

# HOSPITAL WINTER PRESSURES: HOW DID NHS TRUSTS PERFORM IN 2016/17?

## INTRODUCTION

The NHS has faced intense pressure over the winter months as it tackles record levels of demand during the longest and deepest financial squeeze in its history. Winter is traditionally the NHS' busiest time, but this year there is a sense that the health service has faced its toughest winter on record.

This NHS Providers briefing examines the performance of the NHS over the three peak winter months: covering 1 December 2016 to 26 February 2017. During this period, daily winter performance data for 152 hospital trusts has been collected and published weekly by NHS England. This briefing summarises the trends we have seen week-by-week, and includes recommendations for future action by health system leaders.

## DATA SOURCES

Winter performance is shown against the following measures:

- **A&E diverts:** the number of temporary diverts of patients from one A&E department to another
- **A&E attendances:** all unplanned attendances at A&E departments, whether the patient was admitted or not
- **Emergency admissions:** all patients admitted as an emergency
- **General & acute escalation beds:** the number of additional beds opened temporarily to provide extra capacity
- **General & acute bed occupancy:** the percentage of open beds (core and escalation) that are occupied
- **Number of beds closed:** due to diarrhoea and vomiting or norovirus-like symptoms
- **Adult critical care bed occupancy:** the percentage of intensive care, high dependency unit and other critical care beds that are open and occupied
- **Operational pressures:** the number of times trusts declared OPEL 3 or 4<sup>1</sup>, indicating major pressures in the system compromising patient flow and their ability to deliver comprehensive care.
- Data is also collected on any **A&E closures** throughout winter; this has been zero for all weeks so far.

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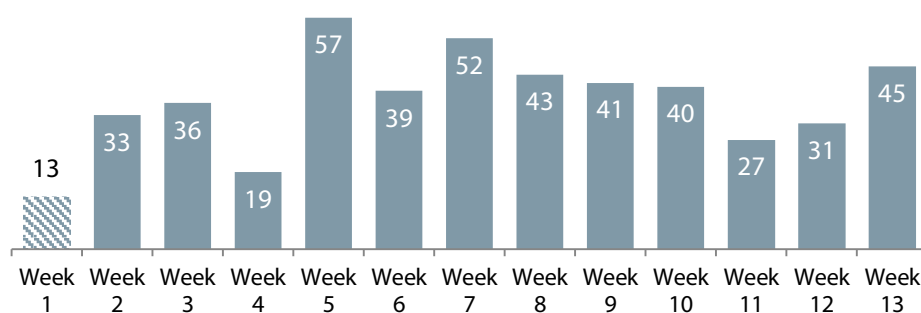
<sup>1</sup> The "OPEL", or **operational pressures**, figures reflect trusts' judgements about the pressures they face. They range from level one, where all is well, to level four, requiring "decisive action" to ensure patient safety.

## WINTER PERFORMANCE

This section looks at the performance of the 152 hospital trusts across the eight measures outlined above. Week 1 starts on 1 December 2016 and week 13 finishes on 26 February 2017.

### A&E divers

"a temporary divert of patients to other A&E departments"

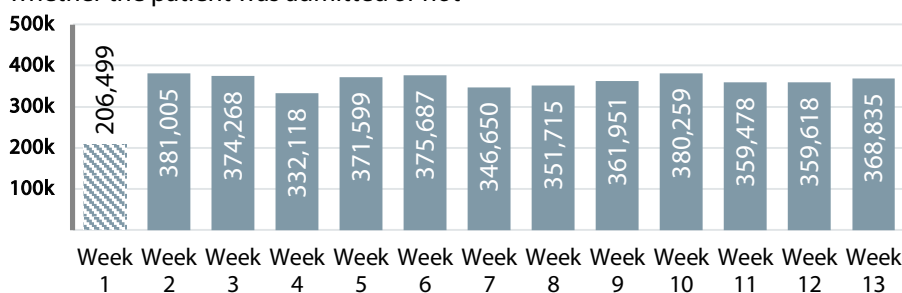


Note: 1 Dec started mid-week so week 1 only 4 days

The number of A&E divers peaked over the bank holiday period (week 5: 26 Dec-1 Jan) and then gradually decreased but has started to rise again over the past two weeks (13-26 Feb). Over December to February 2015/16 there were a total of 266 A&E divers, in 2016/17 this nearly doubled to 476. Trusts can have multiple divers on a given day; over the bank holiday period (26 Dec-1 Jan) 19 out of 152 reporting trusts diverted patients.

### A&E attendances

"all unplanned attendances at A&E departments, whether the patient was admitted or not"

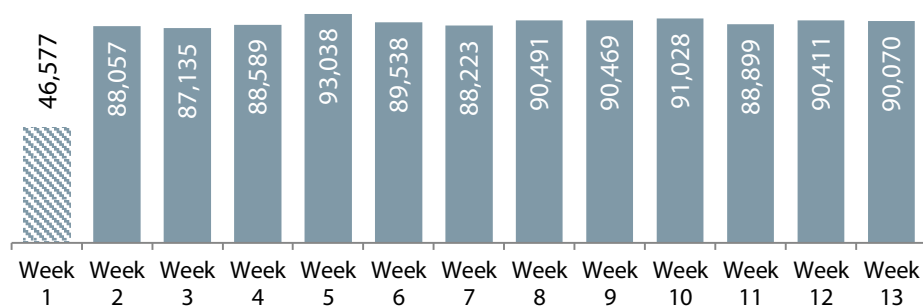


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The total number of A&E attendances across all providers peaked in weeks 2 and 10 (5-11 Dec and 30 Jan-5 Feb) with over 380,000 attendances (this includes all types of A&E, from major consultant-led centres to urgent care centres). In both of these weeks this is the equivalent of 38 patients per minute attending A&E departments, 24 hours a day.

## Emergency admissions

"all patients admitted as an emergency"

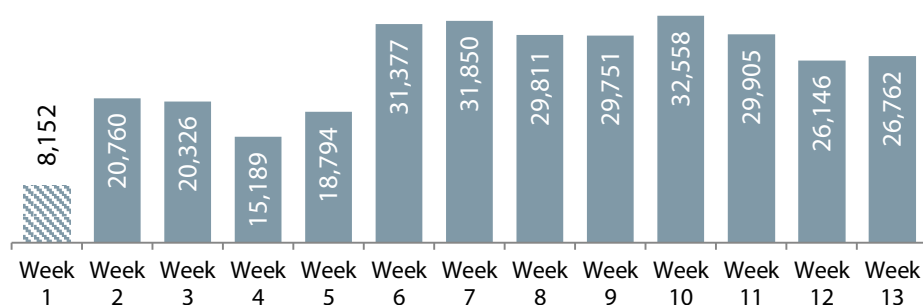


Note: 1 Dec started mid-week so week 1 only 4 days

Throughout December to February 2016/17 the number of patients admitted to hospital each week as emergencies hasn't dropped below 87,000. If they were spread evenly across all 152 reporting trusts, that is equivalent to every trust admitting over 80 emergency patients every day. In total there have been 1.1 million emergency admissions over the three months, compared to 1.2 million for the same months in 2015/16.

## General & acute escalation beds open

"additional beds opened temporarily to provide extra capacity"

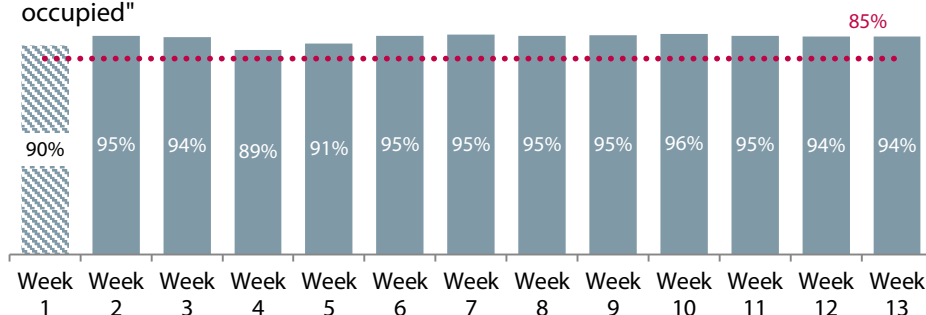


Note: 1 Dec started mid-week so week 1 only 4 days

The number of open escalation beds almost doubled in week 6 (2-8 Jan) to over 31,000. On average, a hospital has around 550 general and acute beds available per day (3,850 bed days per week) so **this is the equivalent of opening an additional eight hospitals to cope with winter demand.**

### General & acute bed occupancy

"the percentage of open beds (core and escalation) that are occupied"

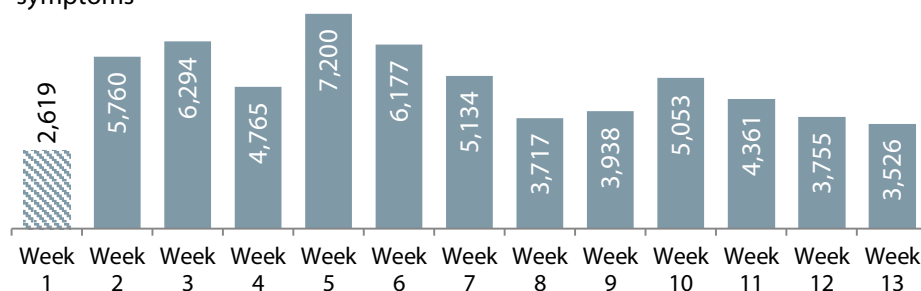


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Apart from a slight dip in occupancy over weeks 4 and 5 (19 Dec - 1 Jan) general and acute bed occupancy has been extremely high. Research has shown that bed occupancy levels above 85% can negatively impact the quality of patient care and increase the risk of infection. Despite additional capacity created by escalation beds and a lower number of emergency admissions, all weeks have been above 85%, peaking at 96% in week 10 (30 Jan - 5 Feb).

### Beds closed to D&V/norovirus

"number of beds closed to diarrhoea and vomiting or norovirus-like symptoms"

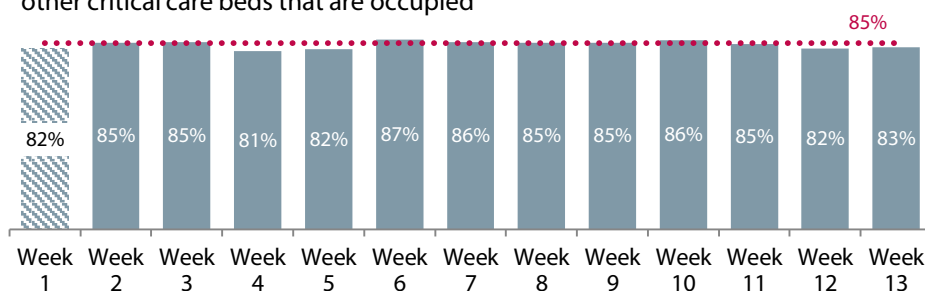


Note: 1 Dec started mid-week so week 1 only 4 days

The number of beds closed to prevent the spread of diarrhoea and vomiting or norovirus peaked in week 5 (26 Dec - 1 Jan) and then generally decreased to the end of February. In winter 2015/16 on average 562 beds were closed each day, over winter 2016/17 that has risen to an average of 708 beds per day.

### Adult critical care bed occupancy

"the percentage of open intensive care, high dependency unit and other critical care beds that are occupied"



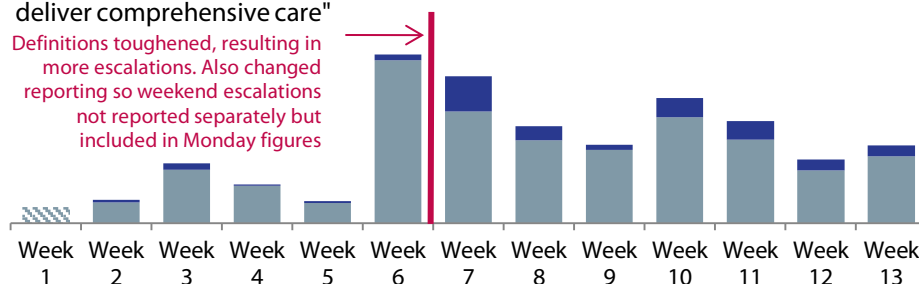
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As for general and acute beds, there was a dip in critical care bed occupancy over weeks 4-5 (19 Dec – 1 Jan), but otherwise they have been consistently high for all weeks. Occupancy was at or above the recommended safe level of 85% for 8 out of 13 weeks.

### Operational pressures

"the number of times OPEL 3 or 4 was declared, indicating major pressures in the system compromising patient flow and ability to deliver comprehensive care"

Definitions toughened, resulting in more escalations. Also changed reporting so weekend escalations not reported separately but included in Monday figures



Note: 1 Dec started mid-week so week 1 only 4 days

This year a **new system** was introduced to record instances when trusts faced serious operational pressures; 'OPEL' replaced the 'black alerts' reported in previous years. Changes to OPEL reporting criteria in week 6 mean it is not possible to compare operational pressures across the whole winter period. However, since week 6 at least a quarter of reporting providers have declared serious operational pressures at the two highest levels (OPEL 3 or 4) once or more in each week.

## WHAT DOES THIS SAY ABOUT NHS PERFORMANCE THIS WINTER?

The figures from the winter performance reports for December 2016 to February 2017 show a health service that is consistently overstretched. As other figures from this winter are published these too are showing that despite the best efforts of NHS trusts, this winter has seen some of the worst performance on record. For example, [the latest monthly statistics](#) from NHS England show:

- performance against the A&E four hour waiting time target continues to fall, with 86.2% of patients seen within four hours against the 95% standard,
- delayed transfers of care are worse than ever as trusts struggle to find the appropriate care setting for patients who continue to need to support but who are medically fit to leave hospital,
- the 92% standard for patients starting consultant-led treatment within 18 weeks continues to be missed and the waiting list is growing,
- and, the ambulance service has not met the targets for reaching 75% of the most seriously ill patients within 8 minutes since 2015.

Earlier this winter the British Red Cross described the situation as a “[humanitarian crisis](#)”. We believe the data suggests that this was an exaggeration. However, we believe it is true to say that the NHS has experienced unprecedented pressure this winter. The NHS has, by and large, coped with this pressure but there have been a number of instances where, for short periods of time, individual trusts have failed to cope, despite their best efforts.

For patients these difficulties are distressing and potentially dangerous. They are also demotivating and demoralising for the [clinical workforce](#), who sometimes feel they are [struggling against all odds](#) to provide the best possible care.

That NHS trusts have largely coped with this unprecedented demand and pressure is due to:

- the outstanding effort, commitment and professionalism of frontline NHS staff who are often working way beyond the reasonable call of duty. This needs to be recognised and applauded. But trust leaders are very clear that this level of call on staff goodwill is becoming unsustainable
- good winter planning – trusts have worked hard with NHS Improvement and NHS England to improve local system management, to empty beds in preparation for the period of greatest stretch, and systematically improve accident and emergency performance.

This situation is unsustainable, and planning for a new approach to the 2017/18 winter must begin now.

## WHAT DOES THIS SAY ABOUT THE UNDERLYING STATE OF THE NHS?

Our recent *State of the NHS provider sector* report set out our view that there is now a gap between what the NHS is currently being asked to deliver and the funding available. We also set out how a combination of the longest and deepest financial squeeze in NHS history and a series of workforce challenges are increasing levels of risk in the NHS; both in terms of safety and in terms of capacity to maintain services overall.

We **argued**, for example: “The capacity levels at which we are now permanently running our hospital, ambulance, community and mental health services and the length of time for which we have been doing this has seriously reduced resilience. We are seeing precipitous drops in A&E performance in particular hospitals on particular days, which have a clear negative impact on patient experience and patient safety. Many are traceable back to an inability to cope with activity shocks that five years ago could have been absorbed but now cannot be.”

The performance pressures on the NHS this winter add further weight to the above analysis.

As we set out in our report, we believe the NHS Five Year Forward View gives a clear long term vision for the NHS. However, ahead of the NHS Five Year Forward View delivery plan, which is expected in late March 2017, we believe the following is needed:

- a credible plan for the rest of the parliament that sets out what the NHS can realistically deliver given that the government has said the current NHS funding envelope is fixed
- a proper strategy to meet the growth in demand for health and care services that we now face
- a sustainable long term approach to funding health and social care.

## RECOMMENDATIONS FOR FUTURE ACTION

The current approach to managing winter pressures, the NHS and our overall health and care system is no longer sustainable. NHS Providers has called for a formal review of how the NHS has managed winter pressure this year. The review should be led by NHS England and NHS Improvement with the input of NHS trusts, which bear the brunt of the current approach; both in terms of managing in the current environment of increased demand and managing the current approach to winter planning. It is important that the review includes the views from expert bodies, such as the Royal College of Emergency Medicine. The results should be made public so that patients and service users can be confident that the health service is learning from this year’s experience. It should be conducted rapidly, with a target finish date of end April 2017.

NHS Providers believes that the review should consider the following:

- How effectively the NHS prepared for this winter
- How effectively the new A&E delivery boards have worked
- Whether the NHS should revert to specific, dedicated, winter funding (many trusts believe that mainstreaming dedicated winter funding into the overall NHS budget has led to the loss of much needed extra winter capacity)
- How effectively the cancellation of elective operations worked, the knock-on impacts, and where this approach should be extended or reduced next year
- How primary care access, particularly to general practice, can be extended over the holiday period

- What can be done to consistently ensure social care fully supports the NHS
- How to rapidly and consistently implement the important new A&E performance work. NHS Improvement has signalled a more standardised approach to streaming patients, prioritising support for the sickest patients and ensuring there is a consistent and holistic view of providers' performance on emergency care
- How to enhance the support providers receive from NHS Improvement and other NHS system leadership bodies
- What short term measures can be taken to close the current supply/demand gap before next year in key staff groups and areas such as the shortage of A&E consultants in many smaller, rural, hospitals
- What can be done to ensure NHS staff have a reasonable workload over the winter pressure period.



## APPENDIX A: DATA NOTES

- 1 Week 1 was a partial week, only 4 days (1-4 December).
- 2 Week 5 (26 December to 1 January) included two bank holidays.
- 3 Week 6 (2-8 January) included one bank holiday.
- 4 While data is available for previous winters changes to reporting mean comparisons are often not possible.
- 5 NHS England are continuing to publish winter daily sitreps for another month, final publication due 7 April.

TABLE 1: WEEKLY DATA FOR WINTER 2016/17

Wk.	A&E diverts	Total A&E attendances	Emergency admissions	G&A escalation beds open	G&A bed occupancy	Beds closed to norovirus	Adult critical care bed occupancy	OPEL alerts
1	13	206,499	46,577	8,152	90%	2,619	82%	27
2	33	381,005	88,057	20,760	95%	5,760	85%	39
3	36	374,268	87,135	20,326	94%	6,294	85%	100
4	19	332,118	88,589	15,189	89%	4,765	81%	64
5	57	371,599	93,038	18,794	91%	7,200	82%	37
6	39	375,687	89,538	31,377	95%	6,177	87%	281
7	52	346,650	88,223	31,850	95%	5,134	86%	245
8	43	351,715	90,491	29,811	95%	3,717	85%	162
9	41	361,951	90,469	29,751	95%	3,938	85%	131
10	40	380,259	91,028	32,558	96%	5,053	86%	208
11	27	359,478	88,899	29,905	95%	4,361	85%	170
12	31	359,618	90,411	26,146	94%	3,755	82%	106
13	45	368,835	90,070	26,762	94%	3,526	83%	130