



Reforming Emergency Care

First Steps to a New Approach

Introduction

In the NHS today, too many people have to wait too long for the care and treatment they need. That has to change.

The NHS Plan sets out an ambitious programme of investment and reform to improve patient experience of the NHS. The targets for emergency care are:

- By December 2002 ambulance response times will be improved so that, an ambulance will respond to 75% of calls to life-threatening emergencies within 8 minutes.
- By 2003 75% of heart attack patients will receive thrombolysis (clot-busting drugs) within 20 minutes of their arrival in hospital. Ambulance crews will also be trained to provide thrombolysis for appropriate patients before they arrive in hospital.
- By March 2004 all patients to see a GP within 48 hours, and other primary care professional within 24 hours.
- By 2004 no-one to wait more than 4 hours in an A&E department from arrival to admission to a bed in the hospital, transfer elsewhere or discharge. The average length of waiting should fall to 75 minutes.

Why we need a new approach

The NHS is second to none in responding to major emergencies – at Hatfield and other appalling accidents the response from front line NHS staff and across the health system is something we can take pride in. What we have to do now is bring the response to everyday events up to this first class standard so that the child who is injured does not wait hours in A&E or the older person who requires an emergency hospital bed does not wait for far too long on a trolley.

Nearly 80% of all A&E attenders spend 4 hours or less in A&E. Very long trolley waits (over 12 hours) have been reduced by 50% since 1999 and over 24 hour waits have been eliminated. 87% of patients admitted via A&E who need a bed are found one within 4 hours of a decision to admit. But a minority still wait far too long. This is not good enough.

When people use the present emergency services in the NHS, they often find:

They have to wait too long for care and treatment at each stage within the emergency care system:

- to get an appointment to see a GP or for the GP to visit them at home
- for an ambulance to take them to hospital
- to be seen by a nurse or doctor when they arrive at hospital
- to have diagnostic tests taken, or for the results of those tests

- for drugs to be dispensed or to be told they can go home
- for a bed to be found on a ward if they need to be admitted to hospital
- for an assessment to allow them to be discharged from hospital
- for a domiciliary care package, or for nursing or residential care to be available

The problems in emergency services do not exist in isolation. The whole health and social care system is sensitive to emergency pressures and pressure on the emergency system has an impact on other services and causes delays for other patients. An increase in emergency admissions to hospital may result in the cancellation of planned (elective) operations.

Equally, what happens in A&E departments is almost entirely dependent on how the whole of the local health care system is working. For example, the absence of diagnostic tests out of hours, or a shortage of available beds in the hospital can mean patients wait in A&E, often on trolleys, effectively queuing for the next bed. In many hospitals empty beds are in short supply because of delays in patients being able to leave hospital.

These problems are not the fault of the dedicated staff in these services who are working under real pressure, but due to fundamental problems with the way the emergency care service is organised – a service which is crying out for change.

We have made a start on improving emergency care. Over the past 3 years £150 million has been invested in upgrading A&E Departments. By next year, £34 million will have been invested in improving ambulance response times and the clinical care patients receive from the ambulance services so that, for the first time, every ambulance service in the country answers 75% of emergency calls within 8 minutes. In primary care, NHS Direct has teamed up with GP services to provide a seamless point of access at night and weekends for 3 million patients and this will be extended to cover 10 million by March 2002.

There is still, however, a long way to go to reform emergency care throughout the country. We need a new approach.

Problems and solutions in emergency care

Patients wait too long and have difficulty getting the right service for a number of reasons. We are determined to address each of these problems. That is what this new emergency care strategy does. These are the problems and the solutions we are proposing:

Staff capacity in A&E departments is too stretched as demand for emergency services has increased dramatically over the past ten years. The numbers of patients attending hospital A&E departments has increased by almost 2 million – over 16%.

Capacity will be increased by:

- Recruiting an additional 183 A&E consultants by 2004 – an increase of 40% – as part of the planned expansion of consultant numbers in the NHS Plan. This will allow senior presence in hospitals to cover the busiest period for patients attending with emergency care needs.
- New investment of £40 million between now and March 2003 to recruit 600 additional A&E nurses. This will provide sufficient staff to allow separation of services for patients with minor

injury or illness from those for patients with more serious conditions in all A&E departments. The minor injuries service will be nurse led.

Capacity in hospitals is not sufficient. Emergency admissions to hospital have increased by 20% and bed occupancy rates have risen to almost 90% as the NHS has sought to maximise efficiency. Research shows that bed occupancies of more than 82% for an average sized hospital leads to a high risk of long waits for admission and the cancellation of some planned operations.

Capacity will be increased by:

- New investment of £50 million to buy additional planned operations for NHS patients. We will use spare capacity that exists in NHS hospitals but will principally be looking to use spare capacity in private sector hospitals. We aim to reduce occupancy levels in general & acute NHS beds to around 82%. This will free up capacity in the NHS for emergency patients and dramatically reduce the number of planned operations that are cancelled at the last minute.

Delays in discharging patients from hospital add to the pressure on acute beds, contribute to delays in emergency or elective care, and damage the health of people who no longer need to be in hospital. Many of these patients are medically ready to leave hospital but cannot due to lack of social services, NHS, or other support in the community.

Delays will be reduced by:

- The allocation of an extra £100 million in 2001-02 to Local Authorities for investment in social care, which will result in 1,000 extra hospital beds being available by April 2002. Additional capacity will be brought on line in intermediate care, nursing and residential homes. A further £200 million will be invested in 2002-03.
- Delivering the standards in the National Service Framework for Older People through service reconfiguration and organisational change. This will improve preventative and domiciliary care, avoiding admissions to acute hospitals.

Patients with emergency needs compete with those who have routine (elective) needs. Competition for resources leads to disruption of both services.

This will be addressed by:

- Increasingly separating elective and emergency workload into different 'paths' of work, each with dedicated resources. Already £27 million has been invested in purchasing the National Heart Hospital in central London to expand cardiac facilities and to create a Diagnostic and Treatment Centre to treat at least a further 3000 patients a year, thus protecting elective cases from emergency pressures. Funding will be made available to establish at least a further three such centres next year in London and the south east where waiting list pressures are at their greatest.
- For emergency services, staff should not be expected to handle emergency care at the same time as having to do other work. Primary care and hospital staff should be able to respond to patients' emergency needs without having to wait until they are free of routine work such as morning surgeries in general practice or outpatient or operating theatre sessions in hospitals. The Primary Care Development Team of the NHS Modernisation Agency has shown how this can be done in primary care within existing resources. Additional investment will be necessary in hospital services. The NHS Plan projects over 600 extra consultants by 2004 in those medical specialties involved in treating patients with medical emergencies. This will allow time to be dedicated to this service without the interruption of elective work.

Diagnostic and other services are not available at evenings and weekends. These services usually operate for 8 hours a day, Monday to Friday except for life-threatening emergencies, whereas A&E departments operate 24 hours a day. This is a particular problem when services, especially radiology, are crucial to the rapid assessment and diagnosis of those patients who have urgent but not life-threatening conditions.

This will be addressed by:

- The provision of 24 hour, seven day a week services. However, the NHS is experiencing particular difficulties in recruiting radiologists and radiographers at present.
- Extending the work underway to address skills mix in breast screening services to other radiographic procedures.
- In the meantime, Trusts will be asked to produce detailed proposals to improve out of hours diagnostic services by extending the working day, making use of the private sector, adopting new technologies and by 'near patient' testing.

Patients are expected to wait within a single queue in many A&E departments. This is often the result of the prioritisation of their clinical needs by a process of triage. This means that those with the least serious problems often find themselves continually at the back of the queue when more seriously ill patients arrive. This is unsatisfactory for patients and hinders the work of the rest of the department as large numbers of patients wait to be seen.

Queuing will be reduced by:

- Separation of patients with minor injuries or illness from those with serious conditions. This can be in place in all hospitals during 2002. Each stream will be seen in parallel by staff dedicated to that stream. Data from the University of Warwick shows that introducing streaming for minor injuries can reduce the risk of waiting more than one hour by 30%. Streaming of patients means that substantial progress can be made towards the NHS Plan target of patients spending an average time in A&E of less than 75 minutes in every Trust.
- The 600 additional nurses funded by the additional resources which accompany this document will be used to deliver this streaming.

Demarcation of working practices. These exist between staff groups within and between organisations. Traditional working practices can result in barriers to team working, duplication of services and repeated requests for the same information from patients. They prevent modern, flexible delivery of services.

Demarcation will be tackled by:

- Adopting new ways of working. Many examples exist around the country:
- Nurse practitioners are seeing patients with more minor injuries and assessing medical emergencies.
- In Norfolk paramedics are assessing patients on behalf of GPs.
- In Essex paramedics are performing simple technical procedures in patients' homes which prevent them having to attend their GP surgery or hospital A&E department.
- In Doncaster patients requesting appointments with GPs are being assessed by nurses using NHS Direct decision support systems first, resulting in 40% of patients being able, with advice, to manage their own care: this also reduces demand on GPs time.
- In some A&E departments, GPs see patients who have primary care needs.

- In Leeds the involvement of senior clinical staff in A&E in a patient's assessment from an early stage minimises waiting and ensures appropriate care. Research shows that this can reduce the number of patients with emergency needs who are admitted to hospital by between 10 and 20%.

Through the Modernisation Agency all emergency care services will be asked to adopt this best practice. In some but not all hospitals, nurses already have the authority to discharge patients, order x-rays, supply medications including thrombolysis and order other tests. There is no reason why this should not be uniform throughout the service.

Integration of services will be promoted by:

- Specialists from medicine, surgery, critical care, anaesthetics and general practice coming together with those in accident and emergency medicine to form a hospital based emergency service. This could lead to further developments in the specialty of 'Emergency Medicine'.

Each of these initiatives has been developed to meet a particular need. Each community needs to work out the best pattern of staff use for their particular area. These issues will be pursued through Professional Associations, the Royal Colleges, the Workforce Confederations, the Changing Workforce Programme Pilot, and the NHS University. This will allow staff to work across organisations and deliver a much wider range of services.

Patients end up going to the 'wrong' service. It is often difficult for patients to identify the most appropriate part of the emergency care system for their needs. They may end up in the 'wrong' place where services struggle to meet those needs in the best way. Sometimes services are duplicated. Usually patients are repeatedly asked for the same information by different members of staff.

Access and assessment can be improved by:

- Ensuring that wherever and whenever a patient makes contact with the NHS, they receive the same consistent assessment of their problem, based on clear, authoritative, professional advice. This should identify their needs and the most appropriate response to them. Patients contacting NHS Direct receive structured assessment in this way through the Clinical Assessment System, some GP co-operatives are now integrated into this system. Evidence from Nottingham and Northumberland shows that this can reduce demand on GP services and reduce referrals to hospital.
- Staff in other services will be supported in their assessments by a decision support system, developed from the Clinical Assessment System currently used by NHS Direct and now being introduced into 46 NHS Walk in Centres.
- New investment of £18 million will be allocated between now and March 2003 to extend this system to 25 exemplar A&E sites to test this approach.

Improved assessment will result in patients attending the 'right' service for their needs.

- Those patients who can manage care themselves will be supported to do so. Data from the University of Warwick and North Tyneside General Hospital demonstrate that 20% of patients attending an A&E department can be given self care advice and safely discharged within 20 minutes of arrival. This amounts to approximately 6600 patients each day or 2.4 million patients each year.
- Patients who need GP or community services will not need to go to emergency departments to receive care. Instead they will receive their care closer to home from the full range of staff in primary care. Data from the University of Southampton shows that up to 80% of people presenting with urgent needs to primary care can be safely managed by staff other than doctors.

Duplication of data gathering will be reduced by:

- Improvements in the information technology infrastructure. By 2004, all GP night time and weekend (out of hours) services and NHS Direct will be able to pass information between them, eliminating the need for patients to repeat information and making the results of previous assessments available to the next professional to see the patient (always subject to the patient giving consent).

The whole system is fragmented. Disjointed working and lack of co-ordination results in patients waiting too long at each stage of their care.

This will be addressed by:

- Appointing Emergency Care Leads in each organisation. They will co-ordinate the systems for emergency care within their organisation.
- Each Emergency Care Lead will form part of an Emergency Care Network. This will help co-ordinate all aspects of the local emergency care system. Emergency care collaboratives will be introduced to cascade knowledge and to spread best practice throughout the service.
- New investment of £10 million by March 2003 will free up clinical time to lead the networks whilst at the same time ensuring that clinical activity is maintained. Similar approaches in the care of patients with cancer and critical care have been successful in improving the quality and delivery of that care.

Standards of care vary in different parts of the system. Patients with similar problems receive different advice from different services in different parts of the country. There is also wide variation in the time patients have to wait for care. The NHS Plan promotes the use of protocols and, although many organisations are developing these for patients who need emergency care, national standards are not yet uniformly agreed.

This will be addressed by establishing a quality framework:

- Current standards for emergency care will be reviewed and applied to the whole system.
- The Department of Health in conjunction with professional groups and the National Institute for Clinical Excellence (NICE) will recommend the introduction of care pathways for emergency care. This will ensure consistent delivery of care across all services, based on evidence of best practice and cost effectiveness regardless of how services are configured locally.
- The Commission for Health Improvement (CHI) will be asked to review emergency services as part of its programme of inspection of the health service.

Looking to the future

These changes are only a start. But they demonstrate that with more capacity, more staff and new reforms we can begin to make a difference. We expect that the introduction of this extra investment and new reforms will purchase up to 25,000 additional operations in the private sector, free up capacity in the NHS for emergency patients, help to eliminate long trolley waits and dramatically reduce – by up to 75% – the number of planned operations cancelled at the last minute.

In time, many of the initiatives outlined will be extended:

- To simplify access a number of different parts of the NHS could be brought together – for example Walk-in Centres and minor injuries units could be developed into local centres for emergency care.
- To standardise assessment and subject to successful pilots in 25 sites next year, the clinical assessment system will be introduced to hospital emergency departments and GP surgeries.
- To improve ‘streaming’, A&E departments could further separate services for patients with different needs. In particular by integrating services for patients with primary care needs with those of other local primary care services. This will be achieved in different ways depending upon local circumstances. In some areas GPs will see these patients in A&E departments. In others, where a walk-in centre or GP co-operative is on the same site as the A&E department, patients will be seen in those services.
- The development of new prioritisation systems for handling emergency requests will mean that emergency ambulance services will respond faster to immediately life-threatening calls because they will be freed from having to transport those patients who dialled 999 but who did not need emergency care.

As with other major changes, full implementation of these new ways of working will take time and will be dependent on more staff as set out in the NHS Plan and new ways of working. Implementation will be supervised by a central Emergency Care Implementation Group. Membership will be broadly based and will involve everyone in the service including the Royal Colleges, professional organisations, and patients. It will oversee the development of standards and care pathways for patients with emergency care needs and will ensure uniform adoption of best practice.

The major impact of this programme of reform and investment for patients and for staff will be the delivery of fast, responsive, and effective emergency care services:

- Ending long waits in A&E departments and for admission to hospital via emergency departments.
- Improving ambulance responses to life threatening emergencies.
- Providing a wider range of services appropriate to patients’ needs.
- Ending widespread bed blocking in the NHS.
- Minimising the number of cases where patients have their operation cancelled on the day of surgery.

The longer term vision offers the potential to transform completely the way emergency services are delivered.

This document and an expanded version containing further details of the model of care outlined in this new approach and its implementation are available electronically at www.doh.gov.uk/capacityplanning



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