

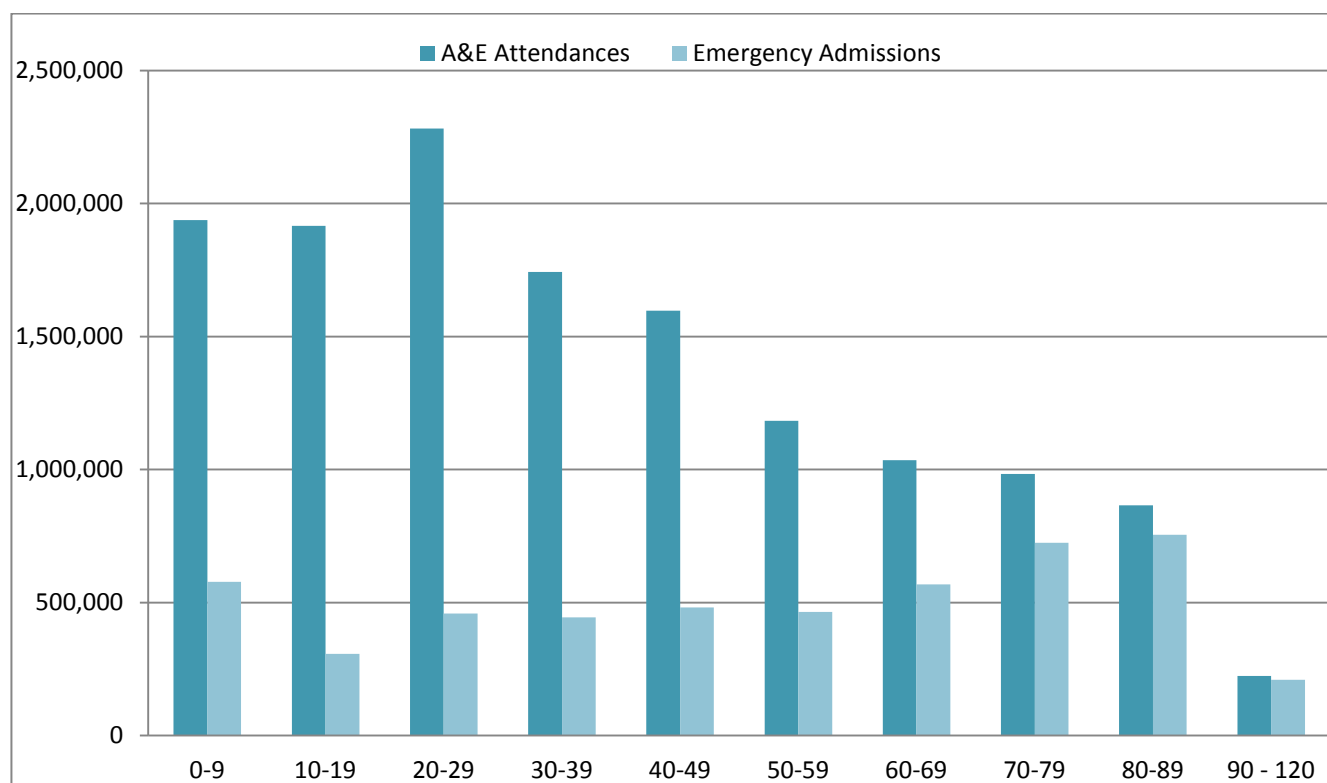
Understanding Winter Pressures in A&E Departments

Winter pressures in the NHS come every year but despite planning the NHS faces considerable challenge. It is not simply about A&E attendances, which are at their lowest in the winter months. The major issue centres on emergency admissions and the number of people requiring hospital care predominantly with respiratory conditions or decompensating other conditions – for example the failure of the heart to maintain adequate blood circulation, after long-standing vascular disease - usually brought on by cold weather and viruses.

Many of those most affected tend to be our elders and vulnerable who have increased care needs as much as a medical need. For example, for those over the age of 75 years there is a greater than 80 per cent chance of needing admission from A&E, whereas for the under 30, it is less than 20 per cent. Once in A&E these patients will require a bed or trolley space until they are discharged from hospital. If the onward flow stops, new patients cannot be received from the ambulance service or examined – this is known as “congestive hospital failure”.

The total time in A&E and compliance with the 95 per cent standard is reported for all-comers to A&E. If reported separately for admitted patients, and non-admitted patients, we see nationally the median time in A&E for *non-admitted patients* is 1 hour 49 minutes, with less than 5 per cent of patients spending longer than 3 hours and 55 minutes in A&E.

For *patients needing admission* the median time in A&E is 3 hours 37 minutes averaged across the whole year. In the winter months, it is these patients that account for most of the 95 per cent quality standard not being met. In general, even in the busiest months of the year, A&Es cope well with the higher volumes as there are many more patients with single system injuries or illnesses.



The **demand** in winter for A&E trolley space and beds for emergency admissions can only be managed by better self / family care and surveillance, early recognition of illness and response, urgent access to medication, community care/support and primary care. The **supply of capacity** can only be improved by quicker facilitated discharge into community services and social care either from A&E, rapid assessment and treatment units, or from in-patient beds and by providing 7 day senior input and routine diagnostics and pharmacy. **The problem appears in A&E, the solutions are mostly upstream and downstream.** The following graphs illustrate the key messages:

Message:

A&E Departments can cope with the majority of activity within 4 hours that is assessable and treatable in A&E and discharged home. In fact better year on year since 2008

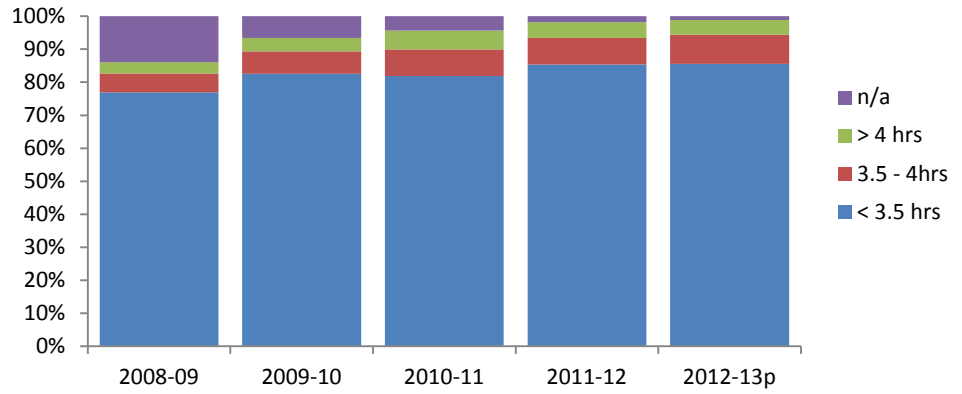
Message:

The predominant cohort of patients that breach the 4 hour standard are those who require admission to a hospital bed and in the winter

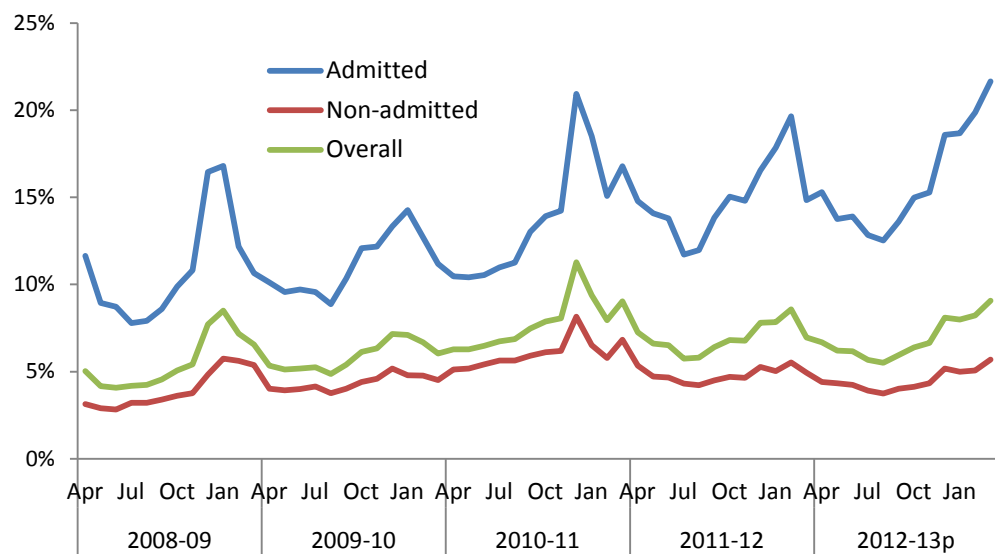
Message:

Of those who require admission and spend the longest time securing a hospital bed are the elderly with 20% of over 65 yr olds exceeding 4 hours

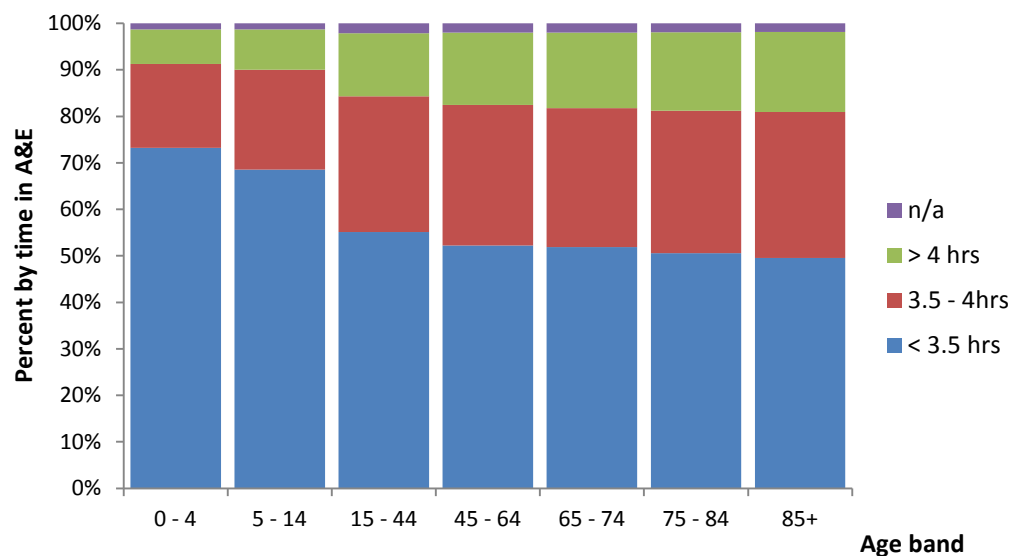
HES duration in A&E for non-admitted patients



Percentage of A&E attendances over 4 hours

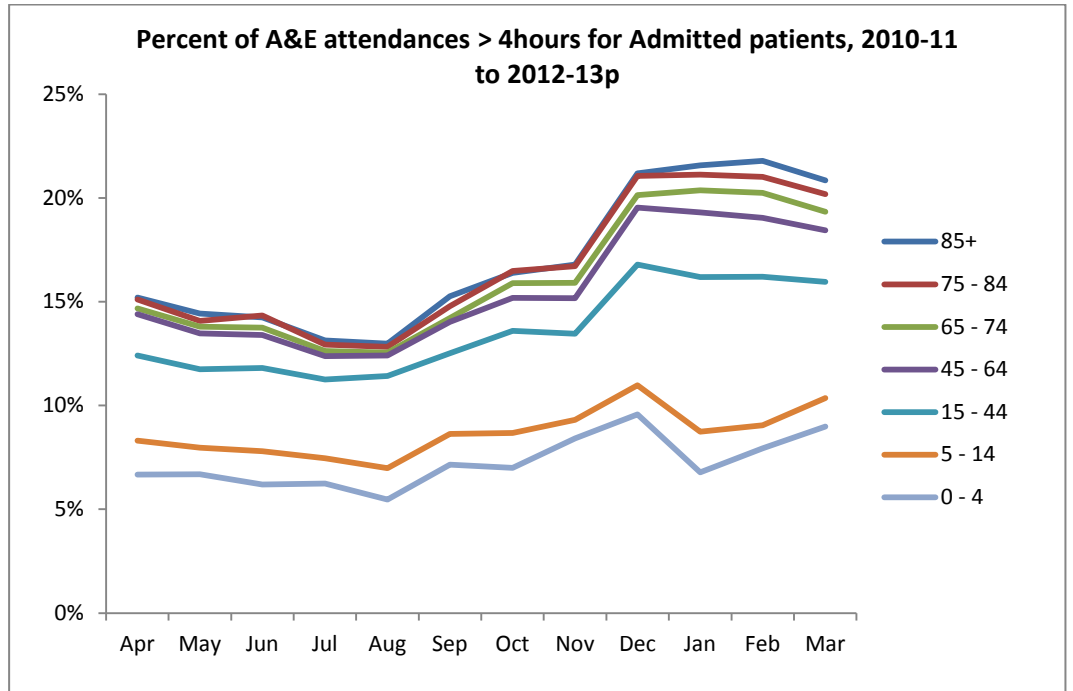


Time spent in A&E for admitted patients, by age band, 2010-11 to 2012-13p



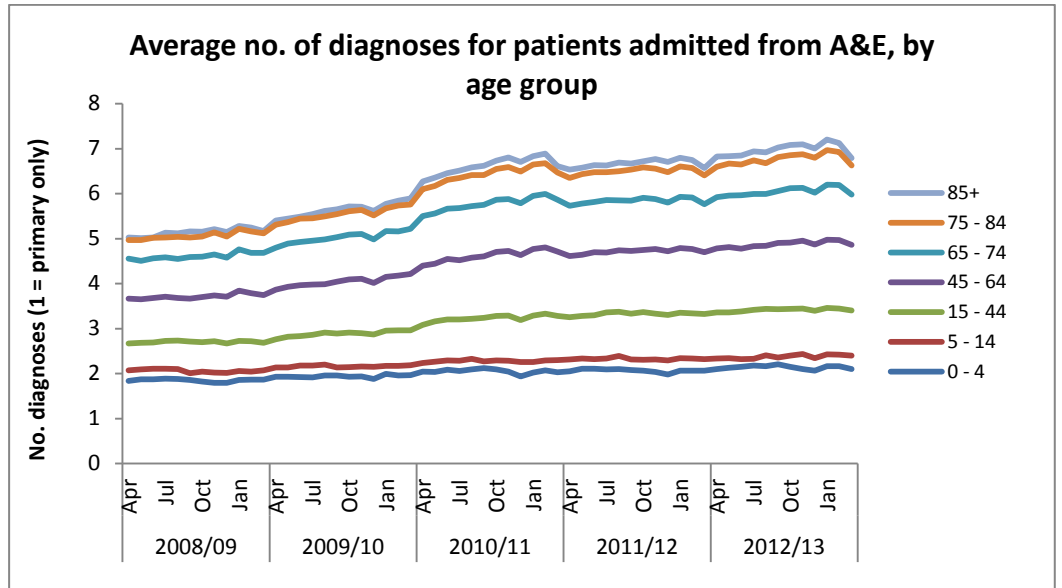
Message:

The majority of breaches of the 4 hour standard occur between November and March and are mostly those over 45 years of age



Message:

There is coding evidence of an increasing number of diagnoses in admitted patients from 2008 to 2013 consistent with the clinical impression of greater complexity and frailty



Message:

The diagnoses that accounts for the winter demand emergency admissions are RESPIRATORY

A higher number of admissions for infections occurred in 2012/13

