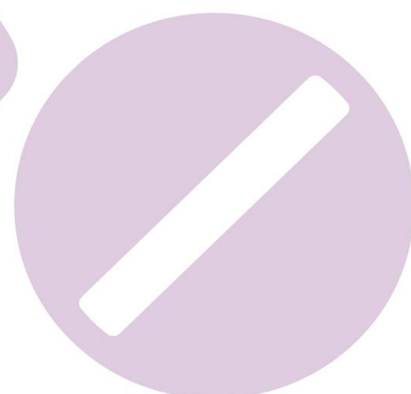
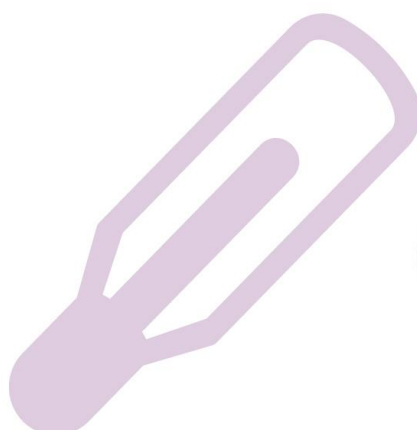


RCEM Winter Flow Project

Interim Report: 28th February 2018



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 nations 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 third year. 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. This data together better reflects pressures, constraints and consequences for system performance. However, in an effort to reflect on-going difficulties in recruiting sufficient numbers of permanent staff, the project this year has also asked participating providers how many locum and agency staff are working in their Emergency Departments.

The data is 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 this 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 includes all four countries of the UK though the majority of participating sites lie within England. It is a just sample of Trusts/Boards, albeit a large and representative one.

The data has already been of immense value to the College and allows informed comment and analysis rather than just speculation.

The project has now reached the half-way point and it is therefore timely to summarise the data and our findings.

Royal College of Emergency Medicine

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56 locations are contributing to the project. The nation analysis of contributors is as follows:

England	Scotland	Wales	Northern Ireland
48	1	3	4

As an indication of size, the bed capacity of the contributing sites ranged from 160 to 1,849.

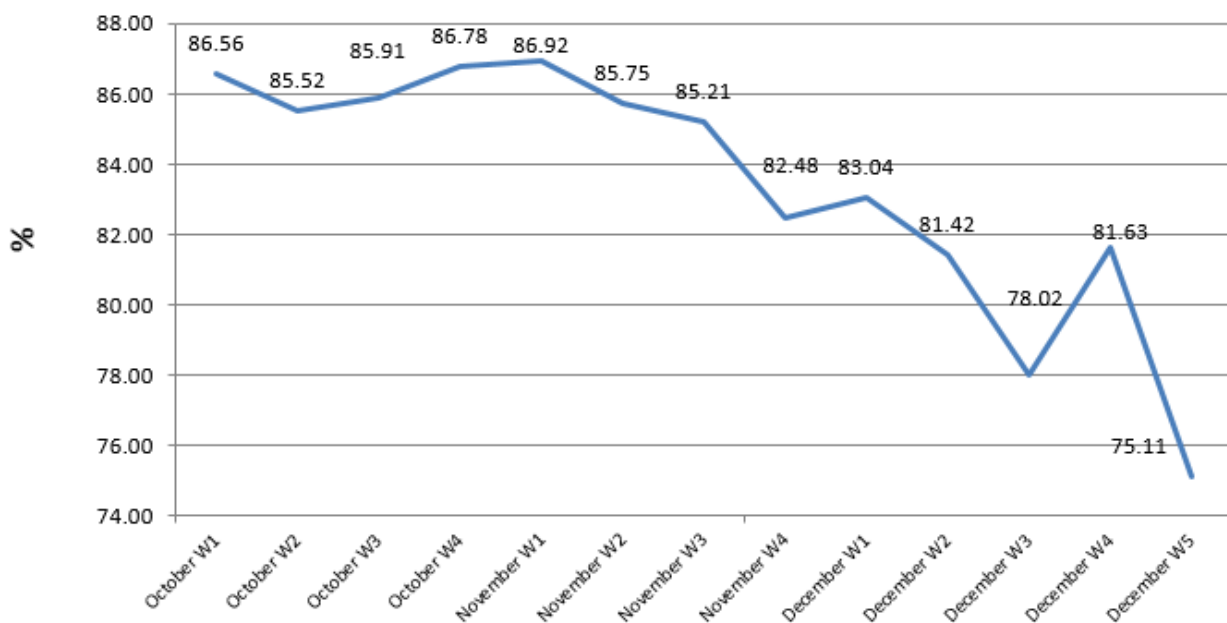
The five measures reported on a weekly basis were;

- 4-hour performance
- Acute bed stock
- DToC (Delayed Transfers of Care) instances
- Cancelled elective operations
- Locum numbers (qualified doctors and nurses)

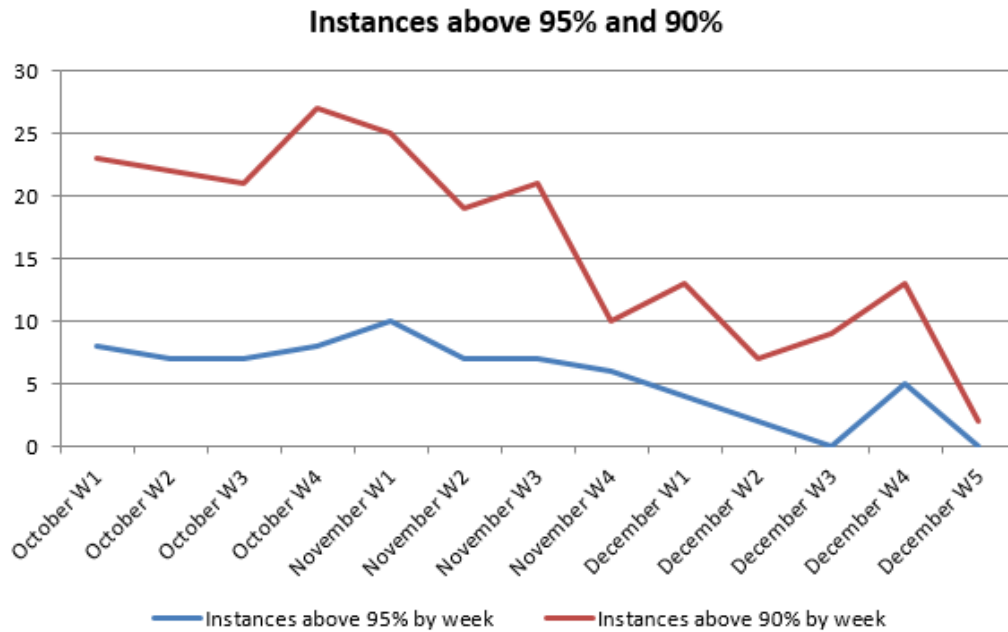
4 Hour Performance Standard

56 sites each contributed 13 consecutive 4-hour performance scores. The range of performance against the Four-Hour Standard was 51.16% to 99.47%, with an overall average of 83.41%. The overall weekly trend was as follows:

4 Hour Standard Performance - Simple Average Basis



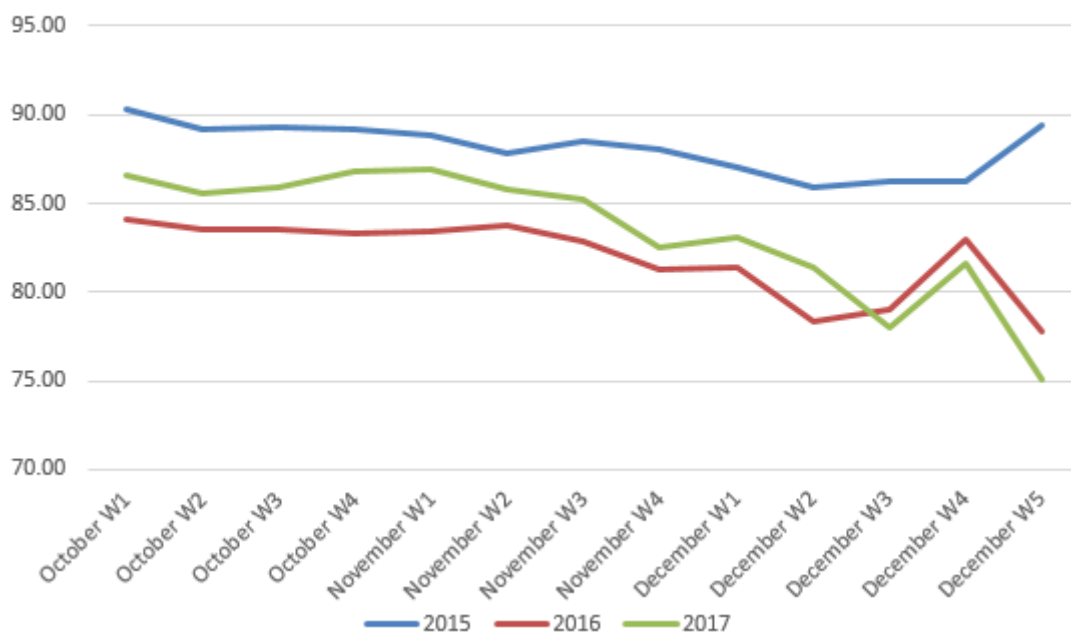
Three sites achieved an average of 95% Four Hour Performance over the 13 week period but not one achieved this target every week. The best performing site recorded 11 weeks at over 95% and two at over 90%. However, 10 sites averaged over 90% for the 13 week period.



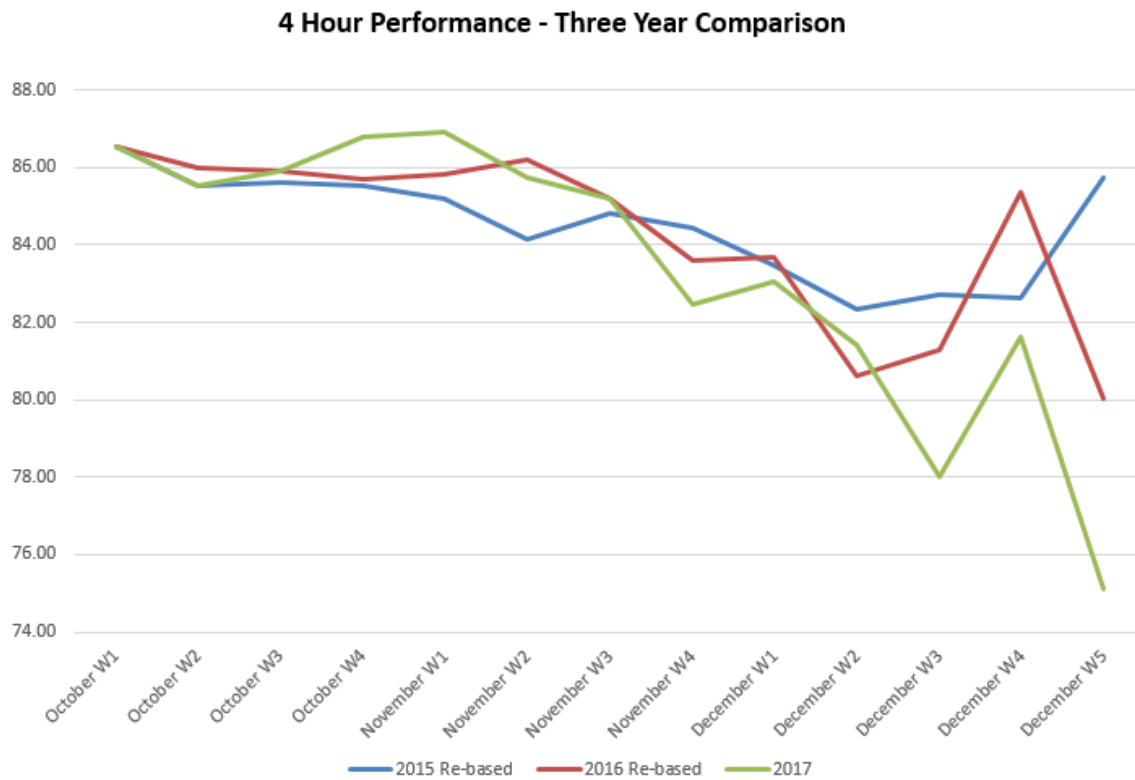
The above chart shows the number of locations achieving the 95% target compared to a 90% performance level on a weekly basis.

The picture to emerge over the three seasons of the Winter Flow Project to date is as follows:

4 Hour Performance - Three Year Comparison

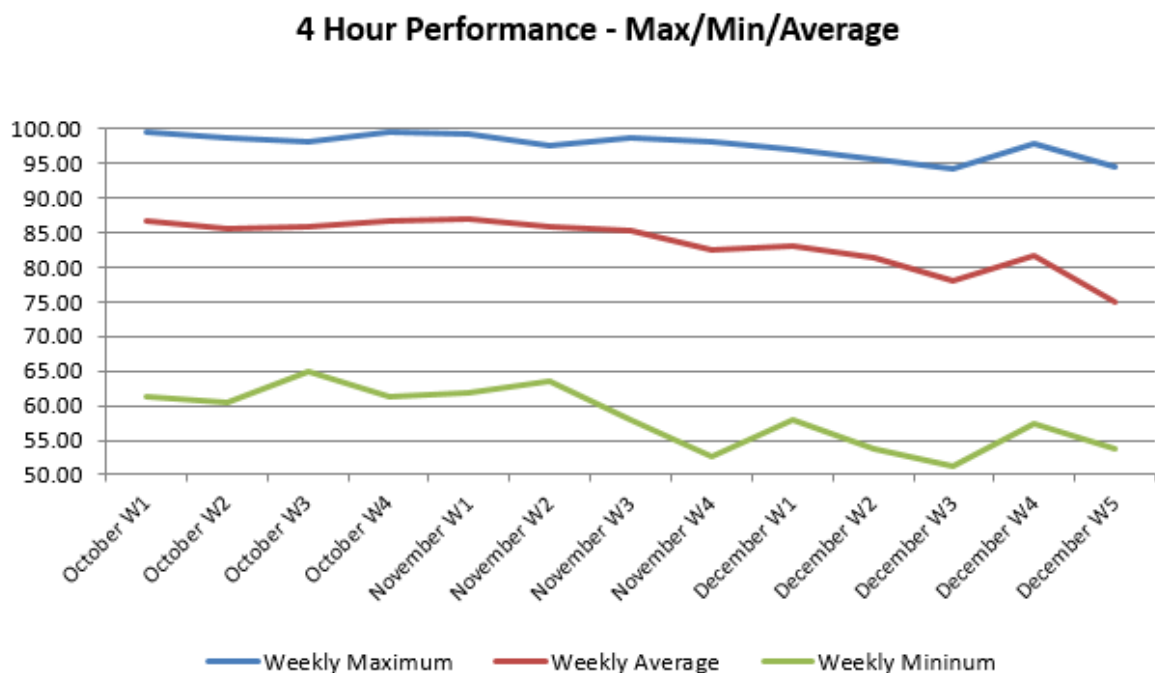


These figures can also be expressed by adjusting the previous years' figures to a common start point. In this way the relative performance may be compared over the three years. The following chart demonstrates this.



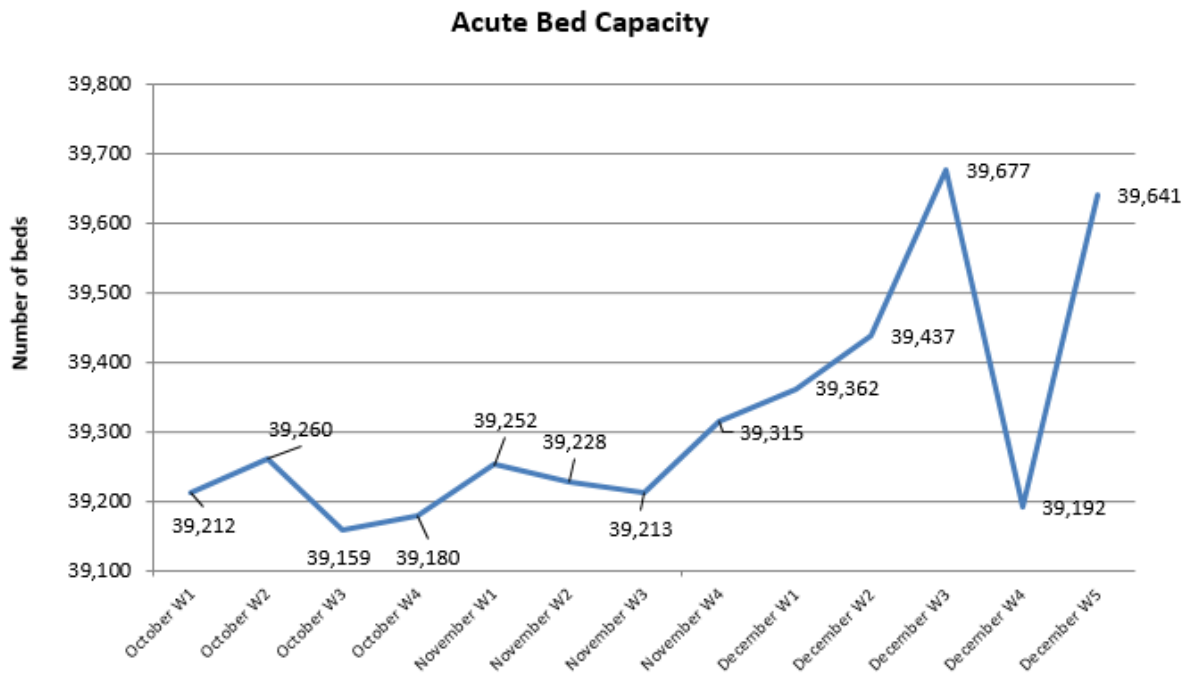
Performance over the first seven weeks of this winter was relatively strong. However, the subsequent decline was more pronounced than in previous years.

Comparing the weekly maximum, the minimum and average four-hour standard performance of the total population shows the following results:



Acute Bed Stock

The overall profile of bed stock over the period was as follows:



Over the course of the 13 weeks the increase in total bed stock was 1.1%.

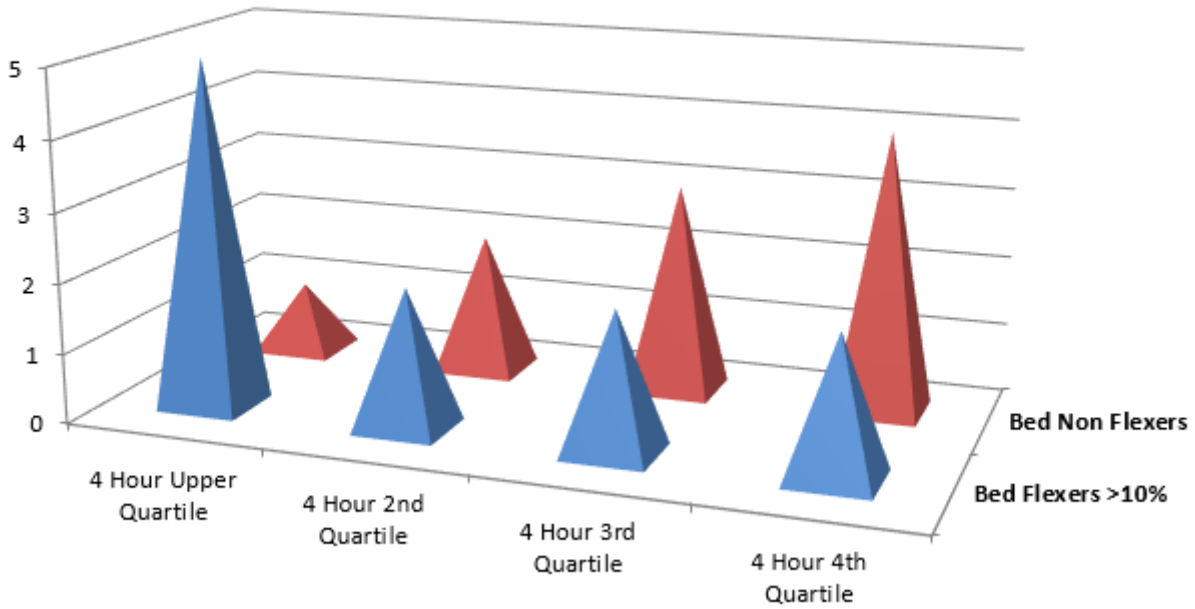
Acute Bed Stock Flexing

The extent to which the individual participating sites flexed their bed stock (minimum to maximum) to meet demand is shown in the table below:

	No flexing	0 – 5%	5 – 10%	10 – 15%	15%+
Number of sites	10	19	16	6	5

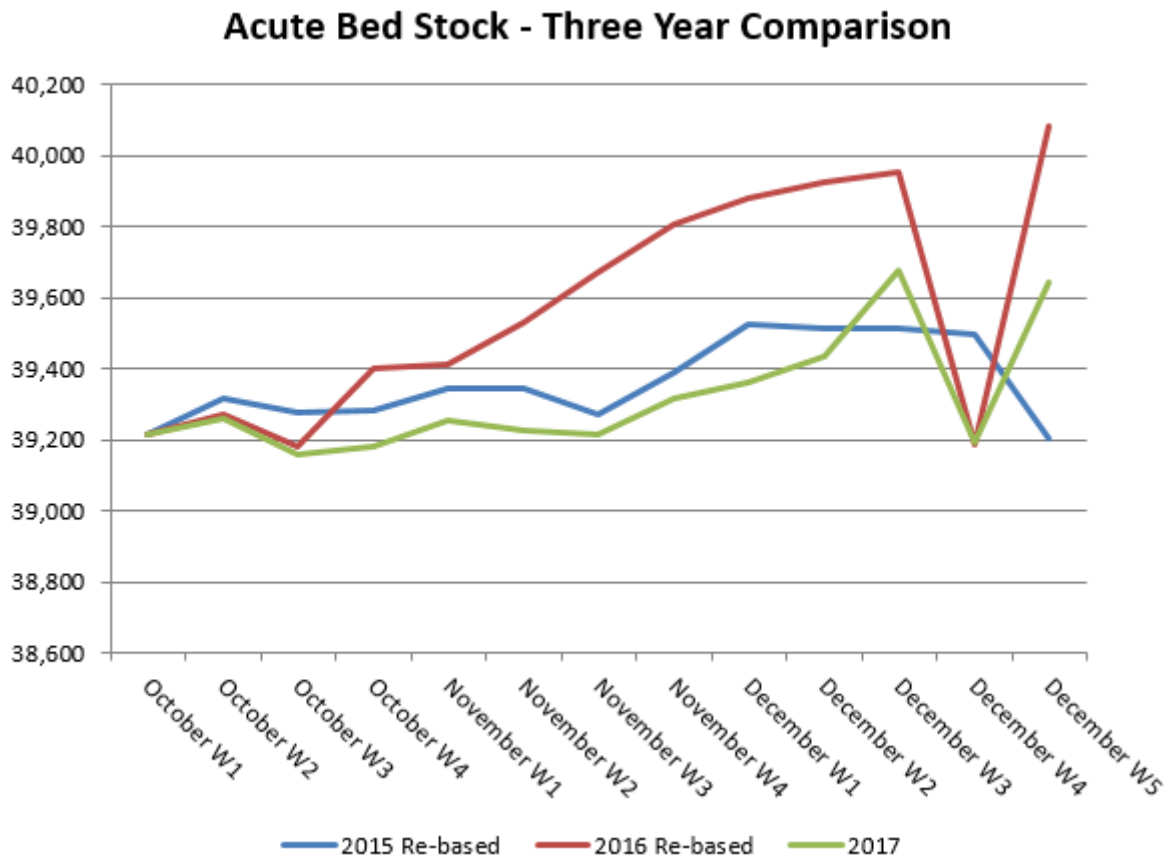
The following chart compares the largest bed-flexers (>10%) and the sites which have not flexed their bed capacity at all with their quartile performance in the four-hour measure.

Bed Flexing Compared to 4 Hour performance quartile



What this shows is that those sites which flex their beds to an extent greater than 10% performed better as a cohort than those that did not flex bed stock at all.

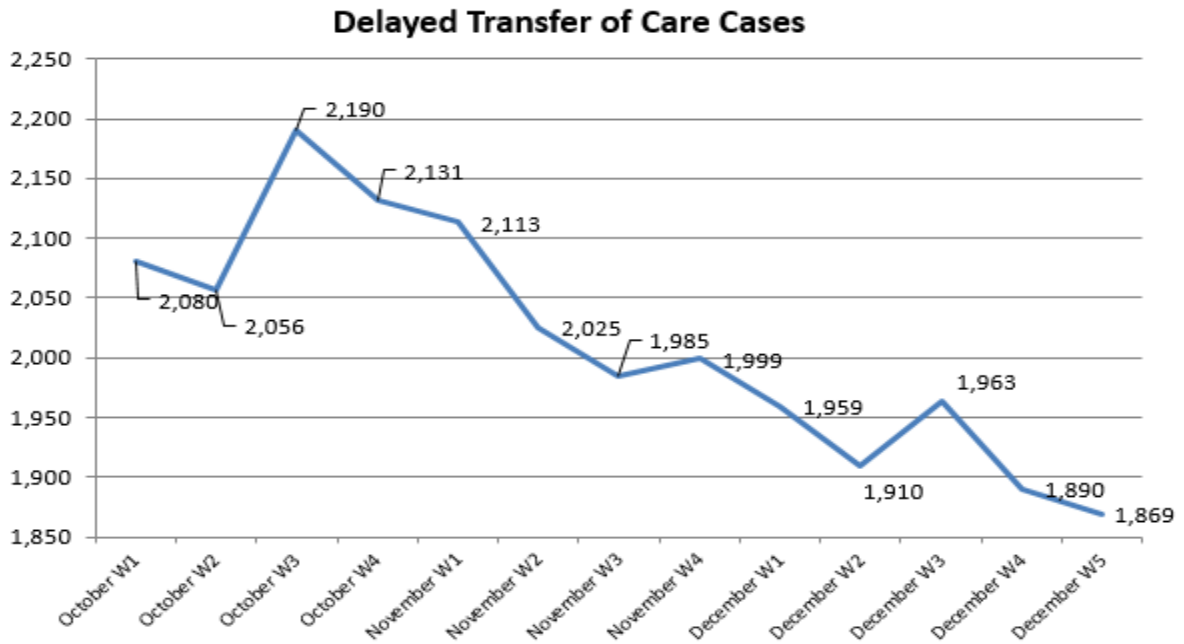
If the bed stock figures for the past three winters were adjusted to show the movement for each year from a common starting point, the following picture emerges:



The above chart demonstrates that, although the total number of beds at week thirteen was in between the numbers of 2015 and 2016, the rate at which bed stock was increased over the current winter was slower than in the previous two winters. This indicates – as we will see further below – that available bed stock has been more constrained than in previous years.

Delayed Transfer of Care – DToC

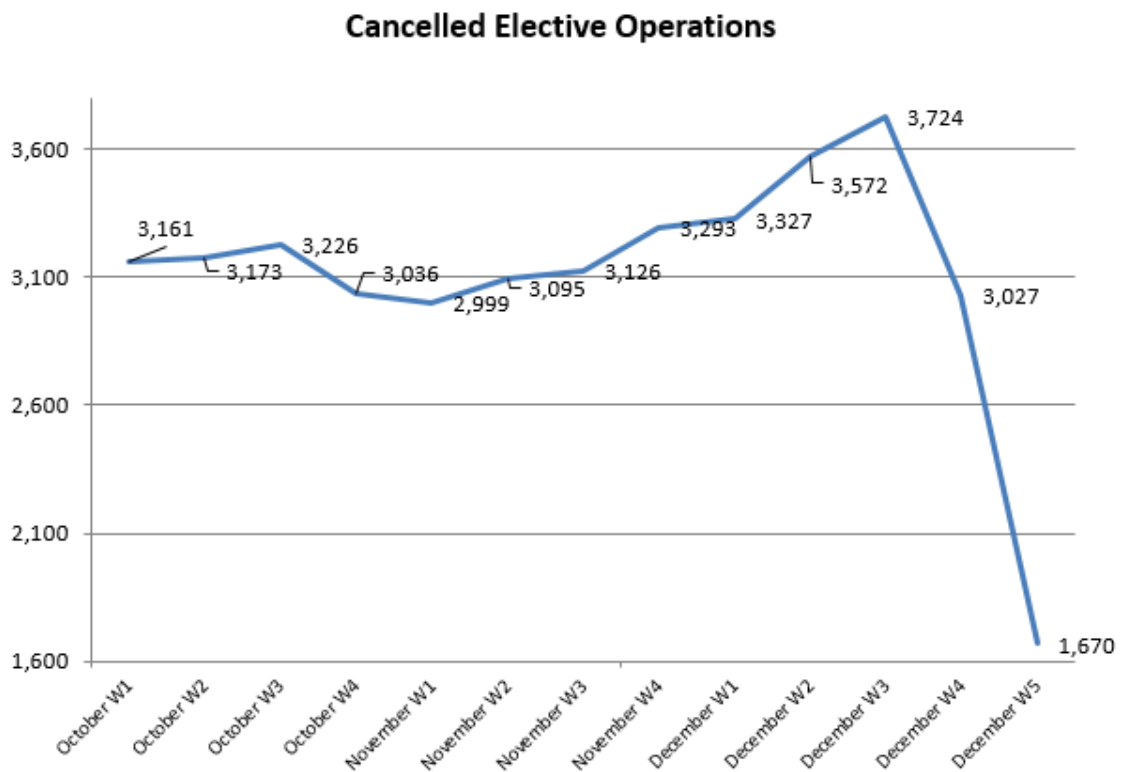
The overall picture of DToC was as follows:



The overall proportion of acute beds occupied by DToC patients has averaged 5.1%.

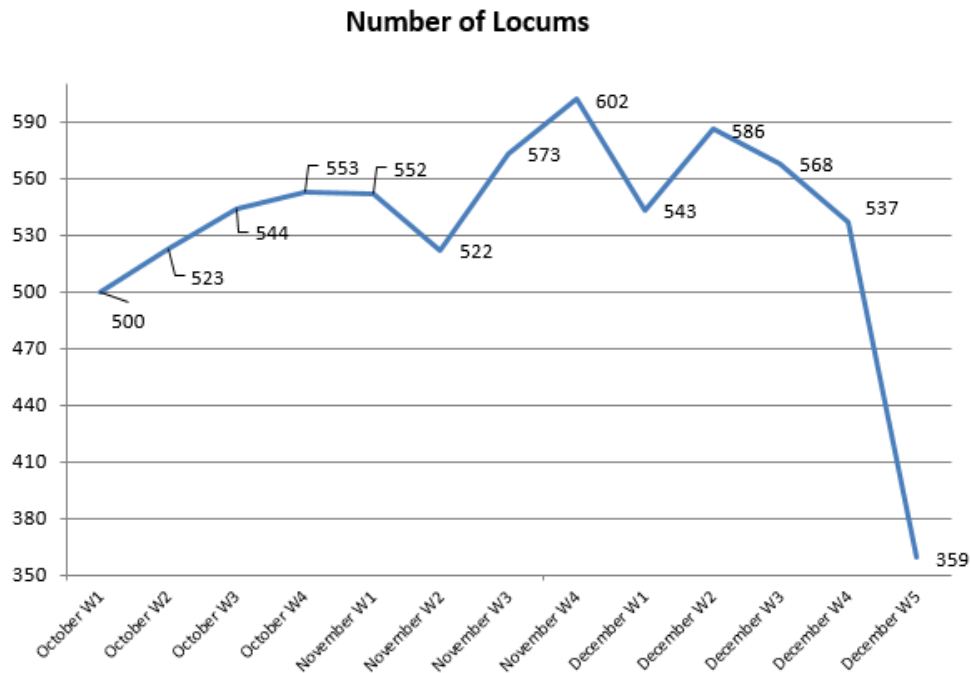
Cancelled Elective Operations

The overall picture for Cancelled Electives was as follows:



Locums Engaged – Qualified Doctors and Nurses

The overall picture was as follows:



Further Analysis

The Winter Flow Project is intended to allow the Royal College and others to comment on ED performance using data which is published more contemporaneously than many of the datasets released by NHS England. It is also intended to broaden the debate around emergency medicine by pointing out that four-hour standard performance is affected by other factors which impact the availability of hospital beds.

While there are significant difficulties in presenting this point in a single chart, considered on the level of individual contributors, the data collected so far illustrates this quite clearly. Those Providers who are more able to manage their bed provision through flexing their available bed stock and minimising the number of patients subject to Delayed Transfers of Care, also tend to have lower percentages of cancelled elective operations and better four-hour standard performance.

And it is only fair to point out that in terms of measures that support patient flow, Providers throughout the UK have had some considerable success in reducing the number of patients subject to Delayed Transfers of Care. In fact, at 5.1%, DTOCs as a percentage of available beds is considerably lower than was recorded by last year's Winter Flow Project at the same point (6.4%).

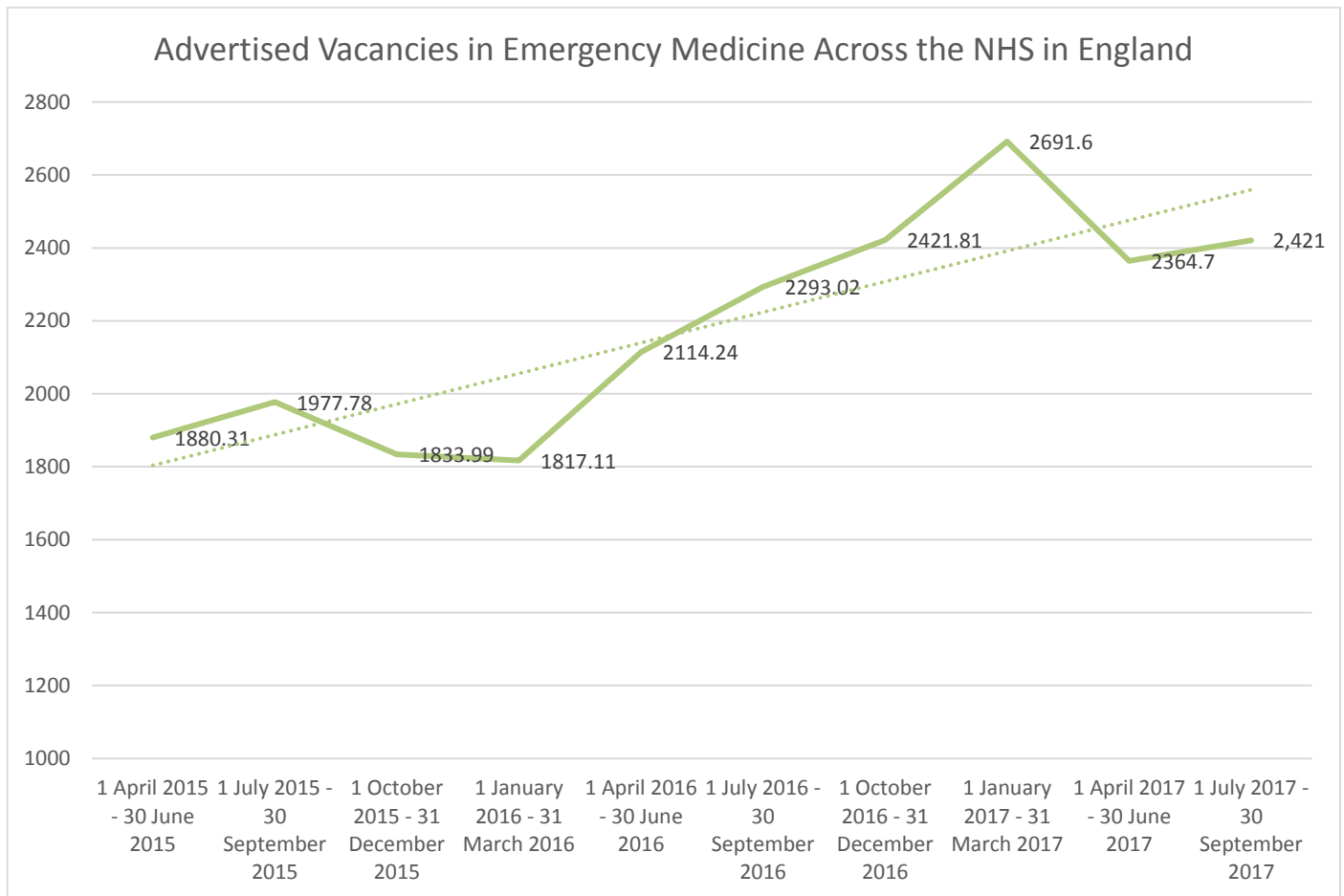
Moreover, in terms of four-hour standard performance, at the beginning of October there was some room for cautious optimism. 2017-18 Type 1 performance across the project contributors stood at 85.56%, this is 1.42 percentage points better than had been the case

the previous year (84.14%). Not only that, but the performance figures recorded by Winter Flow remained slightly ahead of the previous year until the second week of December.

Yet despite these positive signs, by the end of December performance had dipped to 75.11% which is 2.69 percentage points than had been the case at the same point in the previous year (77.80%). Data published by NHS England and NHS Improvement presents a similar picture. Overall recorded performance in Quarter 3 declined from 81.92% in 2016-17 to 81.77% in 2017-18.¹

So far so familiar, Emergency Departments are in the grip of yet another winter crisis, and as has been said in previous years, this winter appears to be even worse than last year. So why is performance still deteriorating?

The first point to make is that Emergency Departments, like the wider NHS are in the grip of an acute staff shortage. The latest workforce data published by NHS England showed that there were at least 2,421 unfilled vacancies for ED clinicians in September 2017 and the problems appears to be getting worse.²

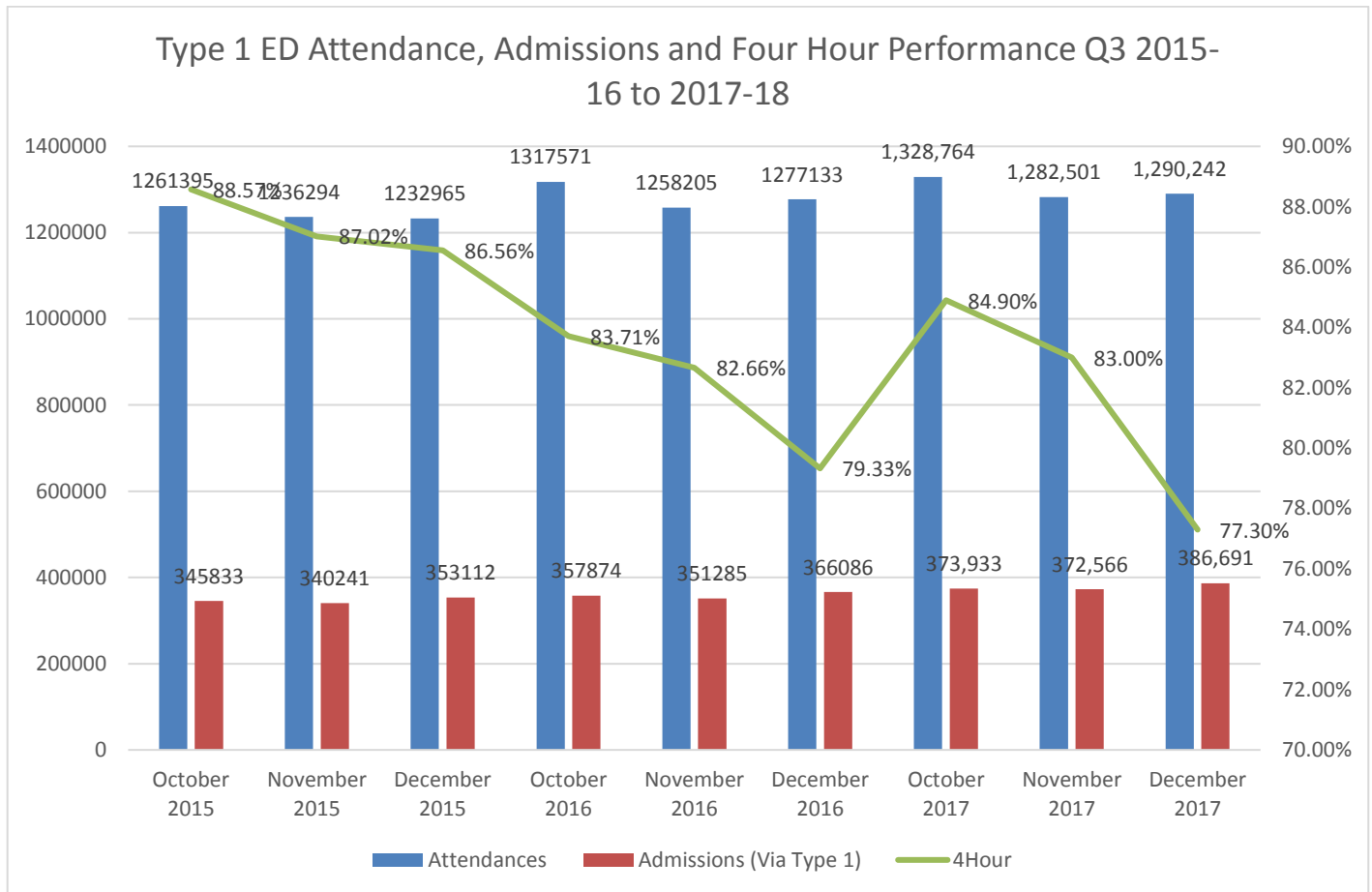


Similarly, although this figure has fluctuated, the number of locum and agency staff employed by Winter Flow contributors shows a steady increase in the number of gaps they are required to fill and speaks of a persistent shortfall in the numbers of permanent staff.

¹ [NHS Improvement: Quarter 3 2017/18 performance report](#) & [NHS Improvement: Quarter 3 2016/17 performance report](#)

² [NHS Vacancy Statistics England, February 2015 - September 2017, Provisional Experimental Statistics](#)

Secondly, the number of attendance and admissions at our Emergency Departments continues to rise. Data published by NHS England has shown that in Quarter 3 of 2017-18 attendances at Type 1 Emergency Departments were 1.26% higher than had been the case at the same point last year and admissions were had risen by 5.39%.³



Thirdly, despite this increase in demand, which is entirely predictable⁴ because our population is both growing and increasingly elderly, the practical realities of the NHS resources mean that we are still failing to plan for these increases in a way which means providing more resources with which to treat the patients.⁵ There is also a real risk that Sustainability and Transformation Partnerships and the range of organisations which look set to replace them⁶ are continuing with this flawed planning approach.

The Winter Flow data published up to the projects half way point has shown that contributing Providers have had less scope to flex their bed stock in response to demand than had been the case in previous years. Here again this is borne out by the wider data.⁷

³ [NHS England: A&E Attendances and Emergency Admissions](#)

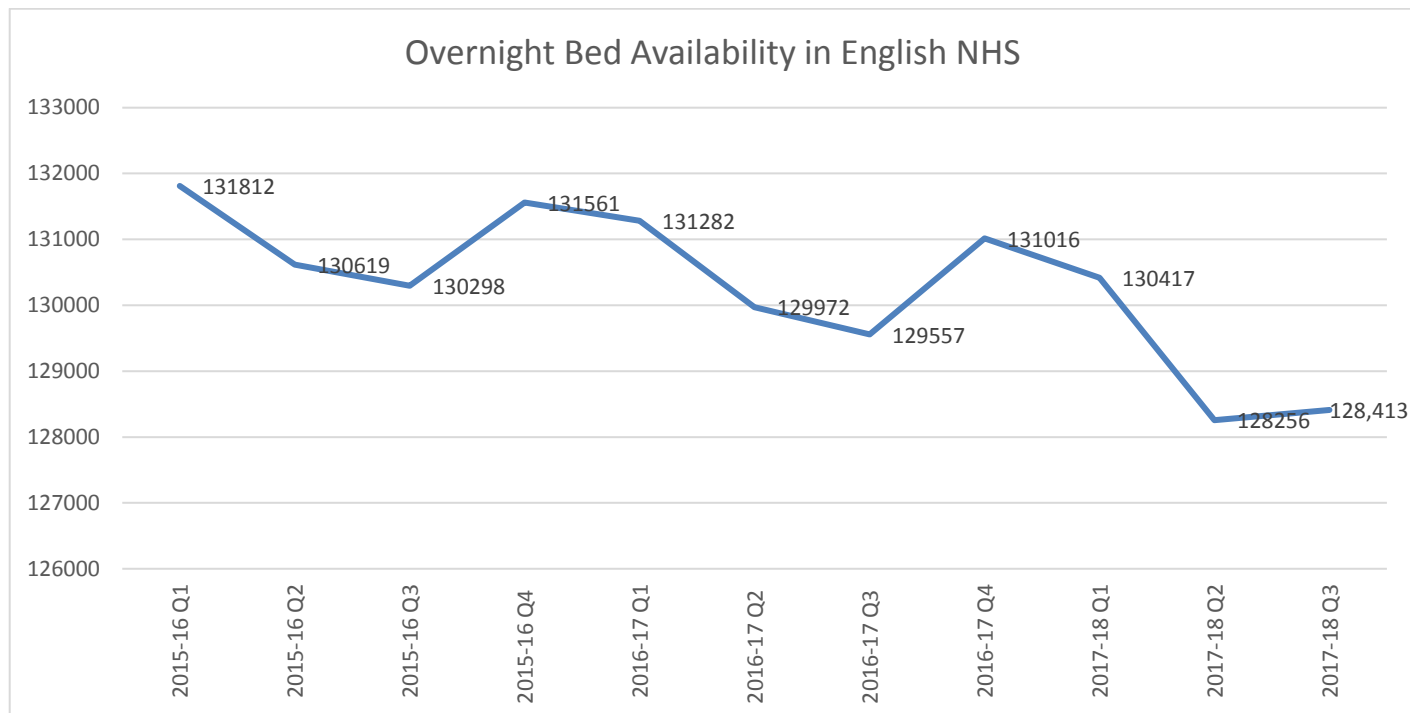
⁴ Royal College of Emergency Medicine [Staffing Patient Demand and the Implications of Brexit](#) Some element of attendances can also be attributed to a lack of GP appointments, cancelled elective operations and cuts to public health budgets.

⁵ Royal College of Emergency Medicine [Staffing Patient Demand and the Implications of Brexit](#)

⁶ [King's Fund: Making sense of integrated care systems, integrated care partnerships and accountable care organisations in the NHS in England](#)

⁷ See above Acute Bed Stock Three Year Comparison
Published 28 February 2018

As recently as December, Ministers claimed to have either freed up or created 1000 additional beds.⁸ While this may be true for individual weeks,⁹ and as we have noted there have been some successes with Delayed Transfers of Care, this has not translated into higher bed availability or lower bed occupancy when compared with the previous year. In fact, NHS England's own figures show that the opposite is the case.¹⁰



While there was a modest improvement in the number of beds in Quarter 3 2017-18 compared with the previous Quarter (157), there were 1,144 fewer beds available than was the case at the same point in Quarter 3 2016-17. Perhaps unsurprisingly given what we have already said about admissions, bed occupancy was also higher at 88.40% compared with 88.30% at the same point in the previous year.

If all of this seems familiar, it is because Winter Flow and other available datasets have been telling much the same story for at least the last three years. Despite all the evidence to the contrary those responsible for resource decisions in the NHS continue to make the same mistakes and yet to expect different results. Specifically, year on year we are asked to believe that it is possible to treat increasing numbers of patients with an ever-diminishing bed base, with insufficient staff resources.

The reality should suggest that this is not the case. The practical consequence of these decisions is Exit Block; large numbers of patients waiting on trolleys with an increased risk of avoidable mortality.¹¹ In order to improve care for patients in our Emergency Departments this urgently needs to change.

⁸ <http://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2017-12-18/119890/>

⁹ [NHS England Sitrep Data](#)

¹⁰ [NHS England: Bed Availability and Occupancy Overnight](#)

¹¹ [NHS England: A&E Attendances and Emergency Admissions](#)