A&E is often seen as a service in crisis and is the focus of much media and political interest.

But A&E is just the tip of the iceberg – the whole urgent and emergency care system is complex, and surrounded by myth and confusion. To understand what’s really going on and uncover whether there is a real crisis we need to take a look at the whole picture.

If you’ve got an urgent health problem, a range of services are available in addition to A&E. These include walk-in centres, urgent care centres and minor injuries units. GPs also provide urgent care in their surgeries.

From the headlines you might think that the numbers of people going to A&E have increased, but this is a myth. Major A&E attendances have remained broadly stable. There has though been an increase in the number of people using the various services that were developed to try and reduce demand for A&E.

Even so, people don’t always know about these services and head to A&E even though they don’t need the kind of care it was originally set up to provide.

1 in 5 people attending A&E are admitted into hospital. The rest are either referred on to other services, including their GP, or given advice, or receive some treatment with no follow up required.

Some people find it convenient to use A&E so they can be seen straight away. Others (for example homeless people) may not be registered with a GP. A lot of people who end up in A&E are anxious and can’t assess the severity of their condition.

Some people think that lack of access to GPs is causing people to go to A&E instead. This is a complicated issue – most people who attend A&E do so in working hours, so it’s not about out-of-hours care. It is hard to pin down the number of people who come to A&E because they think they will not be able to get an appointment with their GP, whether or not this is actually the case.

It’s a myth that, once people get to A&E, those with more minor conditions have to wait because the more serious cases go in front of them in the queue. This used to be true, but in most A&Es now, people with less serious conditions are assigned into a specific minors queue. They are generally dealt with quickly and sent home. Serious blue light emergency cases also get seen quickly, increasingly in specialist trauma, stroke or heart centres.
In order to understand the real crisis in A&E, we have to look at the groups of people who are waiting longest. These are usually people with complex needs and multiple illnesses, often frail older people and people who need specialist assessment or to be admitted into hospital. For people with mental health problems, A&Es can be poorly equipped, often lacking the staff expertise, access to the patient’s care plan, or even the space for people in distress.

The real challenge in A&E is the flow of patients into, around and out of the hospital. More than two thirds of all hospital beds are occupied by people admitted in an emergency. When wards are full, and staff overstretched, people who need to be admitted to hospital end up waiting in A&E.

It’s a myth that problems in A&E are just down to a lack of staff. The real issue is not just the total number of staff, but having the right combination of staff, particularly senior medical posts. Hospitals are struggling to recruit to these posts and often end up relying on temporary, more junior staff.

Once people are admitted, they can sometimes get stuck in hospital when they’re fit to leave. This is sometimes because the social care they need can’t be put in place quickly enough – there is often a shortage of care home beds and limited home care services in some areas. But this is not all about social services - in fact two-thirds of patients waiting to go home are stuck because of delays within the hospital and between NHS services. For example patients may need tests or scans which might not be available late at night or at weekends.

If patients don’t get the NHS and social care support they need in the community, they may have an avoidable health crisis and a cycle of emergency readmissions.

But it’s not all a disaster. Waits are on average much shorter than they were 10 years ago with almost all patients being seen and discharged or admitted within 4 hours. And some specialist care such as trauma and stroke has been centralised in fewer, more specialist A&E’s.

There’s also lots of ideas about how to improve, like more 7-day working in the hospital and community, increasing mental health expertise in A&Es, using GPs and other clinical staff in A&Es, and more support for people to self-care at home.

All of this may improve the situation but in order to get the best possible care we need to think more radically about the system as a whole.

It needs to be less confusing for patients, responding to their needs and preferences and supporting them to understand their own health need.

Services should prevent people being admitted inappropriately. When a hospital admission is necessary, we need the right resources in the hospital and the community to help people to leave as soon as they are able.
All parts of the urgent and emergency care system, including A&E, Walk In Centres, GPs, pharmacies, the ambulance service, NHS 111 helpline and crisis response teams need to work as part of a single system, well understood by people when they need care and advice. People at home should be supported by community teams which include the social and voluntary sector, co-ordinated by GPs with access to hospital specialists.

All of this requires a transformation of care – one system that is easy to use and that makes best use of all the resources wherever they may be. A&E may be the presenting problem but the underlying causes go much deeper and demand a joined up response across all services.