SUPPLEMENT ON WINTER PRESSURES IN ENGLAND
DECEMBER 2013

Welcome to an additional supplement from the Technology Strategy Board (TSB) Knowledge Transfer Network and the Telecare Learning and Improvement Network. This supplement looks at winter pressures 2013/14. It is also helpful to read it in conjunction with the Integrated Care Supplement from November 2013.

1 Background and Performance Information

With a period of sustained growth in the NHS in England over the last decade, capacity problems appeared to have eased just a little, but in 2013, A&E and emergency care pressures became a big issue again and to cap it all the winter pressures continued into the Spring and early Summer with no let-up.

Summaries from various sources including NHS England, National Audit Office and Care Quality Commission tell us that:

- A&E waiting times reached a nine-year high at the end of last year (2012)
- A million more people are visiting A&E annually compared with three years ago
- 2012/13 saw the largest increase in avoidable admissions in the last six years
- Of all admissions, 11% relate to people aged 65yrs+ with an avoidable condition
- The percentage of all people waiting 4 hours in A&E is 4% in 2012/13 compared with 2% in 2008/9
- Approximately 22 million patients were seen in Emergency Departments last year and it is possible that 15-30% of them did not require Emergency Department services
- In 2012-13, over a quarter of all patients attending major A&E departments were admitted - up from 19 per cent in 2003-04. The rise in emergency admissions is dominated by patients who stay less than two days (short-stay) in hospital
- 40 per cent of A&E patients are discharged requiring no treatment
- Up to one million emergency admissions were avoidable last year; and up to 50 per cent of 999 calls could be managed at the scene
- More than half a million people aged 65 and over were admitted as an emergency to hospital with potentially avoidable conditions in the last year
- The number of avoidable emergency admissions varies from place to place, with some parts of the country managing much better than others
- Among people living in care homes, hospital admissions for avoidable conditions were 30 per cent higher for people with dementia. Once in hospital, people with dementia also have poorer outcomes than those without dementia
- One in four people have a long term condition and half of all GP appointments and two-thirds of outpatients and A&E visits are now made by patients with multiple long term health problems
• Overall, the number of people going to A&E departments in England has risen by 32 per cent in the past decade and by one million each year since 2010
• The over-65s represent 17 per cent of the population, but 68 per cent of NHS emergency bed use. They also represent some of the NHS’s most vulnerable patients, and those most at risk from failures to provide seamless care
• The NHS England analysis of available data suggests that the average (median) time in A&E for patients not admitted to hospital is 1 hour 49 minutes, with less than five per cent of patients spending 4 hours or longer in A&E
• For patients needing an inpatient hospital bed, the median time in A&E is 3 hours 37 minutes averaged across the whole year. In the winter months, it is these patients that account for most of those who exceed the 4 hour standard
• Older people make up the largest proportion of those who need a hospital stay. For those over age 75 years there is a greater than 80 per cent chance of needing admission from A&E, whereas for the under 30, it is less than 20 per cent
• While patients admitted to hospital are generally older, they are also increasingly frailer and have more complex care needs
• Analysis of the types of illnesses that prompt admission to hospital over the winter months shows that respiratory disorders peak to twice the summer level

On the 8 August 2013, the Prime Minister announced £500m to relieve the pressures on A&E over two years. The £250m in 2013/14 would be for the most at risk areas. On 22 November 2013, an additional announcement covered a further £150 million to help hospitals not deemed to be the most at-risk. Section 3 of this supplement covers the recent announcements in more detail.

In October 2013, the National Audit Office said:

“All organizations in the health and social care sector have a role to play in managing emergency admissions: by reducing avoidable emergency admissions, effectively managing those patients who are admitted and ensuring they stay no longer than is necessary. However, there are large variations in performance at every stage of the patients’ journey through the health system, suggesting scope for improved outcomes”.

It is clear that all parts of the health & care system are being impacted eg increasing bed occupancy is limiting the capacity of some hospitals to cope in winter and delayed discharges are placing more pressure on bed availability. There are continuing issues about staffing of hospitals in particular A&E and emergency medicine. This becomes increasingly critical if the NHS moves to more seven day working as envisaged by the Keogh reviews.

Although A&E attendances peaked in the Spring/Summer, emergency admissions to hospital peak in the winter months because of colds, flu and more serious infections. As beds fill up, it has a knock-on effect on A&E and referral/admission arrangements. This in turn can increase waiting times.

Primary care along with community and social care services in addition to public health programmes (eg flu vaccination)along with patient awareness of self-management can all play a part in ensuring people with minor illnesses and injuries are treated in the most appropriate setting so that A&E can concentrate its efforts on the most serious cases.

A whole system approach has also brought in other important health and care initiatives including integrated working (Better Care Fund, links with social care and housing), Vulnerable Older Peoples Plan, GP contracts (including GPs leading on care for older people), consultant contracts (including weekend working) and social care (restricted eligibility, 15 minute visits, Care Bill and self-funders).
Information flow is vital and key data needs to be available where people appear and are being treated – this would lead to a more effective treatment plan and could save patients giving their details over and over again.

2 How can the problems be addressed?

People need to know where to go for different healthcare responses particularly when it is not an emergency. Many commentators have said that we are fighting a losing battle as patients are now making choices to go for free consultations at hospitals rather than visit their pharmacy or wait for a GP appointment.

So, do you steer people in other directions or provide better services when people walk through the door of A&E? Patients in the wrong place can deny access to those that really need help.

As the volume of patients at A&E and admissions continue to rise, many options have been put forward in reports with varying degrees of supporting evidence of their potential effectiveness. These include:

- Put primary care services in hospital A&E if this is where people go
- Provide unscheduled care services
- Provide less intrusive procedures and better bedside management that allows earlier discharge to free up capacity
- Make better use of consultants and other emergency care staff over seven working days
- More centralised specialist A&E units
- Delay hospital bed closures and ensure that community services are in place
- Minimise A&E attendances and hospital admissions from care homes by appointing hospital specialists in charge of joining up services for older people
- Implement seven-day social work, increase hours at walk-in centres, increase intermediate care beds and extension to pharmacy services to ease pressures on A&E departments
- Carry out consultant reviews of all ambulance arrivals in A&E so that a senior level decision is taken on what care is needed at the earliest opportunity
- Train paramedics to provide treatment on site rather than bringing people to A&E
- Extend GP opening hours
- Extend intermediate care, step-up/down models
- Extend the role of pharmacists, nurses and AHPs
- Better community and home-based end of life care
- Provide more urgent care centres with GPs, nurses
- Improve 111 services
- Improve primary care out of hours services
- Develop more integrated health and care teams
- Improve district nursing services in particular long term condition management
- Develop smart triage where presenting patients can be intercepted and channelled towards appropriate services in the hospital
- Extend early supported discharge, intermediate care/home nursing support and rapid response/re-ablement services/community equipment
- Improve integrated community services and provide more support closer to home with self-management
- Use technology to manage referral and patient flow/better triaging and data sharing, home remote monitoring and self-management
There are ongoing debates about the best evidence for what works as some initiatives do not always scale well or don’t always transfer because of local differences. It is important to learn from successes and failures around the country. In some cases, ineffective services will need to be decommissioned to free off resources as there is little scope for parallel running.

Several reports mentioned in this supplement refer to good practice examples from around the country.

3 Recent reports and announcements (from July 2013)

a) July 2013

In July, the House of Commons Health Committee report on urgent and emergency care considered that growing demand on A&E departments will make them unsustainable.

Launching a report following the Health Committee’s inquiry into emergency services and emergency care, Committee Chair Stephen Dorrell MP said:

“The A&E department is the safety valve. When demand for care is not met elsewhere, people go to A&E because they know the door is always open. It is vital to ensure that the needs of patients who don’t need to be at A&E are properly met elsewhere so that those who do need to be there receive prompt and high quality care”.

“The Committee conducted this review in the knowledge that Sir Bruce Keogh is currently conducting his own review of urgent and emergency care on behalf of NHS England. We hope that our recommendations will be reflected in his findings.

“We were not convinced that the plans presented to us represented an adequate response to the challenges the system faces.

“We were concerned that witnesses disagreed about the nature of demand for urgent and emergency care. The system is “flying blind” without adequate information about the nature of the demand being placed upon it. NHS England needs to establish a proper information base to allow informed decisions to be made.

“Even if the information was adequate it is unclear who is responsible for using it. We were told it is the responsibility of Urgent Care Boards, but witnesses were unclear about how many UCB’s are planned, what powers they will have, and how they will relate to other commissioning bodies – particularly the recently created Health and Wellbeing Boards whose remit also covers urgent and emergency care.

“The Committee is mindful of pressures which will build during next winter and is concerned that current
plans lack sufficient urgency. It recommends that NHS England should ensure that Urgent Care Plans are
agreed for each area before 30th September 2013 The Committee goes on to argue that there is a
requirement to restructure provision of urgent and emergency care if patient need is to be met in the longer
term. Stephen Dorrell says, “It is clear that the structures established 60 years ago are not appropriate for the
21st century. We need to reorganise the way in which emergency and urgent care is delivered.

“Enabling primary care to assume a more active role in dealing with urgent cases is an important part of this. We recommend that NHS England, as the commissioner of GP services, should actively seek innovative proposals for community based urgent care services, including improved access to step-up/step-down residential facilities.

“It is also clear that emergency care in acute hospitals needs to change. There is strong evidence that
centralised specialist units save lives, but proposals for change must be genuinely evidence-based and reflect local needs and conditions. We know that what works well in London is not right for many parts of rural England”.

House of Commons Health Committee - July 2013

The Department of Health responded to the report.

b) August 2013

August saw the announcement by the Prime Minister of £500m to relieve A&E Pressures with NHS England looking at how to allocate the first £250m fund for winter 2013/14 in collaboration with Monitor, the NHS Trust Development Authority and the Association of Directors of Adult Social Services based on plans from urgent care boards around the country.

c) September 2013

In September, funding details were announced for the 53 most at-risk Trusts - £500 million over two years would be available.

Of the first £250 million:

- Around £62 million for additional capacity in hospitals – for example extra consultant A&E cover over the weekend so patients with complex needs will continue to get high-quality care
- Around £57 million for community services – for example better community end of life care and hospices
- Around £51 million for improving the urgent care services - for example for patients with long-term conditions
- Around £25 million for primary care services – for example district nursing, to provide care for patients in their home, preventing them from being admitted to A&E
- Around £16 million for social care – for example integrating health and social care teams to help discharge elderly patients earlier and prevent readmission and
- Around £9 million for other measures – for example to help the ambulance service and hospitals work better together
- £15 million to be spent on NHS 111 - to increase the number of clinicians and call handlers so that non-emergency visits to A&E can be avoided

Any NHS Trust eligible for a share of the £250 million A&E funding for next year (Winter 2014/15) will need to ensure that at least 75 per cent of its own staff have been vaccinated against influenza this year.
c) October 2013

In October 2013, a report by the National Audit Office considered avoidable admissions and length of stay.

“Many emergency admissions to hospital are avoidable and many patients stay in hospital longer than is necessary. This places additional financial pressure on the NHS as the costs of hospitalization are high. Growth in emergency admissions is a sign that the rest of the health system may not be working properly. Making sure patients are treated in the most appropriate setting and in a timely manner is essential to taking the pressure off emergency hospital admissions.”

Amyas Morse, head of the National Audit Office, 31 October 2013

The NAO report said that improving the flow of patients through the system would be critical to the NHS’s ability to cope with future winter pressures on urgent and emergency care services. The NAO said that the main factors behind the increase in emergency admissions include:

- Slowness with which the NHS has developed effective alternatives to admission to hospital
- The four-hour waiting standard for A&E departments has reduced a hospital’s ability to keep a patient in A&E for monitoring and observation
- An increasingly elderly frail population are more likely to present at A&E and then be more likely to be admitted to hospital
- Changing medical practices and models of care – such as the increasing admission of patients in A&E to assessment centres

d) November 2013

(i) In November 2013, Sir Bruce Keogh (National Medical Director of NHS England) proposed in a first stage report that there should be a fundamental shift in the provision of urgent care, with more extensive services outside hospital and patients with more serious or life threatening conditions receiving treatment in centres with the best clinical teams, expertise and equipment.

The report(s) can also be followed via the Keogh blogs.
Sir Bruce said that the current system is under “intense, growing and unsustainable pressure”. This is driven by rising demand from a population that is getting older, a confusing and inconsistent array of services outside hospital, and high public trust in the A&E brand.

He advocates a system-wide transformation over the next three to five years, saying this is “the only way to create a sustainable solution and ensure future generations can have peace of mind that, when the unexpected happens, the NHS will still provide a rapid, high quality and responsive service free at the point of need.”

In a letter to Health Secretary Jeremy Hunt and NHS England Chair Sir Malcolm Grant, Sir Bruce says:

“Our vision is simple. Firstly, for those people with urgent but non-life threatening needs we must provide highly responsive, effective and personalised services outside of hospital. These services should deliver care in or as close to people’s homes as possible, minimising disruption and inconvenience for patients and their families. Secondly, for those people with more serious or life threatening emergency needs we should ensure they are treated in centres with the very best expertise and facilities in order to maximise their chances of survival and a good recovery.”

_NHS England, November 2013_

The report makes proposals in five key areas:

- Providing better support for people to self-care
- Helping people with urgent care needs to get the right advice in the right place, first time
- Providing highly responsive urgent care services outside of hospital so people no longer choose to queue in A&E
- Ensuring that those people with more serious or life threatening emergency needs receive treatment in centres with the right facilities and expertise in order to maximise chances of survival and a good recovery
- Connecting urgent and emergency care services so the overall system becomes more than just the sum of its parts
Sir Bruce indicated that Phase 2 of his review was underway and that it will take three to five years to enact the change necessary and that he expects significant progress over the next six months on the following areas:

- Working closely with local commissioners as they develop their five-year strategic and two-year operational plans
- Identifying and initiating transformational demonstrator sites to trial new models of delivery for urgent and emergency care and seven-day services
- Developing new payment mechanisms for urgent and emergency care services, in partnership with Monitor
- Completing new NHS 111 service specification so that the new service – which will go live during 2015/16 – can meet the aspirations of this review

(ii) In November, NHS England published analysis that shows many of the pressures faced by the NHS over the winter occur because of a seasonal rise in the number of patients attending A&E departments who need to be admitted to hospital.

They say a key way of addressing this winter’s pressures on hospital A&E departments is to encourage the prevention and early treatment of illnesses, particularly breathing problems.

The number of people arriving normally sees a seasonal dip over the winter months - A&Es see fewer patients in January and February than in the summer. Despite this, there are still more breaches of the NHS four hour standard. In the winter months there is a higher proportion of frail and elderly patients who require much more assessment in A&E and in the absence of alternatives often need a hospital bed.

The Department of Health has responded to NHS England’s report on winter pressures faced by accident and emergency departments.

(iii) Also in November 2013, the State of Care Report from the Care Quality Commission shows that avoidable* emergency admissions are increasing.

*‘avoidable conditions’ can be treated in the community (in people’s own homes or in community settings) or caused by poor care or neglect eg bone fractures, dehydration, pneumonia, respiratory infections.

The CQC considers that ‘GPs, care homes, home care agencies, community health services and hospitals, with local commissioners, must plan effectively and make sure that older and more vulnerable people are cared for in the way they deserve. ‘Where care can be provided for people outside of hospitals, it is better for them and eases pressures on hospital services.’

The CQC report says that over the last six years, the number of admissions for avoidable conditions has risen.

It has overtaken both:

- The demographic growth in the number of older people
- Growth in total emergency admissions among older people
The number of people aged 75 and over who have been admitted to hospital in an emergency at least once during the year increased from seven per cent in 2007/08 to almost 10 per cent in 2012/13.

The number of admissions for some conditions has risen, including those for:
- Pneumonia: 64 per cent increase
- Inhaling food or liquid: 52 per cent increase
- Urinary tract infections: 45 per cent increase

Among people living in care homes, hospital admissions for avoidable conditions were 30 per cent higher for people with dementia.

At the same time, waiting times in A&E have also risen. Annually, the proportion of people waiting more than four hours in A&E increased from two per cent in 2008/09 to four per cent in 2012/13.

There are similar trends between the increase of avoidable admissions and the increase in waiting times. They share the same quarterly and seasonal fluctuations and both substantially increased during the second half of 2012/13.

(iv) Finally, in November 2013, a further £150 million funding was announced. This is in addition to the £250 million targeted to the most at-risk areas in September 2013. The distribution of the extra £150 million will include those communities that are not deemed the most at-risk, to bolster and enhance their existing plans to maintain services and reduce the pressure on A&Es caused by cold weather.

The money will be paid as an additional allocation to 157 Clinical Commissioning Groups (CCGs) responsible for the planning and purchasing of most hospital and community services in their own local areas.

Decisions on how the money will be spent will be taken by Urgent Care Working Groups – the new collaborative groups of hospital, community and primary care clinicians responsible for ensuring A&E services meet four-hour standards and provide high-quality care.

As with the funding announced by the Department of Health in September 2013, health services can use this additional money to improve other services away from A&E to reduce unnecessary visits and avoidable emergency admissions, as well as boosting individual A&E departments.

Local initiatives could include:

- minimising A&E attendances and hospital admissions from care homes by appointing specialists in charge of joining up services for the elderly
- improved access to out-of-hours social work, increased hours at walk-in centres, increased intermediate care beds and extension to pharmacy services to ease pressures on A&E departments
- consultant reviews of all ambulance arrivals in A&E so that a senior level decision is taken on what care is needed at the earliest opportunity
e) December 2013

(i) In December, HSCIC published some new figures to provide further insight into A&E activity. The report shows that in 2012/13:

- Departments dealt with 21.7 million attendances overall - or 60,000 a day. This is an 11 per cent growth on four years ago (2008-09) and compares to a 3.2 per cent growth in the England population during the same period
- Minor units dealt with almost 32 in every 100 attendees (up from 28 in 2008-09), while major units dealt with about 66 in every 100 (down from 69)
- 63 in every 100 minor unit attendees were aged under 40 (up from 59 in 2008-09), while 12 in every 100 were aged over 64 (down from 14)
- In major units, 54 in every 100 attendees were aged under 40 (down from 57 in 2008-09), while 21 in every 100 were aged over 64 (up from 19)

2012-13 A&E activity patterns consistent with recent years (where data is available) include:

- Attendances at A&E peak slightly in April to June (based on 2008-09 data onwards)
- The majority of attendances are during normal working hours of 9am to 6pm (2008-09 onwards)
- Around one A&E patient in five is admitted to hospital. For people aged over 64 this rises to almost one in two (2009-10 onwards)
- Of every 20 attendees, 13 refer themselves to A&E while around one is referred by a GP (2009-10 onwards)
- Overall, about a third of patients receive guidance or advice only when attending A&E (2009-10 onwards)

(ii) On 17 December, the Board of NHS England considered a report from Sir Bruce Keogh on developing seven day working in the NHS over the next three years. The report sets out ten clinical standards eg how quickly people admitted to hospital should be assessed by a consultant, the diagnostic and scientific services that should always be available, and the process for handovers between clinical teams. He recommends they be adopted by the end of the 2016/17 financial year.

To do this in a way that is financially and clinically sustainable, NHS providers and commissioners should explore new ways of working – in networks, collaboratives, and federations – that consider distribution of services between organisations. Sir Bruce says delivering the standards should be part of the five year strategic plans being developed by clinical commissioning groups all over the country. He says a similar set of standards is already being developed for primary care.

In December, the Department of Health is due to make a further announcement on the Vulnerable Older People’s Plan.

In early 2014, 152 local authorities and 211 CCGs will be putting together their plans for the £3.8bn Better Care Fund (previously Integration Transformation Fund) which commences in 2015-16 (although some additional NHS funding is to be made available to social care in 2014/15). More information is available on these integration fund plans (deadline 15 February 2014) in the November 2013 supplement.

4 Collecting the data - NHS England Situation Reports

Daily situation reporting (SITReps) for winter 2013-14 started on 4 November 2013 and will be reviewed at the end of February 2014. The data is collected from acute trusts each weekday during winter and indicates where there are any winter pressures on the service around the country such as:
- A&E closures
- cancelled operations
- bed pressures
- ambulance delays

‘Daily Flu’ highlights the number of patients with confirmed or suspected influenza in critical care beds at 8am.

Guidance is available for the Daily Sitrep reports. Daily reports are required from acute hospitals only.

Weekly updates are also provided by NHS England.

The NHS England Operations team make the data ‘public’ on the Unify2 system by 2pm each day (some adjustments over Christmas/New Year period).

The table shows a time series example via an Excel spreadsheet.

For each hospital, the Excel spreadsheet covers:

1. A&E closures
2. A&E diverts
3. Trolley-waits of over 12 hours
4. Urgent operations cancelled for the second or subsequent time in the previous 24 hours
5. Urgent operations cancelled in the previous 24 hours
6. Number of cancelled operations in the previous 24 hours
7. Non clinical critical care transfers out of an approved group
8. Number of non-clinical critical care transfers within approved critical care transfer group
9. Ambulance handover delays of over 30 minutes
10. General & Acute Beds
11. Critical Care Beds
12. Given the answers above, and any other relevant factors (eg staffing issues, adverse weather conditions), has the trust experienced serious operational problems during the past 24 hours?
13. Further Comments

Further information for 2013/14 for DTOCs is available to end of October 2013.

The position at 13 December 2013

On 13 December 2013, Hospitals did not meet the four-hour treatment target in A&E departments for the first time since April. In the previous week, 94.8% of NHS patients in England were treated within four hours. It is the first time emergency departments, including minor injuries units and urgent care centres, have missed the 95% target since April 2013.

Waiting times were worst in major A&E wards where 92.2% of patients were seen within four hours. Across England, 3,678 patients had to wait between four and 12 hours. In the week, hospitals treated more than 415,000 patients in A&E – 3,500 more than the previous week. There were 105,800 emergency admissions – the highest number of emergency admissions since 2010 when data was first collected.

The BBC is using HSCIC/NHS England data to monitor A&E performance.
Real time monitoring of hospitals via dashboards (eg South Australia) could in future identify pinchpoints and provide the basis for local action (ED Chart, Ambulance Services Chart).

5 Can telecare and telehealth contribute to handling winter pressures?

The issue of winter pressures for health and care services is currently a high priority as headlines appear on a regular basis. The Secretary of State for Health and even the Prime Minister are receiving regular updates on difficulties experienced at local level as well as the main indicators.

For social care, there is a long history of local authorities and housing associations providing alarm, sensor and telecare systems on discharge to support re-ablement and homecare programmes. Indeed, around 1.7m people are benefiting from telecare services around the clock as part of preventative programmes and ongoing support plans. Where there is good infrastructure in place with a local control centre, it is possible to link up with a wide range of local community services. With very tight social care eligibility criteria for social care, it is likely that many other people including self-funders could potentially benefit. In some cases, short term provision following a hospital discharge can provide additional re-assurance. Telecare can also provide support for carers and families particularly those that are not able to visit on a daily basis. In some parts of the country, telecare response services are working closely with ambulance services to handle less serious cases (eg minor home falls) where the person does not require medical attention. There is scope for providing telecare in hospitals, care homes and other settings to provide reassurance and sensor alerts. Telecare is already a well established 24/7 service (updated map) and control centres could have a wider support role in conjunction with 111 service, out of hours, housing, social care and hospitals to coordinate services around users/patients especially at critical times (eg hospital discharges).
The current position on telehealth in England is very different to telecare. The number of people with remote monitoring for long term conditions is probably in the region of around 10,000 across 211 CCGs and there is very little in the way of video-conferencing support into homes, care homes, GP practices and other community sites apart from the work of Airedale NHS FT Trust. Where solutions involving technology have been proven to be cost-effective locally they could play a very important part in discharge planning/management and upstream preventative programmes as hospital admissions for heart failures, COPD etc can involve much longer lengths of hospital stay. Monitoring data from increasing numbers of people with complex co-morbidities could also enable earlier interventions and better titration of medication.

Commissioners and service providers will need to examine their local performance and outcome data and put forward the appropriate business cases for investment as part of local health and care plans linked with the Integration Transformation Fund (now the Better Care Fund).

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