

The A&E winter crisis: lessons from last year

Key points

- Winter crises in A&E are caused by blockages in moving patients through hospital beds and sending them home – not by more people turning up.
- These blockages happen because NHS wards are fuller than they should be. The Health Service is 14,000 beds short of a level that would provide reliable capacity.
- 41% of extra winter funding last year was spent on simply adding additional beds and staff. But there is nowhere near enough funding to actually close the gap in number of beds.
- Instead, money and focus should be used more strategically. 3.6% of patients account for 37% of time in NHS beds. Finding ways to safely treat these people outside hospital should be a major priority.

England's NHS has faced a succession of winter crises in A&E departments. In 2013/14, £250m in additional funding was allocated to address the anticipated pressures – but it failed to head off pressures and was criticised as a “sticking plaster”.

In 2014/15 an extra £700 million was spent as the Government, promised the Health Service would be “better prepared than ever”. But this did not prevent the worst waiting times performance in a decade, and a string of black alerts.

This year the NHS faces a daunting winter with no extra money on tap. This briefing draws on expert seminars and analysis by the Nuffield Trust and others to answer the question of what happened to the £700m spent on addressing winter pressures last year, and how we can avoid repeating the same mistakes.

Why does winter cause crisis in A&E?

The popular perception of winter crisis being caused by more people coming to A&E in cold weather is incorrect. In fact fewer attend in cold weather, although admission rates are relatively higher.

Instead, the number of patients within A&E departments grows to problem levels because fewer people leave the department in winter, not because more arrive. The specific reasons in winter include



sudden spikes in occupancy after people avoid hospital to spend Christmas at home, and a growth in people with breathing-related conditions who need longer in hospital.

The fundamental underlying reason that this leads to crisis is because bed occupancy is very high in the NHS. 85% has been pointed to by studies as the level above which safety and bed availability may be threatened. However, few hospitals achieve this, and many base their plans on planned occupancy of 92%.

Our analysis suggests getting back down to an 85% bed occupancy rate would largely eliminate breaches of the target of people being admitted or sent elsewhere within four hours of arriving at A&E. But this would require 14,000 extra beds, with a major building programme for wards and thousands more nurses. With the NHS under the greatest financial strain for generations, this is now not an option. The NHS does not have this money, and even if it did, these beds would take many years to build.

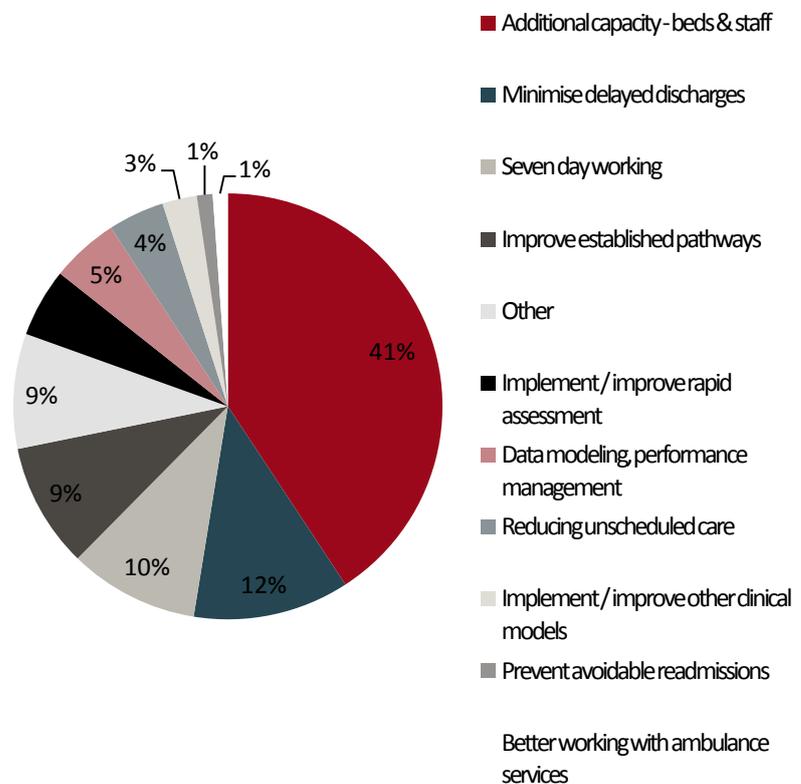
Our analysis and our discussions with managers, consultants and experts who deal with A&E pressures suggest that in a system where wards are this full, minor interruptions to the flow of service can snowball. A “one in, one out” dynamic, with any space available immediately filled from the queue, means the pressure simply rolls on. This leads to extended periods of escalating problems and growing queues.

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Where did the extra money go last year?

- £254 million (41%) was spent on extra beds and staff. We know that an underlying problem is how full wards have become. However, the sheer scale of the pressure on occupancy means it is simply not feasible to address it in a matter of months by investing in more space.
- £74 million (12%) of money spent on minimising delayed discharges addresses a real problem but again is probably too small an investment to make a real difference.
- Seven day working absorbed £61 million. In certain fields this may have helped make it easier to keep moving patients through the system on the weekends. However, some of the seven day initiatives will contribute little or nothing to addressing pressure on A&Es.

Actual use of A&E winter funding, 2014/15



These might seem sensible targets for funding, but they did not prevent the proportion of people seen within than four hours falling well below the target of 95%. It has stayed there almost every month since.

Why didn't it work?

Although so much of the money was put into additional hospital beds and staff, it was still a fraction of the amount which would be needed to bring occupancy back down to levels which made crisis less likely.

Since neither last year's funding nor any part of the recent Spending Review settlement could fund anything like 14,000 more beds, money to address winter pressures should be used in a more strategic

way. Our analysis shows that just 3.6% of patients account for 37% of time in NHS beds. There needs to be a focus on this small number of patients who account for so much use of hospital beds.

Many of them can be cared for in settings such as their own homes, special housing or nursing homes. Patients do better in these environments, especially if supported by community nurses and geriatricians. In hospital, guidance suggests that a nurse is needed for every eight patients. But in a care home, a nurse may look after close to twenty patients.

Reducing length of stay among this group could make a disproportionate impact in controlling how full wards get. Looking carefully at how they are treated could also help to avoid the hold-ups in moving people around that tend to form the triggers for blockages and crises.

Our full briefing on improving patient flow, early next year, will look in more depths at drivers of A&E pressure and what leaders in the health service can do to address them.

Further reading

[Election Paper: What's Behind the A&E "Crisis"?](#)

[QualityWatch: Focus On A&E Attendances](#)

[A&E Delays: why did patients wait longer last winter? \(Monitor\)](#)