

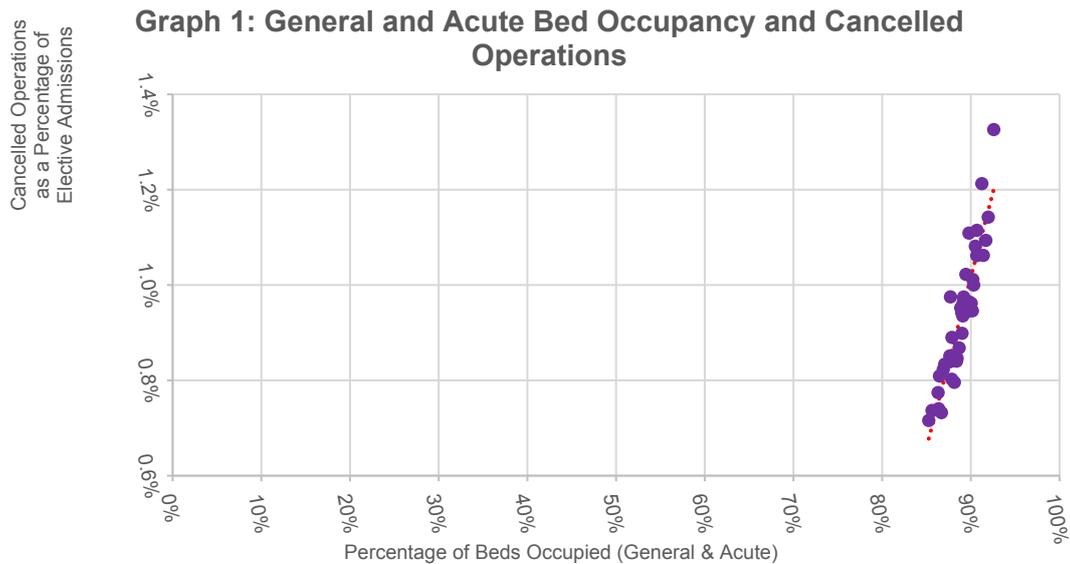
**Written evidence submitted by The Royal College of Emergency Medicine (RCEM)**

**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 (EDs) in the NHS in the UK and other healthcare systems across the world.

**The Link between the Elective Backlog and Emergency Demand**

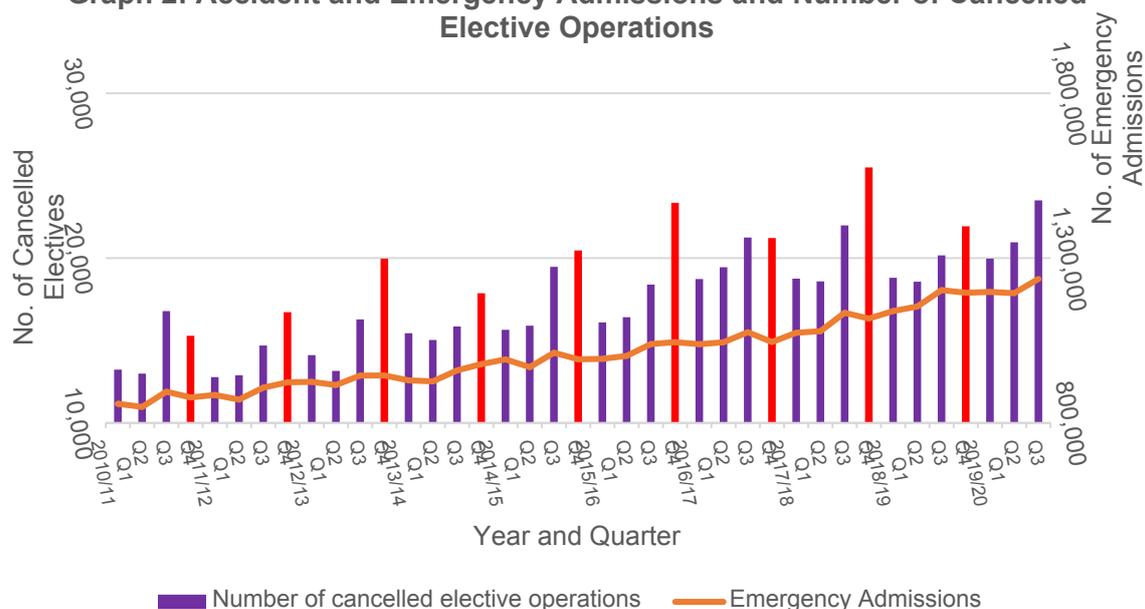
Before the pandemic, elective surgery was compromised every winter due to increased emergency demand and a lack of hospital capacity. Crowding and corridor care, which were experienced all year round in many departments, became increasingly dangerous. Graph 1 demonstrates the relationship between high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



ignored.

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 Quarters 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.

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



Not only is the scale of the backlog unlike previous years, but demand in EDs is increasing and performance is continuing to deteriorate. Since May 2021, each month has had the highest number of type 1 ED attendances for that respective month on record and admissions have returned to the same levels as 2018 and 2019. As of October 2021, the 4-hour target stood at only 61.9%, meaning that less than two thirds of ED attendances are admitted, transferred, or discharged within 4 hours.

Moreover, the 12-hour Decision to Admit (DTA) waits figure has substantially increased over recent months and in October 2021 it was at an all-time high at 7,059. This performance metric refers to the number of people that wait more than 12 hours from the decision made to admit them and does not account for the time they may have waited before this moment. This often means that patients are suffering long waits in an ED because there is not a bed available to them due to a lack of capacity in the hospital system. In 2021 so far, there have been 25,133 12-hour DTA waits, compared to 14,239 in 2020 and 8,262 in 2019. This significant increase shows that hospitals are facing capacity issues more than ever and this could have the potential to derail the elective recovery as beds become reprioritised for Urgent and Emergency care.

As shown above, there is a clear link between emergency demand and elective cancellations and therefore the increase in ED attendances coupled with the decline in performance poses a serious worry for the potential number of cancelled elective operations this winter and beyond.

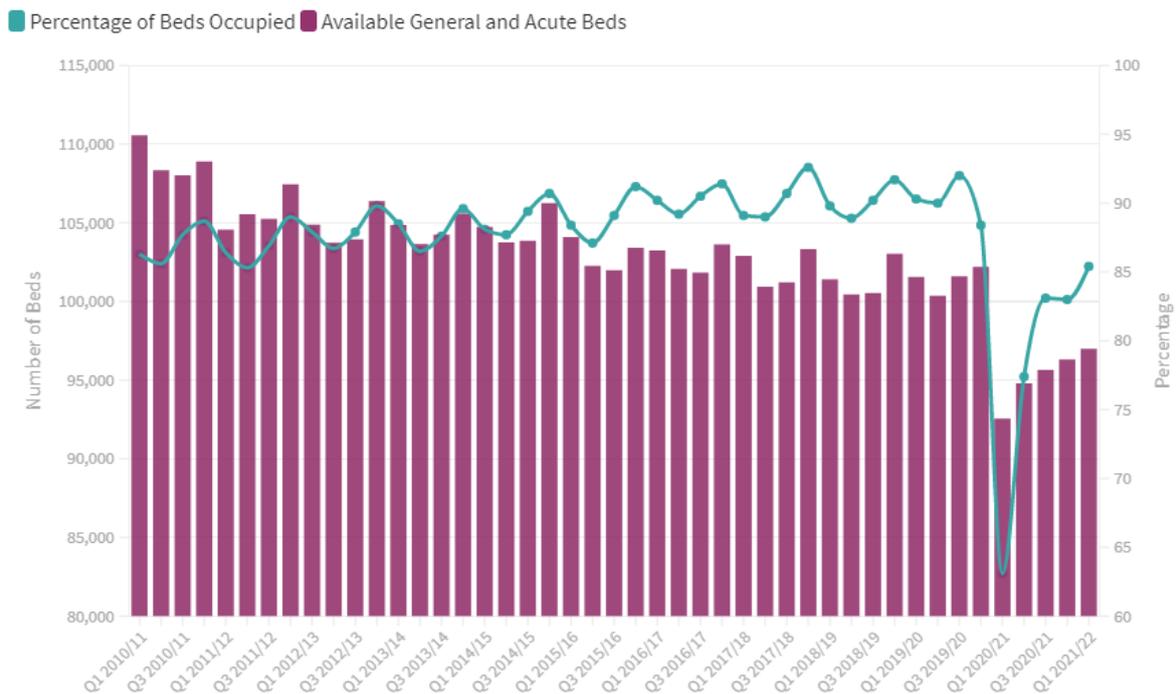
**Beds**

As graph 1 shows, bed availability is linked to the cancellation of elective operations and therefore there needs to be an adequate bed stock available to ensure that the elective backlog is not further derailed as we continue to move through the pandemic. However, hospitals are not in a strong position to do this due to the number of beds that have been lost over the past decade and, in particular, as a result of the pandemic. To keep patients safe from Covid, hospitals have been reconfigured, resulting in a loss of beds. 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 are slowly increasing again, hospitals are short of 4,000 beds compared to pre-pandemic levels. In the long term, bed numbers prior to the pandemic should not be seen as the standard that we need to return to, as bed occupancy levels have long been higher than what is deemed safe, putting strain on hospitals. To ensure that both elective and unscheduled patients receive the care that they need at the right time, bed numbers need to be expanded further to meet this demand.

### Graph 3.

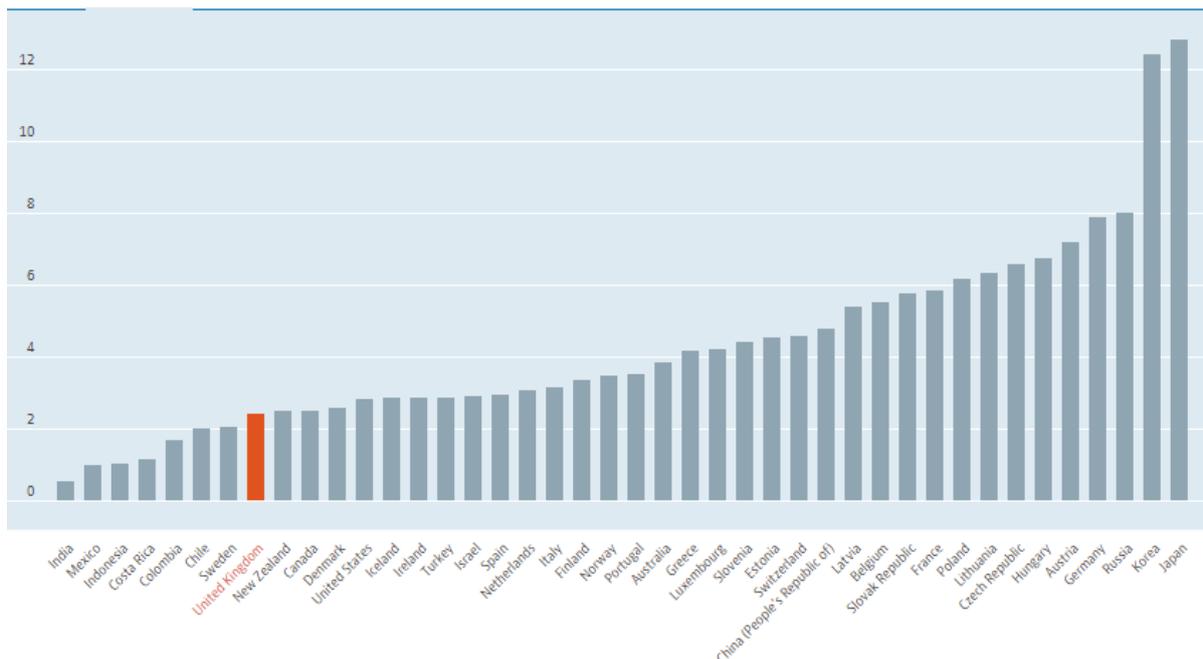
#### Bed Availability over the Past Decade



The UK has traditionally run its hospitals with relatively few beds per head and this has contributed to 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 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. Graph 4 shows that the UK has one of the lowest numbers of hospital beds per 1,000 inhabitants in OECD nations.<sup>1</sup> As of 2020, the UK had only 2.4 beds per 1,000 inhabitants. This figure has consistently decreased each year, standing at 2.9 in 2010 and 4.1 in 2000. Only Mexico, Colombia, Chile and Sweden have lower beds per capita in comparison to the UK. The lack of physical beds within the UK means that hospitals are less able to handle surges in demand and can become overwhelmed more easily, leading to patients staying in the ED for longer and an increase in elective cancellations.

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



**Graph 4. OECD (2021). Hospital Beds per 1,000 Inhabitants**

One of the main factors behind the lack of available hospital beds is inefficient discharge processes. There is a lack of integration, and funding, between the hospital system and social care sector, which often leads to delayed discharges for many patients. While medically fit to leave, patients may need help to recover in the form of a social care package, which may not be immediately available. This decreases hospital capacity as it means that the hospital bed is unavailable to the next patient, whether that be the patient waiting in the ED or the patient waiting for elective surgery.

In recent months, alongside an increase in crowding, the number of hospital beds occupied by people who are medically ready to be discharged has been steadily growing. The most recent figures show that levels are worse than winter 2020<sup>2</sup>. It is estimated that around 1 in 5 hospital beds are occupied by long-stay patients. The 'Discharge to Assess' models have proven helpful during the pandemic by freeing up beds in hospitals and reducing unnecessary long stays, but the recent increase in hospital stays shows that an expansion and greater investment in this service is needed. Timely discharges are essential to maintaining good flow in hospitals and ensuring that beds are available to all types of patients.

A longer-term restoration of hospital beds cannot happen without addressing the staffing crisis in the NHS. 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.

There is an urgent need to improve the 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. Data from RCEM's snapshot surveys of clinical leads conducted in November 2021 found that 13% of clinical

<sup>2</sup> HSJ (2021). <https://www.hsj.co.uk/commissioning/sustained-rise-in-long-stay-patients-stuck-in-hospital-leaked-figures-reveal/7030675.article>

leads in England reported no effective SDEC in their Trust and 48% reported limited SDEC available, less than 12 hours a day or weekdays only.<sup>3</sup> Expanding SDEC provision will help to ensure admissions are reserved for only those who need inpatient care.

### **The effect of the pandemic going forward**

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>4</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.

The cancellation of all elective procedures at the beginning of the pandemic has further exacerbated demand in EDs. Alongside fewer patients being treated, 6 million fewer people were referred into consultant-led elective care in 2020 compared to 2019.<sup>5</sup> It is highly likely that many people are now attending EDs because their conditions have significantly worsened due to the lack of clinical oversight. People are not only presenting to EDs due to complications relating to their delayed procedures but those who delayed accessing healthcare last year as a result of the pandemic are now attending EDs again with potentially more serious issues.

The Academy of Medical Sciences report on winter 2021/22 highlighted Outbreaks of RSV in the autumn and influenza in the winter could be around twice the magnitude of a 'normal' year and might overlap (at least partially) with a peak in COVID-19 infections. Circulation of flu and RSV were very low during winter 2020/21 due to lockdown restrictions and social distancing, so there is an increasing chance that these respiratory infections could re-emerge more strongly as we move into the winter months due to diminishing population immunity.<sup>6</sup>

A generalised increase in respiratory infections over the autumn/winter could place enormous pressures on NHS capacity. In recent years, between approximately 10-30,000 deaths a year have been associated with influenza in England. The winter of 2017/18 was the most recent significant influenza season, with approximately 26,000 deaths associated with influenza in England. During this time, the NHS experienced the following pressures:

- A 5% increase in attendances when compared to the winter of 2016/17.
- Over 163,000 ambulances were delayed in handing patients over to A&E by 30 minutes or more. This equates to an average of about 1,800 per day or 13% of all ambulances arriving during that time period.

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<sup>3</sup> RCEM (2021). Data and Statistics. Available [here](#).

<sup>4</sup> Ayoubkhani D, Khunti K, Nafilyan V, Maddox T, Humberstone B, Diamond I et al. (2021). Post-covid syndrome in individuals admitted to hospital with covid-19: retrospective cohort study. BMJ: 372

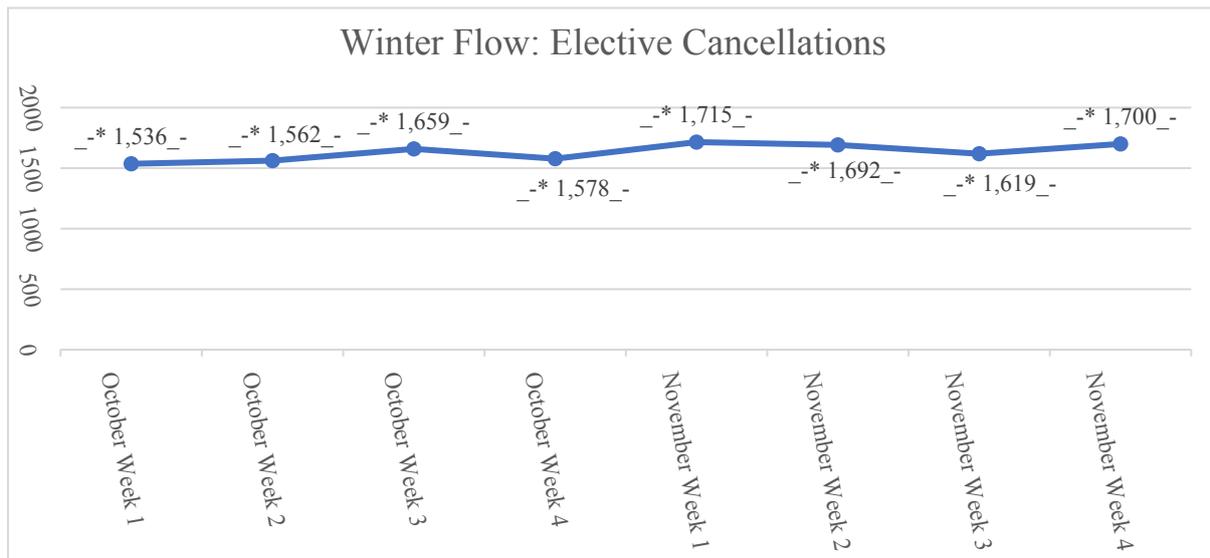
<sup>5</sup>The Health Foundation (2021). <https://www.health.org.uk/news-and-comment/charts-and-infographics/how-is-elective-care-coping-with-the-continuing-impact-of-covid-19>

<sup>6</sup> Academy of Medical Sciences (2021). [Winter viruses and COVID-19 could push NHS to breaking point, warns new report | The Academy of Medical Sciences \(acmedsci.ac.uk\)](#)

- All elective operations were cancelled in January 2018 and the NHS performed 62,000 fewer NHS treatments, including surgical operations, when compared to the previous winter.

Therefore, 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.

### **Elective cancellations this winter**



Data from RCEM's Winter Flow Project 2021/22 reveals that in November 2021, 6,726 elective care operations were cancelled and in October 2021 6,335 elective care operations were cancelled. These cancellations occurred at just 40 hospitals across the UK, so these cancellations are an underestimate of the true scale of the problem. On the whole, the number of elective cancellations each week are slowly increasing, implying that this issue is only going to get worse over the winter months. Tackling the NHS backlog needs to be considered in conjunction with rising emergency demand to ensure that the backlog does not get further derailed.

### **RCEM's recommendations**

We cannot address the elective backlog without addressing the pressures facing the Urgent and Emergency Care system. Our RCEM CARES<sup>7</sup> campaign provides solutions to address these pressing issues so that ED staff can deliver safe and timely care for patients. The campaign focuses on five key areas: Crowding, Access, Retention, Experience, and Safety. Our key asks of the Government include:

- Provide 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.
- Safely restore staffed bed capacity to pre-coronavirus levels in order to achieve a desirable ratio of emergency admissions to beds. In the medium term, an additional 7,170 beds are required across the UK.

<sup>7</sup> RCEM (2021) RCEM CARES: The Next Phase. Available [Here](#).

- Publish a new, actionable, long-term health and social care strategy to enable the delivery of high quality Urgent and Emergency Care.
- 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.
- 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. 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.

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