NHS Providers briefing: The real story of winter 2018/19

Introduction

On the surface, it appeared as though the NHS experienced a relatively quiet winter in 2018/19. Media and political commentary over the season have become instrumental in shaping the public, and political narrative around the NHS. But the usual media stories about performance against the four-hour A&E target, ambulance delays and patient experience, were noticeably absent or significantly reduced this winter. This was reflected in Westminster, with a reduction in the number of parliamentarians flagging pressures in their local hospitals and communities.

However, what were the real reasons for this reprieve and what was the real story of winter for trusts, their patients, and hard pressed frontline staff? During the winter months, NHS Providers monitored the weekly data and asked our members what they were experiencing on the frontline. We tracked what was happening each week in our Winter Watch series. This briefing tells the real story of winter 2018/19 for the provider sector.

Overview

The reality is that media and political focus on Brexit diverted attention away from: the worst A&E performance since records began; people waiting longer than ever for cancer diagnosis and treatment; routine operation waiting list ballooning; delays for hundreds of thousands of diagnostic tests; and the sustained increase in demand for an already overstretched system.

The scale of this increase in demand over the winter in 2018/19 was somewhat unexpected. Much milder weather, with a less severe strain of flu and a significant reduction in the prevalence of norovirus, should, on the face of it, have meant a less stretched health service than last year. Despite the more benign external conditions, demand for emergency care services grew by 6% compared to the previous year, and when we take a longer view, emergency admissions have increased by nearly a fifth (18%) since 2014/15 – a staggering rise in activity in just four years.

Once again, NHS staff showed remarkable resilience and commitment through the winter months in keeping services going, treating more patients than ever, and ensuring that the overwhelming majority received good care, often in the face of considerable pressures.

In parallel, proposals which could significantly change what the public should expect in terms of NHS access standards across a range of services have been published. Under the clinical review of access standards, which underpins the NHS long term plan, a number of trusts are now piloting different ways to

measure performance in urgent and emergency care. The review also proposes new ways in which trusts measure standards in emergency care, cancer services, planned care and in mental health with the potential for significant changes to be rolled out as early as this autumn.

With an ambitious NHS long term plan to deliver, a growing need for additional capital investment and severe workforce shortages, the provider sector is already busy preparing for winter 2019/20.

Winter 2018/19 in numbers

- 6,111,958 A&E attendances
- 94% average general & acute bed occupancy
- 3,988 escalation beds on average open each week
- 11% of ambulance handovers were delayed by 30 minutes or more
- 7.5% reduction from last year in number of stays over 7 days
- 555 beds closed to D&V and norovirus on average each week
- 85% of A&E attendances were seen within four hours
- 12% reduction from last year in number of stays of 21 days or more
- 26 A&E diverts on average each week
- 27% decrease in 12-hour breaches in A&E since last year
- 5.2 million emergency admissions
- 1,273396 ambulance arrivals

The mismatch between demand and capacity

- 6,111,958 A&E attendances
- 94% average general & acute bed occupancy
- 3,988 escalation beds on average open each week

The NHS is in need of additional capacity, both in community services, mental health services and inpatient settings. The number of beds in the NHS has reduced over the last decade. However, at the same time demand for all services spanning primary, secondary, tertiary care services, and social care, has been rising. The disparity is only exacerbated by years of financial constraint and difficulties in recruiting and retaining key groups of staff within the workforce.

The mismatch between demand and capacity is most prominent during the winter months- but it is now a year round problem across the NHS.

Metrics across the service show that demand is rising, but the focus over winter is heavily focused on emergency care and specifically the A&E four hour target. So much so, it has become a proxy measure for the performance of local health and care systems in addition to that of individual trusts. Along with

measures such as length of stay, we are able to monitor how patients flow through hospitals at an aggregate level. Our members also glean valuable insight on local issues by looking at the profile and acuity of the patients they serve. This local intelligence shines a light on the pressures in parts of the system and the gaps in community, mental health crises services and social care provision.

Despite milder weather conditions, over the three-month winter period there were 6.1 million A&E attendances; an increase of 5% on the previous winter and an increase of 16% since 2014/15. The same trend was observed in emergency admissions, as the NHS admitted 1.6 million emergency cases; up 6% on last winter and an increase of nearly a fifth (16%) since 2014/15. On average, that's over 66,300 people being admitted in England each day over winter.

With such significant increases in demand, trusts and their partners are working tirelessly to see more patients. They have become more productive than ever. Nearly 5.2 million people were seen within four hours in A&E – an increase of 4.8% on last winter and an increase of 8% compared to 2014/15.

As providers prioritise the most unwell patients coming to hospital through the emergency care pathway, beds fill up. This was reflected in bed occupancy levels of 94% over winter. The fact that trusts must prioritise the most acutely unwell patients, coupled with constrained resource has compounded the decline in performance against other key constitutional standards.

Over the winter the NHS saw its poorest ever performance against the cancer standards and the elective care waiting list is at record levels, with more people waiting longer than the recommended 18 weeks for routine operations. In relation to diagnostics, in January 2019, 3.6% of people waiting for a diagnostic test breached the six week standard; this equates to nearly 36,000 people waiting longer than you would expect. Trusts are telling us that particular workforce challenges in diagnostics are to have a knock on impact on other services.

The welcome ambitions of the NHS long term plan- such as the meaningful alignment of primary and secondary care and better integration of health and care services - may be the key to solving the demand management conundrum. However, preliminary research by the health think tanks has indicated that new care models are uncovering more unmet needs, rather than driving existing demand away from hospitals into the community as envisaged. Furthermore, we are not seeing a quick enough expansion of community provision to meet the current growth in demand.

Preparation, resilience and learning

- 11% of ambulance handovers were delayed by 30 minutes or more
- 7.5% reduction from last year in number of stays over 7 days
- 555 beds closed to D&V and norovirus on average each week

Operationally, the health and care sector, entered last winter in a more difficult position than ever before. Despite the welcome funding increase announced for the NHS' 70th birthday to underpin the long term plan, additional funds did not come on stream until 2019/20. Looking ahead, independent experts still say the funding settlement falls short of what is required to recover performance and transform services to meet future needs, following the longest and deepest financial squeeze in the history of the NHS.

But the real story of winter highlights how the NHS adapts to the challenges it faces and how - with preparation, resilience and by adopting learning – the health service can find innovative ways to maintain the high standards of quality we all expect. Below we summarise the vital lessons that can be taken from 2018/19 based on feedback from our membership:

1) The importance of preparation

This winter showed just how useful preparation can be in supporting providers to maintain performance. This year there was a specific focus on reducing length of stay, improving patient flow, increasing the use of ambulatory care units, and trying new staffing models. Trusts across England also made every effort to ensure all staff were offered the flu vaccination. The preparation resulted in a number of successes over the winter months.

Up until Christmas the sector was performing well. A&E performance remained stable and there was less anxiety about operational risk in the run up to winter compared to the previous year. Although the conditions changed in the New Year, the story underneath the figures shows that the preparations trusts made really did help them cope and better accommodate the extra demand. Among trusts' achievements were:

- A 12% reduction in the number of patients waiting 21 days or more and a 7% reduction in the numbers waiting more than seven days. Providers rolled out a range of initiatives such as green/red days, setting up ambulatory care units, implementing the SAFER patient flow bundle and expanding assisted discharge services.
- Shorter ambulance handover delays. Despite the ambulance service having the highest activity levels ever, there were fewer handover delays than last year. This meant that ambulances could get back into the community where they were needed more quickly. And ambulance trusts have been working more collaboratively with providers in their patch to better manage demand across multiple systems.
- A 27% reduction in the number of people waiting longer than 12 hours from the decision to admit to admission. There were 1,416 people who waited longer than 12 hours – which works out as 10 patients per one of the 134 trusts with an emergency A&E department.
- Additional capacity created by local innovation which also helped meet some of the extra demand and saw fewer escalation beds open than last year.

2) The commitment and compassion of NHS staff

Yet again staff pulled out all the stops to deliver the best care possible for their patients during a very challenging start to the year. Although performance against key standards fell, NHS staff responded by;

taking more people to hospital by ambulance than ever before; seeing an additional 240,000 patients within four hours in A&E; carrying out an additional 332,000 diagnostic tests over the three months; and reducing the number of patients waiting over 52 weeks for elective care each month.

But we must not take for granted this high level of commitment and service from staff. Given the year round pressures the NHS now experiences, staff wellbeing is beginning to suffer with increased risk of burnout and increasing sickness absence.

Although frontline staff display extraordinary resilience and dedication, workforce shortages make current working conditions more difficult with trusts increasingly having to move staff around to ensure they are providing safe care across services. The NHS interim people plan is a step in the right direction in terms of increasing future supply of staff, but with public satisfaction with the NHS at its lowest level in more than a decade, continued staffing shortages understandably impact on morale.

3) National bodies and trusts must share what is working well and learn when things work less well.

There are three systemic issues which national bodies and trusts can learn from when thinking about how we prepare for future winters.

Firstly, building local relationships and system working is instrumental to finding creative solutions to the problems that the NHS and the care sector are experiencing. Better collaboration between the NHS and local authorities, between physical and mental health services and between primary and secondary care are unlocking new initiatives that are better for patients.

Many of our members shared examples of how these relationships are developing locally to support improvements including; partners in Sussex having a co-ordinated response in trying to reduce out of area mental health placements; collaboration in Dorset aimed at reducing readmission rates of older people; and the Red Cross working with trusts to support quicker discharges, helping with hospital transport or reducing frequent A&E attenders – highlighting the valuable role the third sector can play.

Secondly, central bodies must allocate any additional winter funding as early in the financial year as possible. Over the last few years there have been capital investment announcements later and later, and this year trusts were asked to apply for funding for winter projects they had to be able to complete by 31 December 2018. The quick turn around means that trusts are not able to factor in this additional resource to their preparations, creating missed opportunities which also drive poor value for money as trusts need to spend the money within tight timeframes. The national bodies must also be more open and transparent when it comes to the process for allocating additional funds as communication was muddled with some trusts not eligible for additional help.

Lastly, we must acknowledge that demand for the NHS is going to keep increasing and manage the expectation of what trusts can be asked to deliver so they have a realistic task. Early evaluations of some of the new care models suggest that they are uncovering more unmet needs and increasing the pressure on

acute services – the very thing it was hoped they would begin to reduce. Furthermore, the expansion of mental health provision along with a multitude of other factors is continually uncovering more demand for mental health services.

Our members told us that this winter it wasn't just the high volumes of people they were seeing, but also the severity of their illnesses which was striking. Therefore this isn't necessarily just a matter of redirecting patients to other services or a public education campaign – although these things are also important. We must acknowledge that this increase in patient acuity and dependency puts even more pressure on staff and is reflected in the evolution of clinical practice over the last 20 to30 years.

Now, with a funding settlement in place, together with more than 300 new commitments set out in the long term plan, there is a real risk of expectations running still further ahead of what the NHS can realistically deliver.

Recovering performance

- 85% of A&E attendances were seen within four hours
- 12% reduction from last year in number of stays of 21 days or more
- 26 A&E diverts on average each week

Under the umbrella of the NHS long term plan, the clinical review of NHS access standards was published in February. The aims and objectives of the review are commendable, and it is right that we reflect modern clinical practice in the access standards the service sets out to the public in the NHS constitution.

Currently, the constitutional standard for accessing emergency care states that 95% of people who attended A&E should be seen within four hours. The metric has become the pillar around which emergency care has been delivered over the past 15 years. It acts as a barometer for performance across individual trusts and the local health and care system in which they operate.
Yet this winter trusts delivered the worst performance against the standard since its inception. On average, over winter, 85% of attendances were seen within four hours – with performance falling to an all-time low of 84.2% in February 2019. Five years ago, 91% of people were seen within four hours over the 2014/15 winter; a reduction of 6 percentage points in performance in five years.

Yet more worrying is that the vast majority of the sector cannot meet the standard. The latest data for April 2019 showed that only seven trusts with a major A&E department achieved 95%.

The clinical review of standards includes a range of new proposals which would mark a significant change it what the public can expect from the NHS and is a clear departure from how we are used to measuring operational performance, access and patient experience in the NHS.

Faced with these pressures, it is vital that the NHS works towards agreed standards that command the confidence of patients and the public, of frontline clinical staff, and of trust leaders who will be held to account to deliver them.

However, this challenge – testing at the best of times – is particularly difficult when performance is slipping against existing goals. While it is helpful to review standards which have been in place for several years to ensure their ongoing relevance clinically and to the public, we must ensure the process is transparent, rigorous and inclusive.

NHS Providers view

- 27% decrease in 12-hour breaches in A&E since last year
- 5.2 million emergency admissions
- 1,273,396 ambulance arrivals

It is clear that the media did not highlight the difficulties the NHS faced last winter as it did in previous years despite the sector facing comparable – or in some ways even more severe - performance challenges. The NHS long term plan, clinical review of access standards and NHS interim people plan have all been published at a time when the public and politicians are divided. A national preoccupation with Brexit has diverted considerable political attention away from other key challenges, not least those we face across health and care services.

It is critical that the ambitions set out in the long term plan are balanced against recovering performance to a standard that is best for patients and reflects evolving clinical practice. The current operational model and pressure on NHS staff can not be normalised by simply moving the goal posts.

It is important to review quality standards which have been in place for some time to ensure their continued relevance. However it is also important the review of clinical standards is done with enough time to test the proposals, but also that we return to knowing a clear trajectory for recovery of performance that's transparent to the public and providers. The 'ask' of the provider sector from the centre should be stretching but feasible.

We know that trusts and staff have become better at managing seasonal spikes and are adopting quality improvement methodologies to adapt services. However the underlying issue persists - without filling vacancies and better supporting our workforce, securing an injection of capital investment to repair estates, and funding to mitigate the growing mismatch between demand for services, and capacity to deliver, the service will remain in a vulnerable position.

We must be transparent about the problem so the NHS continues to hold the trust and support of the public and its staff, and deliver a service that meets expectations that are balanced against the existing levels of funding.

We must work together and build a consensus across clinicians, trust leaders, health and care partners, politicians, and crucially we must engage with the public, to win engagement and support for the ambitions set out in the long term plan.

We look forward to continuing to work with colleagues in the Department of Health and Social Care, and the national bodies to support trusts to plan as effectively as possible for spikes in demand in the winter months, and to input constructively to the clinical standards review.