BMA

NHS pressures
– winter analysis

British Medical Association
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Last year, the BMA published an **analysis** of how NHS secondary care in England coped over the winter months of 2016/17. One year on, we revisit the data, in addition to examining how doctors working at the frontline experienced the most recent winter.

The data

Every month NHS England publishes data relating to several key A&E indicators (attendances, admissions, trolley waits and the four-hour wait). During the winter months (December, January and February) it also publishes weekly 'situational reports', which include data on ambulance handover times, bed occupancy and closures, long-stay patients and A&E diverts. Other publications include bed availability and occupancy (quarterly), delayed transfers of care (monthly) and referral-to-treatment waiting times (monthly).

Headline statistics

A&E activity (the following statistics compare the period Dec-Mar from 2010/11 to 2017/18)

- Having fallen for the first time in four years in 2016/17 (by 142,000, or 1.8%), A&E attendances rose by 292,000 (3.9%). There were 7.9m attendances at all A&Es, with 5m attendances at major A&Es. The increase in attendances between 2016/17 and 2017/18 was notably higher than the average annual rate of increase between 2010/11 and 2016/17 (1.6%).
- Performance against the four-hour wait target continued to deteriorate, falling from 87.2% in 2016/17 to 85% in 2017/18. This figure has now fallen by over 10% since 2014/15. In March 2018, aggregate performance at all A&Es reached its worst level since records began in 2010/11, with just 84.6% of patients seen, admitted or discharged within four hours.
- Emergency admissions continued to increase, reaching 2m between November and March. This represents a 5.2% increase from the previous year, significantly higher than the 1.9% average annual increase between 2010/11 and 2016/17.
- Trolley waits increased by 56,000. While the rate of increase has slowed from a high of 126% between 2013/14 and 2014/15, it remains high (23.5%). There were more trolley waits of four or more hours recorded between December and March of 2017/18 than in the same months of 2010/11, 2011/12, 2012/13 and 2013/14 combined.

RTT (Referral to treatment)

- In February 2018, the total number of patients waiting to begin treatment stood at 4.01m (186,000 more than February 2017).[1]
- The proportion of patients beginning treatment within 18 weeks stood at 87.9%, the lowest figure since March 2009.

1 Includes estimates for missing data

Beds

- Occupancy between the start of December and the end of February averaged out at 94.4% in 2017/18, compared with 93.7% the previous year. Bed occupancy peaked at 95.2% in the last week of February (which was 0.3% lower than the peak from the previous year).
- 54 trusts (of 137) recorded occupancy of 100% on at least one day during the most recent winter. In total, those trusts reached 100% a combined 736 times. Almost half (48.8%) of those instances occurred at just six trusts (Walsall Healthcare, North Middlesex, The Hillingdon Hospitals, James Paget University Hospitals, The Princess Alexandra Hospital and London North West Healthcare).
- On average, 822 beds were closed due to norovirus and related symptoms every day this winter (Dec-Feb), compared with 705 last winter.
- The number of beds occupied by long-stay patients peaked at 46,331 in the first week of March for stays of 7 or more days, and 17,991 in mid-February for stays of 21 days or more.[2]

Ambulance handovers[3]

- In the available data (20th Nov – 04th Mar), 1.4m arrivals by ambulance were recorded. Of those arrivals, 186,000 (13.2%) involved a delay of at least half an hour during the patient's handover. 3% of handovers involved a delay of an hour or more.
- The worst week (25th – 31st Dec) saw 17.3% of all arrivals include a delayed handover.

Delayed transfers of care

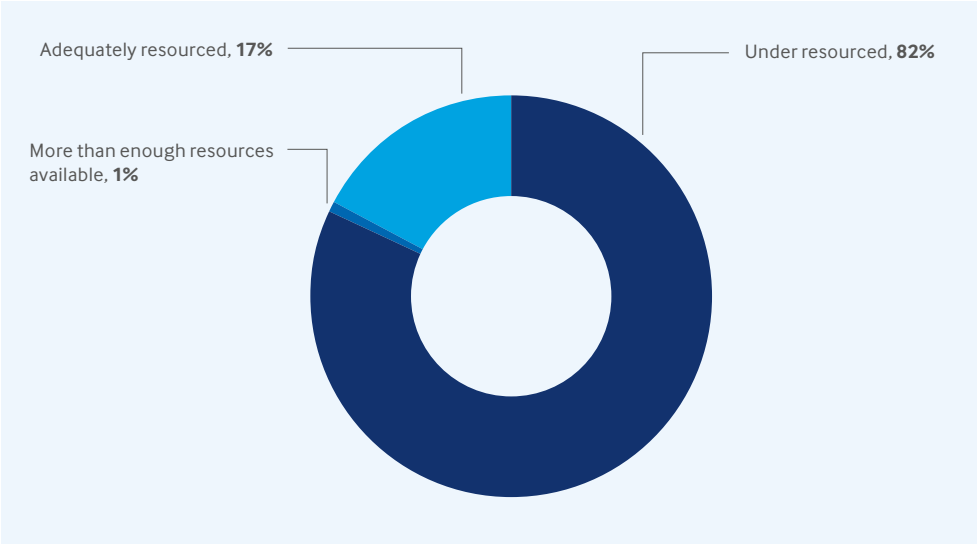
- There were continued signs of improvement in the number of delays. In February 2018, there were 140,000 delayed days recorded, compared with 186,000 in February 2017. This represents a 25% decrease.

2 This is a new dataset included in the winter sitreps, and is thus not comparable with any previous data
3 As above

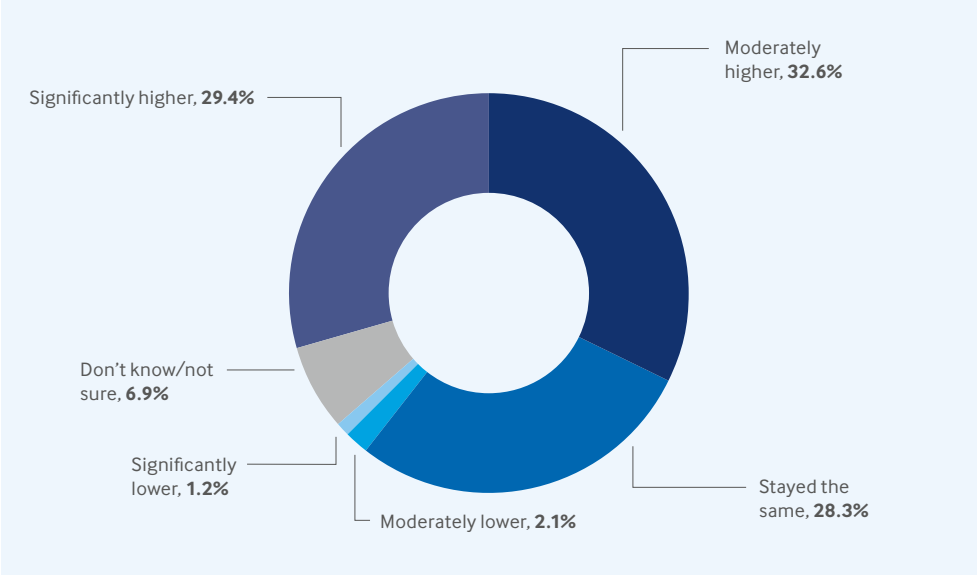
Doctors' views

In a recent survey, we asked several questions about how the NHS coped with the increase in demand and pressures over winter. The questions and answers were as follows:

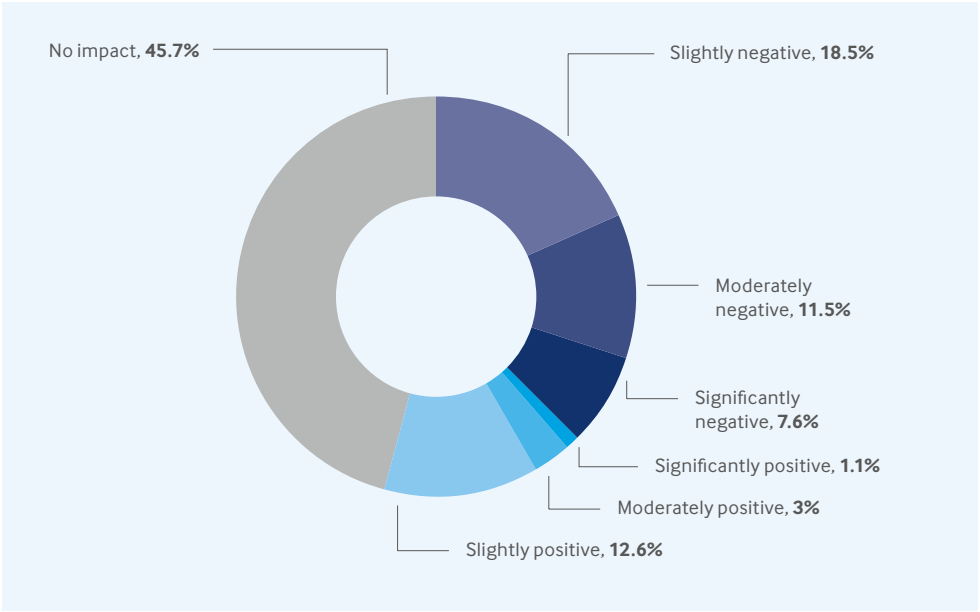
How would you rate the resourcing levels of the service where you work over the past winter season?



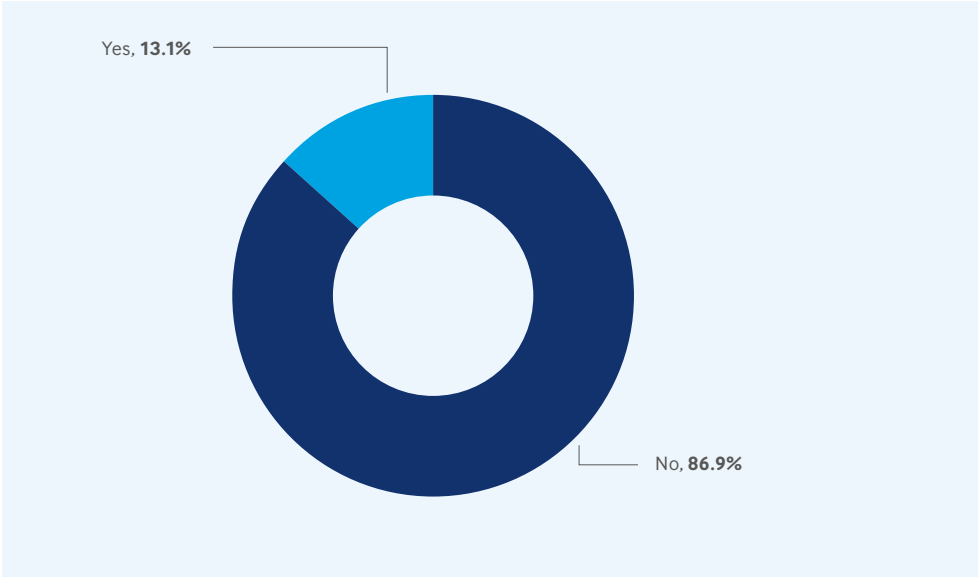
Compared to the previous winter season, how was your overall workload this winter?



What impact did the cancellation of elective operations have on the overall level of pressure where you work?



Did you see any examples of ingenuity/creative management on the part of clinicians or managers where you work that led to the mitigation of the effects of winter pressures?



Analysis

The NHS has always experienced peaks and troughs in demand, and the coldest months of the year (December to March) represent a difficult period as pressures ramp up due to surges in admissions. Although recent BMA analysis has indicated that Trusts are now under high levels of pressure all year round, the winter months are still typically the most difficult for the NHS.[4]

It should come as no surprise, therefore, that the winter of 2017/18 was the most pressurised in recent history. 81,000 trolley waits were recorded in January (the most ever in a single month), while performance against the four-hour wait reached its lowest ever level in February. Thousands of patients waited in the backs of ambulances outside A&Es every month, while trusts found themselves even further away from meeting the 18-week referral to treatment target.

Perhaps most concerningly, though, was the extremely high bed occupancy figure recorded across the winter months. Overall, occupancy was 0.7% higher than the previous winter (94.4%, up from 93.7%). Following the customary dip during the festive period, occupancy reached 95% in the first week of January. It continued to hover around that mark for the next eight weeks (the lowest figure recorded was 94.8%), and when NHS England ceased publication of the winter situational reports in the first week of March, occupancy was still averaging 95.2%.

Consequently, many trusts will continue to struggle with the consequences of overwhelming demand well into the traditionally quieter summer months. University Hospitals of North Midlands, for example, confirmed in March that it would keep its extra winter capacity open until summer, while Nottingham University Hospitals Trust cancelled all elective operations until the end of March to try to "reset" its health economy to tackle an exceptionally high bed occupancy figure.[5,6]

The flow of patients through hospitals has become extremely disjointed with blockages throughout the system, and the result is that patients wait longer for care, and staff must work harder to meet their needs. Recent analysis from the BMA indicates that pressures this summer are likely to reach similar levels to those reached in winters just two or three years ago; consequently, the process of addressing the many problems arising from massive pressures during winter is now likely to overlap with the process of preparing for the following winter.[7] The term winter crisis seems increasingly redundant, as pressures have begun to overwhelm the health service year-round.

4 bma.org.uk/collective-voice/policy-and-research/nhs-structure-and-delivery/pressure-points-in-the-nhs/pressure-points-projections
5 www.hsj.co.uk/university-hospitals-of-north-midlands-nhs-trust/trust-extends-winter-pressures-plan-until-summer/7021979.article
6 www.hsj.co.uk/nottingham-university-hospitals-nhs-trust/trust-cancels-operations-until-easter-to-reset-health-economy/7022000.article
7 bma.org.uk/collective-voice/policy-and-research/nhs-structure-and-delivery/pressure-points-in-the-nhs/pressure-points-projections

Feedback from the frontline

There was also a clear indication from the responses to the survey that many doctors feel overwhelmed by the increase in demand and pressure during winter.

More than 4 in 5 said that they felt their place of work was under-resourced, while over half said that their workload was higher than previous winters. Results were broadly similar across branches of practice, indicating that these issues are affecting doctors in primary and secondary care to similar degrees. The data indicated that GPs felt that winter pressures had affected them particularly adversely, with 73% saying that their workload was higher than the previous winter, compared with 59% of consultants and 61% of juniors.

Similarly, while the majority of all respondents said that the cancellation of non-emergency surgeries, a contingency measure introduced to ease burdens on trusts, had either no impact at all or a negative impact on pressures, GPs were the most likely to describe the cancellations as unhelpful. 53% of GPs described their impact as negative, compared with 32% of consultants and 15% of juniors.

Anecdotal feedback from doctors also underlined the fact that pressures are now at unprecedented levels. Clinicians spoke of dreading arriving at work in the morning and seeing patients lining corridors awaiting treatment. Others described how all leave was cancelled, and in some cases how administrative staff were asked to help wherever possible in a clinical capacity. Many also highlighted the difficulties posed by rota gaps.

Solutions

The clear consensus from doctors is that winter pressures constitute a symptom of much broader problems within the NHS, and without addressing these points, very little can be achieved to ameliorate the current situation.

Some respondents did discuss their experiences of mitigating the effects of winter pressures, however. Several expanded on the idea of more dynamic deployment of staff and suggestions included the movement of nursing staff around trusts to help in pressured areas. Consultants, it was proposed, could potentially also be redeployed in a similar way, contingent on their possessing the relevant training or skills (although this would be a decision best left to the consultants themselves).

On the question of beds, several doctors said that trusts had paid for beds in local nursing homes to house patients waiting for social care, while others suggested that hospitals should open previously closed wards to create more bed availability.

Similar themes emerged on the issue of better winter pressures planning. Staff, beds, funding and resourcing were all alluded to extensively, with the majority of doctors indicating that the NHS needs more of each.

On a smaller scale, another important discussion point that emerged was that strategy and additional funding should be organised and allocated well in advance of winter (in 2017, the £350m allocated to the NHS to deal with winter pressures was announced in the penultimate week of November).

Many respondents also felt that additional funding or support should be offered to general practice and preventative medicine. Cancelling operations at hospitals, it was felt, put more pressure on GPs, and better collaboration and integration of primary and secondary care was needed.

Next winter

The clear consensus amongst survey respondents was that the NHS was in need of more beds, staff and funding as it headed into winter. Though some areas of the country coped better than others, most experienced unprecedented pressures.

The winter of 2017/18 once again exposed the limitations of trying to plan and prepare for record levels of demand. Whilst NHS England correctly identified the reduction of delayed transfers of care as a useful tool in freeing up beds, occupancy still hovered at around 95% for over two months. Additionally, even with the cancellation of thousands of operations, beds remained full.

Though the allocation of £350m to help ease the burden of winter pressures undoubtedly did help some trusts to achieve positive results, its announcement mere weeks before the start of the coldest months of the year meant that it could only realistically be used to quickly plug holes in services caused by staff or bed shortages, rather than for more efficient, long-term strategic planning.

One solution mentioned was the usefulness of more dynamic staff placement within hospitals; by reassigning under-utilised staff to hotspots, some trusts could tackle blockages and improve patient flow. Additionally, while many felt that the cancellation of elective operations only ensured that pressures would endure for longer by keeping trusts busy well into the spring, others felt that it provided much needed respite and freed up capacity. The conclusion, therefore, would appear to be that strategies and contingency measures work with varying levels of effectiveness depending on the setting.

The previous winter has underlined the need for proper planning, and this summer and autumn, several steps should be taken to ensure that the future winters are less onerous:

- Extra funding should be allocated well in advance of the winter itself, so that it can be factored into planning.
- Last autumn, local A&E delivery boards submitted plans covering resilience arrangements for the impending winter. These plans should be broadened to cover entire regions, focusing not only on A&E but also elective and primary care and taking into account local health economies and demographics. These bespoke, regional strategies should be developed by NHS England and the Department of Health and Social Care in partnership with trusts and CCGs, with strong clinical engagement from primary and secondary care doctors.
- Though it is clear that the level of pressure is increasing within primary care, there is very little data available to quantify those increases. The relevant bodies (NHS England and NHS Digital) should collect and publish more primary care data to improve transparency.[8]
- The Government must ensure that there is no widespread cancellation of operations in future. Local flexibility to cancel operations may still be needed, but there must be a clear commitment to ensure that national-level cancellations on the scale experienced this winter must never be allowed to happen again.
- There should be a Health Select Committee inquiry into the extraordinary levels of pressure that the NHS experienced last winter.
- The Government must increase health spending to address systemic pressures. If the NHS is to avoid enduring winters of similar (or even more severe) stresses then it will need more staff and more beds, neither of which is feasible without more money. Both primary and secondary care should be funded to the requisite levels to ensure that the NHS can cope with peak levels of demand during the year.

8 bma.org.uk/advice/employment/gp-practices/quality-first/manage-inappropriate-workload

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