WINTER PRESSURES IN THE NHS: A BRIEFING FOR GOVERNORS

INTRODUCTION

There is no escaping the fact that over the winter period the NHS faced immense pressure. Comments that you would have seen in the media such as “unprecedented” and “record” levels of demand are correct, and reflections from clinicians that pressures in A&E are “the worst I can remember” ring true. The British Red Cross, which seldom speaks up about the NHS, even warned of a “humanitarian crisis in the NHS” over the winter period.

It is right that the sector acknowledges and addresses these concerns, but we should also be wary of frightening patients and undermining public confidence in our health service. The four hour A&E waiting time standard is widely known as a good measure on how the NHS is performing. But the reasons behind a breach of this standard are complex and, as our recently published briefing explores, if considered in isolation it does not necessarily paint an accurate picture of the standard of care being delivered by providers or what providers are doing to try and address the problem.

WHAT IS HAPPENING?

Trusts are treating record numbers of patients and this significantly increased over the winter period. For example, more than 60,000 people attended A&E departments on 27 December 2016 – the second highest level for a single day. Some trusts even reported increases in A&E attendances during December and January of over 20 per cent compared to the same time the year before.

There are a number of reasons for this rise in demand – patients are often more ill over the winter period; there are ongoing and worsening pressures in social care which means that patients are not always able to be discharged when they could be; there are difficulties in accessing GPs and other parts of primary care in some areas of the country; there is insufficient funding and workforce shortages.

And while official data does show that as a collective hospitals are not meeting the four hour waiting time standard, if you look beyond these figures and at the actual numbers of patients, trusts are admitting, transferring or discharging more patients under four hours than ever before - 5,462,464 patients between July and September 2016 compared to 5,350,952 in the same period in 2015.

WHAT DOES THIS MEAN FOR PATIENT SAFETY?

There are a number of measures in addition to the four-hour A&E standard that are used to assess performance in A&E, such as the number of patients waiting on trolleys and the number of patients waiting to be treated over 12 hours. However there is no simple and linear correlation between performance against these measures and the risk to patient safety. But, as a broad generalisation:

- The four hour A&E standard is a proxy for patient care
- Every breach of the four-hour standard can therefore be regarded as a potentially elevated risk to patient safety
- It is widely accepted that persistently large numbers of ‘trolley-waits’ and 12 hour waits is a proxy for significant elevated risk to patient safety and often result in a much worse experience for patients.
WHAT ARE TRUSTS DOING TO COPE WITH DEMAND INCREASES?

It is because of the outstanding effort being put in by frontline NHS staff and managers that the NHS is able to cope with current record levels of demand. Often when an A&E department identify a high number of four hour standard breaches, the trust’s management team focus on reducing over-crowding, restoring and improving patient flow through and out of the hospital, moving those with less serious conditions to other settings and creating the safest environment for those most at risk.

Local health and care services across the country are also making good progress with longer term initiatives to keep patients well, at home and outside of A&E. These include:

- Trusts are implementing new protocols that help improve patient pathways, by placing clinical expertise at the doors of A&E departments.
- Some trusts have successfully implemented new arrangements where specialist clinicians from other hospital departments are based in A&E, so that patients can be treated quickly and discharged, rather than needing to admit them to hospital to receive this care.
- Others have developed ‘discharge to assess’ schemes that allow patients to receive care assessments within their own homes rather than on an acute medicine ward.
- In many areas trusts have developed “trigger tools” that give staff a prediction with several hours notice on whether patients are likely to breach the waiting time standard based on early warning indicators, meaning there is sufficient time to call in additional staff and resources to support patients being admitted in a timely fashion.

Alongside the above interventions, there has been a renewed emphasis on local communication to improve public awareness of the increased pressure at A&E departments and how to proactively self-manage conditions and illnesses. Local urgent and emergency care system boards have also been established to oversee improved system-wide A&E planning and delivery, focussing on ensuring appropriate primary and social care capacity is available for patients who need it.

WHAT IS HAPPENING AT A NATIONAL LEVEL?

Demand management and addressing winter pressures is a joint effort and cannot just be addressed at a local level – support from the national bodies is also required. This is why NHS England and NHS Improvement have recently appointed a single national leader who will be responsible for overseeing a programme of support for trusts and their local partners to manage increasing demand in A&E. This includes:

- Developing a national core clinical operating model for A&E
- Supporting a ‘getting it right first time’ programme which engages clinicians working in acute care with their own performance data and supports evidence based learning through peer to peer discussion and review
- Broadening the support offer to local areas that are most under pressure

WHAT DOES THIS MEAN FOR GOVERNORS?

Governors will be interested in how their non-executive directors are assured that the trust board is addressing increases in demand within the trust, either by managing patient flow or adopting a new model of care within A&E. Governors will also be interested in how their trust board is acknowledging the efforts of and supporting their busy workforce as well as working with partners across the local health economy to address system wide issues that will
be affecting A&E performance. Councils of governors can also ask themselves how they can best support the trust in delivering new models of care.