The Royal College of Emergency Medicine

# RCEM Winter Flow Project

## Analysis of the data so far: 1st March 2019

# Introduction

In 2015, we launched the 'Winter Flow Project' in an effort to highlight the difficulties facing an NHS struggling with unprecedented financial difficulties and insufficient resources.

The project looked at patient flow within Emergency Departments over the winter. It was a great success because of the generosity of its contributors, with over 50 NHS Trusts and Health Boards from across the UK submitting data over a six-month period. These data helped to provide a better understanding of system pressures and four-hour standard performance.

The findings enabled RCEM to broaden the debate around emergency medicine beyond the usual narrow focus on the four-hour standard and meant that providers, commissioners, the national press and governments in each of the four countries of the UK were better informed about the challenges faced by staff working on the NHS frontline.

The project has proven invaluable and is now in its fourth year. In our view, the project has also been instrumental in making the case for additional resources for the health sector; which is now reflected in the new settlement for the NHS which has recently been announced by the Government.

As was the case in previous years, each participating Trust/Board has submitted weekly data on attendances, four-hour standard performance, delayed transfers of care and cancelled elective operations. In an effort to reflect on-going staff shortages, we have also asked participating providers to tell us how many locum and agency staff are working in their Emergency Departments. This staffing measure is now in its second year. These data points together better reflect pressures, constraints and consequences for system performance.

The data are aggregated to ensure the focus of consideration is the wider health care system rather than the performance of individual Trusts/Boards. Over 50 Trusts/Boards have submitted these data on a weekly basis since the beginning of October.

Published on a Friday of the week following data collection, the summary data provide a current overview of 'winter pressures'. The College is grateful to the participants who represent Trusts/Boards of all sizes and geographical locations.

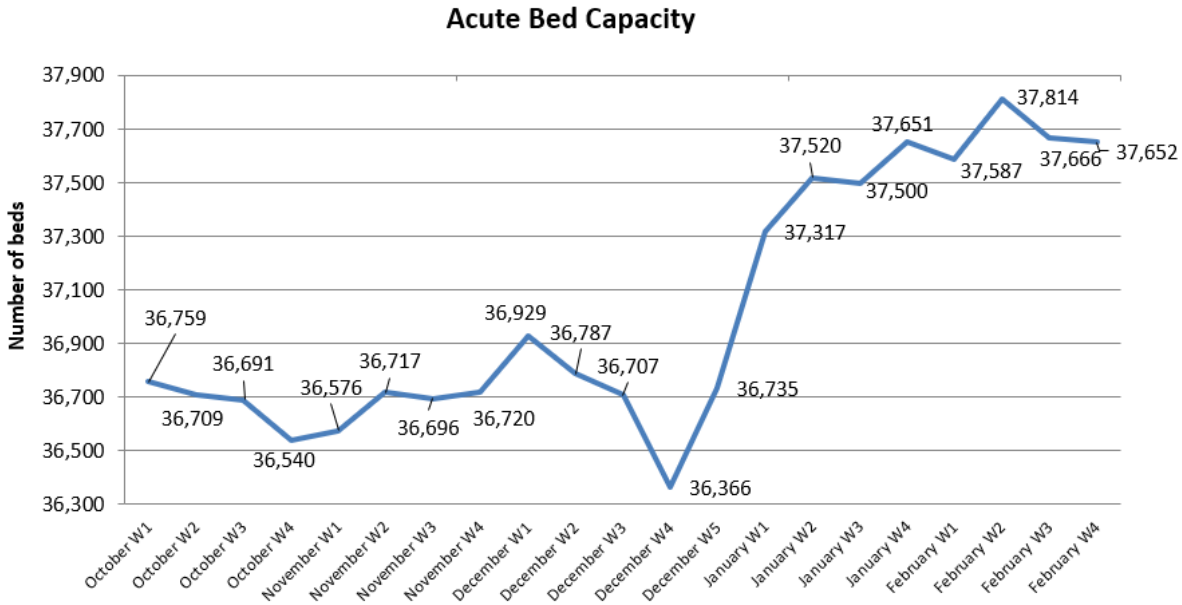
Unlike NHS England datasets, there is no suggestion that our project represents a complete or permanent scrutiny of the healthcare system. Our data include all four countries of the UK, although the majority of participating sites lie within England. It is just a sample of Trusts/Boards, albeit a large and representative one.

The data have already been of immense value to the College and allow informed comment and analysis rather than speculation.

The weekly data and trend data are presented in the following tables.

Published 01 March 2019

## Graph of acute beds in service




## Active Bed Management

In the fourth week of February, the number of beds within the project group decreased to 37,652 – down from 37,666 the previous week. In total, there has been a 4.5% increase in the aggregate bed stock from the project starting point.

The extent to which the participating Trusts/Boards are adjusting their bed stock to meet demand is shown in the table below.

| | No flexing | 0 – 5% | 5 – 10% | 10 – 15% | 15 – 20% |
|---|---|---|---|---|---|
| Number of sites | 3 | 17 | 16 | 11 | 7 |

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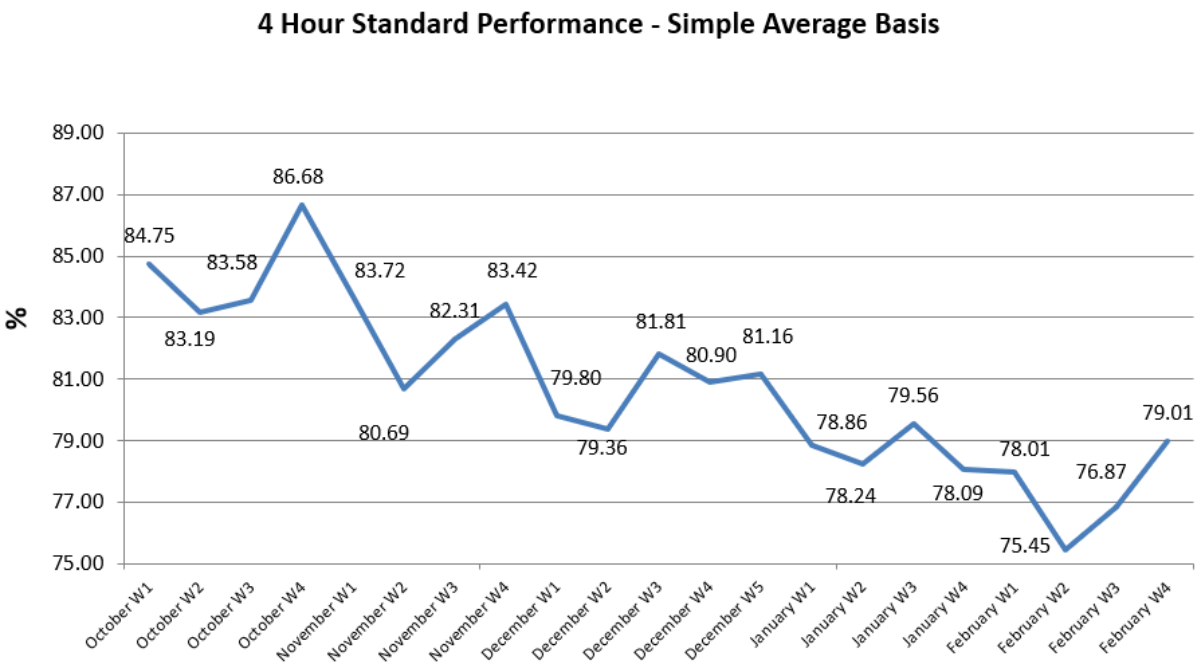
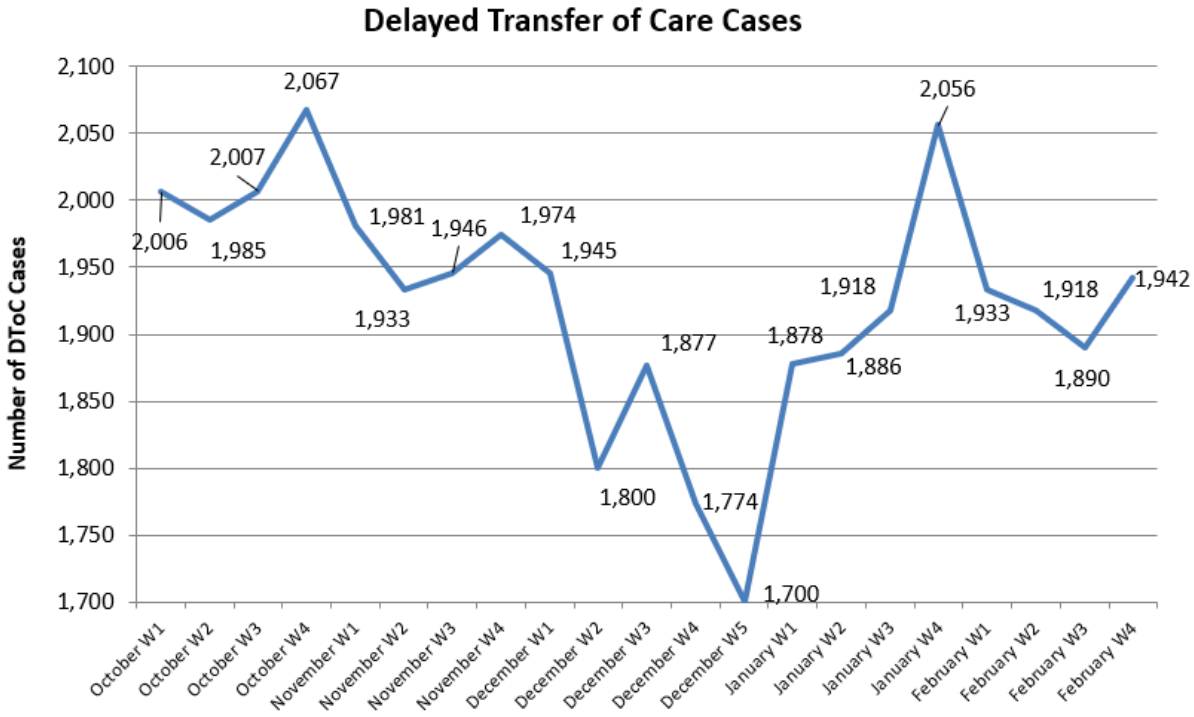
## Graph of four-hour performance by week since October




In the fourth week of February, four-hour standard performance stood at 79.01% - up from 76.87% the previous week. The underlying picture shows 34 increases and 14 decreases across the project group.

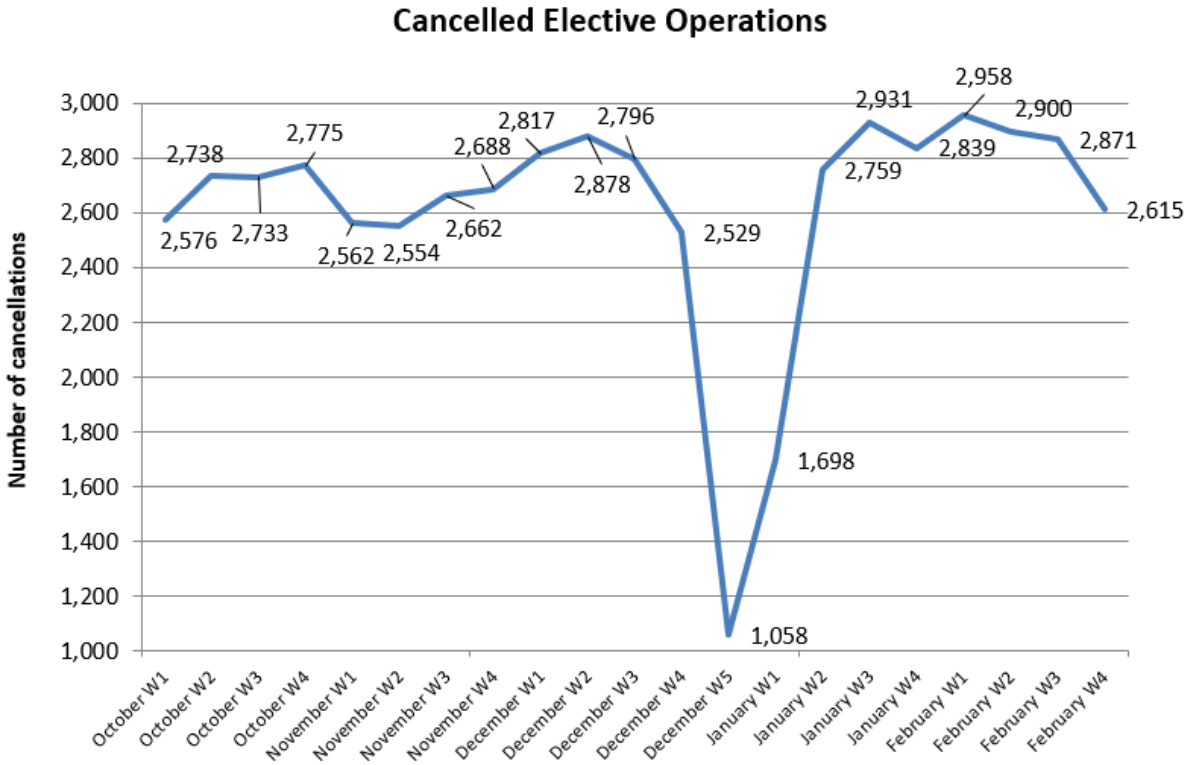
## Graph of Delayed Transfers of Care (DTOCs) by week since October




The number of patients subject to DTOC in the fourth week of February was 1,942 – up from 1,890 the previous week. This translates to 5.16% of acute bed stock - up from 5.02% the

previous week. The range across all contributors for this week is a minimum 0.00% to a maximum 22.4%.

**Graph of cancelled elective operations since October**




A total of 2,615 elective operations were recorded as cancelled this week – down from 2,871 the previous week. A total of 54,937 elective operations have been cancelled over the project to date. This represents an overall average of 49 cancelled operations per site per week over the project as a whole.

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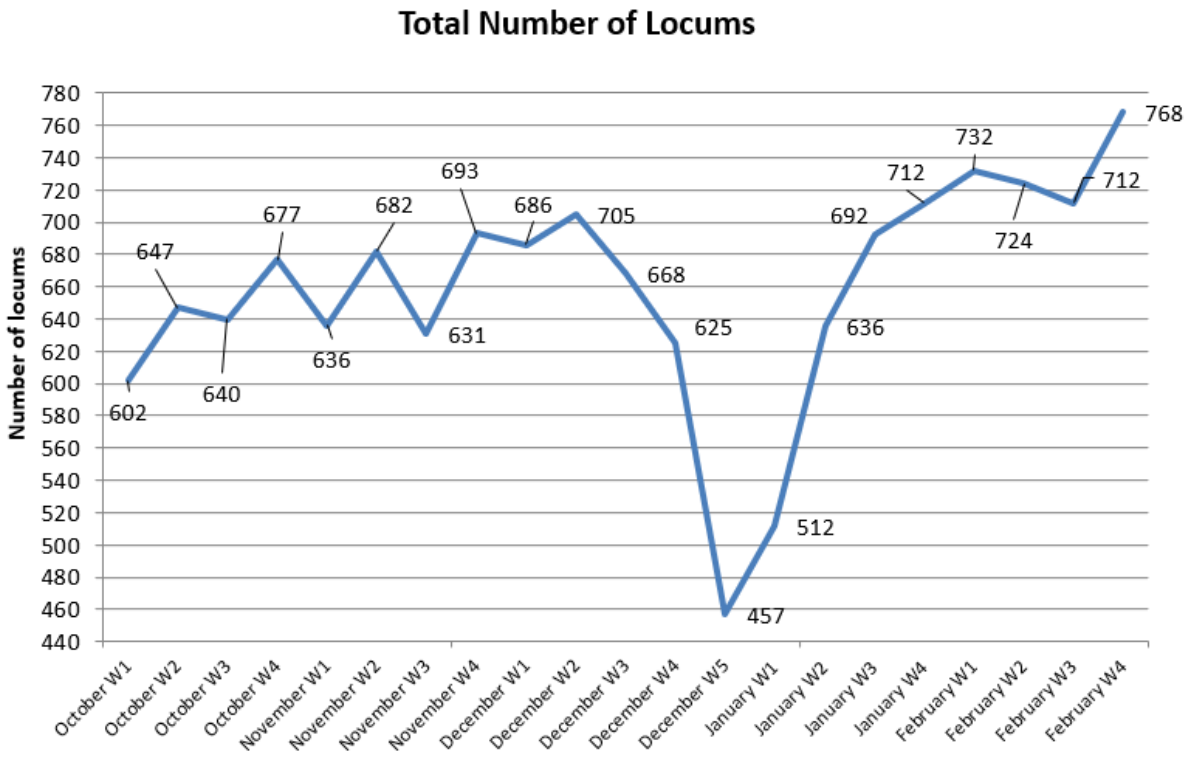
**Graph of number of locum and agency staff since October**




In the fourth week of February, the number of locum and agency doctors and nurses employed within Emergency Departments within the Winter Flow Project group stood at 768 up from 712 the previous week.

## Overall

The Winter Flow data reported this week shows a welcome improvement in four-hour standard performance. At 79.01%, performance is 2.14 percentage points higher than was the case the previous week and at its highest point since the third week of January. In fact it is ironic that – if The Times newspaper is to believed[1] – the Government has chosen the very day in which the Winter Flow Project records the biggest weekly improvement four-hour performance this year (2019) to announce that they intend to scrap the four-hour standard for emergency departments.

In the four years that the Winter Flow Project has been in operation we have seen a steady, if not entirely uniform, decline in four-hour standard performance. By way of illustration, at this point in 2015-16 four-hour standard performance stood at 83.93%. But as we have argued consistently, this is not the fault of the patients, the staff that work within Emergency Departments or the hospitals that employ them. This is the result of a systematic under resourcing of the secondary care sector and a lack of acute beds which had meant it has been unable to keep pace with changes to both the level and complexity of patient demand.

[1] Times: Four-hour waiting limit for A&E to be scrapped
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However, this should not be taken to mean that the four-hour standard is without value, or that it is not in the interest of those same patients who our Emergency Departments are there to treat. Previously changes to performance thresholds have led to near immediate and sustained deteriorations in performance and both patients and staff have had to deal with the consequences.

In 2014 the Royal College of Emergency Medicine concluded that:

> *"Before the introduction of the four-hour standard, resources available to A&Es were grossly inadequate. This standard protects all A&E patients."*[2]

That statement is as true today as it was five years ago. The Government appears to be proposing a target which will only apply to those most vulnerable patients who require admission. The rationale for this being that these most vulnerable patients should be prioritised and that they are not being prioritised at the moment. As we have stated repeatedly, this is not the case, the most vulnerable patients are *always* prioritised, and it is a mathematical certainty that removing large numbers of lower acuity patients from this or similar performance measure(s) will make any time-based target harder to hit. We also have concerns for those patients whose conditions are not easy to diagnose and how they will be looked after in these plans.

It is also worth stating that the way the Government has resourced the system has made hitting the target more difficult in a number of different ways. The idea that insufficient acute beds leads to vulnerable patients facing long waits languishing in corridors is easy to grasp and conceptually straightforward. This has been labelled the 'Exit Block' theory and even the NHS's own Strategy Unit has recently acknowledged its validity.[3]

What is less obvious, as the NHS Strategy Unit also highlighted only a few days ago,[4] is that as bed pressures and admissions thresholds have increased, clinical practice has changed in a way that means we now spend more time testing patients who might otherwise have been admitted, in an effort to keep them out of the hospital. What this means is that waiting times have increased as a result.

Whilst we are open to discussing the clinical quality indicators that could be developed to enhance the treatment of patients, it remains our view that the real solution to these problems is to properly resource the system so that these targets can be achieved. In that way we can ensure the highest standard of care for the patients that our NHS exists to serve.

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[2] RCEM Challenging the myths around A&E to rebuild emergency care 2014.
[3] Waiting Times and Attendance Durations at English Accident and Emergency Departments
[4] Waiting Times and Attendance Durations at English Accident and Emergency Departments
Published 01 March 2019