



## The Royal College of Emergency Medicine Wales

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### **RCEM response to Welsh Parliament Health, Social Care and Sport Committee**

#### **Inquiry into the impact of COVID-19 outbreak, and its management, on health and social care in Wales.**

**Submitted June 2020**

#### **About the Royal College of Emergency Medicine**

The Royal College of Emergency Medicine (RCEM) is the single authoritative body for Emergency Medicine in the UK. Emergency Medicine is the medical specialty which provides doctors and consultants to A&E departments in the NHS in the UK and other healthcare systems across the world. The Royal College works to ensure high quality care by setting and monitoring standards of care and providing expert guidance and advice on policy to relevant bodies on matters relating to Emergency Medicine.

#### **The response to COVID-19 outbreak in Wales**

On the 11<sup>th</sup> March Coronavirus was declared a pandemic by the World Health Organisation (WHO). In Wales there was a nimble response from both health and social care sectors in response to COVID-19 by creating capacity and support to frontline Emergency Department staff. Within primary care there was a rapid roll out of digital solutions to assess patients. Telemedicine was used to triage those who needed to see a GP, refer patients onto secondary care or Emergency Departments and complete GP consultations.

In the initial stages of the pandemic, the infection was designated a High Consequences Infectious disease and so all patients and staff were managed by staff in full Personal Protective Equipment (PPE). There was much work done to deliver the testing needed during the delay phase of the UK response. As the spread of the virus has progressed, there have since been changes to the PPE recommendations and indications for testing. These changes have contributed to frontline staff feeling anxious about PPE and testing.

Emergency Departments introduced new collaborative ways of working; possible new pathways were introduced where possible to redirect patients to specialists as quickly as possible after their arrival in the Emergency Department. Additionally, senior specialty review occurred without the need for junior specialist review first. This was introduced alongside seven day working for many specialists. Collectively these measures contributed to supporting better patient experience and safety within Emergency Departments. By having enough staff and capacity within Emergency Departments there was an improvement in patient flow in most departments.

Emergency Departments quickly introduced COVID-19 pathways that followed national guidance. Initially this guidance was taken from many sources which was confusing and stressful for Emergency Department staff. However, there now seems to be a reliably consistent stream of guidance being produced. In addition, all Welsh COVID-19 secondary care guidance has been developed by NHS Wales, which

means that staff who lack the time to develop their own now possess an excellent resource.

At the onset of the outbreak, Emergency Departments quickly responded by separating areas for COVID-19 suspect and non-COVID patients to improve safety and reduce transmission rates. Most Emergency Departments had a larger footprint available to enable this.

An additional 7,000 critical care beds were identified within secondary care and field hospitals. To date, little of this additional capacity has been utilised. Additional capacity within secondary care was also provided by the rapid discharge of patients who no longer had a health need requiring them to stay in hospital. We have also seen a reduction in patients being transferred from care homes to Emergency Departments.

An all-Wales COVID-19 Dashboard has also been developed which gives the daily availability of the capacity for COVID-19 and non-COVID ward-based care, critical care capacity and field hospital capacity, as well as kit such ventilators and non-invasive support for airways. Unfortunately, not all frontline teams are aware of this facility.

There are some areas of key concerns as we progress beyond the first outbreak of the pandemic including Personal Protective Equipment, testing capacity and the recovery phases as we reset emergency care.

### **Personal Protective Equipment (PPE)**

Frontline staff are grateful for the PPE that has been made available to them to date, but the ongoing supply continues to be a worry, and the fear remains that a significant surge in demand which could stress the supply chain.

Concerns around the supply of PPE in social care also continue which could have adverse consequences for Emergency Departments, as a rising infection rate in care homes will mean more patients requiring admission to the Emergency Department.

### **Testing**

RCEM recognises the efforts that are being made to get both more rapid patient testing, staff testing and eventually population testing. However, there remains an unacceptable variation in terms of receiving tests and the turnaround with regard to results. A rapid result makes it possible to move a patient to a COVID-positive or negative ward quickly and reduces the potential for admitting patients to COVID-19 wards with suspected COVID-19 who subsequently test negative. Keeping community wards safe is paramount but keeping patients in hospital for up to 14 days will put considerable pressure on secondary care.

### **Staffing**

RCEM has welcomed the support to Emergency Department frontline workers during this crisis but are concerned that this support could disappear (for example, specialists or trainees have been moved to work in Emergency Departments, but they will need to return to their specialty as core health care services restart). Whilst RCEM understands the reasons why, we are also mindful that planning, both short

and long-term, will be needed to ensure the Emergency Department workforce has the support it needs going forward.

### **Surge Capacity**

RCEM has frequently raised concerns about high bed occupancy levels and the impact this has had on Emergency Department performance and crowding. We welcome actions taken in securing additional bed capacity and we urge those involved to continue to monitor projection data to ensure there is extra bed capacity within the health and social care sectors to deal with sudden spikes in demand. Realistically this may mean a bed occupancy rate of 75%.

### **Access models**

The pandemic has driven the use of NHS 111, advice lines and new pathways within Welsh Ambulance Services. RCEM recommends these are expanded to direct patients who contact emergency services as soon as possible after contact to the most appropriate service to reduce demand on Emergency Departments.

Along similar lines, when patients arrive in the Emergency Department it should be identified as early as possible if they are suitable for specialist care (e.g. same day emergency care or direct referral for those patients already under a specialist team).

### **Infection screening on arrival at Emergency Departments**

To build upon the good work already in place, RCEM recommends screening possible COVID-positive patients on arrival and to continue keeping COVID and non-COVID patients separate wherever possible.

### **Clinical Governance**

Staff have raised concerns that some patient groups are presenting late. RCEM recommends any such risks are captured using local clinical governance mechanisms such as Datix reports and escalation to clinical leads and medical directors. There is an urgent need to introduce better IT systems to give accurate data about coding and the location of patients within the Emergency Department (i.e. awaiting triage, awaiting to be seen by a clinician or awaiting an admission).

### **Flow**

Clinicians in Emergency Departments are starting to see an increase in attendances from minors and 'well COVID-19' patients who, until very recently, would have avoided attending EDs. Not only will this require the use of more PPE, it also presents a challenge in terms of social distancing in waiting: it is more important now than ever to separate red and green areas. Many Emergency Departments have deployed short-term stopgap solutions and are not necessarily equipped to promote social distancing in the more longer-term. As we are starting to see an increase in activity these altered ED footprints need to be made permanent, either by reallocating Emergency Departments space currently used for other activity or with physical rebuilds.

Some hospitals (e.g. Wrexham) have not seen the expected improvement in performance due to issues with flow onto the wards from Emergency Departments. Others have shown that, given the resources to meet demand, then performance can be sustained when the whole system works together (e.g. YCG). Some clinicians

have noticed that within their own Emergency Department staff who have never experienced flow are struggling and this is something they need to address. Some specialists are also struggling to see patients according to Internal Professional Standards.

### **Advanced Care Planning**

There appears to be issues arising in terms of transfers from care homes, as clinicians have indicated that they are not seeing as many patients as normal. While The reduction in minors could be explained by the reduction in activity resulting from lockdown, there has been little restriction of normal day-to-day activity in care homes.

The reduced number of transfers between care homes and Emergency Departments should be maintained where possible as it is often clinically inappropriate, and patients frequently receive no benefit from attending. In addition, advance care planning and anticipatory care should become normalised to ensure we are giving patients the right care in the right place.

### **Homelessness**

Currently many homeless people are in hotels. When these hotels are reopened and the homeless people being housed there are obliged to leave, it is highly likely that many will present at Emergency Departments . This is linked to the WEDFAN work and the need to restart this work by keeping patients supported in the community and out of secondary care if it is not required.

### **Reintroduction of the British Red Cross**

RCEM welcomes the Minister's reassurance that the withdrawal of this excellent service was a temporary measure to accommodate the safety of the BRC's care workers, and the service would be reintroduced as soon as practicable.

### **Remapping Emergency Care in a COVID-19 endemic world**

Prior to the COVID-19 pandemic, Emergency Departments were already overwhelmed with patients receiving compromised care in crowded departments with sick, vulnerable, and often elderly patients waiting in corridors or ambulances as shown in lost ambulance handovers and 12-hour breaches.

Clinicians are most worried about maintaining social distancing within waiting rooms in the Emergency Departments and the subsequent risk of departments becoming reservoirs for nosocomial infections.

There is a moral imperative to ensure our Emergency Departments never become crowded again. If we are crowded, we cannot protect patients and staff and if not addressed there is the potential for the perfect storm. Crowding has long been associated with avoidable mortality, and COVID-19 reinforces and multiplies this risk. Emergency Departments will need to continue to operate in segregated streams, with an absolute focus on minimising nosocomial infections.

Emergency Departments should return to their original core purpose: the rapid assessment and emergency stabilisation of seriously ill and injured patients. In May, RCEM published a position statement with recommendations to ensure patient safety and high-quality emergency care. You can access *COVID-19: Resetting Emergency Care* [here](#).