A review of winter 2016/2017 –
NHS Improvement and NHS England
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1 Executive summary

1. The NHS faced a very challenging winter\(^1\) in 2016/17. National performance against the 4 hour A&E standard dipped as low as 85.2% in January 2017. Some patients waited unacceptably long times in crowded A&E departments for admission to hospital. Other patients spent long periods in hospital when they were clinically ready for discharge. Hard-working frontline staff worked tirelessly under very significant pressures.

2. Lessons from this winter need to be considered so as to shape action for future winters, improve patient care, reduce pressure on staff and deliver better performance.

3. Performance over this winter followed the pattern of previous years, but with a much deeper trough, reflecting the pressure in the system in November. Specifically, bed occupancy levels and delayed transfers of care (DTOCs) were at historically high levels suggesting a particular problem at the ‘back-door’ of hospitals.

4. The NHS went into the peak holiday period over Christmas and New Year with performance in November nearly 3% lower than the previous year, delayed transfers of care in November were 27% higher than the previous year (largely driven by increases in social care delays) and bed occupancy for Quarter 3 was 90.6%.

5. This pressure continued through the winter period with:
   a. Occupancy for Quarter 4 at 91.4%, and NHSI unvalidated daily sitrep data showed that on occasion this rose as high as 96.4%; and,
   b. Delayed transfers of care reaching their highest ever level in January 2017 (7,104 patients delayed each day).

6. Despite these pressures, and thanks to the huge efforts of frontline staff, patients continued to receive safe care during this period and over 85 in 100 were admitted, transferred or discharged from A&E within four hours.

7. This review looks in more detail at the pressures the system faced in winter, how it performed, the support that was provided by national bodies and the learning that needs to be taken into the coming year.

8. The findings and recommendations of the review are grouped into five main themes.

9. Firstly, it is vital to ensure that there is enough system capacity to meet the pressures of winter. There are three elements to this – ensuring there are escalation processes in place should acute hospital bed occupancy move over 92%; reducing the significant delays to discharge to free up capacity ahead of winter, particularly those due to social care, given the significant growth in the past two years; and, having the right information to understand what capacity is available across the whole system.

10. Secondly, the NHS needs to better plan for peaks in demand over weekends and bank holidays. This year the NHS saw a record number of patients in A&E (over 60,000 on 27 December). The profile of demand across the week and across the holiday period is relatively predictable and the NHS, working with local government partners, needs to be better at ensuring resources are available to meet this demand and patient flow is maintained.

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\(^1\) For the purposes of this report winter is defined as the period from 1 December 2016 to 28 February 2017, unless specified otherwise.
11. Thirdly, there is still significant variation in practice across the country which needs to reduce. Much of this comes down to the operational focus of clinicians and managers in individual systems which can result in best practice not being adopted or implemented. There are also significant workforce gaps across Urgent and Emergency Care, particularly in primary care and emergency care that need to be addressed.

12. Fourthly, NHS England (NHSE) and NHS Improvement (NHSI) need to be more aligned to better support systems to deliver, with more joined-up messaging, prioritisation and support ahead of and during winter.

13. Fifthly, there needs to be an enhanced focus on reforming and redesigning the Urgent and Emergency Care system to develop the offer and services outside of hospital so that patients get the right treatment, at the right time, in the right place. This will include delivery of priorities set out in the Next Steps on the NHS Five Year Forward View such as the development of NHS111 online and ambulance service redesign.
2 Summary of recommendations

14. The recommendations of the review are grouped into the same themes as in the findings. They are:

System Capacity

- **Recommendation one** – Occupancy levels in acute hospitals should be more actively monitored and actions taken to ensure that they remain below 92%, to maintain patient flow and deliver A&E performance.

- **Recommendation two** – To ensure delivery of safe, effective care this winter the NHS needs to free up 2,000-3,000 acute beds. This freeing up of beds should come from a reduction in DTOCs.

- **Recommendation three** – Building on the forthcoming additional collection of data on primary care capacity, the NHS needs to routinely have a more complete picture of capacity available across the system, particularly in community care. This will support better planning to address the current reduction in service provision over weekends and the holiday period, and mitigate the huge pressure placed on A&E departments after these periods. For example, there is no point building a local winter plan whose success is premised on non-existent GP availability.

Peaks in demand

- **Recommendation four** – All parts of the NHS need to work with local government partners to ensure that there are enough resources available to maintain patient flow seven days a week and plan effectively for the predictable peaks in demand at weekends and bank holidays.

Variation across the country

- **Recommendation five** – There needs to be a renewed drive and focus to implement best practice across all systems. Much of this is down to local focus, attitudes, behaviours and cultures of clinicians and managers which need to be tackled as part of the work of NHS England and NHS Improvement regional and improvement teams.

- **Recommendation six** – Specific action needs to be taken to address workforce shortages in key areas in Urgent and Emergency Care, most notably in primary care and emergency medicine, both for this winter and for the medium-term.

National support

- **Recommendation seven** – The NHS should plan for winter earlier than in previous years with decisions made on the ‘winter plan’, including what additional support is needed, in the summer.

- **Recommendation eight** – NHS England and NHS Improvement need to build on the recent appointment of Pauline Philip as joint National Director to be more aligned, and present joint messages to the system, combining improvement resources to best support the system in the coming months.
- **Recommendation nine** – NHS England and NHS Improvement should work with national system partners, including central government departments, to reduce the burden of assurance and reporting to allow space for local delivery.

Urgent and Emergency Care system

- **Recommendation ten** – NHS England and NHS Improvement should ensure the local NHS make rapid progress over the course of 2017/18 in implementing the wider changes to the Urgent and Emergency Care system that will improve patient care and reduce pressure on A&E departments as set out in the Next Steps on the NHS Five Year Forward View document\(^2\).  

3 National action to plan for and manage winter pressures

3.1 A&E Improvement plan for 2016/17

15. In response to the continued decline in A&E waiting time performance and increases in demand, a five point improvement plan was developed by senior operational and clinical leads from across NHSE and NHSI during 2016.

16. This plan was based on the principles set out in *Safer, Faster, Better*³, and focused on targeting improvement at the key points in the Urgent and Emergency Care (UEC) pathway. The five major elements of the plan are set out below.

<table>
<thead>
<tr>
<th>Key Action</th>
<th>How this was achieved</th>
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<tbody>
<tr>
<td>All systems implementing robust streaming models at the front door of all Type 1 A&amp;Es</td>
<td>Systems that did not have primary care streaming began implementation planning. Best practice on streaming was provided in the rapid implementation guidance.</td>
</tr>
<tr>
<td>Increasing the proportion of NHS 111 calls transferred to clinical advisors</td>
<td>Increased to 30% of calls transferred in March 2017</td>
</tr>
<tr>
<td>Implementing the Ambulance Response Programme (Dispatch on Disposition, and the Clinical Code Review)</td>
<td>Over winter all trusts piloted the Dispatch on Disposition trial. Three trusts took part in the clinical code review which is ongoing in 2017.</td>
</tr>
<tr>
<td>Implementing best practice models to improve flow through the system, with a particular focus on the acute sector (such as embedding the SAFER bundle⁴)</td>
<td>Best practice was disseminated after consultation with subject matter experts. The quarterly checkpoint assurance showed progress had been made around each criteria, especially the use of estimated dates of discharge.</td>
</tr>
<tr>
<td>Implementing improved discharge practices (such as discharge to assess⁵ and trusted assessor⁶)</td>
<td>As above, the information collected showed progress made in the quarter. Systems with challenges around delayed transfers of care (DTOC) were identified and supported through the national DTOC programme.</td>
</tr>
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17. Nationally, governance to support the implementation of the plan was formed of senior representatives from all system organisations.

18. Regionally, joint NHSE and NHSI boards were formed and tasked with improvement and delivery. Assurance against the five key points of the plan was conducted in September and repeated in December to determine progress.

19. Locally, Systems Resilience Groups became A&E Delivery Boards, charged with focusing solely on delivering UEC services.

20. A&E Delivery Boards were asked to appoint an acute trust chief executive as chair or appropriate alternative where this was agreed by the board. The majority are now chaired by trust chief executives with a handful being chaired by Clinical Commissioning Group (CCG) accountable officers. Board membership consists of senior representatives from across each local health system who have decision making responsibility for their organisation. This is to facilitate collaborative system-wide change.

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21. The A&E Improvement Plan was formally launched in mid-July 2016. Assurance was conducted through a rolling programme of deep dives with regional teams, which focused on general progress with the improvement plan, what the best performing systems were doing, and specific actions being taken with the poorest performers. There were also more detailed quarterly assurance checkpoint reports submitted by all systems.

3.2 Preparing for winter

22. The winter communication sent to all local A&E delivery boards in October set out the mandated planning actions that all local systems were expected to address in their winter plans. Details of actions are included in the table below.

<table>
<thead>
<tr>
<th>Action</th>
<th>How this was achieved</th>
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<tbody>
<tr>
<td>Ensuring availability of primary care and other out of hospital services, according to locally forecast demand, at all times over the bank holiday periods.</td>
<td>The extensive assurance process prior to the bank holiday period indicated that the majority of systems matched the services to forecasted demand.</td>
</tr>
<tr>
<td>Pacing of elective activity to ensure more capacity was available to dedicate to non-elective activity for periods of peak demand.</td>
<td>Elective care activity data shows a correlating reduction in line with the peak demands for non-elective care.</td>
</tr>
<tr>
<td>Reducing bed occupancy to 85% ahead of the bank holiday periods, to deliver headroom for the busy early January period.</td>
<td>Occupancy ahead of the bank holiday was in aggregate reduced to 87%.</td>
</tr>
<tr>
<td>Increased uptake of flu vaccinations in healthcare workers.</td>
<td>Seasonal flu vaccine uptake among frontline healthcare workers was considerably higher than in the year before – a 30% increase equating to an additional 120,000 staff vaccinated.</td>
</tr>
<tr>
<td>Ensuring NHS 111 providers are sufficiently staffed (both with clinical and non-clinical call handlers) to meet forecast demand, and that DoS are live and up to date.</td>
<td>NHS 111 providers planned for activity by modelling services on previous years. Staffing levels were matched to anticipated demand levels based on activity profiles covering volume and call type.</td>
</tr>
<tr>
<td></td>
<td>As part of its on-call provision during Winter 2017/18, the national DoS team at NHS England provided an on-call facility for providers and commissioners to request emergency changes to DoS every weekend in December and for an entire fortnight covering Christmas and New Year.</td>
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<tr>
<td></td>
<td>Data collected on categorisation and volume of emergency DoS changes requested during this period show an increase compared to previous periods demonstrating an increased awareness and usage of DoS and the growing importance for this facility to be available.</td>
</tr>
<tr>
<td>Ensuring local escalation protocols are aligned to the new national framework, and that daily sitrep reporting requirements are met.</td>
<td>The new national escalation framework was released in October 2016. Daily sitrep data completion was actively monitored and managed by regulators.</td>
</tr>
</tbody>
</table>
23. Plans were submitted for assurance to regional A&E delivery boards, who oversaw sign-off and further work where gaps were identified.

### 3.3 Governance and leadership of winter period

24. In 2016/17 a single management process to manage winter pressures across NHS England and NHS Improvement was put in place. The aim was to create a single point of contact for all winter related activity, manage a joint response and coordinate information flow to and from arm’s-length bodies executive teams, Department of Health and the rest of government.

25. A national ‘winter room’ and four regional ‘winter rooms’ operated over the period as the focal point of activity (this replicated the position of 2015/16). At sub-regional and local level, colleagues were appointed to winter reporting for the duration of the period to assist the information feed.

26. Operational information was collected on a daily basis to support management of winter pressures and public transparency of how the system was faring. This information was used nationally, regionally and locally to understand pressures faced and provide additional support for frontline organisations.

27. There was a daily winter resilience call held on Monday to Friday between the national NHS England performance team and each of the regional winter rooms. The objective of the calls was to gather a national overarching picture of operational pressure and escalation and provide additional support to regional colleagues where needed. This information was provided to senior NHS managers and stakeholders.

### 3.4 Escalation management

28. The Operational Pressures Escalations Levels (OPEL) framework was introduced as the winter process began, to eliminate the discrepancy between serious operational issues being reported on the daily sitrep and escalation of systems under pressure based on the Emergency Preparedness, Resilience and Response framework.

29. The OPEL framework was widely accepted with systems using the required mechanisms to report over the winter period. OPEL streamlined the reporting and provided a common language in terms of pressure.

30. A review of the OPEL framework is underway to build upon learning since the framework was introduced, in order to make refinements based on local experiences and those of national bodies.

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4 The lead up to winter

31. The NHS went into the winter of 2016/17 against a backdrop of a three-year decline in A&E waiting time performance. Seasonal trends have been broadly the same, with performance dipping in winter as the pressure on the NHS increased but then recovering in the summer.

32. However, over the past three years as performance has declined and the system is under more stress these summer improvements have not been as marked. The decline in winter has therefore been greater as the NHS starts each winter from a lower base than the year before.

33. The performance and resilience of the system is largely a product of the interplay between demand, supply and patient flow through the system.

34. In the period leading up to winter\(^8\) emergency demand growth was above the five year trend (in contrast to winter itself, which showed low growth in demand - see page 16).

<table>
<thead>
<tr>
<th>Change in Demand between April and November</th>
<th>Year-on-year growth (2016 vs 2015)</th>
<th>5 year average growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-elective admissions</td>
<td>3.0%</td>
<td>2.0%</td>
</tr>
<tr>
<td>A&amp;E attendances</td>
<td>3.8%</td>
<td>3.4%</td>
</tr>
<tr>
<td>Ambulance calls</td>
<td>5.4%</td>
<td>3.9%</td>
</tr>
<tr>
<td>NHS 111</td>
<td>10.4%</td>
<td>8.1%</td>
</tr>
</tbody>
</table>

Note: NHS 111 is 2 year growth only, as NHS 111 did not reach full rollout until Feb 2014

35. Acute hospital bed capacity increased in October 2016 to March 2017 compared to the same period in 2015/16. There were on average 600 (0.8%) more acute hospital beds in

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\(^8\) April to November 2017 inclusive.
Quarter Three 2016/17 compared to the same period the previous year. However, bed occupancy was on average 1.5% higher.

36. Workforce constraints are also an increasingly important factor in the ability to deliver high-quality and timely urgent and emergency care. Three of the four professions – Paramedics, Emergency Medicine and General Practice – were highlighted by Health Education England\(^9\) as priority shortage areas, where a material gap between funded demand and current supply has arisen related to Urgent and Emergency Care.

37. Flow through the system can often be measured through patients waiting at particular transition points – e.g. admission into hospital and discharge from hospital. The numbers of patients waiting too long to be admitted into hospital (measured by four and 12-hour ‘waits’), has steadily increased over the past three years. These delays are largely caused by poor patient flow through and out of the hospital.

38. DTOCs which look at the ‘back-door’ of hospital have similarly increased. Between April and November there was an increase of 25% compared to the same period in the previous year, so that in November there were 6,771 beds (or 5.2% of available beds in the system), occupied by patients who were classed as delayed transfers. On average, an additional 1,335 people were delayed each day in November 2016, compared to November 2015, meaning that 1,335 more beds were unavailable due to delays each day.

39. A snapshot audit of the system conducted during the course of last year confirmed that the DTOC number was only a subset of patients who were medically fit for discharge (MFFD). The medically fit number was approximately double that of DTOCs, which is roughly consistent with the National Audit Office’s estimate that there are 2.7 times as many MFFD patients as DTOC patients.

\(^9\)https://www.hee.nhs.uk/sites/default/files/documents/HEE%20Workforce%20Plan%20for%20England%202016%2020180516_0.pdf
40. This decline over the last three years has therefore largely arisen because the usual balance between demand and capacity has been altered which has further caused patient flow to slow down. Before 2013/14, the number of emergency bed days had changed little in over a decade, with rising demand every year always absorbed by improvements in patient length of stay (LoS) and flow. However in the past three years increasing difficulties with discharging patients and slower flow have led to a significant rise in emergency bed days (1.8m). This has in turn pushed up occupancy and created significant fragility in the system.

41. In summary the NHS went into winter in a more challenging situation and operating under more pressure than in previous years.

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10 There were 27,828,000 emergency bed days in 2013/14, compared to 28,950,000 in 2003/4.
5 What happened during winter

5.1 Acute hospitals

42. The NHS came under significant pressure during the winter period. From late December 2016 to early March 2017, performance dipped sharply. On some days national performance was as low as 76%. From 27 December to 14 January 2017, a period of 19 days, national performance was below 80% on 11 of these days.

43. By 14 January performance had recovered to around 85%, and while there were further dips in performance in the coming months, performance did not drop below 80% again. Improvements continued (albeit slowly), and published performance for March 2017 was 90%.

44. The pressure the system was under was tracked through the new OPEL framework. Due to the introduction of this new system of reporting it is not possible to compare this position to previous years.
45. Demand growth, from December to March, was lower than the 5 year average growth on all measures.

**Change in Demand between December and March**

<table>
<thead>
<tr>
<th></th>
<th>Year-on-year growth (2016 vs 2015)</th>
<th>5 year average growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-elective admissions</td>
<td>1.4%</td>
<td>2.9%</td>
</tr>
<tr>
<td>A&amp;E attendances</td>
<td>-1.7%</td>
<td>1.4%</td>
</tr>
<tr>
<td>Ambulance calls</td>
<td>1.1%</td>
<td>3.2%</td>
</tr>
<tr>
<td>NHS 111</td>
<td>-4.2%</td>
<td>5.3%</td>
</tr>
</tbody>
</table>

46. Whilst there was little growth over last year (which had seen very significant growth from years previous to that) there were significant peaks in that demand. For example, attendances peaked at record levels on 27 December, when the NHS saw over 60,000 people. It then peaked significantly again on 3 January. These peaks reflect a broader trend that is seen throughout the year, but is particularly acute after bank holidays, of attendances at A&E peaking at the start of the week.

47. Over the traditional pressure period of Christmas/New Year, demand remained relatively steady compared to the previous year (which had seen very significant growth from years previous to that). Admissions rose slightly, whilst attendances were lower.

48. This potential increase in acuity did not come, however, from one of the usual drivers – flu. Winter 2016/17 flu activity rates were among the lowest seen in recent years – only rising above the baseline threshold for approximately 6 weeks. It is important to note regarding flu and infection control issues that national aggregate data masks local issues, and there were a number of localities that did encounter significant spikes, which contributed to increased winter pressures.

49. Seasonal flu vaccine uptake among frontline healthcare workers was considerably higher than in the year before – a 30% increase equating to an additional 120,000 staff vaccinated. Vaccine uptake was also higher amongst most GP patient cohorts in England, with the exception of patients aged 65 or older where the uptake rates were marginally lower.¹¹

50. In aggregate across England, acute providers had more acute hospital beds open this winter than last winter, and were successful in achieving the ambition for general and acute bed occupancy to be reduced to 85% or below ahead of the Christmas and New Years’ Bank Holiday period.

51. Supply was not significantly affected by diarrhoea and vomiting (D&V) and Norovirus. In winter 2016/17 beds closed due to D&V and norovirus started off (i.e. during December 16) higher than the levels seen the year before (but below the levels seen in 2014/15). But from mid-January 2017 onwards, levels were around the same level as the previous year, or slightly lower. Additionally, there was no increase in beds closed to D&V and norovirus in late February/early March, as seen in previous years.

52. DTOC levels reached their highest recorded level in January, with DTOC levels over winter on average 22% higher than the year before.

53. The pressure on the system was borne out in the numbers waiting four-hours and twelve-hours from decision to admit to admission, which were higher than in previous years. Whilst the four-hour waits were distributed relatively widely across the system, the 12-hour waits were markedly concentrated in a small number of systems with two-thirds of the 12-hour trolley waits over this period in only six organisations:

- Pennine Acute Hospitals NHS Trust
- Worcestershire Acute Hospitals NHS Trust
- University Hospitals of North Midlands NHS Trust
- Portsmouth Hospitals NHS Trust
- Weston Area Health NHS Trust
- King’s College Hospital NHS Foundation Trust

54. In summary the pressures seen in the run-up to winter continued through the period, with flow stalling as supply became more constrained by rising DTOCs. The NHS was not resilient enough going into winter to deal with the expected peaks in demand and performance suffered with patients waiting for unacceptably long periods.
5.2 Out of hospital services

**NHS111**

55. Throughout the winter period (December to March) 5,230,256 calls were offered to NHS 111. This is a decrease of 231,395 calls (4.2%) compared to the previous year when 5,461,651 calls were offered. Of the calls answered, 88.5% were answered within 60 seconds this winter, compared to 79.6% last winter. This winter’s performance fell short of the 95% target, but was an improvement on the previous winter. The ambition for 30% of calls to be handled by clinicians was achieved in the last week of March.

56. There were large peaks in demand on 27th December and during the two weekends following Christmas. The 2016-17 Christmas period (23rd December to 5th January) had a 9.5% (72,000) increase in calls offered in comparison to 2015-16. 26 December 2016 to 1 January 2017 proved to be the busiest week ever for NHS111 services with over 455,000 calls. 27 December 2016 had the third highest volume of calls on a single day (108,000). During this period there were technical issues in some parts of the country, which contributed to excessive call volumes.

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**Ambulances**

57. Performance against the Red 1 standard – the only ambulance standard directly comparable to previous years due to the ongoing Ambulance Response Programme redesign - was overall marginally better this winter (68.2%) compared to 2016/16 (67.6%). Monthly data indicates that there was considerable month on month improvement from December 2016 to March 2017. March 2017 was significantly better than March 2016 with an improvement of 6.7%.

58. The number of conveyances by ambulance increased by 16,282 (0.9%) from December - March 2015/16 compared to the same period in 2016/17. The proportion of calls resolved by telephone advice (Hear and Treat) remained very similar to the previous year (less than 1 percentage point difference). The proportion of patients who received a face-to-face response from the ambulance service without need for transport was also maintained at very similar levels to 2015-16 (less than 1 percentage point difference).

**Primary Care**

59. There is limited national data collated on activity in primary care over the winter period. A more sophisticated real time measure of primary care capacity / availability is in development. However, the quarterly ‘extended access’ survey conducted in March showed an increase in provision of full extended access to GP care. In March 2017, full provision of extended access was available at 1,675 (23.6%) practices, an increase of 5.1 percentage points since the previous collection in October 2016. This full extended access served 12.88 million (22.9%) registered patients.

60. A case study analysis conducted on a GP dataset covering 70% of the Leeds population demonstrated that the number of appointments peaked on Mondays, particularly Monday morning. This pattern was not observed on Tuesdays following a bank holiday.

**Community Care and Social Care**

61. We have limited national data on community services and provider activity. What data we do have shows that non-acute DTOCs were 20% higher this year compared to last.
62. We also have limited national data on social care activity and capacity. We know that delayed discharges attributed to social care rose by over a third this winter, and that 2016/17 overall saw continued reductions in funded user numbers and overall spend on older people, but there is little information available on specific causes.
6 What we learned from winter 2016/17

6.1 System capacity

63. Maintaining sufficient capacity is absolutely vital to ensure delivery during winter. The system went into the period without the headroom required to maintain patient flow during the significant pressures that the winter brings. Over winter dips in national performance corresponded with spikes in bed occupancy levels.

64. NHS England and NHS Improvement assess that providers should aim to operate at a bed occupancy level of 92% or below to support patient flow. High levels of occupancy cause a number of problems for the system\textsuperscript{13}. These include:
   a) Lack of sufficient capacity to maintain patient flow and best practice;
   b) Patients not being placed in the most appropriate setting or ward – e.g. medical patients in surgical wards;
   c) Trusts need to open more escalation capacity and often short-stage assessment units or wards are used for this which further compromises flow;
   d) Management teams having to focus on the day-to-day fire-fighting of finding enough beds for the patients admitted into hospital, as opposed to making more transformative changes to patient pathways that will help reduce occupancy; and,
   e) Cancellation of elective activity leading to longer referral to treatment waiting times.

Recommendation one – Occupancy levels should be more actively monitored and actions taken to ensure that they remain below 92%, to allow patient flow to be maintained to deliver A&E performance.

65. There are two key drivers of high occupancy levels. One is ‘in-hospital issues’, such as patients not moving within pathways, lack of continuity of care and red and green\textsuperscript{14} days approach not being adopted among others. Secondly, occupancy is adversely affected by patients who no longer need to be in hospital for medical reasons but are unable to be discharged.

66. Over most winters, the usual annual increase in emergency admissions is offset by decreased average length of stay, and it is this which allows the NHS to function effectively. However in 2016/17 average length of stay increased for the first time since the early 2000s. This meant there was no ‘offset’ for the usual annual admission increases, and hospital occupancy had to rise as a result. Delayed discharges can be for

\textsuperscript{13} https://www.nuffieldtrust.org.uk/resource/winter-hospital-bed-pressures
\textsuperscript{14} https://improvement.nhs.uk/improvement-offers/red2green-campaign/
a number of reasons across health and social care, including delays to assessments, lack of capacity in out of hospital services, patient choice and poor clinical practice.

67. The national measure of these delays, DTOCs, reached record levels this winter – occupying on average over 6,400 beds every day (split across the NHS (3,642), social care (2,287) and both (514)).

68. These numbers have been growing in recent years with particular growth seen in social care DTOCs. Further, we know the DTOC measure underestimates the true number of delays with estimates of patients who are medically fit to leave hospital ranging from two to three times this number. If even some of these patients were transferred to more appropriate care settings, this could very quickly generate the capacity the system needs for winter. This is vital to ensure good patient flow, which delivers improved patient care and efficient use of resources across the system.

Recommendation two – To ensure delivery of safe, effective care this winter the NHS needs to free up 2,000-3,000 acute beds. This freeing up beds should come from a reduction in DTOCs.

69. Delivering A&E performance and resilience in winter is a system wide issue. There were a number of local reports fed back to NHS England and NHS Improvement that capacity was closed in certain parts of the system without a view on what impact that would have elsewhere. In the best systems capacity was planned at Local A&E Delivery Board level to ensure there was a shared system-wide approach. However, this was not routine. The NHS has already taken action to ensure that bed closures are not approved where it would have an adverse effect on delivery.\(^\text{15}\)

70. There is a lack of consistent capacity data across the system. For example, whilst we have good data on capacity in many parts of the system, e.g. acute hospitals, NHS111 and ambulances, for other vital parts of the system there is currently limited operational capacity data which provides a holistic picture or allows aggregation to the national level, e.g. in primary care.

71. It is particularly difficult to understand how this capacity fluctuates (for example, during the course of a week) and the impact that this fluctuation has on the system’s capacity to respond to pressures. Local systems have bespoke solutions for monitoring capacity and demand but there is currently no consistent approach across the country.

\(^\text{15}\) https://www.england.nhs.uk/2017/03/new-patient-care-test/
72. Given the volumes that access primary care, approximately 300m a year, compared to A&E, around 21m a year, even small shifts from one to the other can be very significant, making it even more important to understand the activity across the system to ensure resources are allocated to meet the demands in the system.

**Recommendation three** – Building on the forthcoming additional collection of data on primary care capacity, the NHS needs to routinely have a more complete picture of capacity available across the system, particularly in community care. This will support better planning to address the current reduction in service provision over weekends and the holiday period, and mitigate the huge pressure placed on A&E departments after these periods. For example, there is no point building a local winter plan whose success is premised on non-existent GP availability.

### 6.2 Peaks in demand

73. The peaks in demand that the NHS faces over the winter period are generally predictable and does not vary significantly from previous winter periods and other bank holidays. This was even more so the case this winter given that there was neither a significant flu outbreak nor a very cold snap.

![Emergency Admissions - Daily SITREP](image)

74. Indeed the peaks in demand are a more extreme version of the change the NHS sees each week with performance dropping on Monday as demand is significantly higher than the rest of the week.
75. These peaks in demand correlate with declines in performance which the system then struggles to recover from.

76. During winter 16/17 the average number of attendances on a Monday was above 56,000. Throughout the week this declined, down to around 50,000 by Friday. Average performance tended be lower at the start of the week and improve by Thursday.

77. Systems are in a constant cycle of improvement and decline week on week and from holiday period to holiday period. These pressures can be better planned for across the system to ensure that the resources available match the demand of patients and the service – this may not always be more availability at the front-door, e.g. primary care or A&E, but for example greater support at the back-door to facilitate discharge. In doing this there needs to be a focus not only in capacity across the system but in ensuring the processes and resources are in place to support the transition of patients, e.g. transport services, consultant availability, day cases, pharmacy, and discharge teams.
**Recommendation four** – All parts of the NHS need to work with local government partners to ensure that there are enough resources available to maintain patient flow seven days a week and plan effectively for the predictable peaks in demand at weekends and bank holidays.

### 6.3 Variation across the country

78. There was significant variation in performance between different parts of the country. Some acute trusts continually performed above 98% whilst others performed below 70% over the period.

![](chart.png)

79. This variation cannot be attributed entirely to external factors. The implementation of best practice is still not consistent across the country – such as measures to improve internal hospital patient flow, ownership of the A&E standard across the whole organisation and system, rather than just the A&E, and tools to support efficient discharge. Much of this comes down to local clinical and operational leadership and management focus to drive change which is a core component of any improvement and change in practice.

80. Indeed the assurance against the A&E plan showed significant variation in self-reported delivery of core priorities.

81. Whilst this variation is in many cases not a positive, there are a number of strong performers in the system who are able to continue to deliver under significant pressure. Much of the best practice the system is being asked to implement originated with these systems and there is an opportunity to work with these systems to support poorer performers.

**Recommendation five** – There needs to be a renewed drive and focus to implement best practice across all systems. Much of this is down to local focus, attitudes, behaviours and cultures of clinicians and managers which need to be tackled as part of the work of NHS England and NHS Improvement regional and improvement teams.

82. There is also substantial variation in the levels of workforce in different parts of the country. There is a national shortage of Emergency Medicine clinical staff, paramedics...
and general practice staff. This shortage is not felt evenly across the country: for example, some systems struggled to recruit even half of their workforce substantively, whereas other systems were far more resilient.

83. Feedback from the system is that workforce is now at the top of the list of concern for trust chief executives and it was continually raised over winter as an issue that held back performance improvements and caused challenges in delivering quality care.

**Recommendation six** – Specific action needs to be taken to address workforce shortages in key areas in Urgent and Emergency Care, most notably in primary care and emergency medicine, both for this winter and for the medium-term.

### 6.4 National support

84. The NHS started its planning for winter in earnest in October 2016. Widespread feedback and reflection was that this was too late in the year and did not allow for the decisions to be made that could change course in some systems and deliver the resilience needed to get through the pressurised period.

**Recommendation seven** – The NHS should plan for winter earlier than in previous years with decisions made on the ‘winter plan’ including what additional support is needed in the summer.

85. The NHS has now taken action to address this through the creation of a single programme on Urgent and Emergency Care under the leadership of Pauline Philip, National Director for Urgent and Emergency Care across NHS England and NHS Improvement. As part of this programme each local area will have a single named regional director from NHSE and NHSI to support implementation and hold both CCGs and Trusts to account.

**Recommendation eight** – NHS England and NHS Improvement need to be more aligned and present joint messages to the system, combining improvement resources to best support the system in the coming months.

86. A further change needed is to move the focus of national organisations away from assurance to planning and improvement support. Local leaders report spending too much time ‘feeding information up’, often having to re-cut the information provided in different formats, rather than focusing on making changes necessary to improve patient care. This further amplified the pressures many systems faced.

87. A common theme from discussions with the regions was the volume of requests for information with extremely short timelines. The period from November to mid-December was identified as the most pressurised, servicing multiple weekly ministerial briefings, ad hoc requests and visits.

**Recommendation nine** – NHS England and NHS Improvement should work with national system partners, including central government departments, to reduce the burden of assurance and reporting to allow space for local delivery.

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17 https://nhsproviders.org/news-blogs/news/worries-over-nhs-staffing-a-key-election-concern
6.5 Urgent and Emergency Care System

88. Whilst this review and the focus of public scrutiny has been largely hospital based we are clear progress also needs to be made on implementing the wider changes to the Urgent and Emergency Care System. By doing this we will start to shift growth in demand from the acute sector to out of hospital care services so that patients receive the most appropriate care in the setting that is right for them.

Summary of Out of Hospital Care Deliverables, Next Steps on the NHS Five Year Forward View

<table>
<thead>
<tr>
<th>Deliverable</th>
<th>Progress Made</th>
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<tr>
<td>By October 2017 every hospital and its local health and social care partners must have adopted good practice to enable appropriate patient flow, including better and more timely hand-offs between their A&amp;E clinicians and acute physicians, ‘discharge to assess’, ‘trusted assessor’ arrangements, streamlined continuing healthcare (CHC) processes, and seven day discharge capabilities.</td>
<td>The improved Better Care Fund (iBCF)(^{19}), the extra £1 billion grant, has a number of purposes. One of the grant conditions is for local authorities to work with the relevant CCGs and providers to support system-wide improvements in transfers of care. This includes making progress on implementing the High Impact Change Model for reducing delayed transfers of care, with health partners, and setting out the intended impact on the performance metrics, including DTOC.</td>
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<tr>
<td>Hospitals, primary and community care and local councils should also work together to ensure people are not stuck in hospital while waiting for delayed community health and social care. They need to:</td>
<td>Work is underway to support this improvement and the individuals who have responsibility for CHC assurance are supporting CCGs to develop improvement plans to reduce the number of assessments taking place in an acute location for individuals on the acute hospital pathway.</td>
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<tr>
<td>- Ensure that the extra £1 billion provided by the Chancellor for investment in adult social care in the March budget is used in part to reduce delayed transfers of care, thereby helping to free up 2000-3000 acute hospital beds – the equivalent of opening 5 new hospitals – and regularly publish the progress being made in this regard.</td>
<td>The Better Care Fund Policy Framework, supported by the improved Better Care Fund grant, includes a national condition for areas to work together to implement the High Impact Change Model for managing transfers of care. In addition to this, NHS England, NHS Improvement, the Local Government Association and the Association of Directors of Adult Social Services are working together to deliver support offers for areas in order to enable delivery of the 8 high impact changes.</td>
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<td>- Ensure that 85% of all assessments for continuing health care funding take place out of hospital in the community setting, by March 2018.</td>
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<td>- Implement the High Impact Change Model for reducing DTOCs, developed by the Local Government Association, the Association of Directors of Adult Social Care Services, NHS Improvement and NHS England.</td>
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<tr>
<td>Enhance NHS 111 by increasing from 22% to 30%+ the proportion of 111 calls receiving clinical assessment by March 2017, so that only patients who genuinely need to attend A&amp;E or use the ambulance service are advised to do this. GP out of hours and 111 services will increasingly be combined. By 2019, NHS 111 will be able to book people into urgent face to face appointments where this is needed.</td>
<td>The proportion of NHS 111 calls receiving clinical assessment increased to 30% in March 2017.</td>
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<tr>
<td>NHS 111 online will start during 2017, allowing</td>
<td>Pilot trials are underway in the West Midlands.</td>
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people to enter specific symptoms and receive tailored advice on management.

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<th>Action</th>
<th>Status</th>
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<tr>
<td>Roll out evening and weekend GP appointments,</td>
<td>In March 2017 22.9% of registered patients had access to full extended access to GP care. On track to meet the 50% target by March 2018.</td>
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<td>to 50% of the public by March 2018 and 100% by March 2019.</td>
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<tr>
<td>Strengthen support to care homes to ensure they have direct access to</td>
<td>Work is progressing towards NHS 111 Care Home Line providing dedicated access for healthcare professionals (starting with care home staff) to get urgent advice from a GP out of hours.</td>
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<td>clinical advice, including appropriate on-site assessment.</td>
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<tr>
<td>Roll-out of standardised new ‘Urgent Treatment Centres’ (UTCs) which</td>
<td>Standards for UTCs have been developed in collaboration with colleagues from across the NHS. Locally work is progressing on assessing readiness.</td>
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<tr>
<td>will open 12 hours a day, seven days a week, integrated with local</td>
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<td>urgent care services. They offer patients who do not need hospital</td>
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<tr>
<td>accident and emergency care, treatment by clinicians with access to</td>
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<td>diagnostic facilities that will usually include an X-ray machine. We</td>
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<td>anticipate around 150 designated UTCs, offering appointments that are</td>
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<td>bookable through 111 as well as GP referral, will be treating patients</td>
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<td>by Spring 2018.</td>
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<td>Working closely with the Association of Ambulance Chief Executives and</td>
<td>Recommendations were taken to Ministers for approval following the general election.</td>
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<td>the College of Paramedics, implement the recommendations of the</td>
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<td>Ambulance Response Programme by October 2017, putting an end to long</td>
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<td>waits not covered by response targets. Actions taken will be subject to</td>
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<td>the results of evaluation and approval from Ministers.</td>
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89. Some progress on this was made in 2016/17 as by March 2017 30% of calls received by NHS111 went through to a clinician for advice and the dispatch on disposition changes to ambulance standards to provide greater time for assessment of a callers’ need before an ambulance is dispatched was implemented.

90. However, further progress on other areas, such as the standardisation of Urgent Treatment Centres, needs renewed focus.

**Recommendation ten** – NHS England and NHS Improvement should ensure the local NHS make rapid progress over the course of 2017/18 in implementing the wider changes to the Urgent and Emergency Care system that will improve patient care and reduce pressure on A&E departments as set out in the Next Steps on the NHS Five Year Forward View document\(^{20}\).

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7 Conclusion

91. There is significant learning from this winter that the NHS can take forward into planning for future winters.

92. There has already been action taken to meet many of the recommendations in this review including:

   a. The creation of a single programme across NHS England and NHS Improvement focused on Urgent and Emergency Care;
   b. A renewed focus on delivery of the full range of measures needed to transform Urgent and Emergency Care services as set out in the Next Steps on the NHS Five Year Forward View; and,
   c. A more coordinated approach to assurance than in previous years on Urgent and Emergency Care local plan delivery.

93. Perhaps most notably, the government has also allocated Local Authorities £2bn over the next three year years, including £1bn for 2017/18, to, amongst other things, reduce pressures on the NHS by reducing delays to discharge attributable to social care. Along with the NHS working to reduce its own delays to discharge, this will go some way to towards freeing up the necessary 2,000-3,000 acute beds ahead of winter.

94. The NHS now needs to build on this to develop a winter plan for 2017/18 that begins in the summer and develops the resilience in the system needed to manage the pressures that winter will bring.