



Right Place, Right Care

Learning the Lessons from
the UK Crisis in Urgent and
Emergency Care in 2022

This report has been produced by the Royal College of Emergency Medicine in collaboration with the following organisations:



Executive Summary

This report provides case studies and analyses from our experience of trying to look after patients in a stretched system. Patients are being disadvantaged by an urgent and emergency care system that does not have adequate capacity at every stage. The result is too many patients are in the wrong place for their needs and this creates inefficiency, waste, poor patient experience and avoidable harm.

Capacity problems in providing chronic disease management and elective care are leading to avoidable emergency admissions.

Delays in ambulance arrivals and emergency admissions are making patients sicker. Limited and unequal access to investigations is increasing hospital length of stay.

The greatest harm of this crisis is being borne by the most vulnerable; older people, children, the psychiatrically unwell and those living with serious long-term conditions.

Though the scale of these problems is daunting, they are amenable to improvements in capacity, system co-ordination, and planning. Underlying this is a need to consider the whole patient end to end pathway rather than piecemeal improvements in one service and this will require integrated governance, leadership and clear accountability. Our recommendations are aimed at policy makers.

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Principles and Recommendations

We call on the next government to work with the health service and enable it to improve care, by following these principles and recommendations for action.

Principles

1. Rebuild public confidence in the whole NHS Urgent and Emergency Care system, particularly by focusing on effective time critical treatments and improving access.
2. Stop calling predictable operational problems a 'winter crisis'. While it is true that there is increased non-elective demand for hospital admission in the winter, it is predictable and can be planned for. The crisis is year-round inadequate capacity and reduced resilience.
3. Improve and clarify accountability across the whole patient pathway.
4. Target interventions, innovation and incentives where the clinical need is greatest. This includes a much greater focus on prevention.
5. Make sure interventions, innovations and incentives are properly evaluated before suggesting their wider adoption.

Recommendations

1. Urgently develop and promote strategies to improve retention of healthcare workers.
2. Accelerate the inter-operability of IT systems to improve safety and efficiency.
3. Increase vaccination coverage for respiratory viruses - including flu, COVID-19 and RSV - particularly in high-risk groups of patients and make sure acute respiratory infection hubs or similar are in place across the country to manage additional primary care work during times of higher demand.
4. Reduce the occupancy of acute and psychiatric hospitals to 85% and reduce emergency department attendances by:
 - a. facilitating multi-disciplinary and cross-sector working for patient groups who are particularly disadvantaged, such as adolescents with mental illness, and people at risk of delirium and frailty
 - b. developing accessible family-focused information to support self-management where appropriate
 - c. making sure people get the caring support they need at home, including community mental health crisis services
 - d. increasing the number of staffed beds in appropriate specialties, increasing rehabilitation and recovery capacity, and early supported discharge
 - e. increasing the capacity of Same Day Emergency Care for all medical specialties.

5. Increase the capacity of diagnostic services to improve urgent access to investigations across whole patient pathways.
6. Government to commit to the new response time standards for urgent and emergency mental healthcare in both Emergency Departments and in the community. This includes:
 - a. For community-based mental health crisis services (all ages) - For a 'very urgent' presentation, a patient should be seen within four hours from referral, across all ages. For an 'urgent' presentation, a patient should be seen within 24 hours from referral, across all ages.
 - b. For mental health needs in an emergency department (all ages) - Patients referred from an emergency department should have a face-to-face assessment begin within one hour from referral, by mental health liaison, or children and young people's equivalent service.
7. Develop an Operation Pressures Escalation Levels (OPEL) system for Primary Care when workloads are compromising patient safety.

Introduction

2022 was a difficult period for the entire health and social care system, with significant strains on waiting times for elective care, overcrowding in Emergency Departments, and increased demand on GPs and social care. By examining these issues in-depth, this report seeks to learn from the experiences of 2022 and provide recommendations that can help prevent the recurrence of such a crisis in acute care in the future. By drawing lessons from 2022, we can pave the way for a more resilient and responsive healthcare system that prioritises patient care and minimises disruptions during times of crisis.

What is Urgent and Emergency Care?

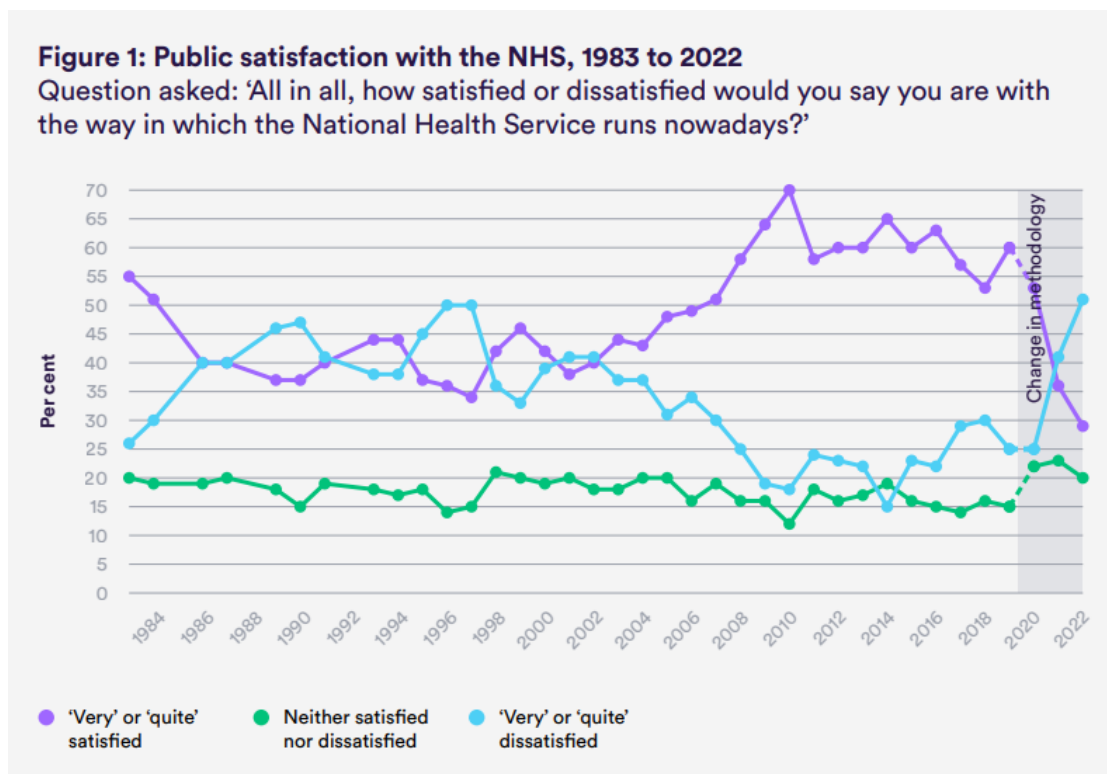
Urgent and emergency care refers to medical treatment focused on providing immediate care for sudden, unexpected severe illnesses or injuries. It is the type of care patients receive when they have a condition that requires urgent attention, such as a heart attack, a broken bone, or a severe infection. This covers a wide spectrum of diseases and severity.

The main goal of emergency care is to stabilise conditions, manage symptoms, and prevent any further complications. Medical professionals are trained to quickly diagnose and treat acute conditions using various interventions, such as medications, surgeries, or other procedures. Other parts of the UEC system focus on diagnosis, treatment, prevention of complications and organising ongoing care.

Effective urgent and emergency care is essential to a well-functioning NHS as it provides immediate and critical medical attention to patients with acute problems. When this part of the system is overloaded, other important parts of the NHS such as elective and cancer care cease to function effectively. A well-functioning system should prevent long-term complications and instil public trust in the healthcare system.

Public perception

The public are very aware of the problems in Urgent and Emergency Care. The Nuffield Trust runs the annual British Social Attitudes Survey. In 2022, 29% of the public were 'very' or 'quite satisfied' with the NHS. This is the lowest level of satisfaction since the survey began in 1983. Furthermore, there was a substantial increase in people who were 'very' or 'quite dissatisfied' with the NHS.



This survey also demonstrated the lowest levels of satisfaction with NHS GP, Dentistry and Accident and Emergency Services since 1983. Despite this, there was still strong support for the founding principles of the NHS; free at the point of access available to all and funded through taxation.

During December 2022, the English NHS 111 service reported a substantial increase in demand that they were unable to meet. This was demonstrated by an increase in call abandonment rates after 30 seconds. In March 2020, the early stages of the pandemic, the call abandonment rate was 38.7%; in December 2022 this was the highest ever recorded, at nearly 50%. Some call centres recorded waits of over an hour to simply answer the phone. This inability to meet demand created health anxiety and further downstream pressure for primary care, the ambulance service and emergency departments.

In December 2022, 66.5k patients brought in by ambulance in England waited more than an hour before it was possible to handover to a clinician in an emergency department. This compares with 20k who had this experience in December 2019. While this undoubtedly worsened in December, clearly ambulances were waiting outside hospitals for too long for much of 2022. In July 2022, all 10 ambulance services in England reached 'black alert' status.¹ The Royal College of Emergency Medicine warned the NHS was at risk of breaking its fundamental promise to the public to deliver emergency care in a timely way.

¹ <https://nursingnotes.co.uk/news/clinical/every-single-ambulance-service-in-england-declares-critical-incident-status/>

Emergency departments across the UK reported the highest level of long waits in 2022. More than 1.8 million people stayed more than 12 hours, from their time of registration in emergency departments, across all four nations. Figure 3 shows that performance against the four hour access standard in 2022 was the worst ever recorded.

Type 1 Emergency Departments are the major units, and exclude minor injury units, urgent treatment units and emergency eye clinics.

Four-Hour Performance (Type-1)

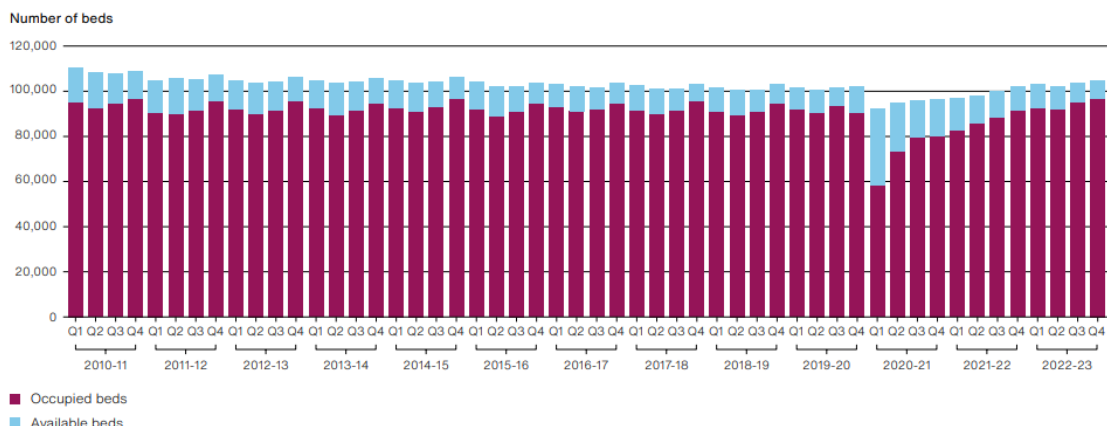


Hospitals reported persistently high occupancy rates. It is generally accepted that hospitals are most efficient when occupancy at midnight is below 85%, though there are caveats related to larger hospitals and more single patient rooms. Higher occupancy levels are often associated with longer length of stay, increased outlying in the wrong type of ward and increased nosocomial infection – that is infection(s) acquired during the process of receiving health care that was not present during the time of admission. High occupancy was mainly driven by long length of stay. Around 13% of all general and acute beds in hospitals were occupied by people who were waiting for some form of social care intervention; this is a relatively expensive way to give poor care to our older patients living with frailty. The National Audit Office identified that hospital occupancy in the fourth quarter of 2022-3 was the highest ever recorded, at 92.3%. Despite a modest increase in bed numbers, the number of long stay patients also increased by about a quarter, compared to 2019.

Demand for child health services, levels of complexity, and the numbers of children attending emergency departments has also been sharply rising, with children's urgent and emergency care experiencing double its usual footfall at some points last winter. The spike in invasive Group A streptococcus, followed by a combined outbreak of Covid-19 and Flu, revealed the fragility of the urgent and emergency care system for all ages, but particularly for children and older people.

NHS general and acute hospital bed capacity and beds occupied, 2010-11 to 2022-23

Bed capacity has been increasing since the COVID-19 pandemic, but only recently returned to pre-pandemic levels



Notes

1 Data are for England only, covering Q1 2010-11 to Q4 2022-23, and reported quarterly.

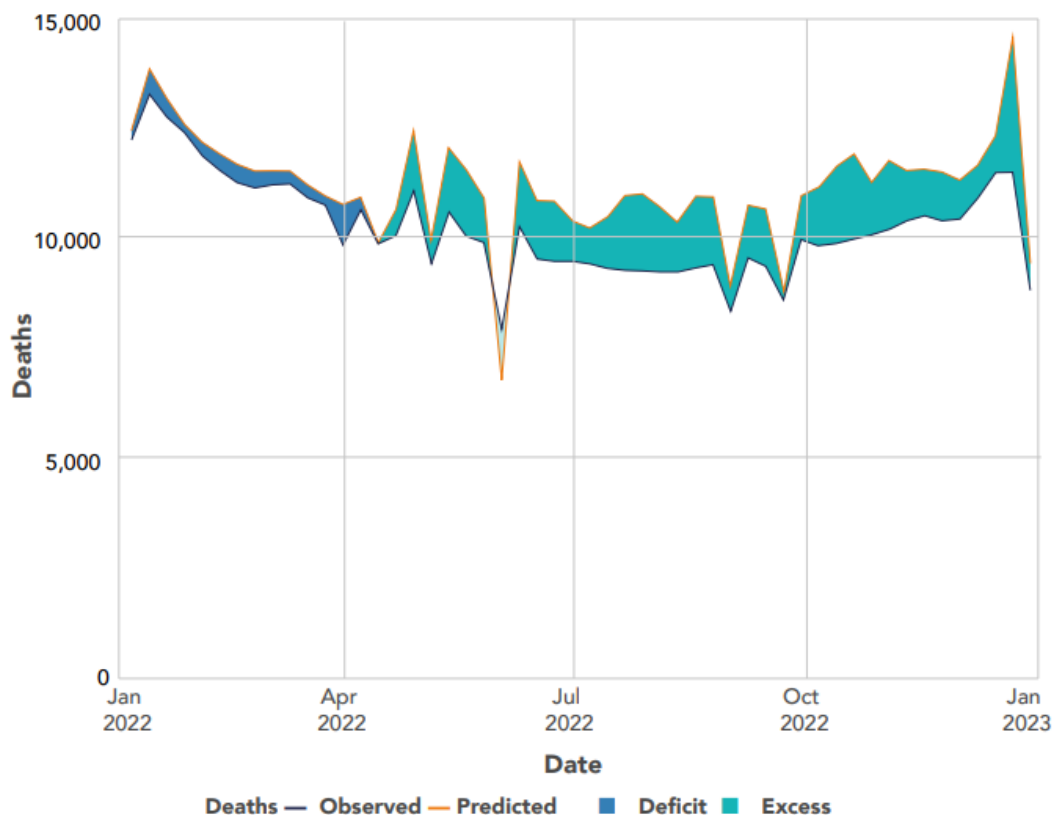
2 Data are for NHS general and acute beds open overnight and count occupied and available beds at midnight on the data collection day for each quarter.

Source: National Audit Office analysis of NHS Digital data

The impact on our patients

There was a persistently high number of excess deaths during the last nine months of 2022. This prompted a number of analyses to try to understand the causes and whether these are modifiable. The Royal College of Emergency Medicine estimated that 300-500 deaths per week were associated with long waits for admitted patients, based on observational data about the association between long waits and risk of death at 30 days. This assertion was supported by the COVID-19 Actuaries Response Group, though they used the same underlying assumptions as the Royal College of Emergency Medicine. [Are NHS waiting times contributing to excess deaths? - COVID-19 Actuaries Response Group \(covidactuaries.org\)](#) A life insurance company also looked at this problem from the perspective of insurance premiums and stated that the pressures in the NHS were plausibly contributing to between a quarter to half of all excess deaths. [PL Re - NHS Crisis Report.pdf \(pacifielifere.com\)](#)

A different methodology was employed by The Economist. It estimated a 10% increase in patients waiting four to twelve hours to be admitted was associated with an additional 1.2 deaths per 1000 patients, resulting in 260 excess deaths per week until November, and it is plausible that there would have been a greater number of excess deaths in December.



There are multiple contributory causes to these excess deaths, of which NHS failings is only a part. 2022 had both severe cold and severe heat episodes and these weather shocks are consistently associated with excess deaths. The UK population is getting older and more people are living with multiple long-term conditions and this will have insidiously driven up demand. There was an early and severe outbreak of invasive Group A streptococcus in November and this was followed by a combined outbreak of COVID-19 and Flu. These outbreaks synergistically created substantial pressure on the NHS.

The impact on clinicians working on the frontline

Every year the General Medical Council conducts a survey of post graduate doctors in training and their trainers. In 2022, 19% of all trainees reported high risk of burnout, compared to 15% in 2021. There was substantial specialty variation, with emergency medicine, general medicine, surgery, general practice and obstetrics and gynaecology reporting the highest rates. However, all specialties reported an increase in self-reported burnout. Trainers reported increased rates of burnout, but to a lesser extent. The 2022 NHS staff survey demonstrated the lowest number of NHS staff being satisfied with the standard of care they were offering.

Behind the graphs and statistics, we saw a lot of avoidable harm and unhappiness among both our patients and the staff we work with. The problems in urgent and emergency care are not insoluble, but they are time-consuming, difficult and require commitment and investment.

Section 1: The Wrong Place

Patients were often in the wrong place. The best place for a patient is the place where they can easily and efficiently get the care they need. The problems in access, capacity and lack of flow mean that patients go to the wrong place and then get stuck there. Flow is the movement of patients between organisations and departments. Some of this is driven by patients lacking confidence and wanting to avoid long stays; patients are often wary of going to emergency departments or being admitted to hospital because of long delays.

Emergencies in Primary Care

The increasing pressures faced across the urgent and emergency care system have had significant repercussions on primary care settings, with negative implications for patient safety, GP workload, and the risks assumed when patients seek care in inappropriate settings.

GPs and their teams play a crucial role in the NHS, handling the majority of patient contacts. By doing so, they help alleviate pressures on other healthcare services, including Emergency Departments (EDs). However, due to the escalating waiting times in EDs, patients often choose to attend their GP practice for emergency conditions, unaware that adequate assessment and treatment cannot be provided in that setting. This decision has detrimental effects on patient safety, as well as increasing the workload and risks assumed by GPs.

The impact of extended ED waiting times extends beyond the ED itself. Ambulance services, responsible for transporting patients to hospitals, also face significant challenges. Data from the Association of Ambulance Chief Executives highlights the potential harm caused by prolonged ambulance handover times. In December 2022 alone, 57,000 people in England were exposed to potential harm, with 6,000 experiencing severe harm due to the delays.^[12]

Disturbingly, there have been anecdotal reports of children suffering harm while their parents transport them to the hospital due to the lengthy wait times for ambulances.^{[13],[14]} Another crucial aspect affected by the ED pressures is the NHS 111 helpline. Designed to direct patients with urgent medical needs to the most appropriate NHS service, this service has experienced a significant increase in calls over time. However, the number of calls answered within the target of 60 seconds has declined from 93% to 59% and consequently, patients are abandoning their calls. Over one million calls were abandoned in December 2022, representing a staggering 41% of the total calls made to NHS 111 that month.^[15] This decline in call answering rates further exacerbates the challenges faced by patients seeking timely medical advice and contributes to the strain on primary care services.

In conclusion, the strain on EDs, as manifested through prolonged waiting times and compromised ambulance services, has far-reaching consequences for primary care settings and the NHS 111 helpline. The safety of patients is jeopardised, while GP practices face increased workloads and assume higher risks when patients seek emergency care in inappropriate settings. Urgent action is imperative to address the underlying causes of ED pressures, ensuring that patients receive timely and appropriate care while alleviating the strain on primary care services.

Case Study 1:

A 55-year-old female attended the GP surgery complaining of acute-onset chest pain. Before that, she had called the surgery. The receptionist, after a brief discussion with the on-call GP, rightly advised the patient to call 999 or attend the emergency department which was very close to the patient's home. However, the patient did not follow the advice and turned up at the surgery instead.

The patient had diabetes, hypertension, and a family history of ischemic heart disease, increasing her risk of acute myocardial infarction.

When questioned by the GP why she had not attended the hospital, the patient replied that she was aware of the long ambulance waiting times and was concerned about attending the emergency department and having to wait for many hours to be seen. She thought the GP could quickly examine her and tell her whether this was a heart attack and whether she needed to attend the hospital.

The on-call GP, a practice nurse, and a receptionist had to leave their existing work and look after this patient, providing her with emergency help whilst waiting for the ambulance to arrive. This resulted in the GP and the nurse running very late for their clinics, while the reception desk was left with fewer staff answering the phone during a busy morning. Moreover, and most importantly, the patient received delayed treatment for their condition reducing her recovery chances.

Case Study 2:

A 74-year-old man was crossing the road, towards a bus stop. It was a cold December morning. He tripped on the curb and fell heavily, sustaining a head injury. The GP surgery he attended happened to be a few yards away, and the on-call GP came out to attend him. While the patient was conscious and alert, he was bleeding from a head wound and needed to go to the emergency department for a CT head scan. Passers-by had found and provided a pillow and blanket for him, as it was very cold. There appeared to be no other injuries.

A call to the ambulance centre was made and the GP was told that it would be at least four hours before an ambulance could attend. The fact he was near a GP surgery was taken to assume he was in a relative place of safety, should anything further happen. This was despite the man laying in the street outside in cold weather. He was unaccompanied, but members of the public were prepared to stay with him while he waited for an ambulance.

Case Study 3:

A three-year-old girl had been unwell for 12 hours. She had a very high temperature, and her mother had noticed a rash appearing around her eyes which did not blanch on pressure.

She called her GP surgery to ask for an appointment and was given one at 5pm on the same day. The GP noticed the appointment at 1pm and called the mother to find out more about the case, agreeing with the mother that the child should be seen immediately at the surgery.

The mother arrived at the surgery at 2pm. The child had a temperature of 39.6 C, she was floppy and drowsy. The rash around the eyes looked petechial, and there were signs of a similar rash appearing on her arms and neck. She was given immediate intramuscular benzylpenicillin and an emergency admission was made to the local paediatric admissions unit. As it was going to take too long for an ambulance to come, the mother took the child to the paediatric emergency department herself, in her car. There was no other accompanying adult.

The child was seen and assessed in the hospital, intravenous antibiotics were commenced following a lumbar puncture, and she made a good recovery over the next two days, returning to the hospital daily for further intravenous antibiotics for a few days after discharge.

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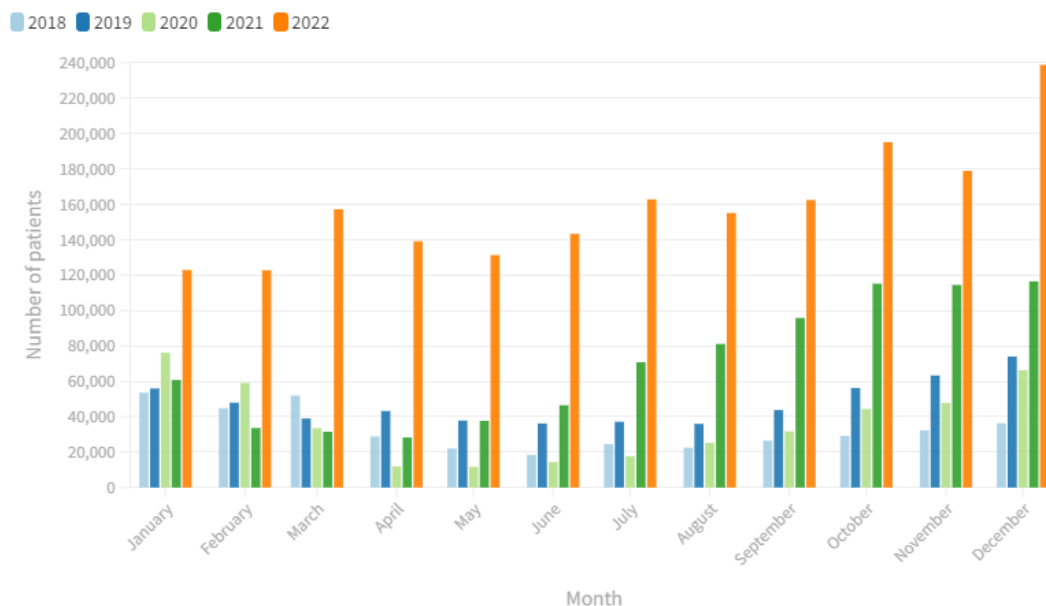
Nuffield Trust (2023), NHS 111.

The Emergency Department

Analysis

Long stays in emergency departments are rightly seen as an important problem by the public. There are multiple scientific studies that demonstrate an association between long stays and mortality. A large observational study in England showed that there was one extra death for every 72 people who stayed between 8-12 hours. Applying this evidence to the 1.8 million people who stayed more than 12 hours in 2022 in the United Kingdom suggests that there were 25,000 deaths associated with long stays. Figure 1 shows 12-hour performance figures for the UK since 2018 and highlights how poor performance was in 2022. The number of people waiting 12 hours or more from their time of arrival increased by 388% between 2018 and 2022. NHS data for emergency department attendances in 2022 were not higher than the norm compared to any period for the last 10 years, suggesting that more people turning up was not the reason for longer waits.

UK wide Emergency Department attendances of 12 hours or more, measured from patient's time of arrival.

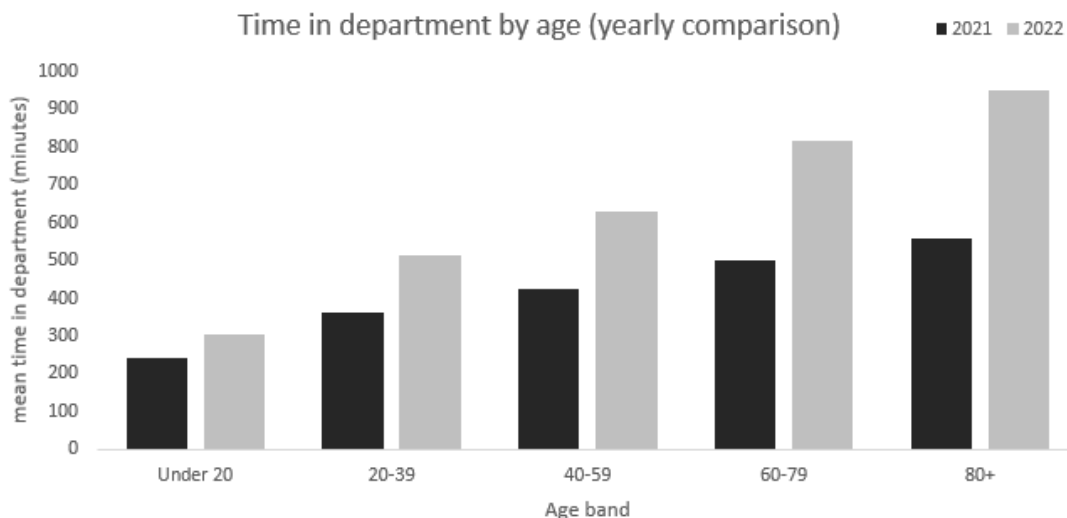


Source: NHS England, Stats Wales, Public Health Scotland and Department of Health Northern Ireland



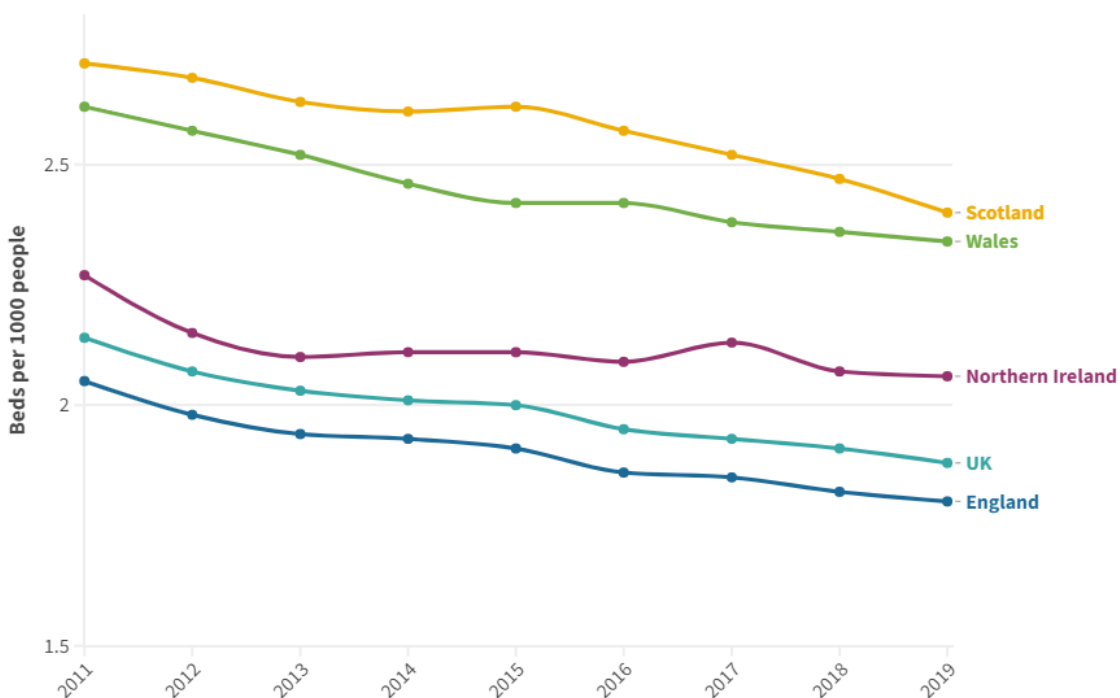
The long waits in emergency departments were not endured evenly. Older people suffered the longest waits, and this position had deteriorated faster for older people. The mean length of stay for a person older than 80 years of age in 2022 was 15 hours.

The increase in total time patients spend in the emergency department places additional care burden on the already stretched workforce as the care hours per member of staff is increasing regardless of the number of attendances.



The long stays are not occurring because too many people are arriving at emergency departments, but because our acute hospitals are too full. Occupancy is difficult to meaningfully measure, but there is a clear trend to increasing occupancy.

Beds per 1000 people across the UK



Sources for population estimates: Eurostat; ONS and the World Bank.

Our relative lack of beds compared to peers in the Organisation for Economic Cooperation and Development (OECD) is compounded by the lack of reform of social care. In England, at least 10% of the acute bed base is taken up by people who could be looked after elsewhere and the picture is likely to be similar in the devolved nations. Our use of inpatient beds is further compromised by our lack of side rooms.

Open bays, with single sex compliance and vulnerability to outbreaks of infectious diseases, reduce the available effective bed stock beyond the reported numbers. Working in an environment like this can become overwhelming and we are worried about retention of clinical staff.

Case Study:

Becky, a 50-year-old woman, developed upper abdominal pains and fever. She visited her GP who was concerned that she might have cholecystitis, an infected gall bladder. He advised Becky that she needed to go to hospital to see a surgeon. Becky had previously endured long waits for admission for an unrelated problem and was very reluctant to go to the emergency department. She stayed at home for another couple of days until the pain was unbearable and then attended an emergency department. She was seen promptly by a nurse and a doctor who all agreed that she needed to be admitted to hospital, but there were no beds. She spent over 24 hours lying on a trolley in a corridor waiting to be admitted. Her husband slept on the floor beside her. While she was waiting, she did not receive many treatments and became more unwell. A full 24-hours after admission, she was admitted to a surgical ward. By now, her gall bladder had burst and she had developed an avoidable acute kidney injury. She required a 10-day stay in hospital as she needed a drain and intravenous fluids to recover. She recovered, but is now waiting at home for an operation to remove her gall bladder. She still lives in fear of this problem recurring. A gall bladder problem is not rare or complicated and Becky's care could have been much better. Her admission and long stay in hospital was an avoidable expense.

Urgent and Emergency Care for Children

Analysis

Children's health systems faced unparalleled pressure during the winter season, with acute and emergency care settings for children bearing the brunt of this strain. Paediatric Emergency Departments experienced a surge in footfall, reaching the highest-ever levels, and in some cases, doubling the number of patients seeking care. Disturbingly, many children had to endure waiting times of over 10 hours before receiving the necessary attention.

Although national data for England and Wales has not yet been published, it is noteworthy that the busiest EDs in Scotland and Northern Ireland were the paediatric EDs at the Glasgow Royal Hospital for Children (RHSG) and the Belfast Hospital for Sick Children (RBHSC), respectively. Despite the immense efforts put forth by the paediatric emergency care workforce, the high levels of demand and long waiting times have undoubtedly impacted the ability to provide safe and effective care for children.

The spike in Group A Strep cases during the winter season may have accelerated the demand for urgent and emergency care. However, it has also brought to light long-standing challenges faced by paediatric urgent and emergency care, which has experienced year-on-year increases in attendance and waiting times over the past decade. This trend emphasises the need to address systemic issues and improve the provision of care for children in need.

One concerning observation is that many children who end up in urgent and emergency settings do not necessarily require such care. Despite the high attendance rates, there was no proportional increase in admissions. A recent study revealed that approximately 40% of paediatric ED attendances are likely to be classified as 'non-urgent,' with an even higher proportion observed among young children and out-of-hours visits. The challenges in accessing primary care and the higher demand for primary care services are key drivers behind the influx of patients seeking urgent and emergency care. December 2022 recorded a record number of 999 and NHS 111 calls, leading to extended waiting times and a significant number of abandoned calls, prompting families to turn to EDs as a last resort.

Furthermore, there has been a concerning increase in children and young people presenting with acute mental health issues, who may end up in paediatric or adult wards that are ill-equipped to support them adequately. While 'exit blocking' is less prevalent in paediatrics, a lack of safe alternatives within the community results in some children remaining in the hospital for extended periods, particularly those with mental health needs, learning disabilities/autism, and those in the care system.

The challenges faced by children's urgent and emergency care are multifaceted. The significant increase in footfall, long waiting times, non-urgent attendances, difficulties in accessing primary care, and the rise in acute mental health cases pose significant concerns. It is imperative to address these challenges and ensure that appropriate resources and support are in place to provide timely and effective care for children in need.

Case Study:

Our patient journey is a common one, concerning a worried parent of an unwell child who tries to seek advice from primary care before ending up in the emergency department.

Katie is concerned about her young son Noah who has a temperature and sore throat. She calls their GP practice, but there are no available appointments. She then looks online, and the NHS website directs her to call NHS 111. Katie calls NHS 111 where she waits anxiously for 40 minutes, before being told the service is very busy but she will get a call back from a clinician soon. She waits for three hours without receiving a call, and her son remains unwell and upset. Unsure about what to do, concerned about her child, and aware of the high levels of Strep A circulating, she decides to go the Emergency Department that evening.

They arrive to an extremely busy emergency department and wait much longer than expected to be triaged. After seven hours, Noah is eventually seen by a doctor and is sent home with self-management advice and reassurance.

Such a crowded emergency environment also has an impact on other children with more acute needs who will have to wait longer to be triaged and to receive care. Children can deteriorate very quickly, but in such a crowded paediatric emergency department this deterioration can sometimes be missed. We were concerned by cases this winter where children were taken straight from an emergency department waiting room to the resuscitation room after deteriorating, which would have been identified sooner in a less pressurised system. We also know of examples of families leaving the emergency department due to the long waiting times, only to have to return with a child in septic shock.

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<https://www.england.nhs.uk/statistics/statistical-work-areas/uec-sitrep/urgent-and-emergency-care-daily-situation-reports-2022-23/> There have been increases every year since 2010/2011, other than a dip during the Covid-19 lockdown in 2020/21

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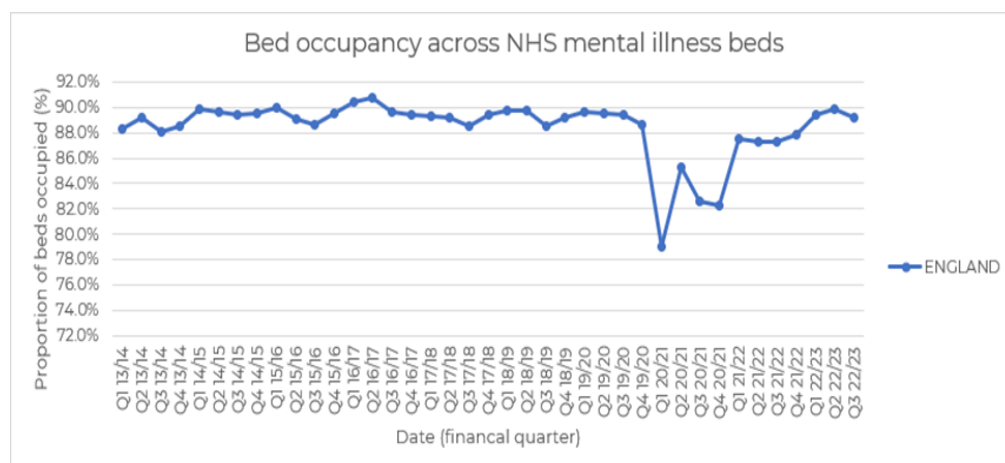
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Mental Health Emergency Care

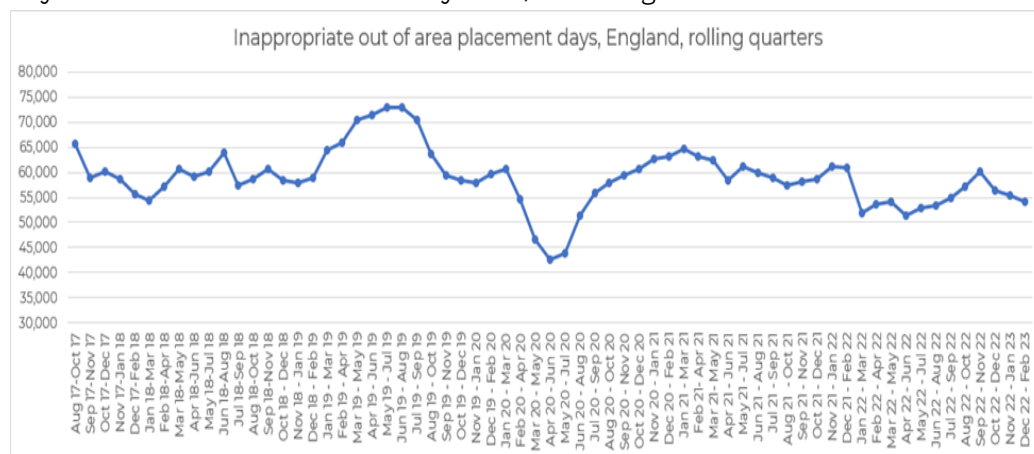
Analysis

The provision of mental health emergency care has been marred by significant challenges in recent years. The reported bed occupancy rates for all mental illnesses across the NHS in England have been a cause for concern. Examining the data dating back to 2013/14, it is evident that bed occupancy rates have consistently remained high. In the most recent period, during the third quarter of 2022/23, the bed occupancy rate reached 89.2%, compared to 87.3% in the same period of the previous year.



The Royal College of Psychiatrists (RCPsych) has set a recommended level of 85% for the safe provision of care. Unfortunately, this recommended level has been surpassed in most periods, with the only exception occurring during the pandemic-impacted year of 2020/21. These persistently high bed occupancy rates underscore the strain on mental health services and the challenges faced in providing optimal care for individuals in need.

In addition to high bed occupancy rates, inappropriate out-of-area placements pose further challenges to mental health emergency care. To monitor performance and mitigate against delayed provider submissions, tracking inappropriate out-of-area placement days on a rolling quarterly basis is essential. In the three-month period of December 2022 to February 2023, a total of 54,015 days of inappropriate out-of-area placements were reported. This can be compared to 60,865 days in the corresponding period of the previous year, reflecting an 11.3% reduction, and 55,620 days in December 2017 to February 2018, indicating a 2.9% reduction.



While the reduction in inappropriate out-of-area placements is a positive development, the overall numbers remain alarmingly high. These placements disrupt continuity of care, separate individuals from their support networks, and pose challenges in delivering effective treatment. Addressing this issue is crucial to ensure that individuals experiencing mental health emergencies receive prompt and appropriate care within their local areas.

In conclusion, mental health emergency care faces significant challenges in terms of high bed occupancy rates and inappropriate out-of-area placements. The consistently high occupancy rates and the limited availability of appropriate in-patient beds highlight the strain on mental health services and the need for increased investment and resource allocation. Efforts to reduce inappropriate out-of-area placements are commendable, but further actions are necessary to ensure individuals receive timely and effective care within their local communities. A comprehensive and integrated approach, involving collaboration between mental health services, policymakers, and stakeholders, is vital to address these challenges and improve mental health emergency care provision.

Case Study:

Sally:

"My GP referred me to a Community Mental Health Team mental health team as my depression was getting progressively worse. I really didn't feel like myself and I was finding it almost impossible to deal with daily life.

"I was left waiting for 13 weeks to start receiving treatment from a psychiatrist. Unfortunately, during this time, I became suicidal. The police found me at home after my brother raised the alarm, and I ended up in the Emergency Department.

"After seeing the liaison psychiatry service fairly quickly, I was waiting overnight - from early evening to late morning - in the chaotic emergency department to be assessed under the Mental Health Act. It didn't feel like there was somewhere safe for me to be in the department, and there were security staff outside my cubicle. It was a very stressful and traumatic experience. When I was eventually assessed by two psychiatrists and an Approved Mental Health Professional (AMHP), who thought I should be detained under Section 2 of the Mental Health Act, there were no beds available at my local hospital which meant I had another long wait to see whether another adult ward had the capacity to take me. The ward I was transferred to ended up being many miles from my hometown.

"It was really difficult for my recovery to be so far away from family and friends. My brother tried to come on weekends but with a young family this wasn't easy. Once I was feeling better, the hospital started to help me prepare for my discharge and we agreed it would be good to have some support to help me in my recovery. I often needed reminding to take my medication, and to ensure I had something to eat, so I was keen to go into supported accommodation. However, there was a long waiting list, so it took a while for me to be given appropriate support."

Acute Medicine

Analysis

Our hospitals were full in December 2022, and many patients experienced long delays for admission. As a result, acute medical care is now routinely being delivered by teams in emergency departments, often in corridors and other unsuitable environments rather than in appropriate wards, such as the Acute Medical Unit (AMU). Caring for patients in such inappropriate environments poses significant risk to patients and is associated with an increased risk of adverse events and mortality. Patients with cancer, heart disease and older patients particularly bear the brunt of this rapidly deteriorating situation.

The Society for Acute Medicine runs an audit (SAMBA) which monitors key measures in acute care clinical performance. Data from SAMBA shows a deterioration in many key measures (see figure 1). Acute medical patients are not only enduring long waits in emergency departments, but also increased waits to receive key interventions which enhance the safety of their care, including initial clinical review, time to consultant physician review and monitoring of their physiological parameters.

Acute medicine plays an essential role in the delivery of acute medical care across all acute hospitals. Acute medicine manages care in AMUs and delivers the majority of Same Day Emergency Care (SDEC). The specialty continues to innovate and develop models that ensure safe and sustainable acute care; much of which is evidence-based, demonstrating that AMUs do make a difference. We work collaboratively with colleagues in primary care and emergency medicine and together our efforts afford a synergy in care for our patients.

Well-resourced analysis and understanding of patient flow informing the delivery of local services is imperative. Inadequate or inappropriate use of direct admission to AMU or SDEC pathways contribute to long waits in EDs. These waits are exacerbated by a lack of inpatient beds that can facilitate onward flow from the AMU. There is also a mismatch between staffing levels and peaks of activity that are exacerbated by workforce shortages. The ideal AMU needs sufficient capacity to process acute admissions and keep patients who do not require transfer to a speciality unit for up to 72 hours, as this continuity of care reduces length of stay. Bypassing AMUs to general medical or speciality beds can increase length of stay.

An increasing range of presentations no longer require that patients remain in hospital overnight and are managed through SDEC pathways. Thirty per cent of older people who do not need hospital care may be managed in a collaborative way between primary and secondary care in the SDEC setting where relevant investigations may be prioritised to avoid the need for an inpatient stay. If more intensive care is required over a short period of time studies have shown that acute medicine hospital at home models can provide care traditionally delivered in hospital. These can include senior clinician decision making, multi-disciplinary assessment and rehabilitation, physiological monitoring using digital technologies, delivery of intravenous treatments and escalation plans, should there be a deterioration in the patient's condition.

Patient complexity and expectation will continue to increase for the foreseeable future. Acute medical services must continue to evolve and adapt and it is imperative that the proven fundamentals are not overlooked in the likely futile search for a “magic bullet”. High quality research, consistent implementation, and rigorous evaluation of new initiatives to understand acute patient flow and performance are mandatory.

Percentage (unplanned admissions) meeting Clinical Quality Indicator	Year							
	SAMBA22		SAMBA21		SAMBA20		SAMBA19	
	%	95% CI	%	95% CI	%	95% CI	%	95% CI
Early Warning Score within 30 minutes	68.8%	67.7-69.9%	78.6%	77.7-79.5%	74.9%	73.7-76.1%	81.3%	80.4-82.3%
Assessment by Tier 1 Clinical decision maker within 4 hours of arrival	78.7%	77.8-79.7%	87.4%	86.6-88.1%	84.4%	83.3-85.3%	87.7%	86.8-88.5%
Review by consultant within target time	49.8%	48.5-51.0%	67.8%	66.6-68.9%	61.9%	60.5-63.3%	68.6%	67.3-69.8%

Figure 1: SAMBA data showing performance in key indicators of acute medical performance from 2019-2022.

Case Study:

A 42-year-old lady was undergoing chemotherapy for breast cancer in the winter of 2022/23. This is treatment given prior to curative surgery. Chemotherapy has a range of potentially life-threatening side effects which require urgent medical assessment, particularly those that may represent sepsis, as the treatment can result in a reduction in the body's white cells which aid in combatting infection.

At 2am following her second chemotherapy treatment, our patient developed a fever, had an episode of profuse diarrhoea and felt unwell. She rang her local cancer telephone helpline, who advised she needed urgent admission. Unfortunately, there were no beds on the acute cancer admissions unit and she was diverted to her local emergency department.

She arrived in an extremely overcrowded emergency department. The waiting room was full. Many patients appeared to have flu-like illnesses experiencing coughs. This made her feel anxious as she knew she was more susceptible to infections following her chemotherapy.

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She was seen by a triage nurse who profusely apologised that there was no space in any cubicles. Some initial tests were commenced. Our patient found a space on the floor in the corner of the waiting room and lay there for a number of hours. She noted how hard the emergency medicine team were working and how many patients were experiencing appalling conditions. She felt a little better, was concerned that she may pick up further infections if she remained in the emergency department and after six hours left. Later in the day, she re-contacted her cancer telephone helpline and was assessed at her cancer centre receiving outpatient treatment.

Following her fourth chemotherapy treatment, she felt unwell with significant fevers. She developed abdominal pain, profuse diarrhoea and oral ulcers. Given her previous experience and also noting pressures on the emergency care system, she decided not to contact the cancer telephone helpline. Two days later, when these symptoms persisted and she started to feel extremely she finally called and she was admitted directly to the cancer centre.

Largely due to her delayed presentation, she was acutely unwell on arrival. She required admission for inpatient care with intravenous antibiotic therapy and supportive treatments. With early presentation, the majority of these patients can be managed in an ambulatory setting.

Timely and high-quality care is essential for patients experiencing complications of cancer therapy, as it is for all patients with chronic medical conditions that have an acute presentation. This not only improves their outcomes, but early assessment can often prevent deterioration so that patients can be managed in ambulatory setting or have a shorter inpatient admission. Patient experience and confidence that this will be delivered is an essential tenet in achieving this.

Pathology and Radiology

Almost all clinical services require timely and reliable support from diagnostic services, mainly radiology and pathology. These are clinical services that are often neglected, but are critical for decision making. Attempts to bring new diagnostic modalities into clinical practice must consider health inequalities. Access to investigations is variable in clinical areas of practice and this creates delay and inequity.

Point of Care Testing (POCT)

Having point of care testing (POCT) brings benefits to patient care; however, without appropriate oversight it can also introduce risks that derive from the inherent characteristics of the device, operator error and, in result, interpretation. The use of POCT as an alternative to central laboratory testing should be considered as a clinical governance issue and needs examination of clinical effectiveness, as would be found in the laboratory. Consequently, before deciding whether to implement a particular point-of-care test it is essential to establish a clinical need, including an assessment as to whether reconfiguration of a central laboratory service would be a more effective option. Consideration of clinical need should be evidence based where possible, involve laboratory experts, and clearly identify benefits and risks of introducing a point-of-care test. The risks and benefits of using POCT are defined in the National Strategic Guidance for at Point of Need Testing. [New strategy for Point of Care Testing published \(rcpath.org\)](#)

Section 2: The Wrong Care

This section describes a series of common chronic and important conditions that present to almost every hospital. In each case, patients were unable to get the right care for their needs and this resulted in avoidable emergency admissions, increased costs, increased length of stay and harm. Emergency and elective care cannot be seen separately, they are interconnected. Problems in one area inevitably affect other areas.

Older people with frailty in Acute Care

Analysis

Frailty describes a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserve. Older people with frailty are more likely to become severely unwell, even if they have a minor illness. We can identify frailty, and how severe it is, using validated scales. In the community general practitioners can do this using the electronic Frailty Index (eFI), which is built into clinical systems. In acute care, it can be identified using the nine-point Clinical Frailty Scale.

Frailty affects up to half of the population aged over 85 and costs UK healthcare systems £5.8billion per year. Around 47% of hospital inpatients aged over 65 are affected by frailty. Older people with frailty are more likely to experience delayed transit to hospital, long waits in emergency departments and delayed discharge at the end of their hospital stay.

Much of the current focus in national policy is around enabling people with frailty to receive care closer to home – for example through Urgent Community Response, Enhanced Health in Care Homes and Hospital at Home. But when older people with frailty do find their way their way to hospital, many of the delays they face are avoidable with appropriate care and management.

The British Geriatrics Society's (BGS) *Joining the Dots* document outlines several important ways in which this can be achieved:

- Front-door frailty services to enable specialised multidisciplinary assessment as soon as possible after arrival at hospital, enabling both prompt initiation of specialist care and discharge to home with support where possible
- Ensuring that older people with frailty can access specialist geriatrician-led frailty assessment and input through Same Day Emergency Care (SDEC) Services
- Avoiding deconditioning once older people are admitted to hospital, through early mobilisation led by nursing staff and supported by therapists, to maximise functional independence and reduce the need for rehabilitation on discharge

- Focus on the principles of 'home first', where early and frequent assessment and liaison with discharge to assess services, supports people to leave hospital as soon as they are safe and able to do so.

'Right-sizing' discharge capacity for older people – making sure that there are enough spaces in the Discharge to Assess pathway and in social care (domiciliary care and care homes) – is essential if the delays experienced by Mr Smith (in our case study) at discharge are to be avoided.

Case Study:

Mr Smith, an 82-year-old man, lives alone at home. He looks after himself independently. He walks around the house without any aids. He uses a walking stick outdoors. He has no family. He has been slowing down with his walking lately and has lost a stone in weight.

He has a past medical history of high blood pressure, atrial fibrillation and heart failure and is taking ten separate medications. He has a fall at home, and eventually manages to crawl to the phone to get help after four hours. An ambulance takes four hours to arrive. He is taken to the nearest emergency department, where he is seen by a doctor after a further four hours and has some blood tests and a brain scan. His brain scan is normal, and his blood tests show minor dehydration.

He is transferred from a trolley to a bed and eight hours later moves to the medical admissions department. When the medical team come to visit him, it is the middle of the night. They put up a drip to help with his dehydration and put in place a plan to do some detailed lying and standing blood pressure measurements the following morning.

He is seen the following morning by a geriatrician. This is 30 hours after he fell, and he has spent 22 of those hours lying in bed. The geriatrician struggles with nurses to get him up and out of bed and finds that his blood pressure drops dramatically on standing. The geriatrician stops three blood pressure medicines, one of which is the likely cause of his dehydration. She asks for the therapy team to come and assess the patient. The therapy team are unable to get Mr Smith up out of bed because of dizziness on standing and postpone his review until the following day.

The following day, Mr Smith has been admitted to a short stay unit ward. His blood tests show that his dehydration has resolved. His blood pressure no longer drops severely on standing. The therapists are able to get him up and standing but unable to get him walking independently as he did before his fall. They provide him with a Zimmer frame and request for him to go home with rehabilitation support under a programme called discharge to assess.

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There is no discharge to assess capacity that day. In the middle of the night, Mr Smith tries to get up to the bathroom and falls, hurting his hip and his ribs on the right-hand side. He is seen by an out-of-hours doctor and a hip and chest x-ray, and a further brain scan, are organised. Fortunately, there is no evidence of fractures or bleeding into his brain.

The following day, the therapy team revisit Mr Smith to find bruising down his entire right-hand side. This has further affected his mobility and he is no longer felt to be safe walking independently with his Zimmer frame. His discharge plan is changed to care home based rehabilitation – a different discharge to assess pathway.

Mr Smith waits a further four days in hospital. The system is under substantial pressure and he is eventually sent to a care home 'spot-purchased' rehabilitation bed on the far side of the county. Because this bed has been purchased by the NHS in a hurry, the rehabilitation staff are able to visit him only infrequently. Planning for discharge to home is complicated by the substantial distance between the care home and Mr Smith's house – 45 miles.

After three weeks in the rehabilitation care home bed, Mr Smith has seen little input from the therapy team, has made little progress with his mobility, and a decision is made that he should be discharged to home. He is sent home with a Zimmer frame, a special chair to help his carers get him up, a special mattress for his bed, a commode to help with toileting, and plans for future modifications to his bathroom. He needs carers to come three times a day to help him get up in the morning, to prepare and serve his meals, and to help him to bed in the evening. They help him get washed twice a week. He never returns to the level of independence he maintained before his fall.

For Mr Smith early specialist assessment in the emergency department could have stopped his harmful medications sooner, and organised therapy assessment, starting a mobility plan before he reached the admission unit. This, in turn, could have prevented his worsening mobility, the need for a Zimmer frame and reduced his rehabilitation requirements on discharge, reducing delays in the process. Ready availability of discharge to assess capacity would have got him home sooner, and right sizing the discharge to assess system would have removed the need for reliance on poorly resourced spot-purchased beds. Many of the delays experienced by older people are a consequence of harms sustained from a healthcare system not designed to meet their needs. Focusing on the principles outlined here, will help prevent such harms from occurring.

Reference

BGS joining the dots: a blueprint for preventing and managing frailty in older people - <https://www.bgs.org.uk/Blueprint>

Delirium in Acute Care

Analysis

Delirium, previously known as 'acute confusional state', is a state of rapid deterioration in brain functioning that emerges over hours or days and which is typically triggered by an acute illness, drug side-effects, injuries, surgery, or psychological stress in vulnerable people. Though anyone can develop delirium, vulnerability is greatly increased with old age, pre-existing dementia, and frailty.

A key feature of delirium is its rapid onset; this distinguishes it from dementia which has an onset of months or years. Most episodes of delirium resolve in three to seven days, but around 20% of cases persist for weeks or months. People with delirium can present in a number of ways. Features include confusion, disorientation, agitation, drowsiness, hallucinations, delusions (often with paranoia), and altered safety awareness leading to an increased risk of falls. Delirium is present in around 50% of patients who fall in hospital.

Delirium is a very common and consequential medical emergency. It affects one in four older patients in hospital. It is associated with several problems including higher death rates, higher falls rates in hospital, and longer length of stay. People with delirium are much more likely to require ongoing downstream NHS inpatient care, often require increase care if discharged, and they have a two to three increased chance of need of new care home admission. Research shows delirium is linked with a much higher risk of future dementia, and also acceleration of existing dementia.

Effective delirium treatment requires several key elements. The first step is to detect it and then to determine what the triggers are, and then to treat the triggers promptly. Delay in detection and treatment of triggers is associated with increased severity and duration of delirium. Delay also likely results in worse longer-term outcomes. Other elements of effective care include recognition and care of symptoms such as distress and agitation, prevention of complications such as malnourishment and falls, communication with family members with involvement of family in care (for example assisting with re-orientation and providing reassurance) if possible, maintaining level of mobility and providing cognitive rehabilitation. Delivery of this complex set of elements requires a skilled and well-staffed team. Poor care resulting from missing elements, especially delays in diagnosis and treatment and lack of a multidisciplinary team in ongoing care, is associated not only with worse outcomes but also increased burden on the NHS and social services.

It is recognised that despite some improvements, delirium recognition and effective treatment, especially in the ED, remains poor. Staff education is effective in improving care and outcomes, but surveys indicate poor staff knowledge of delirium. Many experts in delirium believe that increasing staff knowledge of delirium through education is a key priority in improving care.

Notably, there is emerging evidence that early recognition of delirium at home coupled with robust hospital at home care is effective and can prevent unnecessary hospital admission.²

Case Study:

Mrs PT, an 85-year-old lady, is living at home. She has some concerns about her memory but generally manages with day-to-day activities around the house. She relies on her son Mr AT for shopping and has a carer visiting once per day in the evening to prepare a hot meal.

Mr AT phones his mother at lunchtime but there is no reply. He is concerned and leaves work early to visit. He finds his mother lying on the floor beside her bed. She is sleepy and though she is not speaking much is obviously confused. She looks distressed. She appears to be seeing people that are not there. When Mr AT tries to get his mother to sit up she is hostile to him, pushing him away. At 4pm Mr AT phones the GP who says that Mrs PT will need hospital admission and arranges an ambulance. The ambulance arrives at 11pm. The paramedics note that Mrs PT is unwell with low blood oxygen levels, a low temperature, a raised pulse rate and a low blood pressure. They also note that she is drowsy and confused, appearing to be grasping at imaginary objects, and record that she has delirium. They are very concerned about her wellbeing. Oxygen and intravenous fluids are administered. Mrs PT is transferred to a trolley with some difficulty as she is still resisting being handled. The paramedics take Mrs PT to the nearest ED by ambulance with blue lights, arriving at 11.45pm.

In the ED Mrs PT is reviewed by a nurse at 11.55pm. There is ongoing treatment with oxygen and intravenous fluids, and investigations including blood tests and a chest X-ray are performed. A doctor reviews her at 2.30am, and notes that the history, physical examination findings and investigation results are consistent with diagnoses of pneumonia and delirium. At that stage she remains drowsy. Antibiotics are added, and the doctor arranges for Mrs PT to be transferred to an inpatient acute medical bed. Mr AT goes home at that stage. Mrs PT remains in the ED on a trolley.

At 6am Mrs PT starts shouting out, calling for her son. When approached by a nurse Mrs PT shouts loudly and tells her to go away, and she tries to climb off the trolley. Staff are concerned that she will fall and try to encourage her to stay there. Mrs PT does not respond to the staff's requests and tells them that she needs to go home and that they should not be keeping her 'locked up'. She tells the staff that she is going to call the police and that their behaviour is 'disgusting'. Mrs PT becomes more agitated over the next hour and staff administer an intramuscular injection of an antipsychotic drug called haloperidol in an attempt to sedate her. This does not have any apparent effect and a further dose is administered 40 minutes later. This second dose reduces the level of agitation to some extent. Mrs PT falls asleep, though she wakes up intermittently, calls out, and tries to get off the trolley, and frequently nurses have to move quickly to Mrs PT to prevent her from falling. Her oxygen levels, pulse rate and blood pressure have all improved by 9am. At 1pm she is transferred to an inpatient acute medical bed.

Mrs PT is reviewed by the medical team on the ward who note some improvement in the pneumonia but ongoing delirium. Over the next three days the delirium fluctuates, with episodes of drowsiness alternating with episodes of agitation and paranoia. Attempts at physiotherapy to help Mrs PT maintain her

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mobility are challenging. The staff note that Mrs PT is drinking and eating less than she needs. Mr AT is alarmed that his mother has remained unwell with delirium despite the successful treatment of the pneumonia. He is informed by the staff that delirium can take days or weeks to resolve even if triggering illnesses like pneumonia are identified and managed.

The team of doctors, nurses, physiotherapists and occupational therapists decide that Mrs PT is not well enough to return home at that stage and she is transferred to a geriatric medicine ward. Over the next five days Mrs PT is treated by the team with a combination of ongoing medical care, nursing care including ensuring adequate nutrition and careful skin care to avoid pressure sores, physiotherapy, and occupational therapy. Mr AT visits daily and notes some improvement. Mrs PT is less distressed, is more orientated and less suspicious of staff. However, she is still having difficulty mobilising safely and she is still sleepy at times during the day. The team decide that Mrs AT will need further time in hospital and arrange for a transfer to a medicine of the elderly rehabilitation ward.

Mrs PT is transferred to the rehabilitation ward two days later. In this ward there is ongoing supportive care including physiotherapy. A week after transfer Mr AT feels that his mother is almost back to normal though she is more forgetful and unsteady on her feet than before. The team decide that Mrs PT can be discharged home with an enhanced package of social care, with carers visiting three times per day to assist with personal care and administration of drugs. The package of care takes five days to set up, at which point Mrs PT is discharged home.

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Emergency Surgery

Analysis

Emergency surgeries for abdominal conditions pose significant challenges and carry substantial risks for patients. These conditions, such as bowel obstruction, bowel perforation, and infections, require prompt surgical intervention to prevent further deterioration and organ failure. However, the complexity of diagnosing these conditions and the need for multidisciplinary involvement make timely and effective management challenging.

Approximately 30,000 individuals undergo emergency abdominal surgery each year, and a significant proportion of them are elderly, with around half being over the age of 65. Without timely surgery, patients can rapidly deteriorate, experiencing infections and sepsis that can lead to multiple organ failure. Even with surgery, the mortality rate before patients leave the hospital stands at approximately one in ten. Emergency abdominal surgery is a major procedure that involves general anaesthesia and often necessitates critical care admission post-surgery. The recovery period is long, both within the hospital and in the community, with most patients taking more than six months to return to their usual quality of life. Furthermore, many patients experience long-lasting physical and psychological effects.

The diagnostic pathway for emergency abdominal surgeries is complex and requires careful evaluation and collaboration among various healthcare professionals. Patients do not arrive at the hospital with a clear diagnosis, and abdominal pain - their primary symptom - can have various causes, some of which are urgent and require immediate attention. Proper assessment, including physical examination, blood tests, and CT scans, is crucial for accurate diagnosis and the development of an appropriate management plan. The involvement of specialists such as anaesthetists, intensive care physicians, and elderly care teams is often necessary to ensure comprehensive care.

However, in recent years, the challenges within this diagnostic pathway have intensified, exacerbating the difficulties in providing timely care for emergency abdominal conditions. Patients are presenting late to the hospital with advanced disease, often already in a deconditioned state due to their underlying illnesses. Delays in the entry and triage process at the ED lead to delays in the initial medical review. The overcrowding within the ED limits the physical space available for patient consultations and examinations. Subsequently, delays in diagnosis prolong patients' suffering, increasing pain and sickness, and escalating the risk of further deterioration. Patients may be cared for in corridors or outlying areas of the ED, hindering regular reviews by the appropriate teams and impeding the timely recognition of deterioration.

The impact of these challenges extends beyond the individual patients. The increased demand for medical and surgical admissions, coupled with the backlog of elective procedures, strains hospital resources. Wards are full, leaving no spare capacity to accommodate new admissions from the ED. Poor patient flow through the hospital intensifies pressures within the ED, leading to further delays in

reviewing new patients and establishing definitive management plans. As a result, patients are at risk of deteriorating despite being within a hospital setting.

The eighth patient report of the National Emergency Laparotomy Audit (NELA) sheds light on the standards of care for patients undergoing emergency bowel surgery. The analysis, covering a period from December 2020 to November 2021, encompassed 22,132 patients across 173 hospitals in England and Wales. The findings revealed several areas of concern. The mortality rate for patients undergoing emergency abdominal surgery stood at 9.1% within the hospital. Patients with suspected sepsis experienced significant delays, with a median wait of 15.6 hours until surgery commenced (compared to the target of six hours), and a median time of three hours until the first dose of antibiotics (compared to the target of one hour).

The postoperative care also showed variations in quality. While 79.1% of high-risk patients were admitted to critical care, a concerning 15.7% of high-risk patients were placed on general wards. The length of postoperative stay was considerably longer for patients who experienced serious complications requiring a return to the operating room. Older people, particularly those over the age of 65 and frail or over 80, faced additional challenges. Only 31.8% of these patients received postoperative input from a consultant geriatrician-led team, leading to a higher mortality rate of around 14% compared to approximately 23% for similar patients who did not receive specialised care.

Case Study:

A 78-year-old man had abdominal pain which had been coming and going for a few weeks. His appetite was poor, he tired easily and had lost some weight. He didn't leave the house much during the day and went back to bed most afternoons. One night his pain became much worse, and he started to vomit. An ambulance was called.

He arrived in the emergency department at 9am. He was seen by the triage nurse at 9.30am. The department was busy, he was not seen by the emergency medicine doctor until 10.30am. His family were not with him, he could not remember the medications he took, only that some of the tablets were for diabetes and high blood pressure. An hour later he was reviewed by a more senior doctor in the emergency department and referred to the surgeons (surgical registrar). She was busy operating but promised to attend as soon as possible. She reviewed the patient at 12.30pm, agreed there could be a serious problem within his abdomen and asked for an urgent CT scan to be performed. Due to a car crash and several trauma patients, there was a queue for the CT scanner.

The scan was completed at 2pm but the images were not immediately reviewed as the radiologist was busy dealing with the scans from the patients involved in the car crash. The scan was reported at 4pm and showed what was suspected to be a cancer in the bowel which had caused blockage (obstruction). The bowel was so obstructed that the bowel had torn, spilling faeces into the abdomen outside the bowel. The patient appeared more comfortable after some strong pain relief

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(morphine) but was becoming sleepy and unable to take in much of what was going on around him.

The surgical registrar came back to see the patient again at 4.30pm. She looked at the CT scans and report and talked to both the patient and his family who had now arrived in the department. Emergency surgery to remove the blocked and torn bowel was recommended. The junior anaesthetist came to see the patient and spoke to their consultant who was busy in theatre with a patient. They said they would see the patient in theatre. Antibiotics were prescribed at 5.30pm but not given as the patient was moving to theatre soon. It was some time before the patient was moved to theatre because there were no empty theatres with staff.

The patient arrived in theatre at 8pm, where he was given his first dose of antibiotics. The surgery took several hours but went well. The bowel could not be joined up because of the amount of faeces that were in the abdomen and the patient was given a stoma (bowel stitched to the abdominal wall for faeces to collect in a stoma bag. The patient went to intensive care at 1am and stayed a couple of days, before being moved to the surgical ward. On the ward he was confused, reluctant to start eating, developed swelling of his legs, and even with help of the physiotherapists struggled initially to mobilise at all, even just to sit in a chair. He was unable to manage the stoma bag on his own. His family lived an hour away from him and were not able to help with the stoma. Local care services were not able to provide carers to empty and take care of the stoma bag. After several weeks in hospital, the only safe option was to be discharged and move into a care home.

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Respiratory Medicine

Analysis

Integrated care is increasingly recognised as a way to deliver improved patient outcomes, patient experience, and system efficiency. However, evidence regarding its impact is mixed [1], probably due to all components not being present [2].

As recognized in the NHS Long Term Plan [2] respiratory disease affects one in five people in England and is a major cause of mortality. With hospital admissions for lung disease rising faster than those of other causes, it is noteworthy that up to a third of people admitted with an exacerbation of COPD re-attend within a month [3]. Respiratory admission rates are 2-3 times higher in winter compared with summer. These are common diseases that require good integration of community and hospital care.

Case Study:

Kate is a 60-year-old lady who lives alone. She has a history of asthma since childhood but also a 40-year history of smoking. She was referred to her local hospital respiratory outpatient service in spring 2021 due to progressive breathlessness. No diagnostic tests had been performed in primary care due to the impact of Covid-19 and a failure to yet restart services.

Unfortunately, in spring 2022, she was admitted to hospital due to increasing breathlessness. A clinical diagnosis of an infective exacerbation of Chronic Obstructive Pulmonary Disease (COPD) was made. Following this, inhalers were started and she stopped smoking. Due to capacity issues, and the redeployment of staff, she had still not been seen in the respiratory clinic 18 months later.

To maintain any quality of life she had been using intermittent, and then regular, oral steroids and was receiving antibiotics on a monthly basis. As she was now housebound and could not work, her GP attempted to expedite respiratory review. Since the original referral the acute provider and Integrated Care Board had set up a formal integrated care service for respiratory patients. This involved a respiratory team with input from senior clinicians from the acute provider. Kate was seen in a community clinic by advanced nursing practitioners and her holistic needs were assessed. This included obtaining a chest x-ray, spirometry, reversibility and Fractional Exhaled Nitric Oxide (FeNO) test from a community diagnostic centre, oxygen assessment by the community team in the patient's own home and discussion of the clinical history, examination and results of investigations in a community multi-disciplinary team.

Her inhalers were modified, and ambulatory oxygen was assessed and commenced with plans for starting pulmonary rehabilitation (PR). In late 2022, whilst waiting to commence PR she developed a further chest infection. Unfortunately, there was no admission prevention service covering her location so she could not be offered hospital at home management. She was admitted via

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the ED. There were no beds on the Acute Medical Unit (AMU) so she spent 32 hours in the ED. She then went to AMU as there were no beds on the respiratory ward. During this time she was not seen by a respiratory specialist. She deteriorated and was started on Non Invasive Ventilation (NIV) for type 2 respiratory failure and transfer was expedited to the respiratory support unit.

She required a prolonged course of NIV. Nine days later she was ready for home with some short term re-enablement support, but there was insufficient community re-enablement capacity so she was transferred to a community hospital for a short period of physiotherapy/re-enablement.

The day before planned discharge from the community hospital she contracted a hospital acquired pneumonia, and was transferred back to the acute hospital. Seven days later she was again ready for home. She refused transfer to the Community Hospital and instead waited another three days for home based re-enablement care. Throughout her journey the inpatient respiratory nurses had provided reassurance and explanation, given appropriate information and liaised with the community team around discharge, including assessing inhaler use, social and palliative care needs and consideration of advanced care planning.

Kate was seen again in the community service following discharge and repeat chest x-ray showed clearing of the pneumonia. To reassess her formally full lung function tests and a CT thorax were performed. She remained breathless despite completing pulmonary rehabilitation.

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3: Alqahtani JS, Aldabayan YS, Aldhahir AM, Al Rajeh AM, Mandal S, Hurst JR. Predictors of 30- and 90-Day COPD Exacerbation Readmission: A Prospective Cohort Study. Int J Chron Obstruct Pulmon Dis. 2021; 16:2769-2781. doi: 10.2147/COPD.S328030.

Critical Illness

Analysis

"Given the individual impact on patients, and ripple effects on families and society in general, poor-quality rehabilitation and impaired recovery from severe illness should be regarded as a major public health issue." National Institute for Clinical excellence (NICE) Clinical guideline (CG) 83.

Survivorship after critical illness is often marked by a decline in quality of life, prolonged recovery periods, and various physical, psychological, and cognitive impairments. To address these challenges, coordinated services for rehabilitation and recovery are crucial. However, post-intensive care recovery services are lacking across all four nations, with only 74% of hospitals offering such services. Furthermore, 71% of these services rely on internal or miscellaneous funds, lacking financial security.

The inconsistent commissioning of post-intensive care recovery services perpetuates inequities in care between regions, hospitals, and even among patients in adjacent intensive care beds. Eligibility for rehabilitation can differ based on the reason for admission, creating disparities between patients, such as those admitted for stroke or trauma compared to non-trauma cases.

There is a compelling economic case for UK-wide commissioning of post-intensive care recovery services to ensure equitable and consistently high-quality care:

- Within three months of returning home, 30% of intensive care survivors require readmission to the hospital.
- Only 60% of previously employed survivors of critical illness are able to return to work within one year post-discharge.
- After returning to work, 36% of survivors experience job loss, 66% undergo occupation changes, and 84% experience a decline in employment status.

The UK has been at the forefront of identifying the challenges faced by patients after critical illness and evaluating methods to improve outcomes. In 2018/19 alone, 163,000 patients were admitted to critical care, with 80% surviving to hospital discharge. With an aging population and advancements in medical care and technology, the demand for critical care beds is expected to rise, making it crucial to address the needs of patients and their families.

To ensure the well-being of our patients, immediate and coordinated responses are needed to tackle these challenges and support their full recoveries. Commissioned services, guided by contracting regulations, can standardise care and assume full responsibility for patient well-being throughout their entire health episode. This alleviates the burden on general practitioners who may have limited exposure to post-intensive care patients. It is imperative to establish effective links between community, secondary, and tertiary services to reduce the risks of hospital readmissions and enhance the chances of early return to work for survivors of critical illness.

Case Study:

Paul:

“Within a few days of being admitted to hospital I was diagnosed with Guillian-Barre Syndrome which caused severe paralysis. I spent four months in hospital, one of which was in Intensive Care and it was fourteen months before I was able to return to work on a full-time basis.

“It wasn't long after my stay in intensive care that I began to realise the importance of the support, both psychological and physical, provided by the Rehabilitation after Critical Illness (RaCI) team.

“Before being discharged to a general ward the reduction in the level of nursing care from one to one, to eight or maybe ten to one was explained, triggering a feeling of insecurity in myself and my relatives. This was eased by the knowledge that the RaCI team would be monitoring my progress and would visit if there was any possibility of my condition deteriorating.

“Support by the team continued after discharge from hospital with access to the follow-up clinic. The follow-up clinics provided an opportunity for me and my wife to discuss with the team any problems that had developed since my discharge and any ongoing concerns about my treatment and its possible long-term effects on my recovery. I was fortunate in that the team had involved the Community Trust in my rehabilitation care plan as this enabled me to have physiotherapy for a number of months at home.

“The programme developed by the RaCI team went a long way to alleviate the trauma that I and many others develop after a stay in intensive care. The support provided by the team was, and still is, available to me and my relatives 24/7 as there is no statute of limitations on the effect of a stay in intensive care.

“I was fortunate to be involved in the creation of the Reading ICU Support Network that complements the work of the RaCI team. This has made me aware of the ongoing need to support both patients and their relatives/carers for, in some cases, many years after the experience of a stay in intensive care.”

Diabetic Ketoacidosis

Analysis

Delays in busy emergency departments pose significant risks to patients who rely on time-critical medicines such as insulin, Parkinson's drugs, and steroids. Although these patients are handed over to medical teams for care, they may not be seen for several hours, putting them at risk of harm.

While medical teams are increasingly working alongside emergency department staff, it should be noted that these departments are not designed, nor have established mechanisms, for regularly prescribing medications. Nursing staff responsibilities are split between providing ward type care and assessing new patient arrivals. This can result in the omission of time critical medicines, leading to potential harm for patients.

Prescription charts are not commonly initiated in the emergency department, and even in hospitals where Electronic Prescription of Medicine and Administration Systems are implemented, they are not used until after the patient has been admitted to an inpatient ward. This delay in prescribing processes further contributes to the risks associated with the omission of time critical medicines in emergency departments.

Although emergency departments are aware of the importance of time-critical medicines, the delays and overcrowding within these departments increase the likelihood of medication omission, placing patients at further risk.

To address these issues, it is crucial that patients and their relatives who have been managing their diabetes should be listened to and given the opportunity to self-manage their diabetes medications, if they are capable of doing so, in all locations, including the emergency department. This patient-centered approach can help mitigate the risks associated with delays and ensure that individuals receive the vital medications they need in a timely manner, regardless of their location within the healthcare setting.

Insulin is a time-critical medicine. Lack of insulin can result in potentially fatal diabetic ketoacidosis. The increasing demands on emergency departments have resulted in patients experiencing long waits in ambulances, in the department itself, and sometimes in hospital corridors before they are transferred to the ward. Recently diabetes teams around the country have reported seeing an increasing number of people with diabetes developing diabetic ketoacidosis because this time-critical medicine was not given in the ED. The following case is illustrative.

Case Study:

A 71-year-old man with a 61-year history of Type 1 diabetes was admitted to the emergency department at 5.12pm with a community-acquired pneumonia and acute kidney injury. His previous history included coronary artery bypass grafting, and peripheral arterial disease. Despite these conditions he was previously fully independent and had well controlled diabetes on a basal bolus regimen of rapid acting analogue insulin, 7-18 units before meals (self-adjusting) and a basal insulin, 12 units at bedtime.

At the time of admission, he was alert and sitting up. His Glasgow Coma Scale (GCS) was 15 and News Score 3. He was breathless and ill with pneumonia, but his diabetes was well controlled at this point.

Appropriate treatment for his infection was commenced. However, he was not given insulin, nor was a drug chart for insulin started. This was despite him informing the admission staff that he had missed his bedtime basal insulin and had not had his mealtime insulin.

He remained in the emergency department for the next 10 hours before being transferred to a medical ward in the early hours of the morning, but was not reviewed by the medical team until later that morning. His wife was concerned that he had not received insulin and offered to help him give his rapid acting insulin but was prevented from doing so by the nurse as it was not prescribed. His condition deteriorated and by the afternoon he was found to be in diabetic ketoacidosis.

Despite treatment of diabetic ketoacidosis his condition deteriorated. He died three days following admission. His death was probably avoidable. He had managed his type 1 diabetes for over 61 years, a commendable achievement, but he was disempowered when admitted to hospital which resulted in diabetic ketoacidosis.

Gastroenterology

Analysis

The standards of care for patients with inflammatory bowel disease are established (1) and implementation is dependent upon functioning pathways supported by an appropriately staffed/skilled workforce. Early diagnosis and prompt treatment decreases hospitalisation, the need for surgery (2) allowing the majority of cases to be managed as out patients.

Units should have capacity to deliver services and sufficient time to develop quality improvement. Training numbers should reflect workforce need (currently 48% of newly advertised gastroenterology posts are vacant) and the complimentary workforce should be grown including clinical endoscopists, physician assistants, advanced nurse practitioners and CESAR schools for non-CCT holding doctors.

Effective use of the workforce is vital to deliver the quality improvements identified by IBD UK and GIRFT (getting it right first time) (3). This requires hospital-based gastroenterologist to focus on their specialty and patients with gastrointestinal conditions to be in the correct clinical area for the duration of their care. Ability to provide rapid access outpatient, virtual and diagnostic services is vital to prevent admissions and afford early discharge.

The challenges in bed occupancy negatively impacts upon locating patients in the correct clinical areas and generates further work for an over-stretched clinical body. Addressing flow through the healthcare system should remain a major priority.

The model of Inflammatory Bowel Disease (IBD) standard of care is published and over arches between primary and secondary care. Despite innovative practice in outpatient and endoscopic services, workforce remains a major restriction in the implementation of these standards.

Case Study:

Helen is a 28-year-old single mother who presented to her general practitioner with a four-week history of gradual onset bloody diarrhoea. She was well and observations were normal. Stool culture was negative and blood tests showed a mild anaemia and evidence of mild inflammation. A diagnosis of inflammatory bowel disease was considered and an urgent referral to secondary care made.

The referral was vetted as urgent by a consultant gastroenterologist, but due to workforce issues this could only be delivered at four weeks in a video consultation rather than a face-to-face clinic. There was no direct to test pathway available. Helen seemed well but was fatigued and was finding it increasingly difficult to look after her daughter. An urgent flexible sigmoidoscopy was requested but not performed for three-weeks due to capacity issues. By this time Helen had deteriorated with bowels opening six times a day with increased bleeding and feeling unwell. Sigmoidoscopy showed that her colon was inflamed. Due to the waiting list backlog the endoscopy was performed on a Saturday by a

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private company. There was no specialist nurse available, and the report was only acted upon four days later. Medicines were prescribed. Helen was given the contact details of the inflammatory bowel disease (IBD) nurses urgent follow-up appointment requested.

Despite medical treatments her condition did not improve, and she contacted the IBD nurses. There was a delay of five days in the response as the team had one vacancy and call were not always picked up within two working days. A course of oral steroids was prescribed. Helen continued to deteriorate, the outpatient appointment was delayed, and the Gastroenterology Department had no facility for a rapid face-to-face assessment (flare clinic) for treatment escalation. She was admitted after self-presenting to the emergency department with increasing symptoms. Her daughter was safely cared for by her parents.

Helen spent 24 hours in the emergency department as there were no medical beds available. She was now considerably more unwell. She was started on intravenous steroids and stool cultures, including Clostridium, individually were sent. She was transferred to the acute medical unit and then after a further 48 hours to the gastroenterology ward. Direct transfer was not available because of bed pressures. She received joint gastroenterology and surgical review daily. At day three she remained unwell and the decision to commence intravenous anti-TNF therapy was made. Surgery was considered and she was reviewed by the stoma therapist. Helen became increasingly emotionally distressed and was supported by the team including the IBD nurses; no inpatient psychology services were available.

She made a good response to anti-TNF therapy and was discharged at day seven. A clear medical plan was made with her and shared with her General Practitioner. Steroids were weaned and at six months she remained in clinical remission. However, she remained psychologically traumatised by the admission and was referred for counselling.

Helen's case demonstrates the impact of delays on clinical outcomes which firstly negatively impact the patients and their families, but secondly impact on NHS resources leading to avoidable bed days. Access to outpatient services were restricted and as a result her diagnosis and treatment were delayed. This resulted in an unscheduled admission, escalated treatments and consideration of surgery. In addition to the impact on her physical health she suffered considerable emotional trauma. This expensive admission and treatment could have been avoided.

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GIFT Gastroenterology

https://gettingitrightfirsttime.co.uk/medical_specialties/gastroenterology/

Conclusions

Preparing this report has been a sobering task. We are motivated by a desire to be able to look after our patients better, and we know what good care looks like for our patients. The patients in this report all could have had better care and this would have been cheaper, safer and more efficient. The problems we describe are common and important, our recommendations are implementable. We urge politicians and policy makers to act on our recommendations.

Disclaimer

Though the cases are real, we have changed many of the names and places to avoid identification.

Contributing Organisations

Association of Paediatric Emergency Medicine

British Geriatrics Society

British Thoracic Society

British Society of Gastroenterology

Centre for Perioperative Care

Diabetes UK

Faculty of Intensive Care Medicine

Royal College of Emergency Medicine

Royal College of General Practitioners

Royal College of Paediatrics and Child Health

Royal College of Pathologists

Royal College of Physicians of Edinburgh

Royal College of Physicians of London

Royal College of Psychiatrists

Royal College of Radiologists

Society for Acute Medicine

Contributing Authors

Martin Allen, British Thoracic Society

Jane Bayreuther, Association of Paediatric Emergency Medicine

Adrian Boyle, Royal College of Emergency Medicine

Daniele Bryden, Faculty of Intensive Care Medicine

Tim Cooksley, Society for Acute Medicine

Sarah Clarke, Royal College of Physicians of London

John Dean, Royal College of Physicians of London

Jugdeep Dhesi, British Geriatrics Society & Centre for Perioperative Care

Andrew Elder, Royal College of Physicians of Edinburgh

Adam Gordon, British Geriatrics Society

Kath Halliday, Royal College of Radiologists

Kamila Hawthorne, Royal College of General Practitioners

Adrian James, Royal College of Psychiatrists

Camilla Kingdom, Royal College of Paediatrics and Child Health

Alasdair MacLulich, Royal College of Physicians of Edinburgh

Mike Osborn, Royal College of Pathologists

Gerry Rayman, Diabetes UK

Lade Smith, Royal College of Psychiatrists

Victoria Tzortziou Brown, Royal College of General Practitioners

Andy Veitch, British Society of Gastroenterology



Patron: HRH Princess Royal
 Octavia House
 54 Ayres Street, London SE1 1EU
 Tel +44 (0)20 7404 1999
 rcem@rcem.ac.uk
 www.rcem.ac.uk

