



Briefing June 2022

Was the NHS overwhelmed last winter?

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“Protecting the NHS” has been a mantra for the government throughout the first years of the Covid-19 pandemic, to get the public on board with measures to control the virus. But looking back on the pandemic’s second winter, from December 2021 to March 2022, it is clear that the NHS really struggled and continues to do so.

Covid-19 cases soared last winter, driven by the Omicron variant, but fewer English NHS hospital beds were occupied by patients with a confirmed case of Covid-19 than the previous winter – although at times they still occupied 15% of acute beds. However, NHS staff sickness absence in England was also worse last winter than previous winters.

The data indicates strain across the whole system last winter, with almost all of the measures looked at in this briefing indicating the poorest English NHS performance compared to the most recent winters. There were longer waits across many different services. Poor performance levels follow on from long-term historical deterioration in quality of care, exacerbated by the pandemic. However, poor performance is not explained by higher volumes of activity alone. A combination of people presenting with more serious health problems, and reduced capacity, alongside the toll on staff of the pandemic, are likely to be key factors.

Key messages

We found:

- Ambulance response times were longer last winter than other recent winters. The average waits per month for people in emergency situations, such as after a heart attack or stroke, ranged between 38 and 53 minutes last winter. The average waits ranged between 18 and 30 minutes the winter before, and between 21 and 28 minutes the two winters before that. In December 2021, there was particularly poor performance, with one in 10 patients in these situations waiting nearly two hours for an ambulance on average. But this is not just a winter effect, as response times were longer throughout 2021/22 than previous years.
- Waiting times at A&E departments increased further last winter. At major A&E departments (type 1), nearly 1.25 million attendances waited more than four hours before admission, transfer or discharge – affecting almost two out of five attendances at these departments. The number of these long waits was nearly twice as many as the previous pandemic winter, and compares to one million occurrences or fewer in previous recent pre-pandemic winters.
- The number of times patients who waited more than 12 hours to be admitted to a ward after a decision to admit last winter was nearly 46,000. These ‘trolley waits’ massively increased last winter and were five times more than in the previous winter.
- These long backlogs in A&E departments then further impacted on ambulance services, causing increases in ambulance handover delays. Not only were there more of these delays last winter, they were also longer. The number of ambulances delayed by more than 60 minutes was more than double the number in any of the previous four winters. In total, the estimated minimum amount of time lost in delays last winter was equivalent to over 13,000 12-hour ambulance shifts being lost.

- Difficulties in admitting patients to beds was not just down to bed occupancy rates, which were lower last winter compared to before the pandemic, but also to reduced capacity through other mechanisms, such as enhanced infection control measures and the additional pressures that Covid-19 infections can create for other conditions.
- On average per day, over 11,500 patients who met the current criteria for leaving hospital were not discharged last winter – nearly three in five patients per day who could be discharged but weren't. This means that, on average over one in 10 of available general and acute beds per day were occupied by a patient who, according to the criteria being used, was fit to leave hospital but who was not discharged. Over the winter period, the number of people deemed fit to leave hospital but not discharged grew at a faster rate than those who were successfully discharged.

This briefing looks at what is traditionally thought of as the winter pressure period for the NHS, from December to early March. Further performance data released since shows that the pressures have not reduced as we move into summer. The picture is of an alarming spiral of pressure in one part of the health and care system causing problems for related services, with an ever-worsening impact on patient care.

The NHS has historically prioritised care at the point of need, with urgent care services being a safety net for responding to urgent illness and injury. The last two years have seen extreme demands on the health and care system. This has been punishing for staff, leading to burnout and low morale. The capacity of the system to recover from periods of intense demand now appears to have been reached, and performance levels indicate widespread instances where NHS services are overwhelmed and unable to meet emergency care needs.

What are winter pressures and what was different last winter?

Winter is a time when there are normally **additional illnesses (such as flu and norovirus), and excess winter complications and deaths** resulting from respiratory and cardiovascular problems. These put extra pressures on the NHS not normally experienced during other seasons.

For nearly a decade before the pandemic, the NHS's performance on key measures of urgent and emergency and hospital care that are sensitive to winter pressures has **deteriorated**. And throughout the pandemic, policy-makers have used the yardstick of ensuring that the NHS is not overwhelmed to guide the response to Covid-19.

A definition of what “overwhelmed” means in practice is **hard to pin down**, as the NHS continues to function and accept emergency patients, even if the quality of care that can be provided has deteriorated far beyond expected standards. The Chief Medical Officer Sir Chris Whitty described being “overwhelmed” as a time when people waiting for care has reached unsafe levels, staff-to-patient ratios are stretched to unacceptable levels, and avoidable deaths are occurring.

Here we explore why last winter was particularly challenging for the English NHS, and ask whether the NHS has in effect been overwhelmed.

Why was the winter of 2021/22 a particular concern for the NHS?

This was the second winter of the pandemic for the NHS. This time, however, there were particular concerns with the emergence of a new SARS-CoV-2 variant, Omicron. It was first **identified in South Africa**, and at the end of November the first cases were identified in the United Kingdom.

Early evidence indicated that it was spreading fast and there were uncertainties about vaccine/previous infection protection. It seemed to cause a milder disease than previous variants. Despite this, however, and improvements in Covid-19 treatments, there were still **fears** that if it resulted in large increases in cases then it still could overwhelm the NHS, not least given the **existing problems with staff burnout** within the health service that had already been exacerbated during the pandemic.

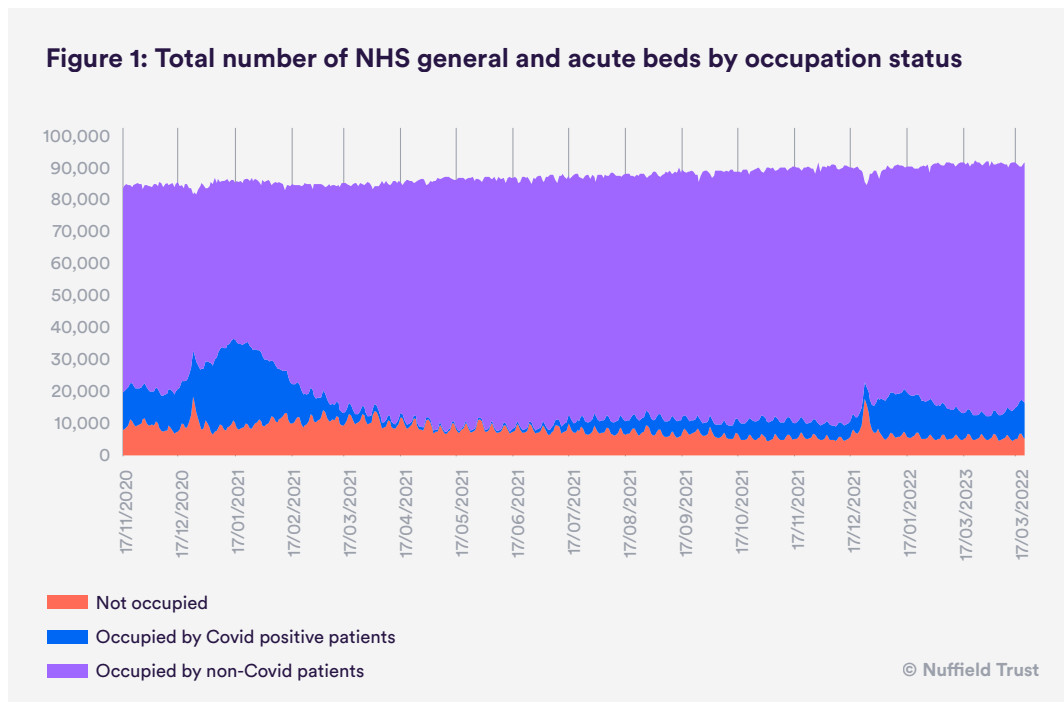
There were also high expectations going into last winter that the NHS could increase the amount of elective work it carried out compared to the first pandemic winter the year before. That previous winter also benefited from reduced numbers of A&E attendances and emergency admissions compared to before the pandemic. With fewer social restrictions in place a year later on, it was unlikely that the NHS would experience reduced demand this time around.

How did the Omicron wave unfold?

Covid-19 cases in the community and NHS beds occupied by confirmed Covid-19 infections

The total number of cases (new and reinfections) in England was considerably greater than the winter of 2020/21, and **at its peak** the number of infections was three times greater than the peak in the previous winter.

However, the number of NHS beds occupied by patients with a confirmed case of Covid-19 was lower during last winter's Omicron wave than in the Alpha wave of the previous winter (see Figure 1). Between 6 December 2021 and 6 March 2022, there were 723,524 fewer bed days for patients with a confirmed case of Covid-19 than in the same period the previous winter.¹



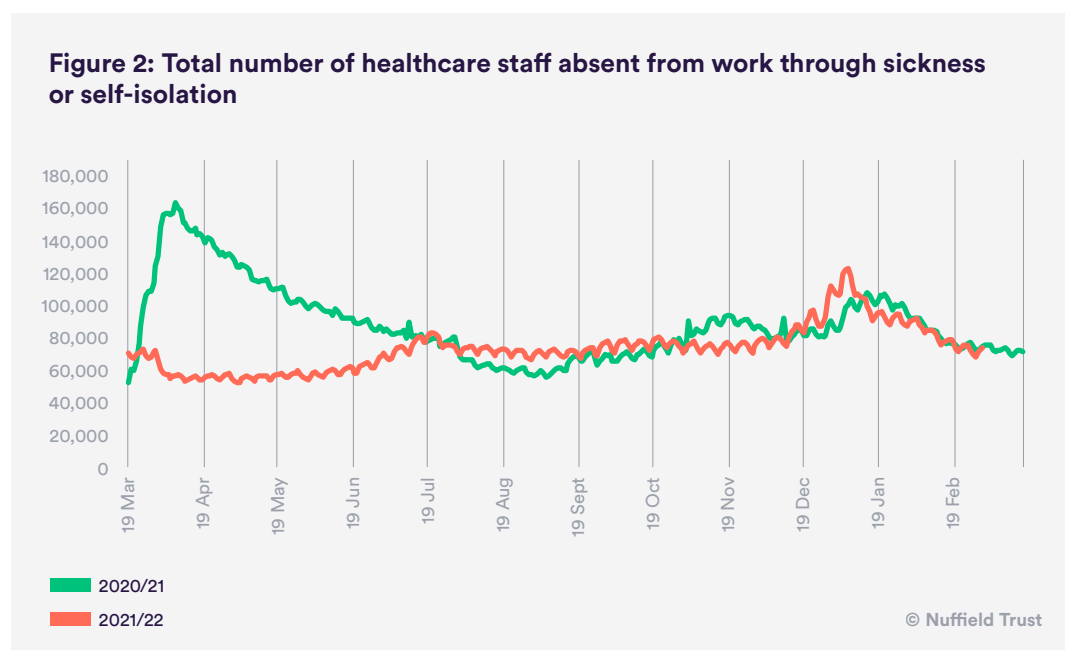
Source: [NHS England, COVID-19 Hospital Activity](#) (accessed 28 March 2022)

1 Bed days were calculated by summing the daily number of beds occupied by a patient with a confirmed case of Covid-19 for each time period, and subtracting the 2021/22 value from the 2020/21 value.

However, there were still a large number of beds occupied with patients with a confirmed Covid-19 infection, peaking at 13,693 beds on 11 January 2022 – equating to three in 20 of all general and acute beds ² on that day. Although these patients may not have been admitted for Covid-19, having the infection can worsen existing conditions and complicate a patient’s care – creating the need for possible extra treatment requirements and subsequently reducing capacity.

Staffing absences

Staff absences for health care workers, due to sickness or the need to self-isolate after close contact with someone confirmed to have the virus, was greater last winter (see Figure 2). ³ Between 6 December and 2 March, on average there were 1.5% more staff absent than in the same period 12 months earlier.



Source: [NHS England, COVID-19 Hospital Activity](#) (accessed 28 March 2022)

- 2 Occupied and not occupied.
- 3 This data covers NHS trusts and independent sector providers.

Using NHS Digital's monthly NHS **staff sickness absence data**⁴, we can see that going into last winter, absence rates in English NHS trusts were already higher than in previous years, including earlier on in the pandemic. The overall sickness absence rate for English NHS trusts in December 2021 was 6.2%, which compared to 5.1% in December 2020 and 4.9% in December 2019. In **January** 2022 the sickness absence rate grew to 6.7%, which compared to the next highest rate of sickness absence in previous winters of 5.8% in January 2021.

Staff in ambulance trusts seemed particularly affected, with absence rates in December 2021 being 9.3%, which was 3.2 percentage points higher than the national rate. This is compared to 2.0 percentage points higher in December 2020 and 1.6 percentage points in November 2019.

Newly published weekly winter **situation report data** show that, for NHS acute trusts, absences peaked in January 2022, in line with the spread in the community.

Using this data, between 6 December 2021 and 6 March 2022, we estimate⁵ that, for NHS acute trusts, there was on average nearly one absence per 15 employees per day, which corresponds to one absence per 13 full-time equivalent positions.

4 Accessed 8 June 2022.

5 Estimates were calculated as the daily average number of **absences in NHS acute trusts** over the time period divided by the **total number of staff** in November 2021 (by headcount and full time equivalent) employed by the same providers submitting acute absence data (accessed 28 March 2022).

How did the NHS perform during last winter?

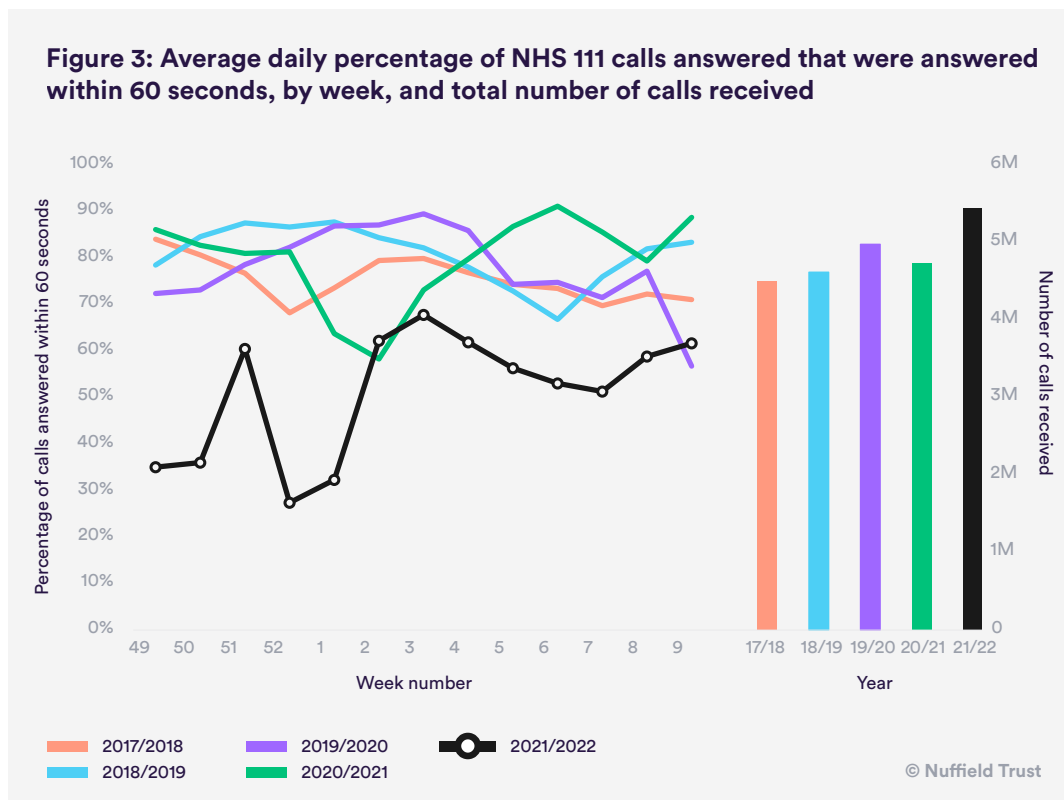
In this section we look at a few key measures of urgent and emergency care and hospital care that are sensitive to winter pressures, to see how the NHS in England performed last winter.

Urgent and emergency care

NHS 111

NHS 111 is the phone and online service that provides people with free 24/7 access to advice about their immediate health needs, and which can help them get the right medical help if it's required.

Between early December 2021 and early March 2022⁶, an average per day of 51% of calls answered by NHS 111 were answered within 60 seconds. This is compared to 80% over the same weeks in the previous winter of 2020/21, and 78% in the pre-pandemic winter of 2019/20 (see Figure 3).



Source: [NHS England, Urgent and Emergency Care Daily Situation Reports](#) (accessed 10 March 2022)

6 6 December 2021 (week 49 of 2021) and 6 March 2022 (week 9 of 2022).

The average time to answer NHS 111 calls was nine minutes 25 seconds in **December 2021**, six minutes 42 seconds in **January 2022** and 4 minutes 27 seconds in **February 2022**. There is no equivalent data for previous winters.

NHS 111 providers **say** that performance last winter was being negatively affected by staffing issues (turnover, recruitment and training) and Covid-19 pressures causing absences due to sickness or isolation.

They also **attribute** slower response times to a higher volume of calls received. Between early December 2021 and early March 2022⁶, there were 5,433,548 calls to NHS 111 (see Figure 3), which was an average of 41 calls per minute.

This volume of calls was 15% more than in the previous winter – equivalent to five more calls per minute on average. The previous winter saw call volumes similar to or lower than the number received during pre-pandemic winters.

Ambulance services

If an individual doesn't get a timely call from NHS 111, they may abandon calls and end up seeking help elsewhere. If they are particularly worried, they may phone 999 to access ambulance services.

In this section we look at the volume of calls and ambulance incidents, the severity of patients, and how long it took for patients to be reached.

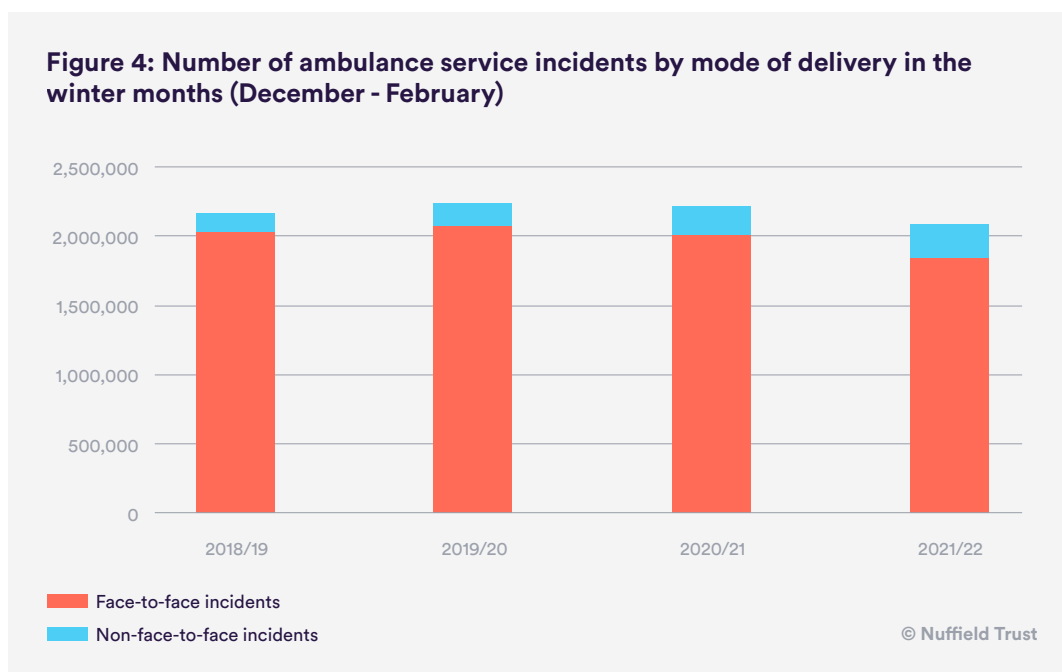
The number of calls to ambulance services was higher last winter compared to recent previous winters.

Between December 2021 and February 2022, the **ambulance service received**⁷ 3,315,443 calls⁸, which is equivalent to 26 calls per minute on average – a 10% increase compared to the same period a year earlier. This increase may reflect difficulties with NHS 111 answering calls in a timely way, but it also could be indicative of patients having more severe health issues.

7 Data accessed 6 April 2022.

8 Includes all telephone calls to 999 and 112, the latter being the pan-European equivalent to 999.

This increase in calls, however, didn't lead to more incidents⁹ or more face-to-face activity by the ambulance service (see Figure 4), as fewer calls resulted in this type of response. 88% of all incidents resulted in a face-to-face response at the scene over this time period in 2021/22, which was down from 91% the winter before and from 93% and 94% in 2019/20 and 2018/19 respectively.



Source: [NHS England, Ambulance Quality Indicators](#) (accessed 4 April 2022)

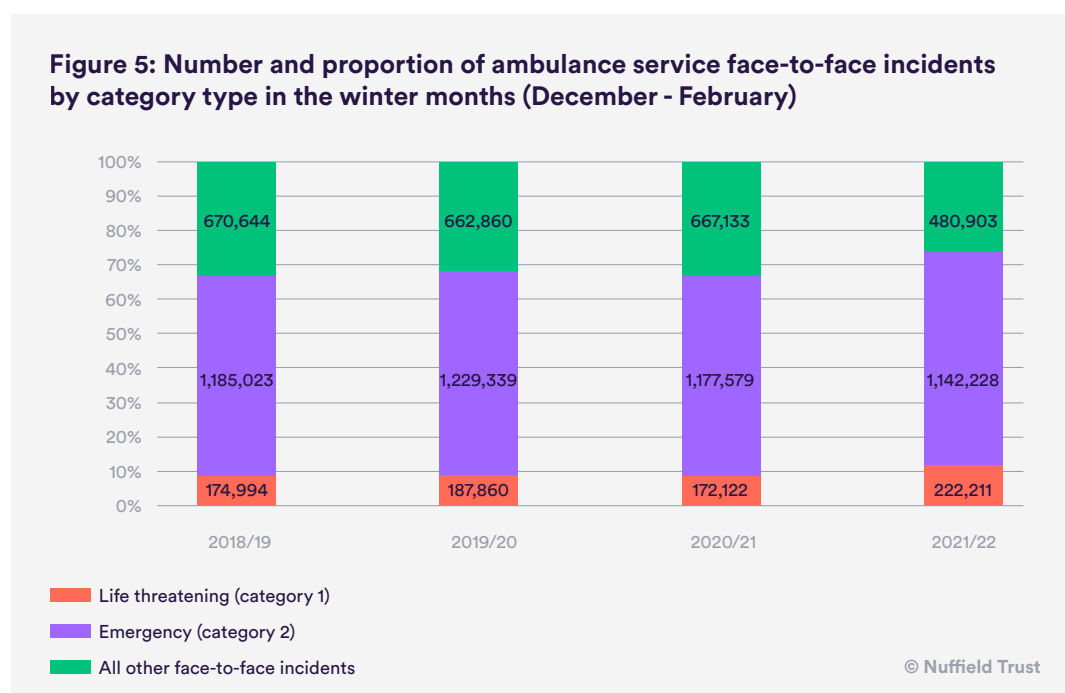
However, how severe and complex these face-to-face contacts were relative to previous years is hard to determine.

The number of life-threatening¹⁰ (category 1) incidents the ambulance service dealt with (222,211¹¹) was greater over this period than in previous recent winters (see Figure 5).

- 9 **Incidents are different from calls received by the ambulance service.** If there are multiple calls to a single incident, only one incident is counted. Incidents comprise not only calls that receive a face-to-face response from the ambulance service at the scene of the incident, but also calls that are successfully resolved with telephone advice with any appropriate action agreed with the patient.
- 10 Life-threatening and needing immediate intervention and/or resuscitation. For example, patients in cardiac or respiratory arrest.
- 11 Category 1 incidents with a response time.

Conversely, the number of emergency¹² (category 2) incidents the ambulance service dealt with last winter (1,142,228¹³) was lower than in previous years. The overall number of transports to emergency departments over last winter after face-to-face responses was also lower than in previous years¹⁴, at 1,080,095.

However, it does look like the face-to-face incidents were being prioritised more for life-threatening or emergency incidents. The proportion of face-to-face incidents that were for these categories, rather than other category calls, were higher than in all previous three winters – 12% and 62% respectively¹⁵ (see Figure 5).



Source: [NHS England, Ambulance Quality Indicators](#) (accessed 4 April 2022)

Given this picture of demand, coupled with the high levels of sickness absence in ambulance trusts going into this period, what was the impact on ambulance response times?

- 12 Emergency or a potentially serious condition that may require rapid assessment, urgent on-scene intervention and/or urgent transport. For example, a patient who has had heart attack or stroke, or suffering from sepsis or major burns.
- 13 Category 2 incidents with a response time.
- 14 Although a change in how one of the ambulance service providers determine their data changed from January 2022 and may have impacted on this reduction, it's unclear to what extent.
- 15 Assuming all category 1 and 2 incidents have a face-to-face response.

Last winter, response times for both life-threatening (category 1) and emergency (category 2) incidents were longer than the previous winters (see Table 1).

Table 1: Ambulance response times to life-threatening (category 1) and emergency (category 2) incidents

		Ambulance response times to category 1 incidents		Ambulance response times to category 2 incidents	
		Mean (min:sec)[A]	90th centile ¹⁶ (min:sec) [B]	Mean (hour: min:sec) [C]	90th centile (hour:min: sec) [D]
2018-19	December	7:06	12:25	22:23	46:22
	January	7:08	12:20	22:58	47:39
	February	7:17	12:41	23:37	48:57
2019-20	December	7:33	13:16	27:57	58:27
	January	7:06	12:27	20:55	42:32
	February	7:18	12:52	22:07	45:06
2020-21	December	7:25	13:07	27:51	59:38
	January	7:31	13:16	29:39	1:04:10
	February	6:46	11:57	18:19	36:04
2021-22	December	9:13	16:12	53:21	1:59:12
	January	8:31	15:05	38:04	1:23:35
	February	8:51	15:43	42:07	1:31:54

Source: [NHS England, Ambulance Quality Indicators](#) (accessed 4 April 2022)

[A] Target is a response time of seven minutes

[B] Target is a response time of 15 minutes

[C] Target is a response time of 18 minutes

[D] Target is a response time of 40 minutes

16 A 90th centile incident response time of 15 minutes means that nine out of 10 incidents were responded to in less than 15 minutes.

However, this does not appear to be just a winter effect. Response times in the months prior to last winter were also longer than comparable time periods in previous years, with these increases in response times starting in May 2021. This January and February's response times were actually similar or lower than the preceding summer and autumn months.

A&E departments

Ambulance handover delays

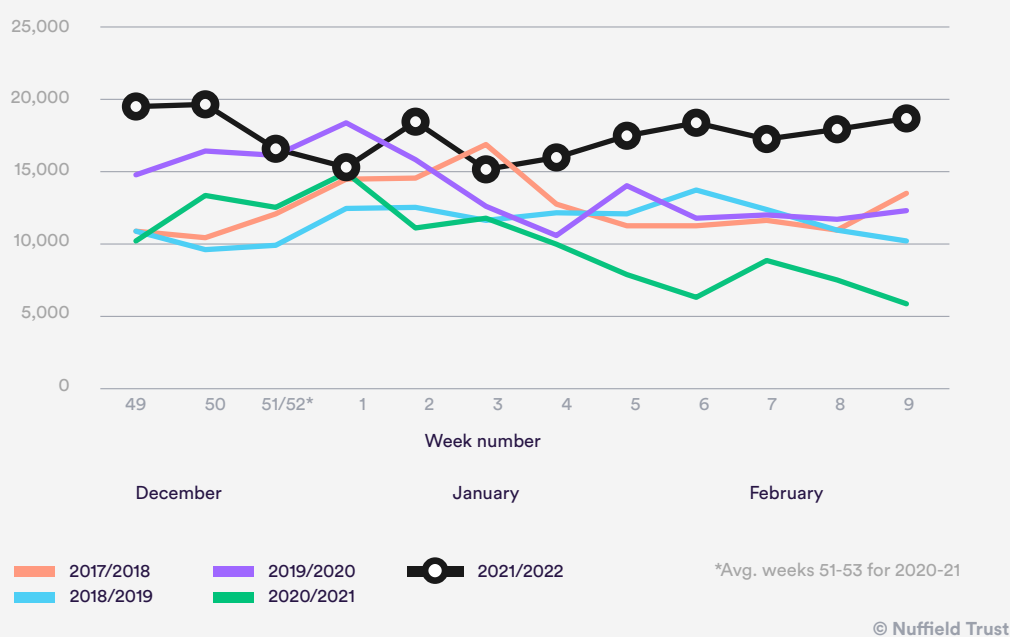
As well as high demand and lack of staff through absences, another reason why ambulance response times may be longer is due to lack of available active crews and vehicles as they get 'stuck' at hospital A&E departments because of an ambulance handover delay.

The NHS aims to transfer of patients between ambulance services and A&E departments within **15 minutes**, and no ambulances should wait more than 30 minutes so not to **compromise patient safety**.

Last winter, between early December and early March¹⁷, the number of ambulances arriving at an English hospital where their handover was delayed by more than 30 minutes frequently exceeded the levels seen in previous winters (see Figure 6). Much of that was driven by a larger number being delayed for more than 60 minutes, with delays of this length doubling last winter compared to any of the previous four winters.

¹⁷ 6 December 2021 (week 49 of 2021) and 6 March 2022 (week 9 of 2022).

Figure 6: Number of ambulance handover delays that were delayed by more than 30 minutes



Source: [NHS England, Winter Daily Situation Reports](#) (accessed 10 March 2022)

Overall, 20% of all ambulances arriving at hospital were delayed by more than 30 minutes last winter, with the highest equivalent figure over any of the previous four winters being 14% in 2019/20.

The minimum amount of time¹⁸ lost to these delays was significant – equivalent to losing over 13,000 12-hour ambulance shifts. The highest minimum amount lost in the previous four winters was 9,263 in 2019/20.

Ambulance handover delays are not routinely published out of the winter months, so we are not able to see if this was a driver of the longer ambulance response times throughout 2021/22.

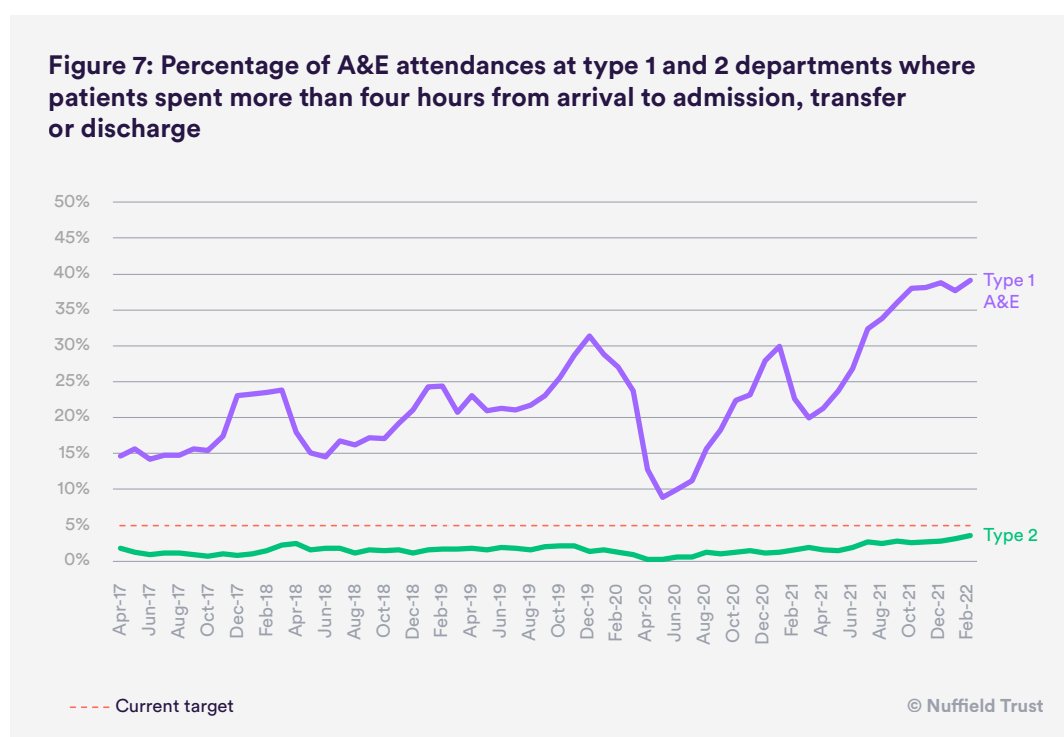
Waiting times in A&E before admission, transfer or discharge

Ambulance handover delays are in part down to insufficient capacity in the A&E department caused by a lack of space or staff, or difficulty admitting patients into a hospital bed.

¹⁸ The minimum number of time spent during ambulance handover delays (in minutes) is calculated as the sum of the number of delays that were 30-60 minutes long over the time period, times by 30, and the number of delays that were more than 60 minutes over the time period, times by 60.

Demand for A&E emergency care last winter compared to previous winters was a **mixed picture**. While the number of attendances to major (type 1¹⁹) and speciality (type 2²⁰) A&E departments were higher than the previous winter, they were at similar or lower levels to recent pre-pandemic winters. The number of emergency admissions via these departments were also similar to the previous pandemic winter, but were lower than pre-pandemic levels.

Despite this demand not increasing relative to pre-pandemic years, last winter the percentage of A&E attendances at type 1 and 2 departments where patients spent more than four hours from arrival to admission, transfer or discharge was higher than in previous winters (see Figure 7).



Source: [NHS England, A&E Attendances and Emergency Admissions²¹](#) (accessed 8 April 2022)

- 19 **Type 1 A&E departments** are consultant-led, 24-hour services with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients.
- 20 Type 2 A&E departments are consultant-led, single-specialty accident and emergency service (e.g. ophthalmology, dental) with designated accommodation for the reception of patients.
- 21 This is based on the adjusted data, which includes data for the field testing sites of the clinical review of standards in the activity data but not in the performance data.

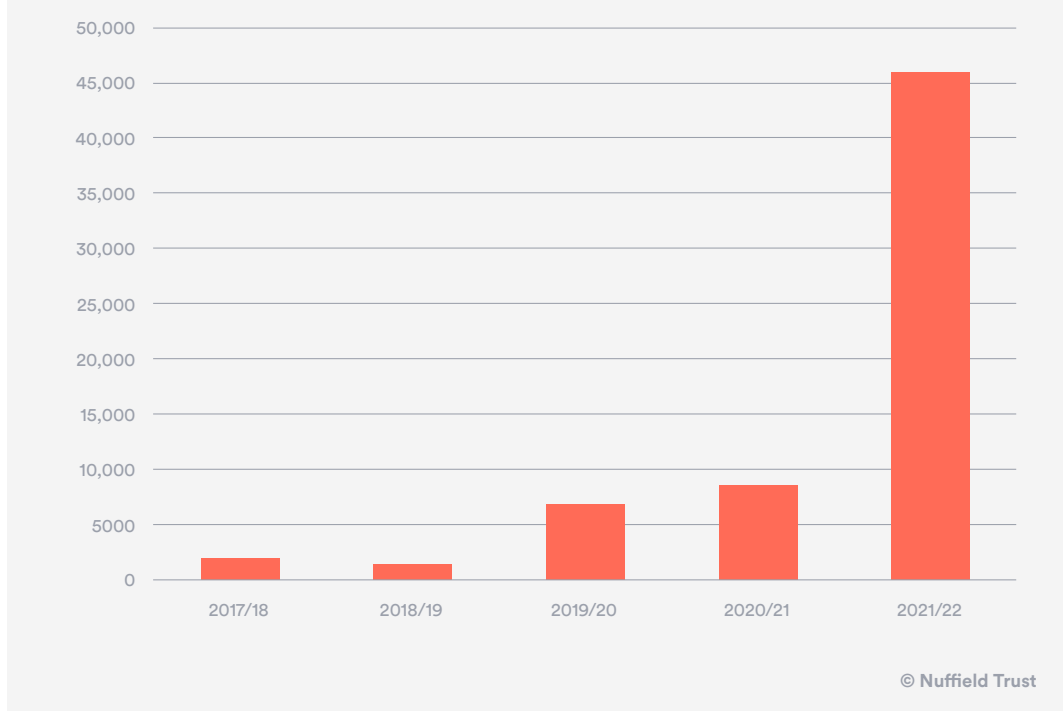
Between December 2021 and February 2022, nearly 1.25 million attendances to type 1 A&E departments waited more than four hours, which was 39% of all attendances at these A&E departments over the same period. This is compared to 29% or fewer in the previous four winters, where there were 681,680 occurrences of these delays in the previous winter of 2020/21, and one million or fewer occurrences in recent pre-pandemic winters. Like with the ambulance response times, this deterioration in performance continues **long-term historical trends**.

Waiting times after a decision to admit

Once a decision to admit has been made, however, there may be difficulty admitting patients into a hospital bed and there could be a wait to be admitted to a ward. These so-called 'trolley waits' further impact on the space and staff capacity within the A&E departments, additionally contributing to prolonged A&E waiting times and ambulance handover delays.

Last winter, between December and February there were 45,948 occasions where patients experienced waits greater than 12 hours to be admitted to a bed after a decision to admit. This was five times worse than in the previous winter, where performance on it was already substantially worse than in pre-pandemic winters (see Figure 8).

Figure 8: Number of times patients spent more than 12 hours from a decision to admit to admission in the winter months (December - February)

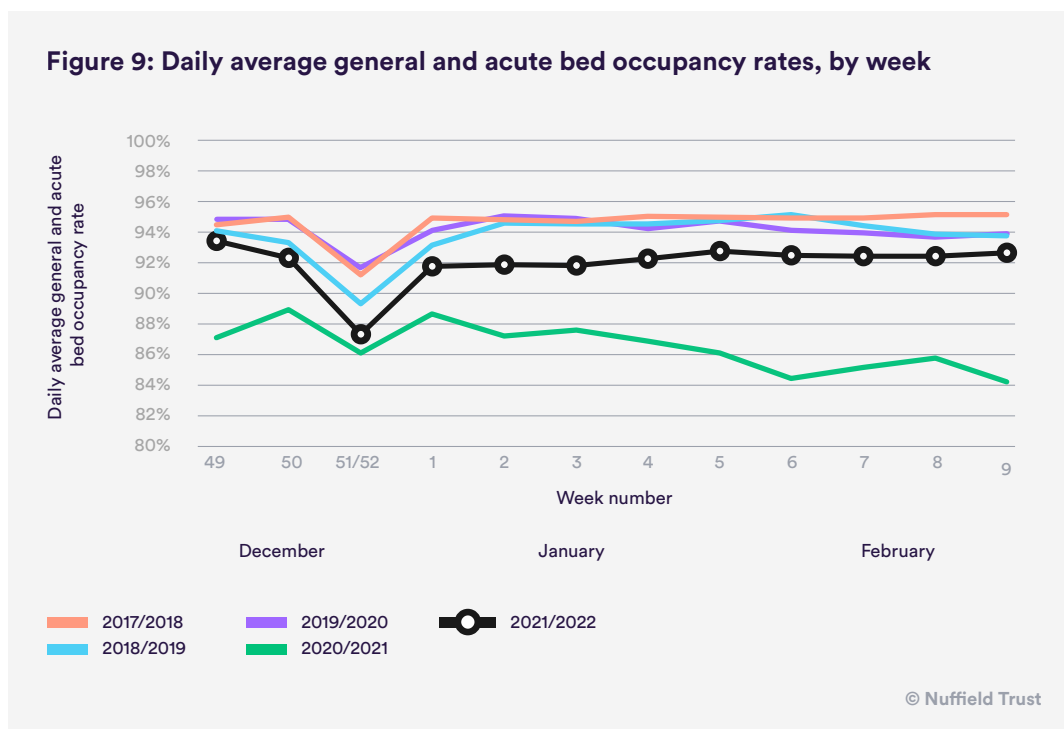


Source: NHS England, A&E Attendances and Emergency Admissions (accessed 8 April 2022)

Hospital care and hospital discharges

Inpatient hospital beds

Rising bed occupancy rates – the percentage of beds available in hospitals that are occupied by patients – are associated with **worsening A&E performance**. Between early December 2021 and early March 2022²², the general and acute bed occupancy rate in English NHS hospitals was 92% on average, which is compared to between 94-95% over the same period in the most recent three pre-pandemic winters. During the previous pandemic winter it was a lot lower over the same time, at 87% (see Figure 9).



Source: [NHS England, Winter Daily Situation Reports](#) (accessed 10 March 2022)

²² 6 December 2021 (week 49 of 2021) and 6 March 2022 (week 9 of 2022).

During the pandemic, however, hospitals have experienced capacity pressures at lower occupancy rates. This is because hospitals have been organised in new ways, such as separating out Covid-19 and non-Covid-19 patients, and putting in place other enhanced infection control measures. A Covid-19 infection in patients can also worsen existing conditions and complicate a patient's care. All this combined reduces capacity, both in terms of staff time and other resources.

Discharges from hospital

Bed occupancy rates are not only influenced by the number of patients being admitted, but also by the numbers of patients leaving hospitals. Reducing discharge delays once patients are medically fit to leave hospital is essential.

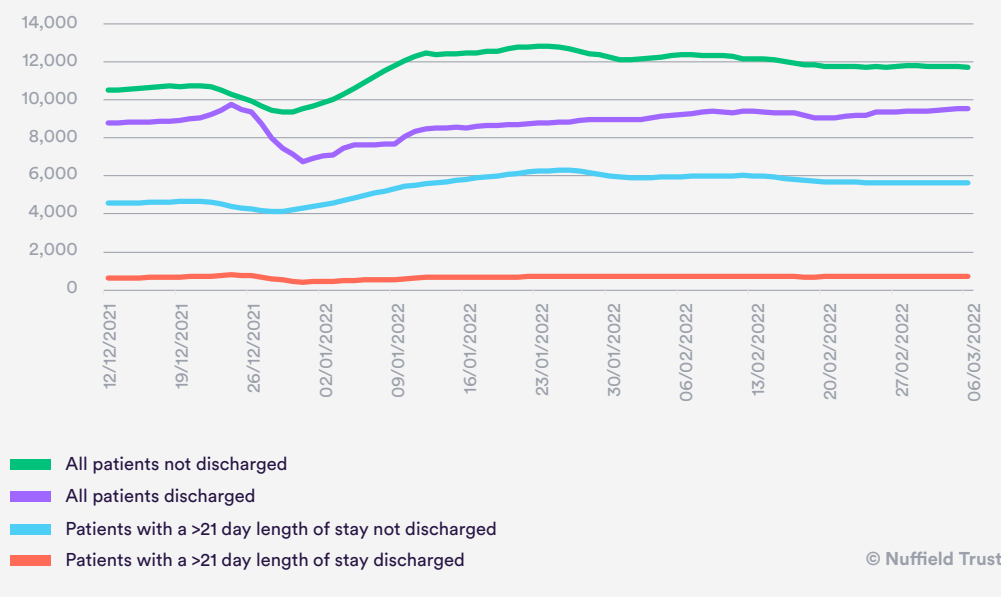
Between early December 2021 and early March 2022²³, an average of 11,556 patients per day who met the current criteria for leaving hospital were not discharged. This is nearly three in five patients (57%) who could, according to the criteria, have been discharged but weren't. By the end of the period, the number of people deemed fit to leave hospital but not discharged grew at a faster rate than those who were successfully discharged (see Figure 10).

Over the period, an average of 12% of available general and acute beds per day were occupied by a patient who, according to the criteria being used, was fit to leave hospital but not yet discharged.

For patients who had a stay longer than 21 days, the situation was even more stark.

²³ 6 December 2021 (week 49 of 2021) and 6 March 2022 (week 9 of 2022).

Figure 10: Rolling seven-day average number of patients that no longer meet the criteria to reside that are discharged and not discharged



Source: [NHS England, Winter Daily Situation Reports](#) (accessed 11 April 2022)

Delayed discharges are not a new phenomenon and although there is no directly comparable data for previous winters, it is likely that the pandemic and Omicron in particular will have made things worse – through higher staff absences causing disruptions in NHS trusts, community and step-down health care services, and social care.

Many **community health care providers still report**²⁴ large backlogs and long waiting lists. The Association of Directors of Adult Social Services reported **longer delays and large waiting lists** and care providers reported large **drops in the numbers of care staff**.

The longer the delay for accessing these care services, the higher the risk that a person’s condition will deteriorate – the consequence of which might be that they require additional support and therefore put more pressure back on other NHS services.

24 [Community-Health-Services-SitRep-Jan22](#) (accessed 12 April 2022)

What does this tell us?

This past winter

All the comparable measures that we looked at indicate that performance in the English NHS last winter was the poorest since records began. While this continues a long-term trend in performance deterioration, the speed of that deterioration has been more rapid. The extent of that decline – particularly for ambulance response times, ambulance handover delays and ‘trolley waits’ – is more than we would have anticipated.

This isn’t just about increased capacity demand through higher numbers of patients, as the volumes of most health care activity looked at in this briefing are at similar or lower levels than previous winters.

However, even though Omicron resulted in a milder disease for many last winter, not least given the added protection of vaccinations/previous infections (alongside better treatments), the severity of patients with other conditions may have been worse last winter. Delayed patient presentation due to many services being reduced and patients putting off seeking care earlier on in the pandemic could have been a related factor, putting more strain on services.

This wave also presented additional challenges for the NHS compared to the previous winter, with increased staff absences. This came alongside **increased numbers of NHS staff already having left** their jobs in 2021, with the overall impact of the pandemic – particularly on **staff burnout** and **morale** – being possibly to blame.

These shifts in demand and capacity mean that, as one part of the system started to struggle with performance, it had a knock-on effect on another part. That then leads to making that part less effective, producing other knock-on effects, which spirals perpetually through the system, resulting in a cycle of declining quality of care in all parts of the system. A lack of support from community and social care services can lead to patients staying in hospital for longer. Problems finding a bed in an emergency lead to long waits in A&E and ambulance handover delays. And longer waits for planned care lead to patients presenting with a more serious condition, or as an emergency.

Beyond winter last year

As we moved into summer, the number of Covid-19 cases declined, which was reflected in the number of patients **admitted to hospital**.²⁵ However, before this happened, there was a second further peak in both in late March/early April, when they had continued to decline in the previous winter.

This is coupled with **data** showing that, into April, staff absences at NHS acute trusts were on the increase again. The number of patients who met the criteria to leave hospital but who were not discharged also continued to grow at a faster rate than those who were discharged at the start of April.²⁶

During March and April this year, we continued to see **extremely poor and, in some cases, worsening performance**. In April, 35% of people attending major (type 1) and speciality (type 2) A&E departments spent more than four hours from arrival to admission, transfer or discharge, which compares to 18% in April 2021. 12-hour trolley waits increased to record levels, and were 46 times higher than in April 2021. Handovers of patients at A&E departments from ambulances **continued to be an issue**. Response time to emergency ambulance incidents were worse during March and April than January and February – on average exceeding 51 minutes in April this year.

These are all indications of the strain that the NHS is under at a time when it normally would have expected pressures to start subsiding. This means that the NHS this year has lost months it would normally use to recover from the winter, with staff unable to recuperate.

This is also against a backdrop of **increasing backlogs and longer waits** for planned hospital care. In March this year, the waiting lists for planned care grew to 6.36 million patients, the highest level since records began, of which nearly one in 20 had been waiting for over a year.

²⁵ Both data sets accessed 8 June 2022.

²⁶ Data accessed 12 April 2022.

This is likely to result in a deterioration in patients' conditions as they wait longer, which will put further pressure on primary, community and social care and urgent and emergency care, feeding back into the cycle. The continued pressure on urgent care is also happening at a time when there are **high expectations** that the NHS will be able to increase planned activity in order to reduce the backlog.

Was the NHS overwhelmed last winter?

“Protecting the NHS” has been a mantra for the government throughout the first years of the pandemic, as it has sought to get the public on board with adhering to repeated lockdowns and restrictions on everyday life.

But our analysis shows that it was not protected adequately – it went into the crisis on its knees and is struggling to come out.

That “protect the NHS” message was aimed at the public, but did not fully take into account the actions that were truly needed to protect health and care services. Staff, money, equipment and infrastructure in the NHS **were already overstretched** before Covid, and have been tested in the extreme during the pandemic. While the “protect the NHS” message enabled services to focus on the Covid response, it overplayed the extent to which people staying at home was sufficient.

Last summer we noted that a third wave would stretch the NHS because it was attempting to restart and recover planned care, rolling out the vaccination programme, and demand was increasing as lockdowns lifted. But at that point, it appeared that the NHS would still be able to deliver effective urgent care, even if this was at the expense of continued delays for people with ongoing health problems or those needing planned surgery.

The subsequent performance last winter suggests an even more worrying picture, with urgent care no longer functioning effectively – as evidenced by lengthening delays in A&E, long trolley waits before admission in an emergency, and delays in priority ambulance responses. The picture is one of emergency care services – usually the last safety net in the NHS – being unable to respond effectively. The chronic lack of investment in the NHS and social care, across staff, buildings and in the community, mean that services are unable to recover from intense pressure, and problems in one part of the system impact on other areas.

Despite the efforts of the public to “protect the NHS”, we now have a service where urgent care no longer works effectively, and where staff – from doctors in A&E, to district nurses in the community – have to make horrible decisions about prioritisation every day. Over winter and more recently, we have seen a growing number of **examples of services** now **not able** to provide safe and **timely** urgent care. The urgent care situation is not sustainable, and action is needed urgently to support staff now, and develop the capacity needed across the system, including in **primary care**.

Given the current level of performance, it is not surprising that there is growing **public dissatisfaction** with the NHS. The challenge for NHS leaders will be how to translate this public concern into action to improve services, rather than further undermining an already overwhelmed service.

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