The Royal College of Emergency Medicine

**3 December 2020**

# Dangerous crowding has returned to our A&Es

**Dear Trust CEO,**

I am writing to you to highlight my concerns about the return of crowding and corridor care in Emergency Departments. This is dangerous for patients, and with COVID, now dangerous for staff. It also has knock on effects for the ambulance service who are less able to respond to emergency calls, and will create nosocomial outbreaks in inpatient wards, further disrupting important care.

You will be fully aware that crowding in emergency departments has returned.

- A staggering 1,267 patients waited longer than twelve hours in an Emergency Department after a decision to admit (DTA) in November. This is an increase of 280% from the previous month and represents the third worst month of 2020 for long waits. 12-hour DTA breaches represent around 1% of all the people who have 12-hour stays.
- Long waits, however measured, are consistently associated with excess mortality and increased length of stay.
- Nearly 1 in 4 patients are waiting longer than four hours to be seen, admitted, or discharged from hospital.

In addition, our Members and Fellows have expressed concerns to us about the way in which their executive teams are dealing with crowding and exit block in their Emergency Departments. We know that there are lots of competing priorities at the moment but there is an urgent need to acknowledge and act against crowding and corridor care. Getting this right and reducing the spread of an outbreak of COVID through the hospital is a wise investment.

We recognise that these are difficult times, and we offer this advice as critical friends. Trust Chief Executives and Senior Managers to take action to ensure there is flow through the hospital:

- Agree and evaluate escalation plans during times of crowding with the Trust Board. Too many escalation plans are overly ambitious and ineffective.
- Ensure Emergency Department performance standards should be viewed as a hospital wide priority.
- Improve specialist clinician involvement with offering telephone advice to GP. Referral rates drop if there is ready access to an experienced clinician to provide advice.
- Prioritise flow from key inpatient wards by concentrating on early discharges during the day.
- Stop wasting managerial time and effort on the misleading 12 hour DTA metric. Report 12-hour length of stay from arrival to discharge or admission.

We all understand the term *Never Event* – we want corridor care to be viewed in the same way – it just should not ever happen. It is inhumane to keep vulnerable patients waiting on a trolley for a bed. Crowding is a serious and largely preventable safety incident that should not occur if preventative measures are implemented.

Please do get in touch if you have any questions or if you would like to meet to discuss the issues raised.

Yours sincerely,

**Dr Katherine Henderson MB BChir FRCP FRCEM**
**President of the Royal College of Emergency Medicine**
*@RCEMPresident*

*The Royal College of Emergency Medicine (RCEM) works to ensure high quality care for patients by setting and monitoring standards of care in Emergency Departments; we are the professional voice of 10,000 A&E doctors.*