

Tip of the Iceberg:

12-Hour Stays in the Emergency Department

Introduction

Emergency Department (ED) patient waiting times provide an important barometer for the wider pressures experienced in the NHS. There are currently alarming levels of crowding in our EDs, indicating that the health service is unable to meet the needs of patients with the current level of resource and capacity. The Royal College of Emergency Medicine (RCEM) has campaigned for many years on this important issue; crowding is not only dangerous, but also inhumane and undignified for patients who have no option but to stay for treatment in precarious conditions.¹

In March 2022, for the first time in the history of the metric, the numbers of patients waiting 12-hours or more from decision to admit (DTA) exceeded 20,000. As we have long argued, this number represents the tip of iceberg, as far greater numbers of patients experience extreme waits of 12 hours or more from their time of arrival. To investigate this issue further, RCEM carried out a Freedom of Information (FOI) request examining the extent of very long stays in EDs, with a particular focus on the numbers of patients waiting 12 hours or more from their time of arrival.

The current political agenda emphasises tackling waiting lists over waiting times in the NHS: the Government's own manifesto commitment to improving waiting times for EDs was downgraded in the Department of Health and Social Care's 2022/23 mandate to the NHS. The Government's aim is now to work towards improving ED performance 'as conditions allow', signalling a lack of willingness to address the pressures facing the urgent and emergency care system and its patients.² Behind every single metric is a patient and the NHS is failing its commitment to provide care to the public without any unnecessary delay; a key pledge outlined in the NHS Constitution. We urge the Government, NHS England, Integrated Care Systems and Trusts to take immediate action to tackle the extreme delays to treatment experienced by our patients.

Policy context

The NHS in England currently measures the number of patients who wait 12 hours from the decision made to admit (DTA) the patient. At present, there are staggering numbers of patients waiting 12 hours or more for admission: in the first four months of 2022 alone there were a total of 79,610 12-hour DTA waits; nearly as many as the cumulative total of the 11 years since data collection began (82,746 12-hour DTA waits between August 2010 – December 2021).³

In the 1990s there was a national drive to 'end inappropriate trolley waits for assessment and admission'.⁴ These waits were called 'trolley waits' as they are made up of patients waiting to be admitted to wards, often on trolleys. It is well established that waiting on trolleys or in corridors can lead to suboptimal standards of care, putting patients at risk. In 1999 the then Government established an "accident and emergency modernisation programme" informally dubbed as the "trolley task force".⁵ The national ambition was to ensure no patient experienced unnecessary delay from admission to a hospital bed. The drive to reduce waiting times had a positive impact, and by 2005 there was a huge reduction in waiting times in the urgent and emergency care system.

¹ Royal College of Emergency Medicine (2021) RCEM CARES Campaign. Available [here](#).

² Department of Health and Social Care (2022) The Government's mandate to NHS England. Available [here](#).

³ Royal College of Emergency Medicine (2021) Data and Statistics. Available [here](#).

⁴ HMSO (2000) The NHS Plan. A Plan for Investment. A Plan for Reform. Available [here](#).

⁵ Hansard (2022) "Trolley Task Force: Volume 345: debated Tuesday 29 February 2000. Available [here](#).

Over the past decade, the reduction of hospital capacity in the wider health and social care system, lack of workforce planning, and the COVID-19 pandemic have resulted in record breaking poor performance. The pressures facing the urgent and emergency care system are no longer seasonal, they exist all year round. Against this backdrop, RCEM has campaigned for a move away from the 12-hour decision to admit metric as it does not capture the true extent of the delays experienced by the patient, but rather the tip of the iceberg. The Clinical Review of Standards aimed to establish a new set of measures that would be better for both patients and clinicians. RCEM played an integral role in pushing for the 12-hour metric to be collected from the time of arrival in an ED as this would better demonstrate the gravity of ED treatment delays to patients. We argue the 12-hour time of arrival (TOA) metric – measured from the moment the patient steps foot into the ED – is a clear, patient centred measure, which brings performance measurement in England in line with the rest of the devolved nations.

The NHS Standard Contract 2022/23 was recently amended to change the way in which 12 hour waits in EDs are calculated.⁶ Data will now be measured from the patient's point of arrival in EDs to discharge, admission, or transfer, rather than from the DTA. Alongside this, the Standard Contract also changed the zero-tolerance standard for 12-hour waits in EDs, setting a requirement instead that no more than 2% of patients must wait over 12 hours. No patient ever has a clinical need that requires them to wait for 12 hours in an Emergency Department. In our response to the Clinical Review of Standards consultation, we said that the number of patients waiting 12 hours from time of arrival should be a very unusual event, and certainly less than 1%.

While hospitals currently have access to their own performance data, the Government and NHS England have still not indicated when the data on 12 hours TOA will be publicly available. Publishing these figures nationwide will allow for transparency across the system, which in turn should lead to much-needed improvements.

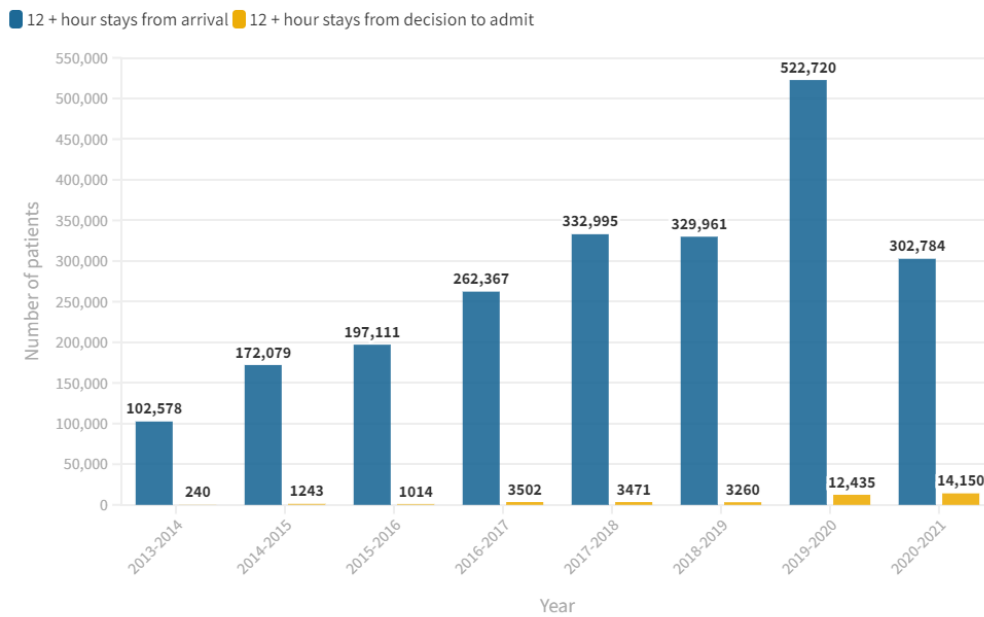
The misleading 12-hour decision to admit metric

Current 12-hour data is a gross underrepresentation of the reality of patient waits, as it fails to capture the vast majority of patients who have no choice but to spend extended lengths of time in EDs. It additionally conceals the patients who are discharged home after very long stays. As figure 1 below shows, whilst 12-hour DTA figures have increased over the past eight years, they are insignificant in comparison to the number of patients waiting for 12-hours or more from their time of arrival. The drop in 12-hour stays for 2020-21 is due to the pandemic and the drastic decrease in ED attendances as well as improvements in hospital flow during the first wave. In 2020-21, this number was **21 times** the number of patients delayed by 12 hours or more from DTA, demonstrating that the situation is much worse than official figures indicate. This disparity is particularly damaging as it proves that the 12-hour DTA obscures ED crowding, which often affects the most vulnerable patients. Additionally, the 12-hour DTA

⁶ NHS England (2022) NHS Standard Contract 2022/23. Available [here](#).

metric does not capture the patients who may have been subjected to long stays and are eventually discharged – or choose to self-discharge – rather than be admitted to hospital.

12 + hour stays from arrival and decision to admit



Source: NHS Digital (2021) Hospital Accident and Emergency Activity 2019-20

Figure 1

Long stays and crowding usually result from full hospitals being unable to find patients a bed, so they are left on a trolley - these are typically older and frail patients. Another important group of patients that face disproportionately long waits are people with poor access to mental health services. To better understand the disparities behind the 12-hour TOA and 12-hour DTA figures, RCEM carried out an FOI request of all acute trusts in England.

Numbers of patients waiting six and eight hours from time of arrival

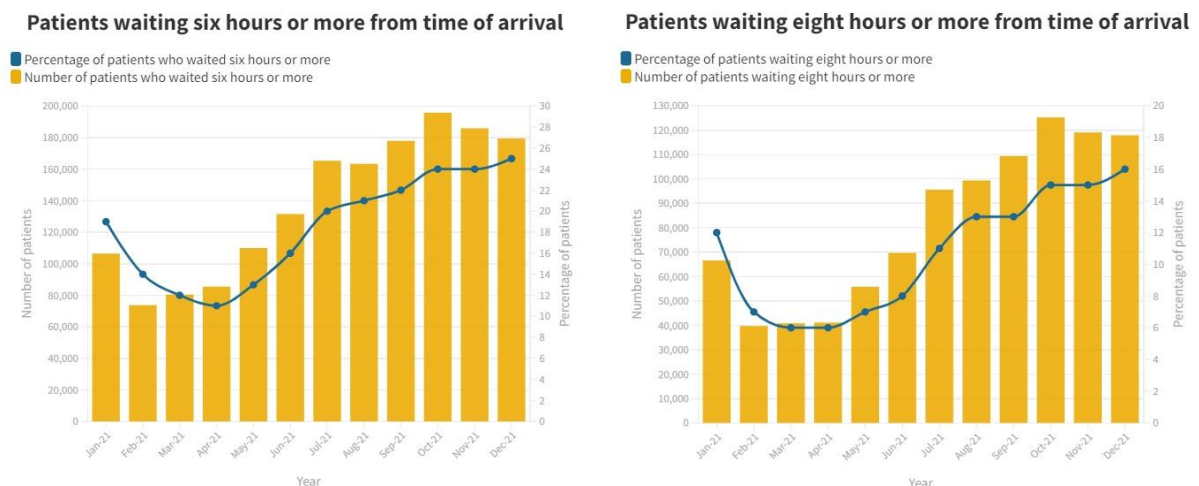


Figure 2.1 and 2.2

It is well established that long waiting times in EDs are associated with poor clinical outcomes, patient experience and are illustrative of wider pressures faced by the NHS and social care system. We have explored the consequences of crowding in detail elsewhere.⁷

Data from our FOI request of trusts reveals information on numbers of patients waiting six and eight hours from their time of arrival. We found that across the sample of trusts, in 2021 **18.5%** of patients waited six hours or more from their time of arrival. This is equal to 4,410 emergency patients experiencing a minimum of a six hour delay each day. **11%** of patients in our sample waited eight hours or more from time of arrival. As the figures 2.1 and 2.2 above reveal, the proportion of patients who were delayed in an ED for more than six or eight hours remained consistently high throughout 2021, indicating that pressures are being experienced in the NHS all year round.

There is no clinical reason for a patient to be in the ED beyond six hours from their time of arrival. NHS England's Getting it Right First Time (2021) report identified an *association* between ED length of stay and inpatient mortality data in England, which persists after adjustment for potential confounders including age, acuity, and arrival method. In particular, there is an associated 30-day mortality risk if patients remain in the ED for longer than six hours.⁸ This is measured using the Hospital Standardised Mortality Ratio, which increases with the length of time patients experience delays to their treatment. For patients spending 6-8 hours in the ED, the Standardised Mortality Ratio stands at 1.14, meaning there needs to be 82 patients waiting for this length of time for one of them to come to avoidable harm.

We have always argued that any form of unnecessary delay to treatment for our patients is unacceptable. We now have modelling to show a linear increase in 30-day mortality for patients who remain in the ED for more than five hours from their time of arrival. Any wait above this is exposing patients to increased risk. The sheer numbers of patients experiencing delays of 12 hours or more from time of arrival is unconscionable.

Numbers of patients waiting 12 hours or more from time of arrival

Our FOI request asked for data on the numbers and proportions of patients waiting in EDs for 12 hours or more from their time of arrival, broken down by month for 2021. We matched Trust level data received from our FOI with data published by the NHS on attendances, admissions, and the 12-hour DTA metric. This provided us with an accurate snapshot of the true numbers of patients experiencing very long stays in the NHS.

⁷ Royal College of Emergency Medicine (2021) Acute Insight Series: Why Emergency Department Crowding Matters. Available [here](#).

⁸ Cliff Mann & Chris Moulton (2021) Getting It Right First Time: Emergency Medicine GIRFT Programme National Specialty Report.

The Tip of the 12 Hour Iceberg

Patients waiting 12 hours from the decision to admit them to hospital, versus the number of patients waiting 12 hours from their time of arrival

Each Icon represents 400 patients who waited in an ED in 2021.

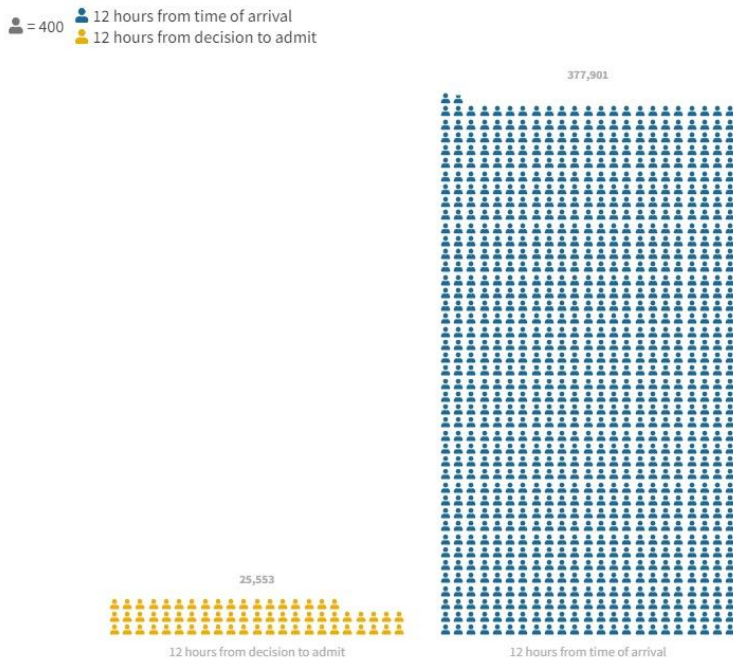


Figure 3

In our sample of trusts, 381,991 patients (4.3%) experienced a 12-hour delay from TOA in 2021. This means on average 1,047 patients were delayed by 12 hours or more from their time of arrival every day across these trusts. To put these figures into context, the annual figures for 2020-21 published by the Hospital Episode Statistics for all trusts across England reported **302,784** patients waited 12 hours or more from time of arrival. Therefore, the numbers of patients waiting 12 hours or more from time of arrival for the last financial year are likely to be substantially higher than the previous year. Our analysis reveals the extent to which the DTA metric disguises the true scale of crowding in our EDs. The trusts in our sample reported 25,563 patients were delayed by 12 hours or more from DTA. This is **fourteen times** the number of patients who waited 12 hours or more from their time of arrival.

Comparison of 12 Hour Figures by Trust

2021 yearly aggregate of 12 Hour from Decision to Admit VS.
12 Hour from Time of Arrival

DTA vs TOA 0  24,912

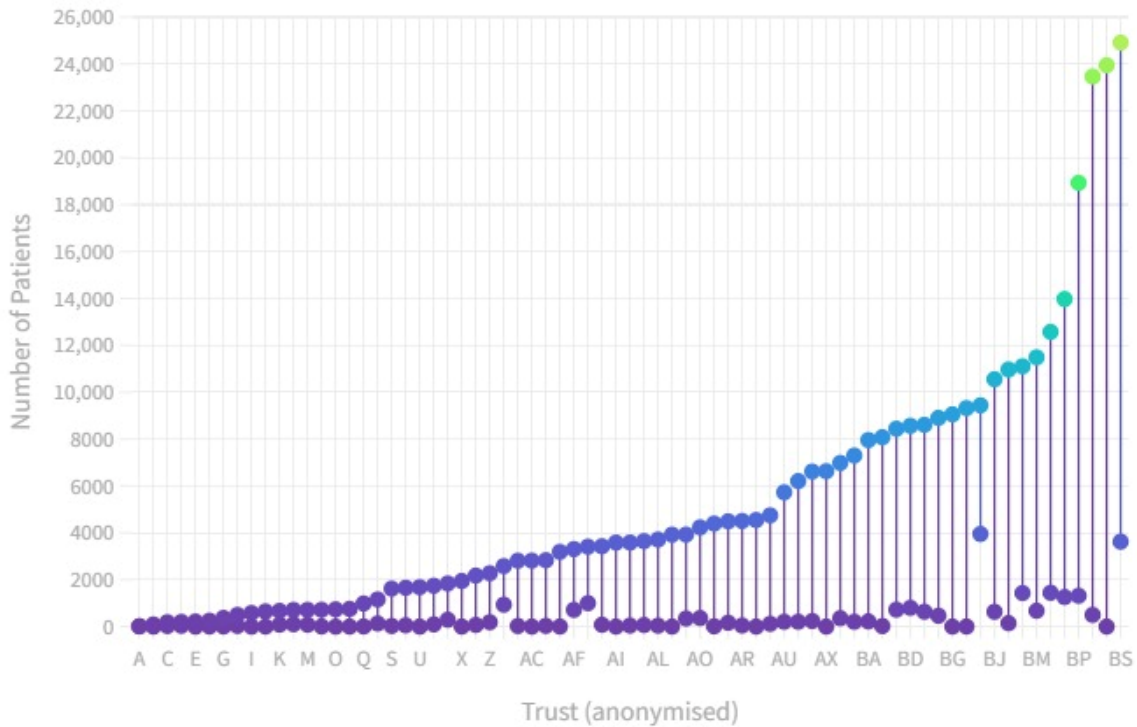


Figure 4

Figure 4 shows the discrepancy in the numbers of patients waiting 12 hours or more from time of arrival for our sample of trusts in 2021. Last year EDs experienced an alarming increase in the number of patients experiencing extreme delays to their care. The comparison of data for each Trust shows substantial, unwarranted and continuous variation in the number of reported 12-hour DTA in comparison to actual 12-hour TOA delays across trusts in our sample. When examining the range across the sample of trusts between the numbers of patients waiting from TOA compared to DTA, the largest difference between the data points in the Trusts was 23,945 patients. Additionally, there were 10 trusts in our sample that did not report a single 12 hour wait from DTA. Between these trusts, there were in fact **31,800 patients** delayed by 12 hours or more from their time of arrival, demonstrating how the DTA metric masks large numbers of patients experiencing long waits.

Comparison of Monthly 12 Hour Figures

12 Hour from Decision to Admit VS. 12 Hour from Time of Arrival

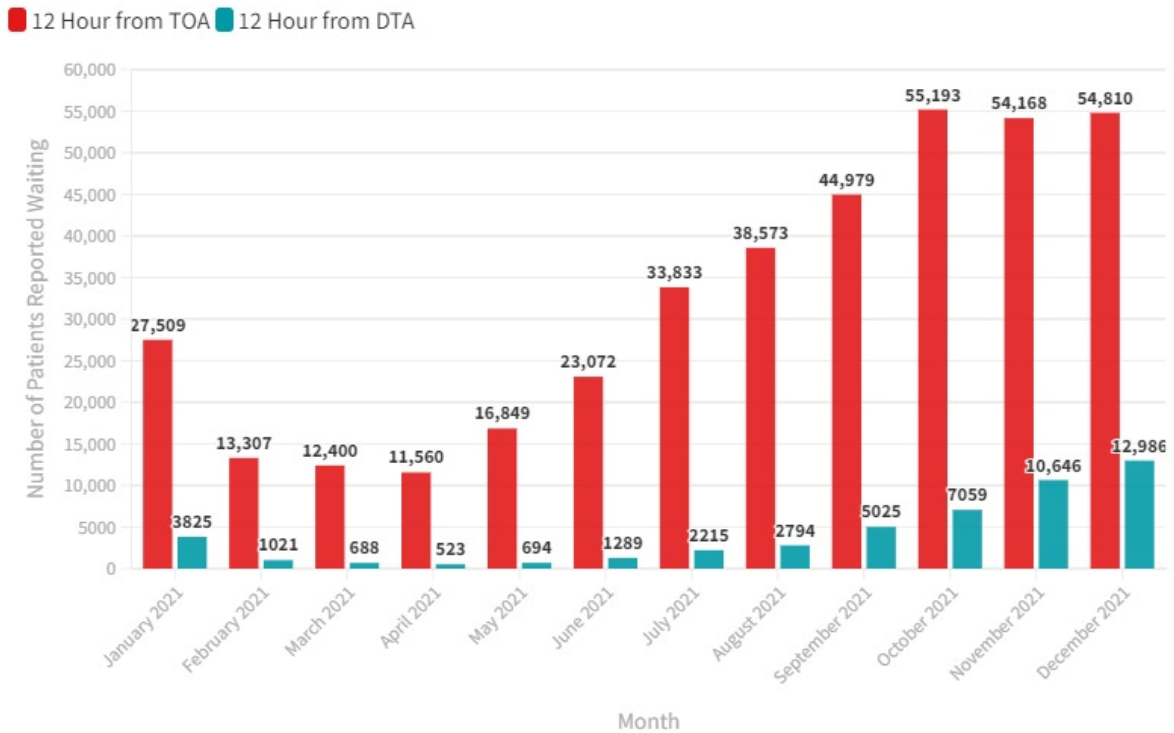


Figure 5

Figure 5 compares the monthly 12-hour TOA figures from our sample against the reported DTA data. Whilst it is important to note the vast discrepancies between the DTA and TOA figures, the 12-hour DTA figures must be put into context. National NHS performance figures for November 2021 revealed the number of patients that that spent 12 hours or more in an ED from DTA broke the 10,000-patient barrier for the first time in the metric's history. It has not dropped below the 10,000-patient marker since. The number of 12-hour DTA waits recorded in July 2021 in this sample exceeds the number of 12-hour DTA waits recorded from 2010-2015. It is important to consider that although the number of 12-hour DTA waits have increased dramatically over 2021 in our sample, the true number of 12 hour stays from TOA have increased even more. Additionally, there was not a single month where the NHS met its own requirement of ensuring no more than 2% of patients are delayed by 12 hours or more from their time of arrival. This monthly breakdown paints a picture of an NHS that is unable to deliver timely urgent and emergency care to its patients.

Solutions

Emergency Department crowding is one of the most serious policy challenges facing the NHS. This report demonstrates the sheer numbers of patients who have experienced extreme delays of 12 hours or more to their emergency treatment. Urgent action is required now to ensure the NHS is able to provide safe, timely and efficient care for everyone who needs it. We call on the Government to:

1. Publish metrics that promote patient flow and prioritise the care of the most seriously ill and injured patients. Every ED across England is collecting data on the number of patients waiting 12 hours or more from time of arrival. This data must be published immediately on a monthly basis so patients and policymakers can understand the true extent of extreme waits.
2. To eradicate exit block, the health and social care system must be able to support the timely discharge of patients when their hospital care is complete. There is an urgent need to support the social care workforce to ensure it can offer provision that meets the needs of our growing and ageing population.
3. Secure the future Emergency Medicine workforce. The Secretary of State's workforce strategy must aim to achieve safe staffing in EDs. At present, there is a shortfall of 2,000-2,500 Whole Time Equivalent consultants in the UK. This gap must be filled with an accompanying increase in ED nurses, AHPs and SAS doctors, and the faculty to train them.
4. An additional 4,500 beds across the United Kingdom be made available between now and next Winter, and approximately 8,500 more over the next five years.

Annex 1: Technical details

Some sites indicated less than 5 patients experienced delays in their metrics – these were not included in our totals.

In February 2022 RCEM contacted 118 trusts across England, requesting the following information on delays in their emergency department. We asked for each month in 2021 (January – December inclusive):

- How many patients spent 6 hours or more in the emergency department in your Trust from the time of arrival?
- How many patients spent 8 hours or more in the emergency department in your Trust from the time of arrival?
- How many patients spent 12 hours or more in the emergency department in your Trust from the time of arrival?
- What percentage of type 1 attendances spent 12 hours or more in the emergency department from time of arrival?

As of April 2022, we received a response from 74 out of the 118 trusts we contacted, representing 104 Type 1 Emergency Departments across England.