



National Audit Office

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## **Report**

by the Comptroller  
and Auditor General

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**Department of Health & Social Care  
NHS England**

# Reducing emergency admissions

## Key facts

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**£13.7bn**

cost of emergency admissions 2015-16

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**5.8m**

emergency admissions in 2016-17

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**2.1%**

increase in emergency admissions between 2015-16 and 2016-17

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- 79%** of the increase in emergency admissions between 2013-14 and 2016-17 was caused by people who did not stay overnight.
- 65%** proportion of hospital emergency bed days occupied by patients aged 65 and over in 2016-17.
- 53%** of growth in emergency admissions came from people aged 65 and over between 2013-14 and 2016-17.
- 27%** increase in people being admitted and not staying overnight from 2013-14 to 2016-17.
- 32%** of local areas reporting they had reduced emergency admissions by the target they set in their Better Care Fund plans for 2016-17.

# Summary

**1** NHS England defines an emergency admission to be “when admission is unpredictable and at short notice because of clinical need”. Some emergency admissions are clinically appropriate and unavoidable. Others could be avoided by providing alternative forms of urgent care, or by providing appropriate care and support earlier to prevent a person becoming unwell enough to require an emergency admission.

**2** Increasing emergency admissions lead to increasing pressures across the health and social care systems. Prolonged overnight emergency admissions can have a significant impact on people, particularly older people who can lose mobility very quickly if they do not keep active, and their ability to perform everyday activities can reduce while in hospital. Increasing emergency admissions can limit a hospital’s capacity to undertake routine elective care. Efforts to reduce emergency admissions can create additional demand for general practice and local authorities’ social services. The cumulative impact of rising emergency admissions is an increased challenge to the financial and service sustainability of the NHS and the already under-pressure acute hospital system.

**3** The Department of Health & Social Care (the Department) sets NHS England’s mandate for arranging the provision of health services. The 2017-18 mandate includes an objective for NHS England to achieve a measurable reduction in emergency admission rates by 2020. The Department and its arm’s-length bodies have an internal ambition to reduce growth in elective and emergency admissions in 2017-18 to 1.5%. NHS England recognises that reducing emergency admissions requires action across the health and social care systems, rather than focusing on activity in accident and emergency (A&E) departments alone. NHS England is aware that there is a direct trade-off between funding going to acute hospitals and funding spent on out-of-hospital services.

## Scope of the report

**4** This report examines progress that the Department, NHS England, NHS Improvement and other stakeholders are making in reducing the impact of emergency admissions on acute hospitals. The report takes a whole-system approach, and looks at action across acute, primary, community and social care systems rather than focusing on A&E departments alone. It builds on our 2013 report on *Emergency admissions to hospital: managing the demand* and our 2016 report on *Discharging older patients from hospital*, which also examined the pressures on the whole health and social care system.

**5** Our report covers:

- trends in emergency admissions (Part One);
- NHS England's and partners' response to increasing emergency admissions (Part Two); and
- challenges in reducing emergency admissions (Part Three).

We have set out the detailed methodology in appendix Three.

## Key findings

### Trends in emergency admissions

**6 Overall emergency admissions continue to increase each year.** Emergency admissions have grown 9.3% from 2013-14, when we last reported on emergency admissions, to 2016-17. In 2016-17, there were 5.8 million emergency admissions, up by 2.1% on the previous year. In 2016-17, 24% of emergency admissions were admissions that NHS England considers could be avoidable (paragraphs 1.3, 3.9, Figures 1 and 6).

**7 A large proportion (79%) of the growth in emergency admissions from 2013-14 to 2016-17 was accounted for by people who did not stay in hospital overnight.** NHS England told us that it, along with NHS Improvement, is seeking to promote a different model of emergency care which shortens the length of time that people stay in hospital, in particular to avoid an overnight stay and an admission to a bed. There has been a 27% increase in people being admitted and not staying overnight from 2013-14 to 2016-17 and a 6.1% increase from 2015-16 to 2016-17. In overall terms, nearly half of emergency admissions in 2016-17 resulted in people staying for two or more nights, and nearly one-third did not stay overnight. There is some evidence that admission thresholds have risen since 2010 and that without this change in practice the number of emergency admissions in 2015 would have been 11.9% higher than it actually was (paragraphs 1.7, 1.8, 1.10 and figure 3).

**8 The increase in emergency admissions is mostly made up of older people.**

Older people make up more than half of the growth in emergency admissions between 2013-14 and 2016-17. Some of this is down to demographic change. Between 2013-14 and 2016-17, the number of people aged 65 and over grew by 6.2%. However, over the same period, emergency admissions for people aged 65 and over grew by 12%, almost twice the rate of population growth. The demographic pressure will only increase as the numbers of people aged 65 and over is projected to increase by a further 20% between 2017 and 2027. The Department is aware that demographic changes do not fully account for increasing admissions and is doing further work to better understand the other drivers (paragraph 1.11).

**9 The number of bed days used by patients has increased.** The number of bed days used by people admitted in an emergency admission has increased from 32.41 million in 2013-14 to 33.59 million in 2016-17. This is a 3.6% increase, which is less than the 9.3% increase in emergency admissions during the same period (paragraph 1.9 and Figure 4).

**10 The cost of emergency admissions has not increased in line with the growth in numbers.** We estimate that the real-terms cost of emergency admissions has increased by 2.2% since 2013-14, from £13.4 billion to £13.7 billion in 2015-16, the latest period for which costs are available. The increase in emergency admissions over the same period is 7% and therefore suggests that the NHS has become more cost-effective in managing emergency admissions (paragraph 1.14).

How NHS England and partners have sought to reduce emergency admissions

**11 NHS England and partners have developed a number of national programmes that aim, among other objectives, to reduce the impact of emergency admissions.** These programmes include the urgent and emergency care programme, the new care models and the Better Care Fund. The programmes focus on integrating health and social care, improving access to general practices' services, improving the performance of A&E departments and improving out-of-hospital care. NHS England and NHS Improvement have approved eight areas to become accountable (now integrated) care systems from 2017-18, and a further two to become devolved health and social care systems. NHS England and NHS Improvement plan that these areas will be given more autonomy over how they spend their resources and manage their own performance (paragraphs 2.3 to 2.9).

**12 While the rate of growth in emergency admissions has slowed slightly, there is limited evidence to show that NHS England's programmes have brought about that slow-down.** There is disagreement among clinicians, other practitioners and evaluators about the effectiveness of some of the interventions within the programmes. On the Better Care Fund, data for 2017-18 are not available, and 2016-17 data show limited progress, with only 32% of local areas reporting they had met their local target to reduce emergency admissions. NHS England is currently unable to demonstrate that the interventions now in place in the urgent and emergency care programme have led to the slight slow-down in growth in emergency admissions seen in 2016-17; further work is underway by NHS England and NHS Improvement to evaluate interventions. Some new care models have had slower increases in the rate of emergency admissions than other areas in England as of June 2017. However, there is considerable variability in performance, with results ranging from a reduction in emergency admissions of 7.4% to increases of 11.4% for multi-speciality community providers (paragraphs 2.10 to 2.17 and figure 9).

**13 NHS England believes that the move to provide daycase emergency care is a significant factor in easing pressure on hospitals.** As part of the urgent and emergency care programme, hospitals are required to provide more daycase emergency care. NHS England considers the move to providing this model of care to be more appropriate for some patients and that it frees up beds. However, it is not possible to identify the numbers of people who receive daycase emergency care, as hospitals cannot record these patients as a distinct population. Some hospitals record these patients as being admitted while other hospitals record them as outpatients. Because of these inconsistencies in how hospitals record patients who receive daycase emergency care, NHS England cannot determine the extent of the impact of people receiving daycase emergency care, although it has started work to look at how these patients could be recorded (paragraph 2.12 and 3.32).

### Challenges in reducing emergency admissions

**14 Bed closures have increased the pressures posed to acute hospitals by rising emergency admissions.** NHS England statistics show that from 2010-11 to 2016-17, the average number of available general and acute beds has fallen by 6,268 beds (5.8%). Our previous work has found that bed occupancy above 85% can lead to regular bed shortages, periodic bed crises and increased numbers of hospital-acquired infections. Bed occupancy has been increasing since at least 2010-11, reaching a seasonal peak of 91.4% in the fourth quarter of 2016-17. In January 2018, NHS England and NHS Improvement's National Emergency Pressures Panel recommended trusts defer their elective activity for January, in light of pressures on emergency care. NHS England expects to publish data on the level of activity that was affected in March 2018 (paragraph 3.2 and Figure 10).

**15 There has been an increase in the number of people being readmitted in an emergency shortly after an initial inpatient stay.** Readmission rates can indicate the success of the NHS in helping people to recover effectively from illnesses or injuries. Readmissions can occur for a number of reasons and are not always preventable, but can serve as a warning indicator that local practices may not be providing the required quality of acute care and discharge planning, particularly when readmissions are increasing. NHS Digital no longer reports readmissions. Using data from 72 Trusts, Healthwatch England has estimated emergency readmissions to have risen by 22.8% between 2012-13 and 2016-17. While there are some issues about the reliability and consistency of the data collected by Healthwatch England, the reported rate of growth raises questions about the appropriateness of some decisions to discharge and/or the support provided to help people recuperate. Over the same period we calculate overall emergency admissions to hospital rose by 10.2% (paragraphs 3.3 and 3.4).

**16 Capacity in the community to prevent emergency admissions does not currently meet demand.** In October 2017, the Department noted that there was not then a clear plan for how the £10 billion it estimated was spent on community health care could be better used to manage current and future demand and that NHS England's proposals for programmes to focus on community care had stalled. Since then, NHS England and NHS Improvement have set up a project to develop community services to support the *Five Year Forward View*. The Department and NHS England told us that they believe by integrating care and bringing services together through new models of care they can prevent unnecessary admissions. In 2012, the National Audit of Intermediate Care calculated that the capacity of intermediate care – which helps prevent people going into hospital and facilitates their move out – needed to double to meet potential demand. In 2017, the Audit noted that there was no evidence to suggest that there had been the necessary change in investment and capacity to meet demand (paragraphs 3.7 to 3.12, figures 11 and 12).

**17 The Department, NHS England and NHS Improvement do not fully understand the reasons for the considerable local variation in the rates of emergency admissions.** After controlling for demographics, deprivation, health needs, and local costs, in 2016-17, the rates of emergency admissions varied across local areas. In 2016-17, the number of emergency admissions across England varied between 73 and 155 admissions per 1,000 weighted GP registered population. The Department, NHS England and NHS Improvement do not know what causes all these local variations and therefore cannot identify the extent to which they are caused by local health and social care practices which lead to better management of emergency admissions, or other factors (paragraphs 3.23 to 3.25 and Figures 13, 14 and 15).

**18 NHS England does not yet have good enough data on emergency admissions.**

The available hospital data do not always accurately record the causes of people attending A&E, the severity of their complaint, the source of referral and their diagnosis once they have been seen. In their assessment of the current Accident and Emergency data set, NHS Digital and the Royal College of Emergency Medicine, noted that the data set only had records on where people come from for 5% of attendances, for example, a road traffic accident. This assessment estimated that only 50% of patients had a diagnosis of their medical condition recorded, and considered that the reporting of diagnosis was often poor. In response, from 5 October 2017, NHS England has required emergency departments to collect more comprehensive data (paragraphs 3.30 to 3.32).

**19 A lack of linked data across health and social care means NHS England cannot assess the impact of out of hospital care on emergency admissions.**

With no national data collection on community care yet, and an inability to link hospital activity data with primary and social care data, NHS England cannot assess the impact of out-of-hospital care on rates of emergency admissions. The lack of linked data means that researchers cannot track patients as they flow through the different systems to identify the impact of various health and social care interventions on their health. NHS Digital and NHS England intend to publish the first phase of a new community data set to better understand capacity across all community health services, and the met and unmet need in Spring 2018 (paragraphs 3.33 and 3.34).

## **Conclusion on value for money**

**20** The impact on hospitals of rising emergency admissions poses a serious challenge to both the service and financial position of the NHS. Over the last four years, the NHS has done well to reduce this impact despite admitting more people as emergency admissions, largely by reducing length of stay and growing daycase treatment. However, it cannot know if its approach is achieving enduring results until it understands whether reported increases in readmissions are a sign that some people admitted as an emergency are being discharged too soon. The NHS also still has too many avoidable admissions and too much unexplained variation. A lot of effort is being made and progress can be seen in some areas, but the challenge of managing emergency admissions is far from being under control.



## Recommendations

**21** There are complex responsibilities for reducing emergency admissions. While these recommendations below are targeted at specific organisations, we are clear that all organisations need to work together more effectively. We recommend:

- a** **The Department, NHS England and NHS Improvement should establish an evidence base for what works in reducing emergency admissions and use this to inform future national programmes.** The Department, NHS England and NHS Improvement have not yet established a robust evidence base to show what works in reducing demand for emergency admissions. Many admission reduction interventions have not been tested at scale, and the Department, NHS England and NHS Improvement are unable to show whether any success is both sustainable and attributable to those interventions.
- b** **NHS England and NHS Improvement should determine and accelerate the dissemination of the learnings from the new care models.** Some of the new care models have reduced the rate of growth in emergency admissions, but NHS England and NHS Improvement have not yet determined which elements of the new care models have brought about the reduction.
- c** **NHS England and NHS Digital should link hospital activity data with primary, community health care and social care data.** This will enable health and social care practitioners to inform or supplement their choice of care so they can make the most informed decision about whether a patient requires emergency hospital treatment. It will also enable researchers and policy-makers to understand what health and social care interventions are effective in reducing demand for emergency admissions.
- d** **The Department, NHS England and NHS Improvement should develop a data led understanding of what causes local variations and set out how and by when they will reduce those variations.** There is considerable regional variation in the rates of emergency admissions which may be due to a number of factors including better management of emergency admissions, but the Department, NHS England and NHS Improvement do not understand fully the causes of these variations.
- e** **The Department and NHS England should set out how community services will support reductions in emergency admissions.** NHS England has stalled its plans to improve the effectiveness of community services although the Department, NHS England and NHS Improvement have begun to explore options for future work.
- f** **NHS England and NHS Digital should build on the introduction of the Emergency Care Data Set to improve data on daycase emergency care and publish data on readmissions.** There are several problems with the data on emergency admissions, including a lack of reliable information on causes of admission, source of referral, severity and diagnosis and whether variation in recorded bed use has resulted from inconsistencies in the way hospitals record stays of less than one day.