

A Season of Major Incidents

What is really causing the A&E crisis this winter?

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Summary

In the wake of the recent A&E winter crisis, this report aims to assess the validity and overall contribution of the different factors suggested as causing the poor performance in emergency care we are currently experiencing in the UK. It also aims to address the effectiveness of funding and performance measurement mechanisms in British A&E departments. Finally, the report aims to assess claims that Labour's management of the Welsh NHS is a contributing factor to the poor performance observed in its A&E departments.

Background

This winter has seen the worst measurable performance from hospital emergency departments in a decade¹ (since 2004 when the 4 hour waiting target was first introduced).² British emergency departments can see in excess of 80,000 new patients each year creating additional demands on the system.³ Circle, the private company running Hinchingsbrooke Hospital in Cambridgeshire, has recently decided to withdraw from its contract, stating pressure on the casualty department as being one of the main reasons that the terms of its contract are no longer financially viable.⁴ Even though life expectancy has increased dramatically over the past century, healthy life expectancy has not increased as fast. A man may only expect to live to 67.3 years free of disease and a woman to 68.1; that is barely past state retirement age. As a result we have a longer-living but less healthy elderly population;⁵ thus increasing both numbers and proportions of elderly (over 65) patients presenting in A&E units.⁶

Emergency departments are the first port of call for many on arrival at hospital. A&E staff must ensure that patients are diagnosed and treated correctly and then sent to the right place for the rest of their care. A poor quality A&E department will thus have negative repercussions for an entire hospital.⁷ It is consequently essential that we address our current emergency care crisis for the good of the whole healthcare system.

Causative Factors

Ageing population

Attendances at major type 1 centres have increased by 12% since 2004⁸ and 28% of patients currently presenting to A&E are subsequently admitted to hospital.⁹ This represents around 5.1 million 'unplanned' hospital admissions each year. Currently, 42.8% of attendees are aged under 29,¹⁰ which suggests A&Es should investigate the reasons for the high levels of this age group's attendance. Nevertheless, it remains the case that elderly persons are three times more likely to be admitted to hospital from A&E than 16-65 year olds,¹¹ and also represent a rising proportion of A&E visitors: currently at 19.4% (up 0.4% in a single year).¹² Hospital beds are in short supply, often requiring patients to remain in the emergency department until beds become free, causing a subsequent backlog of patients into A&E and thus the crisis we are experiencing. It seems fair to say that increases in A&E attendees requiring hospital admission (commonly more elderly patients) could be a major contributor to this winter's crisis. As our elderly population is set to almost double by 2050 (from 10 million to 19 million)¹³ ever more hospital admissions are likely to be required from accident and emergency.

Closure of walk-in centres and an increase in non-emergency patients

After minor injury and walk-in centres were introduced in 2003/4 in order to provide 'routine and urgent primary care for minor ailments and injuries with no requirement for patients to pre-book an appointment',¹⁴ patient presentation to A&E increased by 18%. This was however, due to new, additional data being collected for these types of units.¹⁵ Some argue that walk-in centres provide improved access to primary care, for patients having difficulty in getting a timely GP appointment.

Others claim that walk-in centres create care demand for conditions that would otherwise be self-limited and relatively minor.¹⁶ A&E attendances are recorded as being either type 1: major A&E units, type 2: single speciality units or type 3: walk-in centres and minor injury units. The rise in annual A&E presentations from 16.5 million in 2004 to 21.7 million today, has mainly been the result of increased type 3 activity in these new centres.¹⁷ Annual visits to such centres have increased from four million to seven million since their introduction;¹⁸ however, in three years between 2010 and 2013, 50 of the 230 walk-in centres in England were closed, making it harder to rapidly see a GP. Many now suspect this to have been a cause

of increased major type 1 A&E unit attendance.¹⁹ However, the reason that many centres were closed was due to commissioners' concerns that they were indeed generating unwarranted demand for services.²⁰ The fact that often different commissioning bodies fund walk-in centres and A&E departments could result in demand being offloaded onto the latter when walk-in centres are closed to save money. There has indeed been confusion about which commissioning body is responsible for walk-in type services. At present NHS England commissions primary care while Clinical Commissioning Groups (CCGs) commission acute care. The fact that walk-in centres and minor injuries units lie in between these two categories has provoked debate over which should be responsible for providing their services.²¹ Interestingly, in a recent survey, 21% of patients attending walk-in centres stated that they would have visited A&E if the centres did not exist, demonstrating that these centres are, or were, stopping some of the demand upon A&E by diverting less serious patients away from a type 1 emergency department's doors.²²

Decreased primary and social care

Some argue that, in general, the NHS funding model sees money disproportionately flowing to the acute sector at the detriment of the rest of the health care system.²³ This, twinned with a lack of investment in the social care system, is causing sick people to deteriorate to the point of requiring emergency treatment before they can access any medical help.²⁴ Following the 2008 financial crisis we have seen reduced social care expenditure from central government with allocations to local authorities, who are responsible for social care, reduced by 26% since 2010. This has compelled authorities to reduce social care provision dramatically, and further reductions are planned.²⁵ With less social care older people are more likely to end up in A&E due to a health crisis.²⁶

The numbers of district nurses have also fallen in the UK from 12,000 in 2003 to 5,500 today.²⁷ These nurses perform essential healthcare tasks (such as helping patients with catheters or advising on breathing problems) as well as monitoring each patient's overall condition. Such care helps to keep patients out of A&E by addressing their needs before a crisis point is reached.²⁸ A lack of community nurses also means that it is harder to discharge patients from hospital as their needs cannot be met at home, consequentially stopping new acute admissions from A&E.²⁹

NHS researchers claim that 940,000 patients a year are now seeking care at A&E because they cannot obtain a GP appointment, as compared to 650,000 in 2011

(an increase of almost one third).³⁰ General practice currently receives just 8% of the overall NHS budget, an all-time low, and that is despite their seeing over 1.3 million patients daily.³¹ There has also been an increase of 40 million demands for GP appointments each year despite £450m less funding for the sector in the same period.³² A survey undertaken by the College of Emergency Medicine has shown that 15% of people who visit A&E could actually have been seen by a GP in the community instead of needing treatment in emergency departments had an appointment been available,³³ hence a total of 5.7 million people annually are estimated to attend A&E simply because they are unable to obtain a speedy appointment with their GP.³⁴ There are also concerns of a possible recruitment crisis in general practice with many older GP's retiring early while newly qualified doctors are tending not to wish to train in the speciality.³⁵ The fact that most A&E attendances happen in working hours, particularly during the morning, suggests that changes to the hours GPs work (for example offering more out-of-hours appointments) would not have a large impact to patient volumes.³⁶ What matters is for people to be able to obtain appointments with GPs within a short time of requesting one.

Junior staff/high turnover

Total staff numbers are important for quality, as is the composition of different members of staff.³⁷ A&E departments often struggle to fill senior positions,³⁸ with one in five A&E consultant posts currently vacant in the UK.³⁹ Emergency department consultant levels are described as 'woefully inadequate' by the College of Emergency medicine, with many doctors leaving the sector due to unsocial shift patterns and the intensive nature of the work.⁴⁰ The UK has less than half the numbers of consultants that are engaged in similar emergency care models in Australasia and North America.⁴¹ The college warns that emergency medicine consultancy training rates are also low, inhibiting the future expansion of their numbers within A&E departments.⁴² Being seen by senior medical staff in A&E who can make more accurate diagnoses could avoid admissions and shorten subsequent lengths of stay in hospital.⁴³ If patients are diagnosed early by experienced staff it might also mean that they can get appropriate tests earlier while taking fewer inappropriate tests. More rapid diagnosis would obviously benefit A&E departments by reducing waiting times while an accurate diagnosis would also benefit the ward or clinic to which the patient might then be referred. Currently, senior staff who are in short supply have to adopt a 'command and control' approach in order to manage large sections of the department instead of being able to oversee single areas such as rapid assessment or resuscitation

facilities where their expertise can be put to direct use with patients.⁴⁴ The College of Emergency Medicine states that under-resourcing is one of the key factors driving doctors away from a career in emergency medicine, thereby exacerbating the situation.⁴⁵ As an anonymous senior registrar stated in *The Guardian* newspaper:

For the same amount of training and experience, I could be a dermatologist or a kidney doctor. I'd work the same number of hours for the same pay, but much less (or no) evening and night time work, with regular, predictable, scheduled activities in my day, time for lunch, and no drunk people to deal with.⁴⁶

As a result of staff shortages, A&E departments often have to rely on locum doctors, who are being paid up to three times more than their permanent colleagues despite often being more junior and requiring a briefing on ward protocols and general support at the beginning each shift.⁴⁷

The same doctor further stated:

My junior doctors are waiting to discuss their cases with me. Because I'm the only senior doctor on duty tonight, and I've been busy in resus, the juniors haven't been able to make any real decisions about the patients they've seen. The queue, and the waiting time, is getting longer by the minute.⁴⁸

It seems obvious that staffing issues have the potential to cause a significant reduction in the speed and quality with which patients can be seen, diagnosed, treated and/or referred.

111 telephone line referrals

The NHS 111 phone line was finally fully established in all areas of the country by February 2014.⁴⁹ It has come under criticism for referring an increasing amount of people to A&E⁵⁰ (7% of callers).⁵¹ Significantly, the phone line refers twice as many patients to A&E at the weekends.⁵² This could imply that GP and other community services, if open, would have sufficed. Thus the phone line may be erring too far on the side of caution by referring patients to A&E instead of asking them to wait until Monday to seek medical attention. Sometimes, in busy periods call handlers are unable to refer people to more appropriate services and have to recommend that they attend A&E.⁵³ The fact that the number of incidents requiring an emergency ambulance rose by 3% in the first year that the phone line was in operation could be viewed as evidence that its existence is adding to pressures on A&E.⁵⁴ It should also be remembered that NHS 111 replaces NHS direct, the difference between the two services being that NHS direct was largely staffed by nurses, whereas NHS

111 is mainly staffed by call centre workers, using algorithms to refer people to the most appropriate type of care.⁵⁵ These workers, lacking medical expertise, are unable to make any sort of clinical decisions, suggesting they may be likely to err on the side of caution when deciding on where to refer patients. Dr Peter Carter, chief executive of the Royal College of Nursing, claims that dismantling the effective and highly trusted NHS direct was a 'mistake' as it meant that trained nurses were no longer answering phones, often previously advising people away from their GP if a pharmacy visit would suffice, or reassuring them that a few days wait for a GP appointment would not be detrimental to their health.⁵⁶ Nevertheless NHS England claims that ambulances dispatched by NHS 111 operators transport the same proportion of patients to hospital as ambulances dispatched by 999.⁵⁷ Results show that 20% of callers would have gone directly to A&E if NHS 111 didn't exist,⁵⁸ thus the smaller 7% of callers who are referred on to A&E by 111 suggests that operators are addressing the needs of the other 13% effectively,⁵⁹ diverting them away from seeking treatment at emergency departments.

Cultural change, the desire for immediate service

Some pressures on A&E have been attributed to a 'younger generation who want everything now'.⁶⁰ Professor Keith Williett, director of acute care for NHS England, claims that younger people are using NHS services much more frequently than the older generation stating 'it's like the younger generation aren't bothering to try and get a GP appointment'.⁶¹ He also blames the fact that we live in a 'right now' society, where people expect solutions quickly (for example with the click of a mouse as with online shopping) for the increased strain on our emergency services.⁶² We must also note, however, that young working-age people state that they are finding it hard to find GP appointments which fit into their busy weekday schedules, and thus are increasingly turning to A&E.⁶³ People aged 18-34 are more than twice as likely to go to A&E or an NHS walk-in centre when they can't conveniently see a GP compared to those over 55.⁶⁴ As people aged over 55 are often reaching an age where they might wish to work less, or in a position where they can better negotiate with employers, and with individuals older than 65 often being retired, it is of little surprise that just one out of 17 persons aged over 55 said they had been unable to see their GP when they tried to make an appointment. Compare this to one out of seven people aged 18-34⁶⁵ and we see that it is not so much a cultural change that is causing younger people to seek immediate treatment in A&E but rather an inflexibility of the health system to work around the commitments of people in full-time work. Interestingly it also seems that young

people rate their experience with GPs as being poorer in quality than do older people.⁶⁶

There is hope, however that with new regulations brought in on the 5th January 2015 allowing GP practices to register new patients living outside of residential catchment restrictions, working age people will be able to register with GP practices near their place of work, thus making it easier to see GPs within working hours.⁶⁷

Hospitals' inability to discharge patients

Patients who are medically fit but cannot be discharged pose a major problem for NHS hospitals, with half of all hospitals reporting at least 10% of their beds being taken up by these unfortunate individuals, sometimes unfairly termed 'bedblockers'.⁶⁸ In a one-year period, delayed discharges have increased by 15%.⁶⁹ Addenbrooke's hospital in Cambridge and the Royal Bolton hospital both named this issue as the primary reason for their declaration of a major incident.⁷⁰ Both had record numbers of patients whose medical care was complete, but whose discharge was delayed.⁷¹ The BBC also carried out a survey on 7th January 2015 and found that all but one of the 29 trusts that responded to its request for information had issues with medically fit patients unable to be discharged; with 1,584 beds consequently being 'blocked' in total.⁷² Patients can often end up staying for sizeable periods of time after treatment is completed. For example at Addenbrooke's hospital one patient had remained 72 days after being declared fit to leave and another for 59 days.⁷³ This is a situation we are increasingly likely to witness as we progress into a sustained period of increasing proportions of elderly people in our population suffering from chronic diseases,⁷⁴ more prevalent in older groups.⁷⁵ Worryingly, due to bed shortages patients are also sometimes being sent home in the middle of the night (between 11pm and 6am) in order to make room for new arrivals. Numbers of night-time discharges amount to over 145,000 a year and include many frail, elderly patients for whom safety is a major concern.⁷⁶

A lack of care home beds and staff to home-visit discharged patients have been cited as pivotal factors in why we are seeing the current blockage in the outflow of patients from acute hospitals.⁷⁷ Reductions in social health care spending are thus making it harder to provide required social care for some patients leaving hospital,⁷⁸ indirectly reducing the ability of the NHS to provide its services. There are also logistical problems in arranging home care. For example the reason Elizabeth, the 91-year-old who was Addenbrooke's longest staying patient, medically fit for discharge at the time of their declaration of a major incident, could

not leave the hospital was because she lived outside the city. No other patients requiring a care package lived in her village meaning a 20 minute trip each way would be required to be made four times a day by a nurse. As a consequence the four private companies that provide such care in Cambridge stated that they did not have the capacity to offer their services.⁷⁹ Social care also has issues with care homes run by independent providers being averse to taking on patients with dementia due to their high level of need, making them much less lucrative to accommodate than other residents.⁸⁰

Another sizeable issue, and one that is currently a priority in healthcare discussions is the problem of NHS healthcare and social care having largely separate budgets.⁸¹ Many governments have made small steps in the direction of attempting to merge these budgets, for example by establishing trials in local areas, however no expansion to the national level has been seen.⁸² The reason budgets are hard to merge is because the NHS is centrally funded and remains free to patients at the point of delivery, whereas social care is locally funded and means tested.⁸³ The fact that these two budgets are separate is problematic when transfers between NHS and social care have to take place, as when the discharge of a patient from hospital into care is needed.⁸⁴ Unwillingness of social care providers to take back costly long-term patients can lead to slow discharges.⁸⁵ It also means social care commissioners have no real incentives to take action to limit the numbers of patients seeking acute care, thus ultimately costing the NHS money and demanding scarce NHS resources.

In spite of the above, research by The King's Fund claims statistics do not support the suggestion that problems in social care (both in terms of residential care beds and homecare) are alone in causing the current crisis we see in A&E.⁸⁶ They claim that discharge delays attributable to the NHS (such as delays in accessing community health services) are increasing while the proportion of delays attributable to social care provision is falling.⁸⁷

Users with mental health disorders

Individuals suffering from mental health conditions are likely to be admitted to hospital as emergency cases in greater numbers than ever before this winter.⁸⁸ Despite the government having ceased to publish A&E statistics with regard to such admissions since 2012 it is estimated that the numbers of this group presenting at A&E have increased from 330,000 in 2002 to over 1 million today.⁸⁹ Indeed, senior A&E staff cite mental health as being one of the most problematic issues that they are now dealing with on a daily basis.⁹⁰ As a case in point, today, self-harming represents one of the top

five most frequent causes of attendance at A&E departments.⁹¹ As is also the case with physical illness, we are witnessing an underfunded community system leave untreated patients to reach crisis point where a visit to A&E becomes necessary to receive help. To make matters worse, the fact that 40% of self-harm patients leave A&E without any kind of mental health assessment means that they are much more likely to return on future occasions,⁹² putting further pressure on A&E departments without alleviating these patients' suffering and distress. Tragically, many patients experiencing a mental health crisis are turned away from emergency departments due to wards being full or under staffed, or because, in their distress, those experiencing such a crisis have made themselves drunk. Such patients often spend time in police cells; in effect being punished (in the sense of there being no other alternative provision), for being mentally unwell.⁹³

It seems obvious that society needs to try and reduce the amount of people presenting to A&E whilst experiencing a mental health crisis. A typical A&E department can be a noisy, stressful and frightening place for anyone to find themselves in, and especially for someone experiencing a mental health problem.⁹⁴ Moreover, those psychiatric nursing services available in A&E have been found to have little impact on either improving waiting times or on patient satisfaction and this despite each patient receiving, on average, a 60 minute assessment and an appropriate management plan.⁹⁵ Additionally, only one third of emergency department presentations judged to be due to a mental health cause are referred to these services.⁹⁶ A further complication is 'diagnostic overshadowing' where mental health patients presenting at A&E receive inadequate treatment due to their physical symptoms being incorrectly attributed to their mental condition.⁹⁷ This is both dangerous for the patient concerned and a cause of major delays in diagnosis and treatment.⁹⁸ Individuals with mental illnesses generally have poorer physical health than those without,⁹⁹ but use non-emergency health services less.¹⁰⁰ Hence the risk of a sudden physical health crisis necessitating attendance at A&E is increased for this group. Increased incidence of physical illness amongst those suffering from mental health conditions is caused by both lifestyle and treatment specific factors.¹⁰¹

It is essential that mental health patients encounter specifically trained staff on arrival at A&E, able to address their needs wherever possible in a non-clinical environment. These specialist nurses could aid other staff to distinguish physical from mental symptoms and thereby reduce diagnostic overshadowing. However, it would be better if such patients did not have to remain in A&E at all. Recently, 'Crisis teams' (named differently according to the area of the country) have been established to give immediate help, in the community, to people experiencing acute mental health problems.¹⁰²

Though mental health conditions currently make up 21.9% of the UK's disease burden they receive only 11.9% of NHS funding.¹⁰³ This clear mismatch in the allocation of resources strongly suggests that mental health services are presently underfunded. Worryingly, mental health services specifically directed at children have been cut by £50m since the coalition government was elected in 2010.¹⁰⁴

It seems essential that equal importance is given to the management and treatment of all disease categories within a community setting, and most especially that of mental health, in order to prevent the progression of illnesses to crisis point. By so doing, pressure will be reduced on A&E departments and indeed on acute care generally.

Outbreaks of disease

Outbreaks of diseases can suddenly put pressure on a local area, such as the recent outbreak of pneumonia at the Royal Stoke Hospital resulting in around 90 people urgently needing beds (the crisis in this case leading the hospital to locking the doors of its A&E department).¹⁰⁵ This is obviously a localised incident and such events cannot explain the systematic spout of major incidents declared all over the country this winter, and consequently local outbreaks of disease cannot be considered as a major cause for the NHS's 2014-15 winter crisis.

A&E Targets and Methods of Finance

Unhelpful targets?

The October-December quarter in England saw A&E waiting targets only missed by 2.4%.¹⁰⁶ It could be argued that this is not a large margin. However, walk-in centres and minor injuries units tend to perform much better than units dedicated to more serious conditions, thus bolstering the national average.¹⁰⁷ Some may also argue that before the 4 hour A&E target was introduced as much as 10% of patients could wait longer than four hours for treatment.¹⁰⁸ The waiting target has been criticised for hindering patients from being treated according to their clinical need, with staff worrying too much about missing targets in the case of less urgent patients.¹⁰⁹ For example when less serious patients are approaching their four-hour waiting limit. It may sometimes be necessary to take longer than four hours to obtain diagnosis as well as results from tests in order to make the correct decision about admitting, discharging or treating a patient; a decision that when made correctly will obviously benefit both hospital and the patient. The four-hour target was relaxed in 2010 from a goal of seeing 98% of patients within four hours to that of 95%.¹¹⁰

On the other hand some argue that the targets have improved care by ensuring an equal concern for every patient.¹¹¹ In a study of nurses' opinions the target has been deemed an overall success, having reduced waiting times and increased patient satisfaction.¹¹² Nevertheless, many nurses voiced fears about the consequences for their workload and the quality of care they were able to provide within the rigid target period.¹¹³ As a conclusion we might view a reduction in A&E departments achieving the four-hour waiting target as not necessarily always indicating reduced care quality, but perhaps as an indication that this care is taking longer to be given due to increased demand. Where hospitals have declared major incidents however, it could be assumed that demand is at a point where quality of care may be significantly compromised. It is also unpleasant and even dangerous for patients to be waiting a long time for their treatment, and thus some sort of target for being seen must remain in place.

Funding mechanisms

The College of Emergency medicine claims emergency departments are resourced to 'cope', rather than deliver, safe, high quality care.¹¹⁴ They state 'Patients have as much a right to be treated in a calm, orderly environment, by staff with the time to care, as they do in an operating theatre or intensive care unit'.¹¹⁵ Tariffing for type 1

A&E departments is calculated poorly at present, so that these departments are a financial drain on the acute trusts by which they are managed, thereby discouraging investment.¹¹⁶ The 'marginal rate rule' was introduced in 2011 to try and stem the growth in patients admitted as emergencies. This means that A&E departments have a limit to the income they can receive in relation to the number of their emergency admissions, if they exceed this limit then they only receive 30% of the normal tariff price.¹¹⁷ The intention of this measure is to encourage acute providers to team up with primary and community providers to avoid emergency admissions. Commissioners must reinvest 70% of retained funds to control demand for emergency care.¹¹⁸ Issues arise when emergency departments experience sizeable increases in emergency care demand where some CCGs have set their calculation of the demand for services unrealistically low.¹¹⁹ Monitor and NHS England stress that overall, the marginal rate payment system is producing positive results, with collaboration from community healthcare providers holding back emergency admissions. However, there are serious concerns that the marginal rate is causing some A&E departments to be 'loss-making' and needing to be cross-subsidised by other hospital departments.¹²⁰ There have also been claims that the 70% of retained funds (that are meant to be reinvested into preventing emergency care) are not being used for this purpose, or that such expenditure is not being monitored enough by CCGs.¹²¹

Tariffs do not accurately or adequately reimburse A&Es for the work they are doing, with individual hospitals often funding their emergency departments in a discretionary way; by diverting money away from other areas as needed.¹²² The type of incentives the payment system offers also does not encourage admission avoidance and some provision contracts have reimbursement limits.¹²³ The current system uses payment-by-results (PbR) administered in relation to Healthcare Resource Groups (HRGs) and thereby linked to appropriate reimbursement tariffs.¹²⁴ It is often hard to identify specific HRG's in emergency departments for example chest pain could be caused by heart, lung or muscular problems or even by a cracked rib, and the College for Emergency Medicine claims clinical practice has evolved faster in emergency medicine than has its coding system meaning the reference data used to calculate reimbursement thus is inaccurate (often based on costs from under-resourced departments thereby perpetuating under-resourcing).¹²⁵ They cite the example of the tariff for the major resuscitation of a child being only double that of X-raying a sprained shoulder and putting a sling on a patient.¹²⁶ A well-funded and well-staffed A&E could, they argue, offer procedures that would prevent patients being admitted for such conditions as

fractures and dislocations; thus saving the rest of the system from costly inpatient stays.¹²⁷ Yet such discernment needs to be recognised and rewarded through appropriate tariffing.

The Case of Wales

Why is Wales doing badly and what can be learnt?

This winter has witnessed Welsh hospitals experiencing their fair share of A&E crises; at one stage University Hospital Wales in Cardiff had 11 ambulances queuing outside its emergency department doors.¹²⁸ A senior Welsh A&E nurse, who previously worked in a war zone has claimed that the stress levels she and her staff have recently been under in their department are higher than those she experienced in Iraq.¹²⁹ Wales is performing more poorly than is England, with only 83% of patients being seen within four hours in November 2014 compared to England's 92.6%.¹³⁰ Ambulance response times are also worse in Wales with only 60% of ambulances arriving within 8 minutes of an emergency call as compared to 74.8% in England.¹³¹ It must however, be remembered that Wales is a much more rural country than England with only 4.1% of its territory being classed as urban compared to 10.6% in England.¹³² Labour ministers have been running the Welsh NHS since 1999, and thus Conservative ministers in London have been eager to blame the failings in Welsh healthcare on Labour's ideological influence.¹³³ However, public opinion in Wales views the Welsh government as actually having managed the NHS better than the government has in England. We must remember that Wales has a much lower average per capita income, the Welsh citizen having an average disposable income of just £14,623 compared to £17,066 in England.¹³⁴ Just 15-20% of health inequalities in Britain are thought to be attributable to health care interventions,¹³⁵ therefore care must be taken not to blame the poorer quality of health care the Welsh population receives on its leadership alone. As an average Welsh citizen is poorer than one in England it is likely that socioeconomic and environmental factors are causing poorer general health in its population and thus a greater strain on its healthcare system than in England.

The fact that Wales has higher mortality levels from ischaemic heart disease, cerebrovascular disease, respiratory disease and malignant neoplasm all suggest that the Welsh population does indeed suffer worse health than those in England.¹³⁶ After all, these are all diseases known to be influenced by our lifestyle and environment.¹³⁷ Diabetes, a condition with an even stronger lifestyle causal element,¹³⁸ also has a higher prevalence in Wales than in England.¹³⁹ On the whole, patients in Wales seem satisfied with their healthcare with a study finding nine out of 10 patients in Wales to be satisfied with their treatment experience compared to only six out of 10 in England.¹⁴⁰ We must remember that A&Es all around the UK seem to be experiencing crises this winter, and it seems that

demographic and population health factors may be what are making conditions particularly severe in Wales, indeed a Nuffield Trust report concluded that there is little sign that either country's health system is moving ahead consistently within the available indicators.¹⁴¹ The report further stated that 'there is no evidence linking policy differences to a matching divergence in performance'.¹⁴² It did however voice concern at the reducing set of comparable data between each country, and recommended that each country collects the same data to allow cross border comparisons and thus the impact of divergent policies to be assessed; a useful tool as health systems in the two countries may differ further with time.¹⁴³

Conclusion

Main Points

- There is little disagreement over the fact that many of the health problems in emergency departments and elsewhere in the health system that we are currently seeing (and are likely to see in the future) will and have been caused by an increasing demand for services.¹⁴⁴ This is due mainly to an ageing population.¹⁴⁵ In essence the NHS is becoming a victim of its own success at keeping people alive! The elderly who survive until later ages often suffer from one or multiple chronic ailments that require constant or periodic treatment at great expense.¹⁴⁶
- There seem to be some contributing factors that are highly likely to be causative in leading A&E departments into crises. These are a shortage of GP care, a lack of experienced staff in A&E departments, the closure of walk-in centres and an inability to safely discharge patients from hospital (due to difficulties in arranging out of hospital care for patients).
- We must strive to avoid health crises wherever possible (in both physical and mental health). A key part of improving A&E services is investment in preventative and supportive community services; as well as in the emergency departments themselves.
- It also seems likely that there are serious problems with the NHS 111 phone line, which could be referring more patients to accident and emergency than is strictly necessary. However, if more clinical staff were employed to assist operators in borderline or uncertain cases and GP access was improved at the same time, then the phone line could become much more effective and probably reduce A&E presentations.
- There are other factors, deemed by some healthcare professionals and commentators to be prominent factors behind current A&E crises and this report has shown that the debate is still very much open on some such issues. In particular it is uncertain as to whether the attitudes of younger adults seeking health care have indeed changed to become more demanding of immediate care, or if their life-styles and lack of ready GP access are actually what is causing their over-representation amongst patients in A&E. This is potentially an issue that might be resolved by improving GP access. A full-time worker in Britain currently puts in the longest hours in Europe at 43.6 per week

compared to the average of 40.6.¹⁴⁷ It seems logical that we need to provide non-emergency healthcare when people are actually able to access it, e.g. in the evenings and at weekends.

- Care must be taken when drawing conclusions about the reduction in emergency departments achieving their 95% four-hour waiting target. The target itself could be creating pressure to treat the longest waiting and not the most sick at busy times. It could also be the case that many stretched A&E departments are simply disregarding the four-hour target in order to maintain quality of treatment for serious emergency patients (the essential purpose of type 1 centres).
- Lastly it is impossible to determine if Labour's current policy influence on Welsh NHS services has caused the four-hour waiting time targets to be missed more often than in Welsh hospitals than in England. This is due to demographic differences in population health and income levels between the two countries and difficulties in comparing data.

Is the crisis at A&E a warning of things to come?

The fact that A&E targets are a noticeable and a seemingly objective form of evaluating performance is sometimes worrying. Aspects of other NHS services may be much more subjective in evaluation such as patient satisfaction on wards, the quality of community services or the time clinical staff can actually spend directly in effectively engaging with each patient. Thus major incidents being declared by A&E departments cannot simply be interpreted as being the beginning of a crisis in NHS services generally. They might be symptoms of specific problems that have reached dangerous levels of severity with so far unseen consequences.

The future?

It seems likely that to stem emergency admissions some hospitals may start offering off-site emergency care and that GPs might thereby start collaborating with hospital specialists, community services, pharmacists, etc. to initiate the formation of multi-speciality community providers.¹⁴⁸ What seems obvious is that the divisions between community, primary and acute care need to be broken down, if further winters of crisis are not to occur.

Professor Sir Bruce Keogh, the NHS's medical director has also recommended that we remove the focus of emergency care from hospital as we are trying to do with other medical specialities.¹⁴⁹ He recommends that paramedics and nurses

treat people in their own homes, sometimes taking patients further afield to more specialist emergency units which would specialise in their specific ailment.¹⁵⁰

A&E constitutes an essential part of any acute hospital, and, as well as making interventions that can directly determine life and death, can also greatly influence a patient's subsequent treatment. We rely on emergency departments to make appropriate and accurate diagnostic tests, achieve a reliable diagnosis and then to refer patients on to appropriate wards and specialists. Thus it is essential that A&E departments have well-staffed wards, both in terms of numbers and experience, and that they receive appropriate funding for the essential services they provide; services that the rest of acute care relies heavily upon.

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