# WHAT'S BEHIND THE A&E 'CRISIS'?

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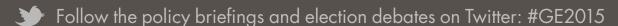
As part of our role to deliver evidence to support better health policy, the Nuffield Trust aims to help the three main political parties weigh the evidence as they draft their General Election manifestos, outlining what we believe to be the most important issues.

We are producing a series of policy briefings on the issues and challenges we believe are critical to the longer-term success of the health and social care system, and which any new administration following the election will need to prioritise.

This briefing is the third in our series – it focuses on what is causing the current pressures on accident and emergency departments. The first briefing from the series examined the state of general practice and the second looked at the issue of rationing in health care.

Alongside our policy papers, we are regularly surveying a panel of 100 health and social care leaders in England for their views on a range of issues, including the state of the NHS and social care system, and what they believe should be the priority areas for reform during the next Parliament. The survey results provide useful insights for policy-makers into the views of leaders as we approach the election.

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Find out more about our work on the 2015 General Election: www.nuffieldtrust.org.uk/general-election-2015

# **KEY POINTS**

- How England's accident and emergency (A&E) departments perform
  against the target to admit or discharge 95 per cent of patients within four
  hours is a source of significant public, media and political interest. Major
  A&E departments have not met this target since the summer of 2013
  and problems in urgent care have intensified over the winter of 2014/15.
- With bed occupancy high, staff under strain and resources tight, there is no doubt that the system is near breaking point. In addition to problems in meeting the four-hour target, there are other signs of pressure at A&E: patients waiting on trolleys for over four hours before being admitted to hospital has almost trebled, and delayed ambulance handovers at A&E have risen by over 70 per cent.
- The continued financial squeeze will accelerate the pace at which the urgent care system reaches breaking point.
- The latest problems in A&E are part of a well-established decline since 2012. But the picture is not straightforward and there has been a tendency among commentators to confuse long-term trends and the immediate causes. A&E attendance at major units has not risen much beyond what we would expect because of population change, and simple explanations such as the impact of NHS 111, cuts to social care, or changes to the GP contract in 2004 do not fully explain pressures on A&E or performance problems. There has been little change in the median time people wait at A&E or in the proportion re-attending within seven days, and patient satisfaction remains high.
- The most significant issue is not the numbers of people presenting at A&E, but the ability to discharge patients safely and quickly from the hospital as a whole.
- There has been an undue focus on the four-hour target. Measuring the
  performance of A&E departments is essential, but the way we react to
  changes in that performance has become disproportionate. The four-hour
  target can distort behaviours inside hospitals and health systems in ways
  that are not in the interests of patients or staff.
- Many answers to the problems facing urgent care already exist. But the
  complexity of the system and the highly politicised nature of A&E have
  impeded progress. Problems will not be solved if policy-makers, political
  leaders and regulators continue to micro-manage A&E. With change
  so urgently needed, it is imperative that there is a cross-party consensus
  on how to move forward and that action is not postponed or delayed for
  political reasons.

# Solutions need to:

Focus on getting things right in primary care to enable prevention to work – but be realistic about how much can be achieved. Policy-makers can help to boost primary care through supporting moves to build up the skills and capacity of health care professionals to provide high-quality urgent care services outside hospital.

Remove some of the complexity of different services that has been built into the system, and which confuses the public and NHS staff. Creating a single point of access to community services for patients and GPs would be one way to achieve this.

Focus on the way patients move through hospital – and be realistic about what policy-makers can and can't do. Policy-makers can help by investing in care outside hospital, but they must let providers find solutions that work for their patients.

Foster a better understanding of the way that local systems work. Promoting better data outside hospital and encouraging the development of systems modelling in individual trusts would be an important start.

Take a longer-term and broader view of performance in A&E – and consider clustered randomised controlled trials of alternative performance measures. Policy-makers should encourage the adoption of a set of richer performance indicators to sit alongside the four-hour target, which could be trialled in certain areas.

# INTRODUCTION

Every minute of every day, an average of 40 people arrive at accident and emergency (A&E) departments in England. A&E has been the focus of public interest and performance management in the NHS for at least a decade – and the speed with which people move through A&E has come to be regarded as a sentinel marker of the health care system.

But the focus on A&E performance has become even more intense since the start of 2015, as problems have worsened; time spent in A&E has lengthened; and the NHS has risen to the top of the list of voters' concerns as the UK General Election approaches.

The reasons for recent problems in A&E are complex and not well understood. This means that many of the solutions proposed are overly simplistic and fail to deal with the real issues.

Moreover, A&E is only one part of a broader urgent care system. A&E departments are divided into major types (consultant-led 24-hour services with full resuscitation facilities) and minor types (units designed to treat less serious cases). Other sources of urgent care include GP practices, GP out-of-hours services and the telephone advice service NHS 111. Any attempt to understand the current pressures on A&E must be considered in this context.

This briefing, part of a series from the Nuffield Trust ahead of the General Election, examines up-to-date data and long-term trends with regard to urgent care in England; analyses common theories and explanations of recent problems; and summarises current thinking about the potential solutions.

# IMPORTANT TERMS EXPLAINED

# A&E 'waiting' time

The length of time a patient spends in the A&E department between being seen by A&E staff and either being admitted or discharged. Unlike other NHS waiting times, this is not the length of time a person waits before they are treated.

# Attendance

Any visit to A&E, whether it results in an admission or discharge.

Average cost to the NHS: £124\*

### Admission

What happens to a patient who is transferred from A&E into another ward within the hospital for further treatment.

Average cost to the NHS: £1,657\*

# Discharge

What happens when a patient leaves A&E to go either home or to an outpatient clinic.

\* Costs data from NHS Reference Costs 2013 to 2014.1

# WHAT DO THE DATA ON A&E PERFORMANCE SHOW?

# TIME SPENT AT A&E

# **KEY FACTS**

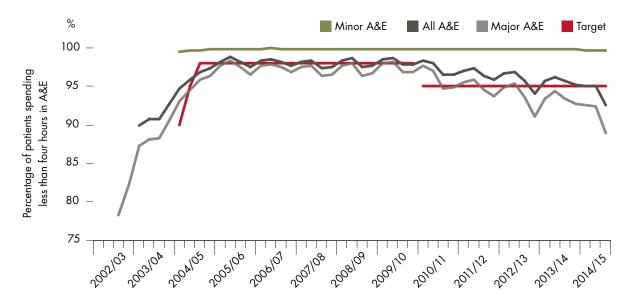
- 95 per cent the national target specifying the proportion of patients that should spend four hours or less in A&E before being sent home or admitted elsewhere in the hospital.
- 92 per cent average performance against the four-hour target by major A&E departments in 2014.<sup>2</sup>
- 3 hours 43 minutes the average time spent in A&E by a patient who is admitted to hospital on leaving A&E.<sup>3</sup>
- 2 hours 17 minutes the average time spent in A&E by a patient who is sent home on leaving A&E.<sup>3</sup>
- +1 hour 4 minutes how much longer on average a patient over the age of 75 spends in A&E compared with those aged under 75.3

'It is a huge achievement that a decade of activity increases have been accommodated by increasing efficiency within A&E departments' There are many ways to measure the performance of an A&E department. Longer waiting times and increased crowding in A&E departments have been linked to worse outcomes and experience for patients,<sup>4</sup> and by far the highest profile metric in England is the four-hour target. This counts patients who spend a total of less than 240 minutes between arrival and leaving the department (having been either discharged or admitted to an inpatient bed in another part of the hospital). Performance on this measure is shown in **Figure 1**.

While target achievement (98 per cent from 2004; relaxed to 95 per cent in 2010) is based on all A&E attendances, Figure 1 makes clear that it is the major A&E departments (which see the highest volumes of patients and most serious cases) that have the greatest challenge in meeting the target.

The target has played an important part in improving patients' experiences of care at A&E. Before the target was introduced, 12-hour waits were not uncommon. Performance against the four-hour target rose steadily following its introduction and the target was first met at the national level in 2005/06. This performance was maintained for the best part of ten years (with the exception of a step-change downwards when the target was relaxed), and it is a huge achievement that a decade of activity increases have been accommodated by increasing efficiency within A&E departments.

FIGURE 1: PERCENTAGE OF PATIENTS SPENDING LESS THAN FOUR HOURS IN A&E, OCTOBER 2002 TO DECEMBER 2014



Source: NHS England, A&E Attendances and Emergency Admissions2

Patients in English hospitals spend far less time in A&E than many of their European counterparts.<sup>5</sup> However, performance at major A&Es has been falling (with some upward blips) since summer 2012. The 95 per cent target has not been met at major A&Es since summer 2013.

The length of time patients spend in major A&E departments differs dramatically by whether they are eventually admitted to hospital or discharged. Those admitted to hospital wait an average of 223 minutes; compared with 137 minutes for those who are sent home.<sup>3</sup> The age of the patient makes a difference too: people aged 75 and over spend an average of 214 minutes in A&E, compared with 150 minutes for those aged under 75. This is related to the increase in comorbidities and likelihood of admission for the over-75s.

# OTHER PERFORMANCE MEASURES

While the time from arrival at A&E to departure is the highest profile performance indicator, it is not the only way of gauging the performance of an A&E department. Additional measures exist in the form of a broader set of quality metrics introduced in 2010,<sup>6</sup> data used to monitor the performance of A&E departments through their busy winter period<sup>7</sup> and information collected from patient surveys.<sup>8,9</sup> Some examples of these measures are given in **Tables 1** and **2**.

TABLE 1: WINTER PRESSURES DATA

	2010/11*	2014/15*
Number of periods when ambulances had to be diverted to other A&E departments	241	250
Patients waiting on a trolley for more than four hours after the decision to admit (percentage of total admissions)	33,909** (3.6%)	105,770 (10.3%)
Patients waiting on a trolley for more than 12 hours after the decision to admit (percentage of total admissions)	46 (0.0%)	835 (0.1%)
Ambulance handovers delayed by more than 30 minutes	52,250	89,368
Elective operations cancelled	16,153	19,668
Urgent operations cancelled	1,043	972

<sup>\*</sup> Measured between 3 November and 1 February (NHS England, Winter Daily Situation Reports<sup>7</sup>)

TABLE 2: A&E QUALITY INDICATORS

	2011/12	2014/15*
Median time to initial assessment (emergency ambulance cases)	4 minutes	4 minutes
Median time to treatment	54 minutes	55 minutes
Patients leaving without being seen	2.9%	2.7%
Seven-day re-attendance	7.3%	7.6%

<sup>\*</sup> Year to date – April to October (Health & Social Care Information Centre, Provisional Accident and Emergency Quality Indicators<sup>6</sup>)

The December 2014 Friends and Family Test showed that 86 per cent of patients would recommend A&E – this is almost unchanged from December 2013 (88 per cent). However, this measure is controversial and is based on responses from less than a fifth of A&E patients. The Care Quality Commission's 2014 survey of A&E patients found that 80 per cent rated their experience of A&E as good; an increase from 76 per cent in 2012. But 13 per cent of patients who requested pain relief medication stated that they waited at least half an hour before they received it, and a further eight per cent asked for pain relief but were not given any. Eleven per cent arriving by ambulance waited over 30 minutes to be handed over to A&E (ten per cent in 2012).

Taking a broader view of quality in A&E, it appears that some of the winter pressures measures have declined (trolley waits, ambulance delays and cancelled operations) but that other measures (the A&E quality metrics and patient opinion) do not appear to have changed significantly.

<sup>\*\*</sup> Based on NHS England, A&E Attendances and Emergency Admissions<sup>2</sup>

# HOW HAS A&E ACTIVITY CHANGED OVER TIME?

# **A&E ATTENDANCES**

# **KEY FACTS**

32 per cent – increase in A&E attendances over ten years.

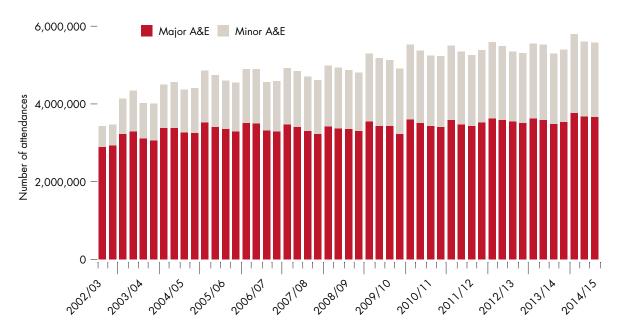
96 per cent – increase in attendances at minor A&E departments over ten years.

12 per cent – increase in attendances at major A&E departments over ten years.

Between 2003/04 and 2013/142,10

There has been a sizeable increase in the number of A&E attendances, from 16.5 million in 2003/04 to 21.8 million in 2013/14; a rise of 32 per cent (**Figure 2**). However, a closer inspection of the data reveals that this rise was almost exclusively to do with minor A&Es (for example, urgent care centres, minor injuries units and walk-in centres).

FIGURE 2: QUARTERLY NUMBERS OF A&E ATTENDANCES, OCTOBER 2002 TO DECEMBER 2014



Source: NHS England, A&E Attendances and Emergency Admissions<sup>2</sup>

Although attendances at major A&E departments grew between 2003/04 and 2013/14, this was at a much lower level – 12 per cent over the same period. The growth in attendances at major A&Es was entirely in line with what would be expected based on population growth.<sup>11</sup>

Much of the increase in attendances at minor A&E departments is likely to have been related to the range of new services available. 12 It is also worth noting that some of the increase is thought to be an artefact of better recording and changes to the labelling of existing services, rather than 'new' service use.

**EMERGENCY ADMISSIONS** 

# **KEY FACTS**

27 per cent – increase in emergency hospital admissions over ten years.

54 per cent – increase in emergency admissions through major A&E departments over ten years.

8 per cent – growth in the likelihood of being admitted to hospital after attending A&E over ten years.

Between 2003/04 and 2013/142,10

'On projected population trends, 17,000 extra hospital beds could be needed by 2022 unless more can be done to treat people outside of hospital'

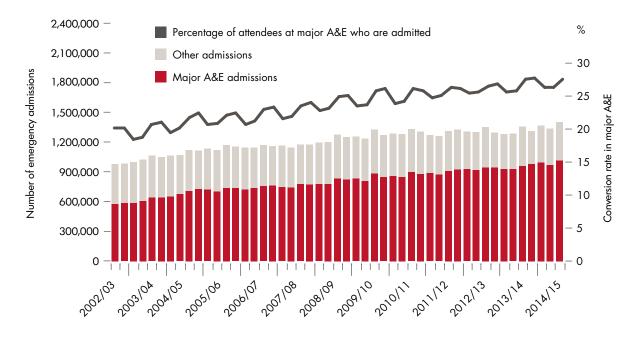
As well as the numbers of attendances at A&E increasing, so too have the numbers of people being admitted to hospital in an emergency (**Figure 3**). The total number of emergency admissions in England grew from 4.2 million in 2003/04 to 5.3 million in 2013/14; a rise of 27 per cent, and a trend that is well established.<sup>13</sup>

The ever-increasing number of attendees and admissions means that hospitals need to generate extra bed capacity – our analysis suggests that on projected population trends, 17,000 extra hospital beds could be needed by 2022 unless more can be done to treat people outside of hospital.<sup>14</sup>

# WHAT MIGHT BE THE CAUSES OF PROBLEMS IN URGENT CARE?

In seeking to understand the causes of pressures on the urgent care system, there has been a tendency among commentators to confuse long-term trends and the immediate causes. Both are important, but the recent problems experienced over the winter of 2014/15 are related more to the dynamics of the health and social care system than wider trends that are driving a long-term demand for health care.

FIGURE 3: QUARTERLY NUMBERS OF EMERGENCY ADMISSIONS BY ROUTE OF ADMISSION



Source: NHS England, A&E Attendances and Emergency Admissions, Nuffield Trust analysis of Hospital Episode Statistics<sup>2,3</sup>

There are a number of ways in which a patient with an urgent need for care can seek help. **Figure 4** shows the numbers of patients seeking care from different parts of the system.

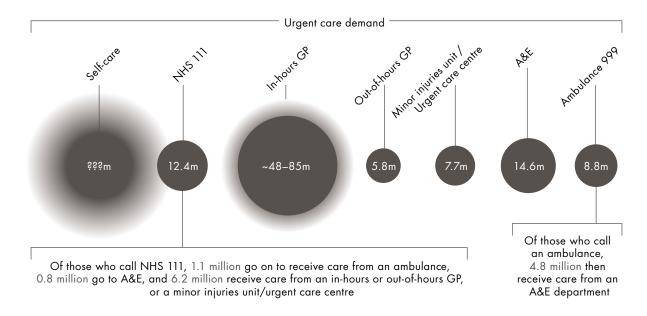
There has been a long-term growth in demand for NHS services as patients have become older and are living with more complex conditions. At the same time, the number of beds available in acute hospitals has fallen by 32 per cent since 2004 (and six per cent since 2010).<sup>15</sup>

Over time this has made the system increasingly fragile, reduced the resilience of the system, and made it particularly vulnerable to small shocks, such as relatively small increases in demand.

As **Figure 5** shows, between 2010/11 and 2014/15 the average occupancy rate (proportion of hospital beds occupied) rose from 86.5 per cent to 88.4 per cent. Over the winter months pressure on beds is even greater: between January and March 2013, bed occupancy rates averaged 89.7 per cent, with over one-fifth of trusts reporting rates over 95 per cent. Once occupancy goes over 85 per cent, we know that the likelihood of beds being available when needed drops dramatically.

The pressure on hospital beds has been further exacerbated by staff shortages and a high turnover in doctors dealing with medical and A&E emergencies, which has further reduced the ability of the system to absorb small shocks and increased costs. This may have also reduced quality due to the extensive use of locum staff.

# FIGURE 4: NUMBERS OF PATIENTS AND THEIR INTERACTIONS WITH THE URGENT CARE SYSTEM



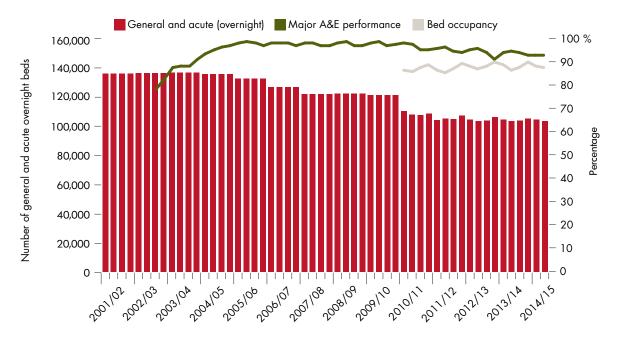
Source: NHS England NHS 111 Minimum Data Set;<sup>17</sup> NHS England, A&E Attendances and Emergency Admissions;<sup>2</sup> NHS England, Ambulance Quality Indicators;<sup>18</sup> House of Commons Health Select Committee, Out-of-hours GP Services in England;<sup>19</sup> Longman H, personal communication; Dunnigan MG, British Medical Journal<sup>20</sup>

However, while A&E staffing is a concern for many, the number of doctors with an emergency medicine specialty increased at a faster rate than all other specialties combined between 2002 and 2012, and the rate and pattern of sickness absence among doctors with an emergency medicine specialty did not differ greatly from doctors in other specialties.<sup>21</sup>

In some hospitals the problem may have been exacerbated because average numbers of attendances have been used to plan their capacity and staff. This seems logical, but is deeply flawed: it means that they are wrong at least half of the time – and as **Figure 6** shows, the numbers of patients in an A&E department can vary hugely from the average. As spare capacity on quieter days cannot be redeployed when it is busier than average, this can cause serious problems.

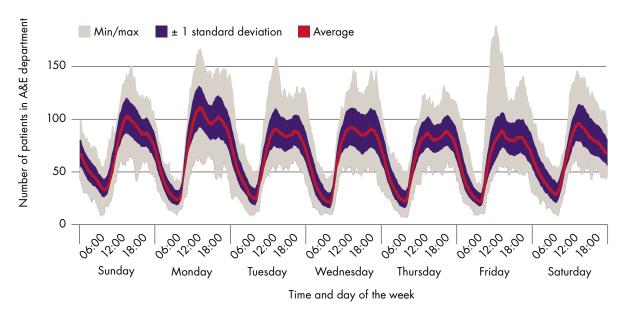
Over the last two decades, other sectors in the economy, such as retail, have seen a shift to a 24/7 culture of rapid and responsive services. The growth in minor A&E department attendances suggests that this has spread to a shift in patients' expectations of health care too, and this is borne out by anecdotal reports from clinicians.

FIGURE 5: QUARTERLY NUMBERS OF BEDS COMPARED WITH OCCUPANCY RATES, 2001/02 – 2014/15



Source: NHS England, A&E Attendances and Emergency Admissions; Bed Availability and Occupancy<sup>2,15</sup>

FIGURE 6: VARIABILITY IN NUMBER OF ATTENDEES AT A SINGLE A&E UNIT BY TIME OF WEEK OVER THE COURSE OF ONE YEAR



Source: Blunt, Focus On: A&E attendances. Why are patients waiting longer?11

# MYTH-BUSTING: COMMON CLAIMS THAT MAY NOT BE TRUE

# 1 THE CHANGE IN THE GP CONTRACT IN 2004 CAUSED A MAJOR INCREASE IN A&E ATTENDANCES

Critics of the 2004 GP contract claim that it made it much harder for patients to access care out of hours, which drove up A&E attendances. But there is no evidence that this is the case (**Figure** 7).

While it is true that the changes to out-of-hours services do seem to have caused public confusion about how to access urgent care services, the GP contract change coincided with the opening of a plethora of walk-in centres, minor injuries units and other services offering immediate access. It was this that created the increase in attendance. The proportion of attendances at major A&E departments happening outside 8am and 6pm on weekdays has changed little since national data have been available (56 per cent in 2007/08 and 59 per cent in 2013/14).<sup>3</sup>

# 2 A LACK OF GP APPOINTMENTS IS CAUSING A&E DEPARTMENTS TO MISS THE FOUR-HOUR TARGET

Patients with more minor conditions who might go to A&E rather than their GP do put pressure on A&E, but they are not the cause of the current (and previous similar) problems with the four-hour target. Patients with minor conditions continue to be seen relatively quickly (an average of 108 minutes for attendances with no significant diagnostic tests or treatment).<sup>3</sup> In fact, a large number of minor attendances can improve overall A&E performance figures: in Wales, where there are fewer minor A&E units than in England, we estimate that A&E performance is around two percentage points lower because of this.

What's more, A&E attendances are higher in the summer and performance is better than during the busier winter period. So while there is evidence that the availability of GP appointments can reduce A&E attendance, the direct connection to performance against the four-hour target is weak.<sup>12</sup>

However, while a lack of appointments is not linked to the four-hour target, it must be remembered that GP services are already encountering higher levels of need as the population ages and patients develop more complex needs. Because the number of GP appointments is much higher than A&E visits, even a small change in the way people use GPs for urgent care could have a dramatic impact on A&E. For example, a five per cent shift out of GPs to major A&Es would increase A&E activity by between 15 and 29 per cent.<sup>2,15</sup>

# 3 NHS 111 IS SENDING TOO MANY PEOPLE TO A&E

The telephone advice service NHS 111 has been accused by some commentators of needlessly sending too many patients to A&E. However, of the 12 million calls received in 2014, only six per cent were advised to go to A&E. This compares favourably to nine per cent sent by the previous telephone advice service, NHS Direct; and 29 per cent of NHS 111 callers say that they would have gone straight to A&E had the NHS 111 service not been available.

However, this still represents a substantial number of A&E attendances, and some patients will head to A&E even after being advised to go elsewhere. The balance between triage by call-handlers supported by expert systems and triage done through clinical advice is still being refined as the NHS 111 service matures, and NHS England's *Urgent and Emergency Care Review* positions NHS 111 as a keystone in the urgent care system.<sup>23</sup>

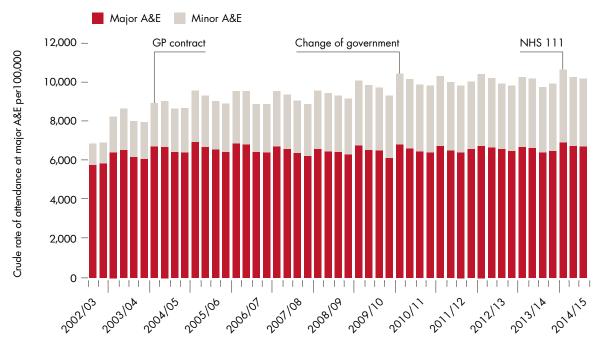
# 4 PATIENTS MISUSE THE SYSTEM

There is much debate about the extent to which use of A&E is appropriate. Estimates for the percentage of cases that could be dealt with by another service range from ten per cent to 40 per cent,<sup>23</sup> but these cases are not necessarily 'inappropriate'. The urgent care system is complicated and difficult for patients to navigate. There is little evidence that attempts to 'educate' patients influence demand – and it can be argued that any system that needs these measures is poorly designed.

Attempts to present a clearer picture (such as the *Urgent and Emergency Care Review*<sup>23</sup>) have often stalled because of fears that they are being used to disguise A&E downgrades.

While there is a popular perception of A&E 'frequent flyers', the data show that it is very rare for people to attend A&E more than ten times in one year. In 2013/14 this represented less than one per cent of patients and three per cent of attendances<sup>3</sup> – often patients with significant unmet mental health and social care needs.<sup>24</sup> This highlights the importance of timely access to liaison psychiatry in A&E departments.

FIGURE 7: A&E ATTENDANCE RATE AND POLICY DEVELOPMENTS AFFECTING URGENT CARE



Source: NHS England, A&E Attendances and Emergency Admissions<sup>2</sup> and Office for National Statistics, Population Estimates for England and Wales, Scotland and Northern Ireland<sup>2.5</sup>

# **SOCIAL CARE**

Just as events in the wider NHS influence performance in A&E, we also know that availability of social care is an important part of the story. Crucially, spending on social care has not been protected in the way spending on health care has – meaning that there was a 16 per cent cut in real-terms net expenditure on social care for older adults between 2009/10 and 2013/14. These cuts have had the largest impact on community-based social care, with almost 300,000 fewer older adults receiving services in the community over the same period.<sup>26</sup>

More social care might have an impact on health services. Several studies have suggested a 'substitution effect', for example each additional £1 spent on care homes reduces hospital expenditure by £0.35.<sup>27,28</sup>

However, it is important to note that these savings are small, and may only apply to residential care rather than intensive social care in the home. The assumption on which the government's Better Care Fund (BCF) is predicated – that investment in social care will accrue £283m from reducing emergency admissions<sup>29</sup> – seems heroic.

The BCF also anticipates benefits of £31m for reducing delays in discharging people from hospital and £30m for more effective re-ablement. This points to the other role that social care may play in relieving pressure on A&E – getting people out of hospital who need social care support to go home. Delays in doing this can create knock-on effects through the whole hospital.

The official discharge data relating to delayed transfers of care do not, however, tell a very clear story: there has been a 43 per cent increase in the numbers of patients delayed in acute hospitals between 2010/11 and 2014/15, but over the same period the delays solely attributable to social care have fallen by 11 per cent, while delays attributable to NHS services are up by 25 per cent.<sup>30</sup> In relation to the reasons for all delays, the biggest growth has been due to people 'waiting for a nursing home placement' (up by 40 per cent) and 'for home care to be put in place' (49 per cent), but there has been a fall of 34 per cent in those delayed 'awaiting public funding'.

Social care, it seems, is an important part of the jigsaw. But it doesn't contain all of the answers when it comes to dealing with pressure on A&E.

# OUR VIEW: WHAT DO THESE FACTORS MEAN?

# RECENT PROBLEMS IN A&E: WINTER 2014/15

The recent problems in A&E performance are part of a complex story. It is clear that recent performance is part of a well-established decline: there was no sudden crisis in January 2015. Indeed, while the publication of weekly A&E performance figures since 2010 is a good thing, we must be cautious about over-interpreting short-term effects, which can contain misleading random fluctuations.

'The most significant issue is the ability to discharge patients safely and quickly from the hospital as a whole' However, the system is clearly under ever-increasing stress from the multiple long-term pressures detailed in this policy briefing. The most significant issue is not about the numbers of people presenting at A&E, but the ability to discharge patients safely and quickly from the hospital as a whole. Small fluctuations are enough to cause the system to buckle, especially with occupancy levels in hospitals being high.

In winter 2014/15, a familiar pattern emerged, replicated in hospitals across the country: as pressure built, patients started to be placed in the wrong wards and were admitted for processing later, and as a result patients were moved around the hospital. This led to increases in the length of time patients stayed in hospital, further restricting the availability of beds to help clear A&E.

As a result, staff in A&E and ambulance services were often enlisted to care for patients who should have been moved on, rather than dealing with new ones. The deterioration in ambulance response times seems to be linked to the growth in delays in handing over patients. In these situations, chaos builds, staff sickness increases and more patients end up in the wrong place. Frequent moves (which have a very negative impact upon patients), internal frenetic activity and reduced capacity in social care can mean that discharges drift even further, or are done in a hurry.

A further pressure can arise because – to deal with high levels of demand – more patients may be discharged rapidly to GPs who already are under strain and are unable to see them quickly. This can cause a re-admission to hospital or may add to the high level of pressure that GPs are under, reducing their capacity to absorb demand from other patients.

Added into this mix is a performance management system in which a significant amount of managerial time is wasted in non-value-adding requirements to report to multiple bodies, such as NHS England, clinical commissioning groups and Monitor. One hospital chief operating officer we spoke to told us that the key person running the hospital spends many hours a day filing reports for these bodies. There is too much focus on providing assurance upwards, which is very unhelpful in its impact on frontline staff. The Nuffield Trust is undertaking further research on the management culture of the NHS, which will explore this issue further.

# WHAT CAN POLICY-MAKERS AND POLITICAL LEADERS DO TO HELP?

Multifaceted problems, such as those behind the recent – and more long-term – pressures on A&E, are not solved by single policy interventions. Many of the 'magic bullet' solutions often suggested do not address the root cause.

For example, while having GPs working in A&E departments can make an important contribution, this would not address the underlying problem of managing frail patients with complex needs. Similarly, it is not clear that additional A&E consultants would deal with the problem of growing hospital admissions of patients with acute medical conditions.

# Solutions need to:

Focus on getting things right in primary care to enable prevention to work – but be realistic about how much can be achieved

Preventing hospital admissions is difficult, so policy-makers should be cautious about seeing prevention as a catch-all solution. But building up the skills and capacity of health care professionals – from community pharmacists to ambulance paramedics – to provide high-quality urgent care services outside of hospital, as set out in the NHS England *Urgent and Emergency Care Review*,<sup>23</sup> should be a priority.

Many of the alternatives to A&E that have been set up have had the effect of increasing the overall level of demand without making any discernible impact on A&E. Workable solutions need to be mindful of the ways in which patients access and use urgent care services.

Policy-makers should also look closely at addressing workload problems among GPs and other primary care staff, consider increased staffing levels in primary care, and improve the way staff are deployed and supported.

Remove some of the complexity of different services that has been built into the system, and which confuses the public and NHS staff

There has been a tendency in the NHS to create a plethora of different services aimed at narrow segments of the population, which have different referral routes, cover different geographies and are not well coordinated. Some places have responded to this by creating a directory of services to help NHS staff navigate the system more effectively. However, rationalising, standardising and simplifying these services, as well as creating a single point of access to community services for patients and GPs, are more important steps.

Focus on the way patients move through hospital – and be realistic about what policy-makers can and can't do

A huge amount of emphasis has been put on preventing emergency admissions, with very limited evidence of success. However, much more can be done to improve the flow of patients through hospitals and increase the speed at which patients are discharged. How staff work and organise care can be improved, but it is difficult to do this when they are already working at or beyond full capacity.

Policy-makers play an important role in ensuring both that there is proper investment in out-of-hospital services, and that payment and regulatory systems do not undermine hospitals from collaborating effectively with community and social care. But beyond this, many of the solutions regarding improving patient flow lie in the hands of providers themselves, rather than policy-makers.<sup>31</sup>

In addition, a number of the penalties, fines and incentives that have been designed to improve the flow of patients through hospitals seem to be having unintended consequences that may be inhibiting progress in this area.

# Foster a better understanding of the way that local systems work

The urgent care system is complex and not well understood. Despite significant additional spending, the solutions that have been developed over time have not been fully successful. Key data, such as those on primary and community care, are missing. Where there are data available on urgent care, they do not provide a full enough picture of the dynamics of the system or how patients flow through it. As a result, some solutions, such as additional beds, or minor injuries units, may actually have increased demand rather than managed it.

In addition to filling the gaps in data, we need to deploy much more sophisticated modelling tools to develop a better picture of how these complex systems work in practice. Examples of organisations currently developing such tools include Bradford Teaching Hospitals NHS Foundation Trust and Southampton Clinical Commissioning Group.

Take a longer-term and broader view of performance in A&E – and consider trialling alternative performance measures

There are questions about whether the performance management system designed to deliver the four-hour 95 per cent target is causing more dysfunctions than is helpful, and is failing to capture patients' experience of the system.

Recent events suggest that there may be an undue focus on this single indicator. Measuring the performance of A&E units is essential, but the way we react to changes in that performance has become disproportionate.

It is used as a stick to beat politicians, when they have little power to manage the immediate problems. Of even more concern is that it can distort behaviours inside hospitals and health systems in ways that are not in the interests of patients or staff. A significant amount of time is spent by NHS staff reporting upwards, with potentially detrimental impacts on the quality of care.

The application of a 'targets and terror' approach to this narrow measure is misguided. But there is not a clear alternative: relying entirely on professionalism has not worked in the past, and it is clear that it is not a problem that can be solved by policy-makers, political leaders or regulators trying to micro-manage A&E.

'Sticking-plaster solutions will not solve the problem. Nor will increased political pressure, unless it is linked to substantial extra resources'

A possible alternative approach is to consider using a richer set of indicators to measure system performance, which would keep the four-hour target as one of a number of indicators and replace the current focus on a single indicator. Many different indicators exist already, but are not sufficiently focused upon. These might include the number of people leaving the A&E department before being seen, or the percentage of eligible patients having heart treatment within 90 minutes of arriving at the hospital.<sup>32</sup> Other possible indicators to consider are trolley waits, median time to treatment and seven-day re-attendance. There should also be a much better way of capturing staff and patient assessment of the quality of the service.

Any group of new indicators should include an emphasis on local systems to sort out problems and an expectation that all calls from commissioners or regulators should be aimed at solving problems, not asking for updates.

If there was nervousness about such a set of new indicators, one approach would be to test this through the introduction of clustered randomised controlled trials of alternatives to managing urgent and emergency care, which could allow new and more effective methods with fewer dysfunctional consequences than the current system.

# CONCLUSION

Our urgent care system is near breaking point. The continued squeeze on resources will accelerate the pace at which it reaches that point. Sticking-plaster solutions will not solve the problem. Nor will increased political pressure, unless it is linked to substantial extra resources and backing for bold strategic re-design, such as that proposed by the *Urgent and Emergency Care Review*.<sup>23</sup>

Many answers to the problems facing urgent care already exist. But the complexity of the system and the highly politicised nature of A&E have impeded progress. With change so urgently needed, it is imperative that there is a cross-party consensus on how to move forward and that action is not postponed or delayed for political reasons.

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