Cafodd yr ymateb hwn ei gyflwyno i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar Flaenoriaethau'r Chweched Senedd

This response was submitted to the Health and Social Care Committee consultation on Sixth Senedd Priorities

HSC PSS 45

Ymateb gan: | Response from: Y Coleg Brenhinol Meddygaeth Frys | Royal College of Emergency Medicine

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Question 1: Initial priorities identified by the Committee

The Committee has identified several potential priorities for work during the Sixth Senedd, including: public health and prevention; the health and social care workforce, including organisational culture and staff wellbeing; access to mental health services; evidence-based innovation in health and social care; support and services for unpaid carers; access to COVID and non-COVID rehabilitation services; and access to services for long-term chronic conditions, including musculoskeletal conditions.

Q1. Which of the issues listed above do you think should be a priority, and why?

You can comment on as many or few of the issues as you want.

In your answers, you might want to think about:

- What impact or outcomes could be achieved through any work by the Committee?
- How the Committee might address the issue?
- When any Committee work should take place?
- Whether there are any specific groups, communities or stakeholders that the Committee should involve or hear from in any work?

Emergency Departments (EDs) are the front door of the health and social care system. The lights are always on, and patients know they will be cared for no matter what. It is often the most vulnerable in society that attend our departments and over the past few years, the rise in demand coupled with a lack of resource throughout the system have inflicted massive strain on our departments. Still, our staff continue to work tirelessly to provide care for all patients despite the fact some might be better cared for elsewhere. EDs were once the safety net for patient but have now become the safety net for the system. A poor performing urgent and emergency care system is a good indicator that there is a much larger system wide issue that must also be addressed. Below we delineate the core reasons for and symptoms of an underfunded and understaffed system that must be tackled with urgency.

Workforce

Staffing Numbers

Emergency Departments represent one of the most intense working environments in the NHS. Over the years, increasing demand and high bed occupancy has led to frequent occurrences of exit block. This results in crowded departments which have become all too common. The demanding nature of this setting is a regular cause of staff dissatisfaction, attrition, and career burnout. Furthermore, the pandemic has exacerbated many of these challenges – there is now an urgent obligation to plan for the future healthcare needs of Wales.

When coronavirus struck Wales, Emergency Medicine staff were already operating in understaffed and under-resourced departments. As illustrated in Table 1 below, the number of attendances is increasing every year, yet the physical size of hospitals has not

increased accordingly. This intense working environment puts a huge amount of strain on staff which can result in attrition from the specialty.

Additionally, ED workforce models are predicated on insufficient numbers of trained Emergency Medicine clinicians, who are expected to deliver safe care whilst quality assuring the actions of staff in training. Trainee staff form the majority of any ED workforce numerically and are expected to be delivering quality assured care in the same episode. Added to this is the churn of learners through EDs and increasing the service delivery, supervision and teaching responsibilities on the existing number of trained clinicians.

The table below shows that despite the number of Emergency Medicine consultants increasing at a constant rate, the expansion in consultant numbers is still not happening fast enough to cope with the level of demand growth. This results in continued understaffing in departments. Understaffing means the Emergency Medicine workforce consistently reports the highest levels of work intensity of all the medical specialties.[1] This leads to high levels of attrition from training and the specialty. RCEM has previously stated that to staff EDs safely, we should aim for a ratio of 1 Whole Time Equivalent (WTE) consultant per 4,000 annual attendances. Table 1 shows that Wales is now

	Year	Average number of WTE consultants	Attendances at Type 1 EDs	Attendances per consultant	Additional WTE consultants required to safely staff EDs
Wales	2016/17	65	787,587	12,116	100
	2017/18	75	809,127	10,788	
	2018/19	77	825,507	10,720	
	2019/20	84	735,902	8,760	

Organisational Culture

As the first wave of covid struck Wales, EDs were resilient enough to mount a scalable response to the pandemic. To cope with undifferentiated patients presenting to departments, EDs were rapidly reconfigured into streams to separate patients more likely to have COVID-19 from those less likely. EDs expanded into new areas of the hospital, changing the way that staff worked. There was a transformation in cross-specialty working, with an "all hands-on deck" approach, and what had previously seemed like an impossibility was achieved overnight. Inter-specialty communication and camaraderie meant that tackling healthcare pressures was no longer a siloed task. This created an environment in which staff felt able to do their job: caring for patients safely and efficiently. This manner of working should be encouraged and fostered; however, it is important to note that is certainly easier to collaborate in this manner when the battle to ringfence capacity disappears as it did during the first wave of the pandemic.

Wellbeing and mental health.

[1] This was well evidenced in the GMC National Training Survey 2019 which showed that 69.2% of EM trainees and 63% of trainers reported moderate or high levels of burnout (compared with the 49.9% and 46.8% average respectively across all specialties). General Medical Council (2020) National Training Survey 2019: Initial Findings Report. Available **here**.

Earlier this year RCEM undertook a UK wide membership survey that investigated the state of the Emergency Medicine workforce. Our report found that operational pressures, patient safety and staff wellbeing are intrinsically linked. The acute pressures that have been building over the past decade have had detrimental consequences on our workforce and our patients, resulting in staff considering reducing hours, changing careers, or retiring early. While we understand there are no easy fixes, there is an urgent need to act now. Only by tackling the root causes of poor staff retention and improving the staffing numbers of our EDs can we facilitate recovery from the mounting pressures of the past decade

Key findings from our report found that:

- *73% of respondents indicated that workforce pressures in their EDs impacted patient safety before the pandemic.*
- *59% of respondents experienced burnout during the second wave of the pandemic.*
- *59% described their levels of stress and exhaustion from having worked the second wave as higher than normal.*
- *In the next two years, 50% are considering reducing their working hours and 26% are considering taking a career break or sabbatical. When asked what prompted them to make this decision, 32% selected workload pressures and 35% selected burnout.*
- *In the next six years, trainee emergency physicians are considering reducing working hours (57%), taking a career break or sabbatical (45%), working abroad (36%), and changing specialty (25%).*

The pandemic certainly exacerbated levels of burnout among staff. One might assume that as we emerge out of the worst of the pandemic, and with levels of positive cases and hospitalisations on the decline that the intensity of work for staff would also be decreasing. However, this is not the case. In July 2021 four-hour performance was at its lowest since records began with only 60.7% of patients being treated, discharged, or transferred within four hours.

We would normally expect to see poor performance such as this exclusively in the colder months, yet EDs have found themselves under an avalanche of demand in recent times. demonstrated the immense pressures currently felt in emergency departments. The recent rise in demand is down to several reasons; EDs are caring for patients with increasingly complex conditions from long covid, people experiencing complications due to delayed or cancelled operations, and difficulties in accessing alternative health services during lockdown. Moreover, capacity pressures can be felt even more acutely due to the continuing Infection Prevention and Control measures that have resulted in fewer beds in the system. This poses significant challenges for the functioning of our NHS – a challenge that needs to be tackled urgently by policymakers.

Innovation in Health and Social Care

The best outcomes are achieved when patients have access to appropriate, well-resourced pathways that are able to deliver timely care. Due to chronic underfunding over the last decade, there has been a deterioration in access to these pathways, resulting in patients accessing healthcare in whatever way they can.

This has been clearly demonstrated by the rise in patients arriving to the ED having been directed there by phone-first services, despite the fact their needs would be more appropriately met elsewhere if these facilities existed or were more easily accessible.

Furthermore, many groups risk becoming excluded, including older people, disabled people, those from deprived areas or who are on low incomes, and those whose first language is not English or Welsh. To accurately assess the efficacy of the NHS 111 Wales service, data regarding its outcomes and effect on emergency attendances should be published, robustly analysed and evaluated.

In our recent membership survey, 51% of respondents felt as though phone-first services had increased or significantly increased demand in their department – in other words the opposite to the intended outcome. There is an urgent need to increase clinical validation in phone-first services, this strengthens clinical risk management, which in turn results in reduced attendances.

Public Health and Prevention

Emergency Physicians should not be routinely caring for people who present with predictable complications of specialised care or minor long-term health issues. The best and most cost-effective health care systems in the world are based on a strong primary care system; patients appreciate timely care, ideally with someone who knows their history. For primary care to be effective, capacity needs to match demand. The most successful healthcare systems in the world are founded on a strong primary care system.

Furthermore, we know that those living in the most deprived areas attended A&E twice as much as the parts of the population living in the least deprived areas.

It is often the vulnerable who feel as those they have nowhere else to go and in turn, attend the ED to receive care. Local Authorities across Wales must invest in preventative health to support the most vulnerable in society, this includes additional support for drugs and alcohol services, homelessness and immigrant health, domestic violence, and youth violence.

Mental Health

We acknowledge that patients experience care offered in our Emergency Departments in different ways. Patients who are suffering a mental health crisis often report having a poor experience, with long waits in an environment that is stressful and stigmatising. Across the UK, Liaison Psychiatry teams play a crucial role in the parallel assessment of mental health patients that attend Emergency Department who might also need medical care. Expansion of Liaison Psychiatry must go hand-in-hand with investment in preventative services, Child and Adolescent Mental Health Services, community support schemes and good telephone triage.

In addition, the coronavirus pandemic has exposed the shocking levels of inequality that persists in society. We do not underestimate the role Emergency Departments play in addressing health inequalities

Looking Ahead

The announcement earlier this year of £25m a year recurrent funding is welcome. The funding is intended to support people to access the right care, in the right place, as quickly as possible. However, this funding will only scratch the surface of what is required to transform the urgent and emergency care system. The six goals for urgent care laid out by the health minister hold a heavy focus on demand management and redirection. While this can be helpful it is only one small part of the solution as it assumes that the low acuity patient is the beginning and the end of the issue. Lasting improvement will require

an increase in capacity, namely beds, expanding the physical size of departments and the workforce in the long term to support the consistent increase in demand from all types of patients that is unlikely to cease.

Question 2: Key priorities for the Sixth Senedd

Q2. In your view, what other key priorities should the Committee consider during the Sixth Senedd in relation to:

- ***a)*** *health services;*
- ***b)*** *social care and carers;*
- ***c)*** *COVID recovery?*

You can comment on as many or few of the issues as you want.

In your answers, you might want to think about:

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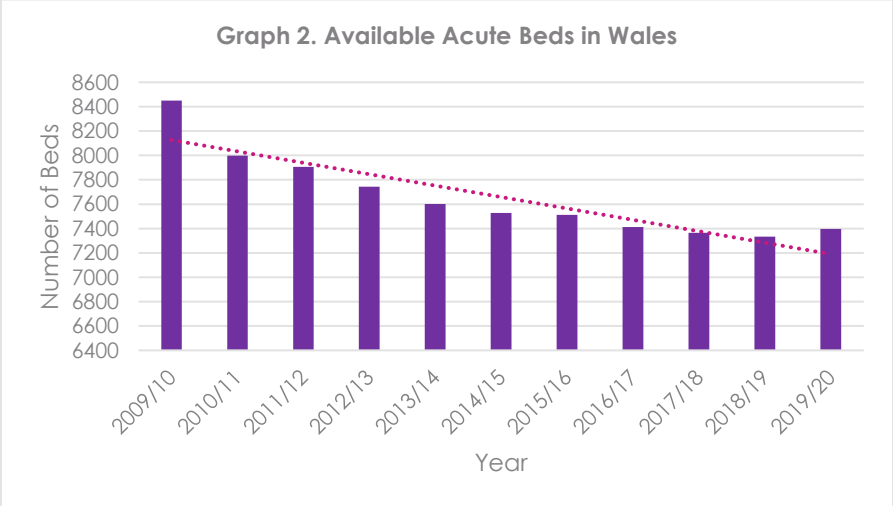
a) Health services

Beds

From Q1 2009/10 to Q1 2019/2020, there was a loss of 1,053 acute available beds in NHS hospitals across Wales. In this same timeframe, bed occupancy percentages rose from 79% to 86%, - higher than the recommended limit of 85%. Moreover, we know that further beds have been taken out the system during the pandemic to allow hospital to comply with Infection Prevention and Control measures. Importantly, bed numbers prior to the pandemic should not be seen as the standard that we need to return to, as bed occupancy levels were higher than what is deemed safe and putting strain on hospitals, which in turn can decrease the quality of care that patients receive.



High levels of bed occupancy are an important indication that the health system is under pressure. Maintaining bed occupancy rates of 85% ensures that there's additional capacity in the system to meet surges in demand and to enable patients to receive the

care they need in a timely manner. Safe bed occupancy levels have not been achieved for Acute beds since 2013. For medical acute beds, safe levels have not been met since records began.[2] Insufficient bed availability can lead to increased waiting times for patients, crowding and consequently corridor care in EDs, and it can increase the rate of hospital-acquired infections, which has become even more dangerous due to the pandemic.

High bed occupancy rates are part of a large domino effect that is indicative of a system under pressure. When bed occupancy levels are high it becomes extremely difficult to admit patients in a timely manner. Most EDs have been stretched beyond the capacity for which they were designed and resourced to manage at any one time. As a result of this, long delays, crowding and corridor care have become commonplace in our EDs. This is distressing for both patients and staff. Studies show that this environment is linked with lower quality of care for patients and increased mortality, with elderly and vulnerable patients most affected.[3]

Furthermore, the effects of crowding trickle out beyond the ED. When bed occupancy is high, ambulances arriving to the department with patients who are ready to be admitted are then required to wait and care for the patient in the ambulance until a bed becomes available. This creates what is known as ambulance stacking. With ambulances tied up outside the ED, they are then not able to respond to calls from the community and this can have devastating consequences.

In In the short term, we're advocating for a safe restoration of bed capacity to pre-pandemic levels. However, we must see an expansion of the bed stock in line with our OECD peers. This cannot happen without addressing the staffing crisis in the NHS. As the Nightingale initiatives during the pandemic revealed, we cannot expand capacity in the NHS if we do not have enough doctors, nurses, and clinicians. Additionally, EDs face the consequences of a failed social care system which does not allow for the timely discharge of vulnerable patients. This often results in patients being cared for in corridors. Any discussion of capacity in the NHS must take into account the challenges facing our social care system. In the long term, bed numbers must restored beyond pre-pandemic numbers to address the consistent high bed occupancy rates and reduce crowding in departments.

b) Social care and carers

Increasing numbers of people are living longer with a complex range of medical needs and as our wider Health and Social Care service has not been developed to address this need, Emergency Departments are now the first port of call for many patients.

Once patients are in the department, many are being kept in hospital for longer than necessary, again, due to a lack of social care. While they may be medically fit to leave, patients need help to recover in the form of a social care package, which may not be immediately available. This means that their hospital bed is unavailable to the next patient, resulting in further Emergency Department crowding.

[2] Wales Stats NHS beds by specialty

[3] The Guardian (2019) Thousands of patients die waiting for beds in hospitals – study. Available **here** and Morley et al (2018) Emergency department crowding: A systematic review of causes, consequences and solutions. Available **here**.

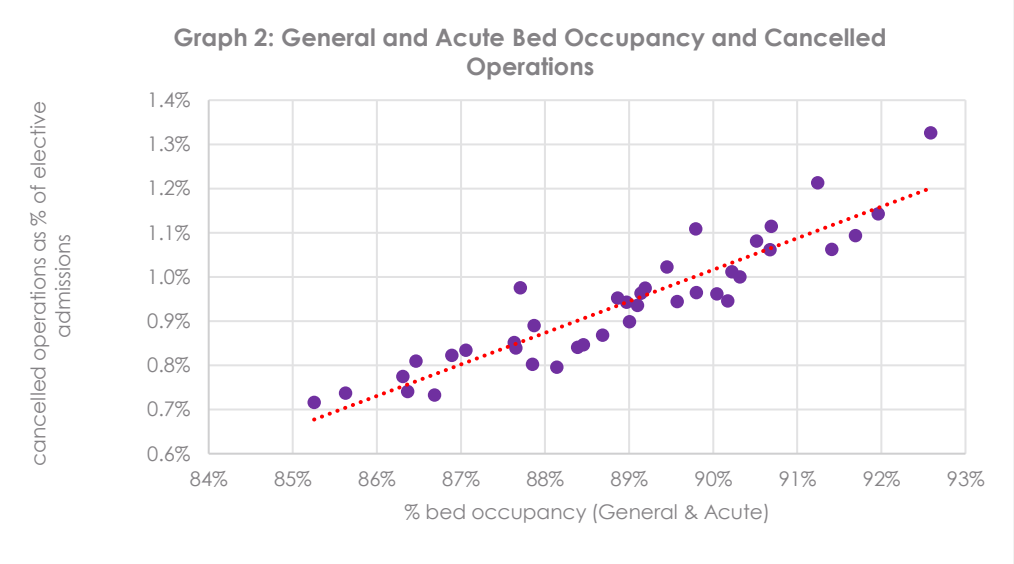
Care should be provided in the community where possible. An example of this is Home First When Ready, an initiative that has been fast-tracked and largely embraced due to the coronavirus. This model of care should be encouraged and continue beyond the pandemic. Health Boards and Local Authorities, working with the third sector and independent providers, should adopt a 'home first' approach to enable more people, who have attended an Emergency Department or have been admitted to hospital, to be assessed and recover in their own homes to avoid unnecessary long stays in hospital beds. This will be achieved through delivery of four 'discharge to recover and assess' active therapeutic pathways, embedded locally.

c) COVID recovery

Impact on the Elective Backlog

NHS Wales faces significant challenges ahead in recovering from the pandemic. Without adequate planning, there is a risk that rising emergency demand could derail progress on tackling the elective backlog. EDs are impacted by the elective backlog as patients may present with potential complications from delayed or cancelled procedures. We do not underestimate the scale of the challenge ahead in terms of tackling the elective backlog however, this issue cannot be considered in isolation. Every winter, elective care is derailed due to increased demand in the urgent and emergency care system and a lack of capacity in the hospital.

It is crucial that Unscheduled Care is firmly embedded into recovery plans so that inevitable future surges do not derail elective care once again and jeopardise efforts to restart our NHS. While the Welsh Government's **Looking Forward** acknowledges the consequences demand surge on urgent and emergency care has had on elective waiting times, it fails to mention that this phenomenon occurs every winter. Data from England in Graph 1 demonstrate the relationship between high General & Acute bed occupancy and an increased rate of cancelled elective operations. There is a clear correlation that must not be ignored.



While no period of the year is easy for ED staff, there is undoubtedly a seasonal effect on ED pressures and demand. Experience on the ground in Wales tells us that there is, quite predictably, a surge in emergency admissions in the winter months which is then followed

by a spike in cancelled electives. This trend must now be considered in the current context wherein the scale of the elective backlog is unlike any other year. Plans to address the backlog must be drawn up in conjunction with a strategy to restore unscheduled care, due to the intrinsic link between these parts of the system.

Capacity and managing demand

Recovery will not be successful without the proper mapping of future capacity needs. To keep patients safe from Covid, Infection Prevention Control guidelines meant that hospitals have been reconfigured, resulting in a loss of beds. Yet, this issue predates the pandemic; Wales has traditionally run its hospitals with relatively few beds per head and this has created exit block. As we begin to recover from the pandemic, we are calling for transparent bed and workforce modelling with a commitment to act on the findings before winter to allow for safe restoration and expansion of bed capacity to above pre-pandemic levels. Further efforts have been made to manage demand on EDs throughout the pandemic. One such initiative has been the increased roll out of the NHS 111 and Direct Wales whereby patients phone before attending the ED either to be given an appointment or to be directed to another service, namely, primary care.

While this service has the potential to improve patient experience and reduce crowding in ambulatory areas in Emergency Departments this winter, it must be robustly evaluated. In **Looking Forward** it is implied that a reduction in attendances during the pandemic may have been as a result of the phone first model. Without data this conclusion simply cannot be drawn. Results must be published in full to determine its efficacy and to understand patient behaviour and its impact on ED presentations. This must go hand-in-hand with increased provision of alternative services that NHS111 can direct patients to.

Data, performance, and recovery

As we emerge out of one of the toughest periods our NHS has ever faced, there is no doubt that the second wave coinciding with winter pressures has left ED staff feeling deflated, burnt-out, and indeed, in need of recovery. Yet, there will be no period of respite or recovery for doctors working in EDs. While indeed the number of covid patients presenting to EDs is falling, the regular footfall is returning.

The latest accident and emergency performance figures published by the Welsh Government reveal that 1 in 10 patients are waiting 12 hours or more in major emergency departments across Wales. It is important to note that the data does not convey the true extent of long delays; clinical and operational exclusions implemented in Wales in 2011 permit patient delays to not be counted as a breach in certain situations. 4 We know that this rule, in some cases, is being abused in order to mask the reality of what is happening on the ground.

Understanding patient activity and flow is going to be a vital part of any plans to transform the Urgent Care system. It allows for forecasting and therefore appropriate planning of both capacity and funding. Every winter, the surge in demand is followed by an unacceptably high number of long stays and patient delays which pose a threat to the safety of the service. We know that this winter will be no different unless action is taken.

[4] **https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Hospital-Waiting-Times/Accident-and-Emergency/performanceagainst12hourwaitingtimestarget-by-hospital**

The 12-hour data must be published and used proactively to manage capacity and demand in EDs.

Recommendations:

Operational pressures are seen by staff as the most significant reason for considering reducing hours, changing careers or retiring early. We cannot deliver safe care in Emergency Departments without making the job sustainable. The following recommendations will help support the retention of ED staff and improve patient care.

1. ***The Welsh Government must act now to achieve safe staffing levels in EDs. At present, there is a shortfall of 100 Whole Time Equivalent consultants in Wales. Expansion of the workforce is needed to ensure patients are treated by staff who are trained in Emergency Medicine. This must also include an accompanying increase in Allied Health Professionals, SAS doctors, Emergency Nurses, and the faculty to train them.***

2. ***The Welsh Government must make funding available to support inpatient teams to enable more effective Urgent and Emergency Care, including Same Day Emergency Care and Ambulatory Emergency Care. These services improve the quality of care and staff morale, are cost effective, and reduce avoidable admission into hospital.***

3. ***Previous long term health strategies are now redundant given the disruption to the healthcare system caused by the pandemic. A new, actionable, long-term health and social care strategy is now required to enable the delivery of high quality Urgent and Emergency Care.***

4. ***The Welsh Government must immediately prepare and manage adequate capacity in order to minimise the harm to patients and staff caused by ED crowding and exit block. This will reduce the risk of emergency demand derailing the elective recovery and improve the working conditions of staff in EDs. Ahead of Winter, this must include but is not limited to:***
    a. ***Making funding available to local health systems to maintain or expand discharge to assess services so they are available all year round.***
    b. ***Expanding clinical validation of Phone First services to ensure patients receive care in the best setting based on their needs. These services are only effective if there are adequate levels of clinical involvement.***

Submitting evidence

Guidance on providing written evidence

If you have any questions about this consultation or providing written evidence, please contact us at SeneddHealth@senedd.wales or on 0300 200 6565. You may also wish to read the advice on "Getting involved with committees", which explains how to prepare and submit evidence to Senedd committees.

Official languages

The Senedd has two official languages, Welsh and English. In line with the **Senedd's Official Languages Scheme**, we request that you submit your response in both languages if you are able to do so. If your response is not submitted bilingually, we will publish in the language submitted, stating that it has been received in that language only. We expect other organisations to implement their own standards or schemes and to comply with their statutory obligation.

How we will use your information

General information regarding consultations, which you should consider carefully before submitting a response to the Committee, is available in our privacy notice.

How to submit your response

We prefer to receive evidence digitally (for both practical and sustainability purposes). Please send an electronic copy of your form to **SeneddHealth@senedd.wales**.

If you cannot provide evidence digitally , you can send a copy to:

Health and Social Care Committee
Welsh Parliament
Cardiff
CF99 1SN

Responses should be submitted no later than 16.00 on 17 September 2021.