is simply not well equipped to deal with the demand and acuity of patients requiring care this winter.

**17.** The main pressure points this winter pertaining to the emergency care system are likely to be 'Exit Block' - or the emergency department 'back door' - and ambulance waits.

**18.** Exit Block occurs when patients cannot be moved in a timely manner to a hospital ward because of a lack of available hospital beds. It is widely acknowledged that Exit Block causes harm to patients and avoidable mortality as well as being detrimental to patient dignity.[14]

**19.** In 2016/17, there were 1,292.6 fewer available beds in the NHS in Wales than there were in 2010/11. This represents a 10.6% decline in the total hospital bed base. In the same timeframe, average bed occupancy across NHS Wales has risen from 84.7% to unsafe levels of 87.4%.[15]

**20.** Delayed transfers of care (DTOC) are another serious cause of Exit Block. DTOC is most commonly a result of a lack of social care resources and continue to pose a serious problem. In 2017, the total number DTOC cases was 5042.[16]




**21.** This is important because the more patients subject to Delayed Transfers of Care – and the data does not specific how long each of these delays lasted – the fewer the available hospital beds to admit patients to when they arrive at A&E requiring further treatment.

**22.** An independent survey undertaken by the College in Wales found that 10 out of the 13 Major Emergency Departments in Wales regularly have patients waiting in ambulances for sustained periods of time. The remaining three Major Departments tend to have queues of patients waiting on trollies in hospital corridors until an appropriate bed becomes available.

---

[14] RCEM, Exit Block, British Journal of Hospital Medicine, Exit block in the ED: recognition and consequences (2014), CEEM, Improving emergency department patient flow (2016) and University of Sheffield, Exit block in emergency departments: a rapid evidence review (2015)

[15] Stats Wales, NHS beds summary data by year

[16] Stats Wales, Delayed transfers of care, delay stage by LA of residence

**23.** Ambulance waits are dependent on the flow of patients in the rest of the system. When Exit Block and ED crowding occurs, ambulance waits are inevitable.

**24.** Like Exit Block, ambulance waits are detrimental to patient dignity, can cause harm and detain emergency teams from reaching other unwell patients. Furthermore, long ambulance waits are a contributing factor in the poor morale and high stress levels of the workforce.[17]

**25.** Despite good intentions, many preventative, redirection and resilient plans have proven to be ineffective because the underlying problems remain - health and social care services are ill-equipped to meet patient requirements. This is in terms of staffing numbers, hospital beds and social care provision.[18] Until these issues are addressed, the College predicts that performance will not significantly improve.

**Question 2. To what extent has the RCEM been engaged in conversations with the Health Boards across Wales/Welsh Government in relation to the sustainability of emergency medicine in Wales and improving emergency department performance?**

**26.** As a Member of the National Programme for Unscheduled Care Board (NPUC), the College continues to inform the Welsh Government on pressures on the emergency care system and advises on possible solutions.

**27.** As a part of this, the College has summitted evidence to the Welsh Government's winter evaluation for two consecutive years. Our evidence draws on the personal experiences of our Members and Fellows in Wales as well evidential research. The report evaluating the winter 2017/18 period was submitted to the NPUC Board on 21 June 2018.

**28.** Due to the ongoing work of the NPUC Board and Welsh Government, the RCEM Wales has seen greater system-wider ownership of the four-hour target, which we hope will aid patient flow. Vital winter planning has also started earlier than previous years and shared learning is encouraged.

**29.** The RCEM Wales also regularly meets with the Cabinet Secretary for Health and Social Services, the Chief Medical Officer, the Chief Executive of NHS Wales and key civil servants specialising in Unscheduled Care, amongst others. We meet with relevant stakeholders all year round to communicate our concerns relating to emergency care and performance and to offer our advice and services where necessary. Our main messages are based on our Vision 2020 campaign.[19]

**30.** In 2016, the Vice President and Vice President Elect of the RCEM Wales met with the Chief Executives of Wales' seven Local Health Boards to discuss system pressures. The College also encourages Health Boards to participate in our Winter Flow Project to widen the debate around emergency medicine. As a charitable body with no regulatory responsibilities, we can only inform and advise.

**31.** We support and encourage our Members and Fellows in Wales and Clinical Leads to engage with the management in their hospitals and to draw upon College guidance where appropriate.

---

[17] Nuffield Trust, Winter Insight: The ambulance service (2017)
[18] RCEM Wales, Vision 2020
[19] Ibid.

**Question 3. To what extent does the deterioration of performance relating to the 4-hour and 12-hour A&E wait across the Health Boards in Wales demonstrate that the aim of shifting to primary and community-based care is not being realised in front line patient services? Has the pace of change been sufficient?**

**32.** As evidenced above, the deteriorating performance in emergency departments is directly related to the availability of beds in the hospital and social care in the community. In essence, the four-hour emergency department target is an indicator of system-wide performance.[20]

**33.** It is also interesting to note that the growth in attendances at Welsh emergency departments is in step with the rising population. Since 2013/14 attendances in Wales have increased by 1.9%, whilst in the same period Wales' population has risen by 1.4%.[21]

**34.** Patient navigation and redirection from emergency departments is a common theme of transformation plans and winter plans across the UK. However, the College has estimated that only 15% of patients in emergency departments could have been treated elsewhere.[22] This is due to several reasons:

- **a.** Often, the A&E Department is the only option available, especially at weekends, nights and public holidays.
- **b.** The growing population and ageing demographic inevitably leads to an increase in ED attendances.
- **c.** The A&E 'brand' is so strong it can be a victim of its own success, being seen by many as the first port of call before an out of hours GP service or a minor injury unit. This, along with the growing demand on services due to a growing an ageing population, suggests that redirection strategies have a limited success.[23]

**35.** Therefore, we would recommend that there is less emphasis on the need to redirect and educate patients away from the emergency department and there should be more impetus to increase resources where they are immediately required.

**36.** The College's co-location campaign proposes that additional services such as pharmacies, GPs, frailty teams and crisis mental health teams should be located alongside emergency departments to help tackle the increasing rate of Major attendances. This model aims to simplify access routes for patients – helping them to get the help they require more swiftly – and to help ease pressure on emergency departments.[24]

**Question 4. Do you have a view on whether the Health Board's winter plans for 2018/19 need a stronger focus on the elderly and supporting people with frailty, particularly in terms of reducing unnecessary hospital admissions during the winter period?**

**37.** NHS Wales' medical and social care workforce faces a significant challenge to meet the complex health and social care needs of the ageing population.

**38.** The figures on the next page show that the population of Wales – which already has considerable needs centred around an ageing population – has continued to become more elderly. From mid-2013 to mid-2017 the population of those over 65 years of age increased by 7.1%. In the same time period, the population as a whole increased by no more than 1.4%.[25]

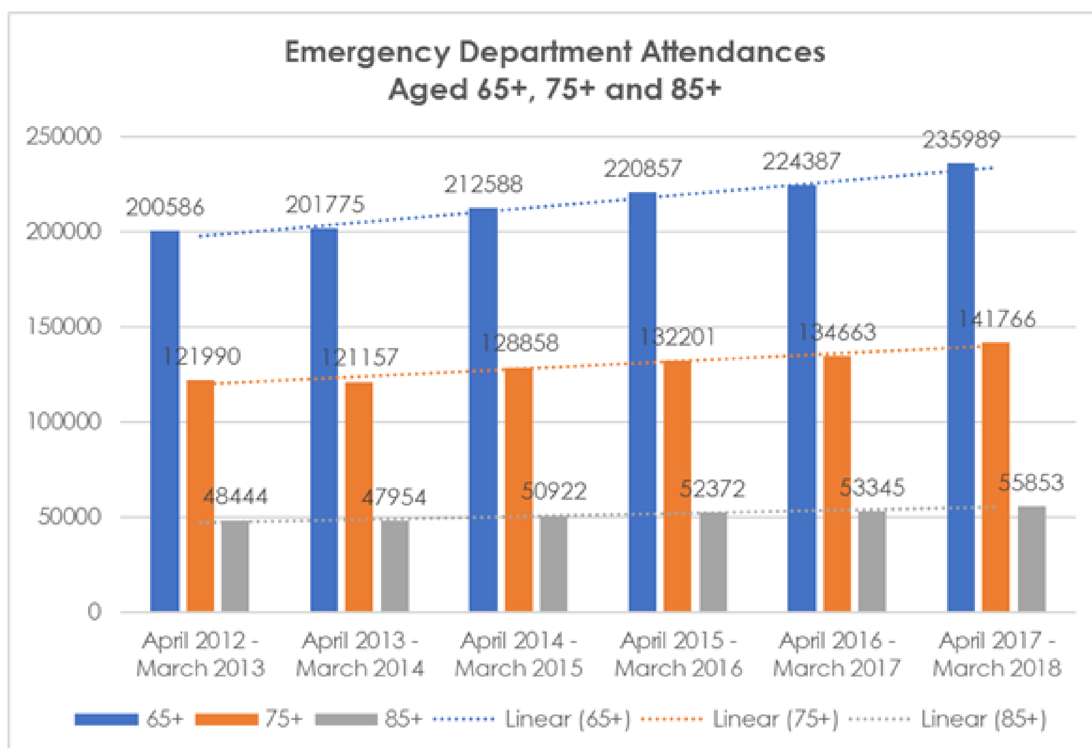
---

[20] National Health Executive, The four-hour target: what's the point? (2016)
[21] Stats Wales, Accident and emergency and National level population estimates
[22] HSJ, Beyond the official data: a different picture of A&E attendances (2014)
[23] HSJ, Why the strength of the A&E brand is its Achilles' heel (2014)
[24] RCEM, Co-Location - the Hub concept
[25] Stats Wales National Level Population Estimates by Year (2016)

| Year | Population all ages | Population aged 65 and over |
|---|---|---|
| Mid 2013 | 3,082,412 | 600,630 |
| Mid 2014 | 3,092,036 | 614,747 |
| Mid 2015 | 3,099,086 | 624,773 |
| Mid 2016 | 3,113,150 | 634,637 |
| Mid 2017 | 3,125,165 | 643,269 |

**39.** This in turn is reflected in an increasing propensity to access health and social care services. Demand from people over 65 years of age continues to grow considerably and has resulted in rising numbers of GP appointments,[26] demand for social care services and pressures in secondary care services, including A&E Departments.

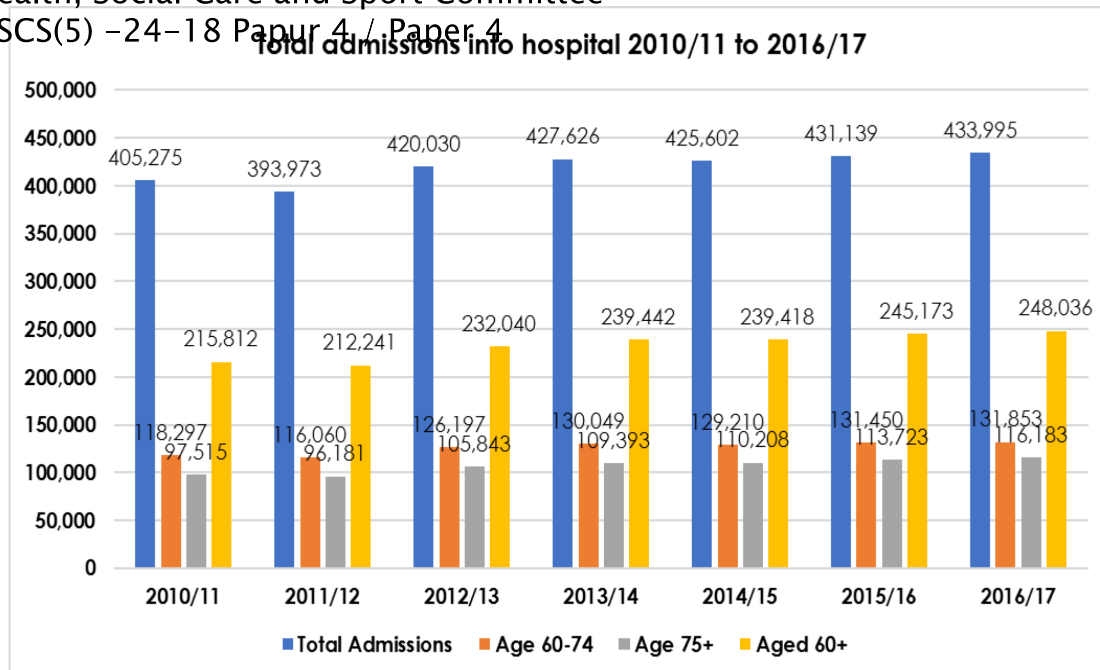
**40.** The figures presented below are taken from Stats Wales. It shows that the number of ED attendances of those over the age of 65 has steadily grown since 2012-13 by 17.6% whilst the overall number of attendances has only increased by 2%.[27] The median time that patients over the age of 75 spend in an A&E Department can be three times longer than patients under the age of 75.[28] This is due to the complexity of conditions that often accompanies older age.




**41.** Data from NHS Wales Informatics Service shows a gradual increase in the number of admissions into hospital over the last couple of years – and a significant proportion of those consist of patients over 65 years of age.[29] The King's Fund bears this out and has found that patients over the age of 65 can account for 70% of bed days.[30]

---

[26] The King's Fund, Understanding pressures in general practice (2016)
[27] Stats Wales, Number of attendances in NHS Wales accident and emergency departments by age band, sex and site
[28] Stats Wales, Mean and Median time spent in A&E and A&E Attendances by age band
[29] Informatics Service, Annual PEDW Data Tables (2017)
[30] The King's Fund, Continuity of care for older hospital patients (2012)




**42.** A frail person's ability to recover their former independence is greatly affected by a prolonged hospital stay.[31] The Health Foundation estimates that 8-12% of admissions into hospital will result in harm to a patient.[32] The longer a person stays in a hospital bed, the greater the impact on their mental health and the more likely they are to develop a life-threatening hospital infection.[33]

**43.** Furthermore, in over half of DTOC cases in Wales, delays are a direct result of hospital staffs' inability to discharge patients into an appropriate social care setting. Whilst more people require care in the community, data from Stats Wales shows that the number of care homes in Wales for older adults has reduced by 9% and the number of places has fallen by 4%.[34]

| Year | Total Settings (Older Adult Care Homes) | Number of Places |
|---|---|---|
| **March 2011** | 704 | 23,340 |
| **March 2012** | 694 | 23,199 |
| **March 2013** | 684 | 23,050 |
| **March 2014** | 675 | 22,816 |
| **March 2015** | 670 | 22,713 |
| **March 2016** | 653 | 22,092 |
| **March 2017** | 642 | 22,217 |
| **March 2018** | 643 | 22,466 |

**44.** Yet, the LE Wales has predicted that the number of over 65s requiring local authority funded domiciliary care or residential or nursing homes will rise by 47% and 57% between 2013 and 2030.[35] Local authorities are already increasingly unable to meet demands for care and the responsibility of arranging care is often left to the patient and their families.[36]

**45.** In light of the above evidence, the College was pleased to see localised attempts to improve links between health and social care, as described by some of the Health Boards. However, more needs to be done to ensure the recruitment and retention of social care staff is improved,[37] social care resources are increased and DTOC diminished.

[31] The King's Fund, Continuity of care for older hospital patients (2012)
[32] The Health Foundation, Is the NHS getting safer? (2015)
[33] Forbes, 4 Ways Hospitals Can Harm You (2014)
[34] Stats Wales, CSSIW Services and Places by Setting Type and Year
[35] LE Wales, Future of Paying for Social Care in Wales (2014)
[36] Welsh Government, Parliamentary Review of Health and Social Care in Wales, Interim Report (2017)
[37] The Guardian, Social care in Wales: 'Brexit poses risks to staffing and services' (2016)

**Question 5. The RCGP has warned that pressures on the Welsh NHS, particularly during the winter period are highly likely to lead to patient safety being severely compromised. Do you share their concerns in relation to the fragility of GP out of hours services and what is the impact of gaps in out of hours provision on the smooth workings of accident and emergency services?**

**46.** The Royal College of Emergency Medicine Wales, along with many other medical colleges, has publicly warned for a number of years that resourcing and staffing issues are detrimental to the safety of patients.[38]

**47.** Rota gaps place strain on the service. It means that sometimes the emergency department is the only option available to patients. It affects the flow of patients throughout the system and it is also detrimental to the wellbeing of staff.[39]

**48.** The College estimates that only 15% of ED patients could have been treated elsewhere.[40] If out of hours GP services were strengthened, this figure might be slightly reduced.

**49.** The latest GP patient survey, for example, showed that 7.3% of respondents went to A&E when their GP practice was closed.[41]

**50.** There is also evidence to suggest that co-locating full time and out of hours GP services next to the emergency department reduces waiting times and improves patient experience. A study published in the BMJ evaluating the impact of integrating a GP into a paediatric emergency department concluded: "introducing a GP to a paediatric ED service can significantly reduce waiting times and admissions but may lead to more antibiotic prescribing".[42]

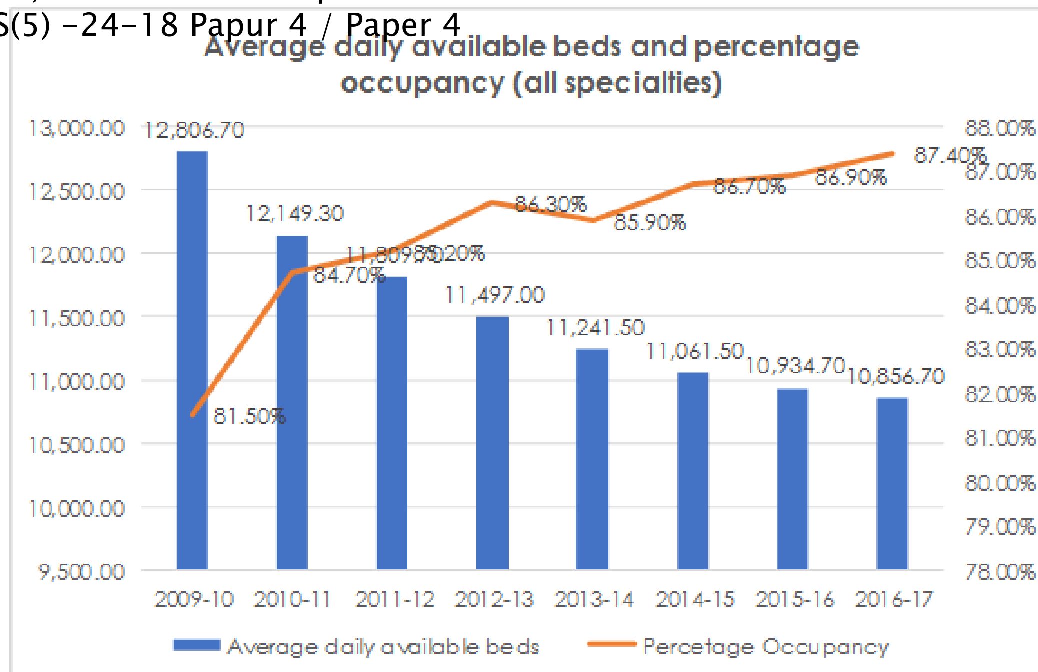
**51.** Nevertheless, as the Nuffield Trusts rightly points out, patients attending minor injury units instead of GP practices are not a significant cause of the A&E demand and performance issues. For Major attendances – which drive performance and Exit Block issues - GP surgeries are not a realistic alternative.[43]

**52.** To improve performance, there needs to be a balance between providing viable out of hours care and resourcing the wider health and social care system to adequately match demand.

**Question 6. How confident are you in the demand projections and capacity modelling that has been done by the Local Health Boards in Wales to inform their winter planning for 2018/19, specifically in relation to additional winter bed capacity?**

**53.** As the next graph illustrates, the number of beds available in NHS Wales has fallen by over 15% in the space of seven years whilst bed occupancy levels have exceeded safe levels of 85%.[44] This is despite a growing and ageing population and a rising number of patients over the age of 65 requiring more complex health care requirements, both within and without the hospital setting.[45]

[38] For example: Wales Online, 'Catastrophic' surge in A&E waits are 'compromising patient care' (2018), BBC, A&Es in Wales 'like a battlefield' (2018), ITV, 'Emergency care in Wales is in a state of crisis,' says senior A&E doctor (2017)
[39] RCEM, Sustainable Working
[40] HSJ, Beyond the official data: a different picture of A&E attendances (2014)
[41] GP Patient Survey (2018)
[42] BMJ, To GP or not to GP (2017)
[43] Nuffield Trust, Why extending GP hours won't solve the A&E crisis (2017)
[44] Stats Wales, NHS beds by organisation and site
[45] RCEM Wales submission to the Finance Committee's inquiry into the cost of caring for an ageing population (2018)




**54.** The NHS Confederation wrote in its written evidence: "a wide range of positive actions have been planned to further improve local and national resilience, including an increase in available bed capacity both in hospital and in the community". Despite highlighting that there were almost 400 additional beds or bed equivalents identified for last winter, it was not made clear how many more beds will be committed for winter 2018-19.[46]

**55.** It is also important to note that available beds can become superfluous if there aren't enough staff to manage them. In many cases, it is also not clear how many more beds there are, where those beds are situated and for how long.

**56.** Many Health Boards in their written and oral evidence also noted that there were an insufficient number of beds last winter, there were no firm commitments to increase bed capacity in the short or long term. This is mostly due to budget constraints.[47]

**57.** Having the correct number hospital beds, and the nursing staff on the wards to manage them, is important to tackle Exit Block and ED crowding. The College estimates that we need at least 250 more hospital beds in Wales to get occupancy rates back to safe levels.[48]

**Question 7. What are the key emergency medicine workforce challenges this forthcoming winter? For example, is there sufficient capacity across the Health Boards to ensure additional senior decision-makers are at the 'front-door' to promote early assessment and treatment?**

**58.** Emergency departments require a workforce of sufficient size and with the necessary number of senior decision makers to treat patients effectively and in a timely fashion.

**59.** Although the total A&E workforce has increase by 7% between 2014 and 2017[49] many of our Members and Fellows have reported feeling stressed or burnt-out at work. There are several reasons for this: a lack of resources in the rest of the system that creates difficult working environments; an insufficient number of middle grade emergency medicine staff; and too few emergency medicine consultants to keep up with demand compounded by existing vacancies.

---

[46] Meeting of the Health, Social Care and Sport Committee, 19 July 2018, Public Document Pack
[47] Health, Social Care & Sport Committee, Evidence session on winter resilience plans, 2018-19 (19/07/18) and Public Document Pack
[48] RCEM Wales, Vision 2020
[49] Stats Wales Medical and dental staff by grade and year

**60.** Whilst emergency medicine training posts at year one (ST1) have a 100% fill rate in Wales, only 67% of higher specialist training posts (ST4-6) in Emergency Medicine are being filled.[50]

**61.** Furthermore, the number of specialty doctors have decreased by 3.5% between 2014 and 2017, the number of senior house officers has diminished from 16.0 to 5.0 and the number of foundation house officers (2) has fallen by 21%.[51] This means that consultants are sometimes required to cover rota gaps of junior doctors.

**62.** To achieve safe, sustainable staffing levels, the College is calling for 100 extra emergency medicine consultants in Wales, and at least 20 extra emergency medicine training places per annum for four years.[52]

**63.** As well as aiding patient care, increasing the workforce should help to reduce the £13.6 million being spent annually by the Welsh NHS on agency, bank and locum doctors to cover staffing shortages in EDs.[53] It should also aid the recruitment and retention of staff and will help to ensure that there are enough senior decision makers at the front door.

**Question 8. How effective have fast track referral systems been in Welsh hospitals - where some patients bypass the emergency department, such as in paediatric services and mental health in terms of improving patient flow, reducing ambulance hand over delays and alleviating some pressure on emergency departments?**

**64.** The RCEM Wales has seen little evidence that fast track referral systems have noticeably reduced pressures on emergency departments. In fact, attendances have increased by 4.8% in the space of six years.[54]

**65.** This is partly because many fast track referral systems are not full time, seven days per week measures. Like our co-location concept, referral systems must be made available out of hours for the benefit to be realised.

**Conclusion.**

**66.** The situation laid out above is not a new phenomenon. Difficulties treating patients in a timely fashion because of a lack of available beds and social care in the community has been a feature of the Welsh and other UK health systems for some time. Planning must address the need to cope with rising numbers of the frail elderly – with complex interactions between health and social care and long-term co-morbidities. This solution requires significant planning and funding, but it is necessary for the sustainability of the Welsh NHS.

**67.** To address pressures in EDs this winter, the College recommends that Health Boards focus on Exit Block and DTOC. Promoting system-wide ownership of the four-hour target, ring-fencing emergency department space and perhaps boarding patients onto hospital wards during times of peak escalation might help to safeguard patients and increase flow. We also need to plan discharges earlier, within 48 hours of admission to a ward, to decrease cases of delayed discharges.

---

[50] Data provided by the Head of School for Emergency Medicine (May 2018)
[51] Stats Wales Medical and dental staff by grade and year
[52] RCEM Wales, Vision 2020
[53] Data released in 2017 revealed that Health Boards across Wales spent nearly £14m on agency, bank and locum doctors to cover shifts in emergency units during 2016.
[54] Stats Wales, Performance against 4 hour waiting times target