

Transforming Emergency Care in England

A report by Professor Sir George Alberti



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Foreword – Professor Sir George Alberti



Accident and Emergency (A&E) is the shop window of the NHS. Experience of A&E shapes people's views of the NHS. Over the past decades A&E departments have become increasingly busy. Demand has grown and now more than 16 million people attend A&E departments, minor injury units and Walk-in Centres each year. For many years this important part of our NHS received less attention than other priorities. However, in response to increased dissatisfaction with long delays and the physical environment from both patients and staff, *The NHS Plan* adopted a radical approach.

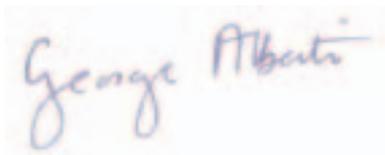
It set ambitious objectives for improvements in how A&E departments managed and delivered care. This was underpinned by the publication of *Reforming Emergency Care* – nothing less than a blueprint for the major overhaul of our emergency services. I can now report on the progress made in tackling these difficult challenges.

In the two years that I have been in post I have seen dramatic improvements in the provision of emergency care. The National Audit Office highlighted these in its recent report *Improving Emergency Care in England*. Over 96% of patients now spend less than four hours in Emergency Departments. Soon after I took up post it rapidly became clear that improvements in A&E on their own were not enough; a comprehensive modernisation of the whole system was needed. The basic principle has been to start with the patient and to follow him or her through the system. This is leading to changes in how healthcare is delivered in the community with better, more accessible local services.

The improvements to local services have been mirrored by changes within acute hospitals, which go well beyond A&E and affect whole system bed management, the development of assessment units and the rebirth of acute medicine as a specialty. Specific groups of patients, such as children, older people and those with mental ill health, are beginning to receive customised and appropriate attention.

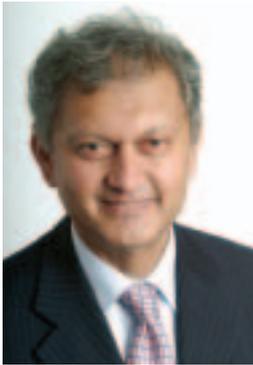
All these improvements have been made possible by major changes in the workforce. More doctors and nurses now work in emergency care and there has been a significant development in skill mix with nurses, paramedics and allied health professionals expanding their roles. Changes in the ambulance service have been made hand in hand with the changes in acute Trusts. However, despite this progress it is recognised that the workforce needs further investment.

The progress made so far is a tribute to all those working in the service. However, more needs to be done. Colleagues in primary, secondary and social care are now working closely together to provide a truly integrated emergency and urgent care service that puts the patient and their needs firmly at the centre of the future development of the service.

A handwritten signature in blue ink that reads "George Alberti". The signature is written in a cursive style.

Professor Sir George Alberti
National Director for Emergency Access

Foreword – Dr David Colin-Thomé



I am delighted to join my colleague Sir George Alberti in introducing this report on emergency care. Much progress has been made to the great benefit of patients and the public, but, as outlined by Sir George, more still needs to be done. By far the largest numbers of emergency and urgent contacts by patients occur in primary care. For too long this has been considered in isolation from both the Emergency Departments in acute hospitals and ambulance services. We are now committed to whole system working.

I look forward greatly to ensuring – in partnership with my colleagues in emergency care, the ambulance services, social services and other specialist areas – that primary care is an integral part of emergency and urgent care across the whole spectrum of need and disease. After all, what matters is that the service we provide transcends organisational and geographical boundaries and provides appropriate care for the person in need.

A handwritten signature in black ink, appearing to read 'David Colin-Thomé', written in a cursive style.

Dr David Colin-Thomé
National Clinical Director for Primary Care

Executive Summary

In the last two years there has been an unprecedented improvement in the delivery of emergency care across the country. Nineteen out of twenty patients spend less than four hours in A&E from the time they arrive to the time they are admitted, transferred or leave. Patient, carer and staff experience has been transformed as a result. This has been recognised across the NHS and by the National Audit Office in its recent report *Improving Emergency Care in England*. Martin Shalley, President of the British Association of Emergency Medicine, states:

'The increasing importance of emergency care to the health service has led to the setting of targets, which have focused clinicians' and managers' minds. This has led to improvements in staff morale and great improvements in the throughput of patients in emergency departments.'

This transformation is a direct result of the dedication, commitment and professionalism of all those across the whole system of emergency care. Each obstacle to progress has been systematically identified and tackled, from waiting for beds to be available to improving services for patients with mental ill health. Every part of the emergency care system has contributed, from ambulance services to Walk-in Centres. Alistair McGowan, President of the Faculty of Accident and Emergency Medicine, states,

'The lot of the patient in the Emergency Department has improved greatly as a consequence of the recent focus on access to urgent care.'

There is still further to go. In 2005 a clear strategy will be developed for delivering a comprehensive, patient-focused emergency care system that transcends the conventional boundaries of primary, secondary and social care. The success to date will provide a platform for delivering a radical new service, one that truly places the patient at the centre of the provision of care.



Photograph Courtesy of King's College Hospital NHS Trust

1 The background to Emergency Care

When the NHS was founded in 1948, Accident and Emergency (A&E) departments as we know them today did not exist. Casualty services varied depending on the size of the hospital. Some ran large departments able to deal with major accidents, while others offered services at the level of a minor injury unit. Some hospitals had ‘casualty wards’ which dealt mainly with accident and emergency cases.

In the 1960s casualty wards began developing into A&E departments. This change was prompted by a highly influential report in 1962 by the Standing Medical Advisory Committee. A&E continued to evolve when the then Department of Health and Social Security piloted the first posts in the A&E specialty in 1972.

A&E and its predecessors were sometimes described as ‘Cinderella services’, as they lacked the profile of other specialties. The commitment of the British Association for Emergency Medicine, the Faculty of Accident & Emergency Medicine, the Royal College of Nursing Emergency Care Association and the Department of Health was influential in developing the profile of the specialty and particularly the clinical roles in Emergency Medicine.



Photograph Courtesy of Airedale NHS Trust

A&E departments have now become the accepted and appropriate place for the full range of ambulance, GP-referred and self-referred emergencies. They are increasingly operating as a ‘front door’ to the hospital with particularly close links to the general medical specialty. The full range of cases that A&E departments handle explains why professionals often refer to the ‘emergency department’ and the emergency medicine specialty rather than A&E.

Emergency care as part of the wider system

Whilst the concept of a specialty of Accident and Emergency medicine was being established and developed, there remained the issue of how emergency care was integrated and co-ordinated with other parts of the healthcare system.

The problem became most acute in winter when increases in 'flu and other seasonal illnesses, combined with reduced capacity, exposed weaknesses in both primary and secondary care. The result was long delays and poor experiences for patients and frustrations for staff.

Early attempts to improve access to services

These long delays meant that the need to improve access to care in A&E gained a high profile in the mid 1990s. This resulted in the first standards being set for how long patients had to wait to be assessed and admitted. These included the requirement that every patient, regardless of clinical priority, should be assessed within five minutes of arrival. This later developed into a wider and more detailed assessment.

The problem increasingly attracted criticism from the public and the media. Staffing was also a concern with relatively junior doctors doing much of the work. A radical rethink followed about who could deal most appropriately with patients. There was a clear demand – not least from emergency care professionals themselves – for decisive action to tackle the problem. Over the last two years a sustained effort has been made to meet these challenges and as a result emergency care in England has been transformed.

2 The results

Summary

In the last two years there has been a revolution in the delivery of emergency care. The recent National Audit Office report, *Improving Emergency Care in England*, noted that ‘...there has been a significant and sustained improvement in waiting times and...in the environment for patients and staff’.

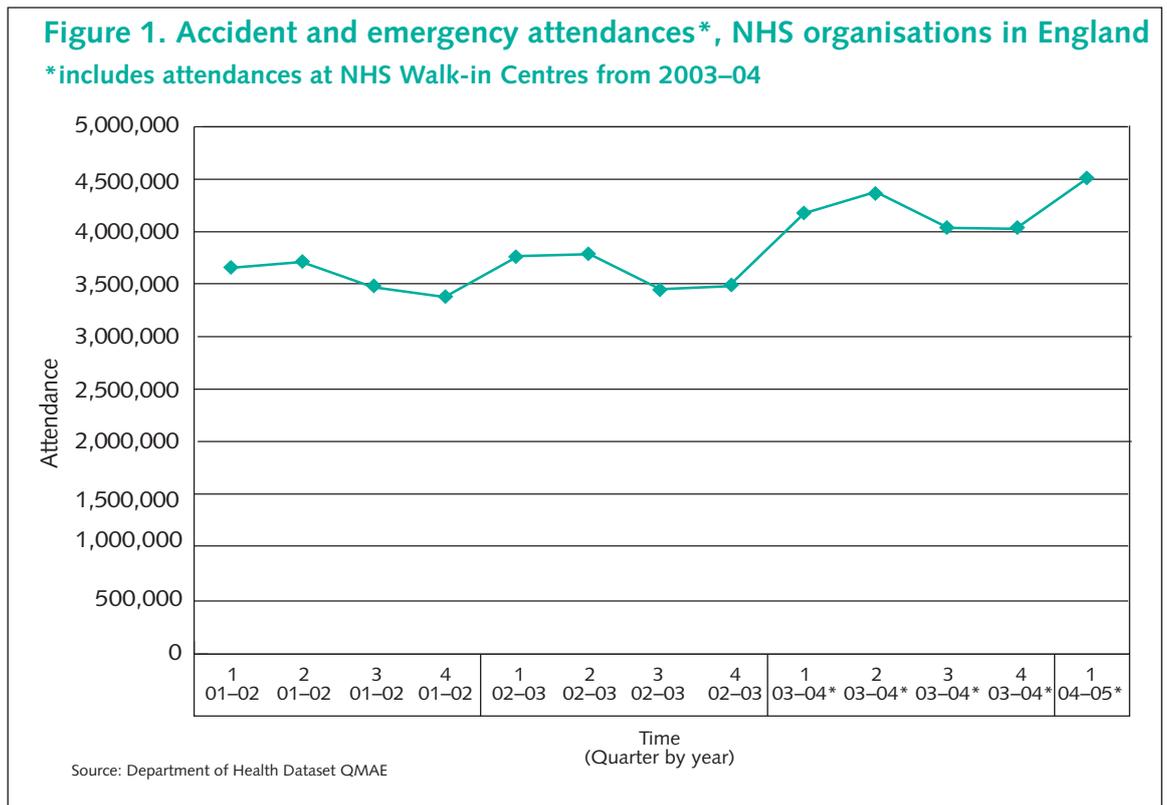
The NHS has transformed its emergency care performance so that it is now the envy of the world. Improvements have been made in the following four key areas:

- A&E performance;
- patient and carer experience;
- expanding the workforce and skill-mix; and
- ambulance performance.

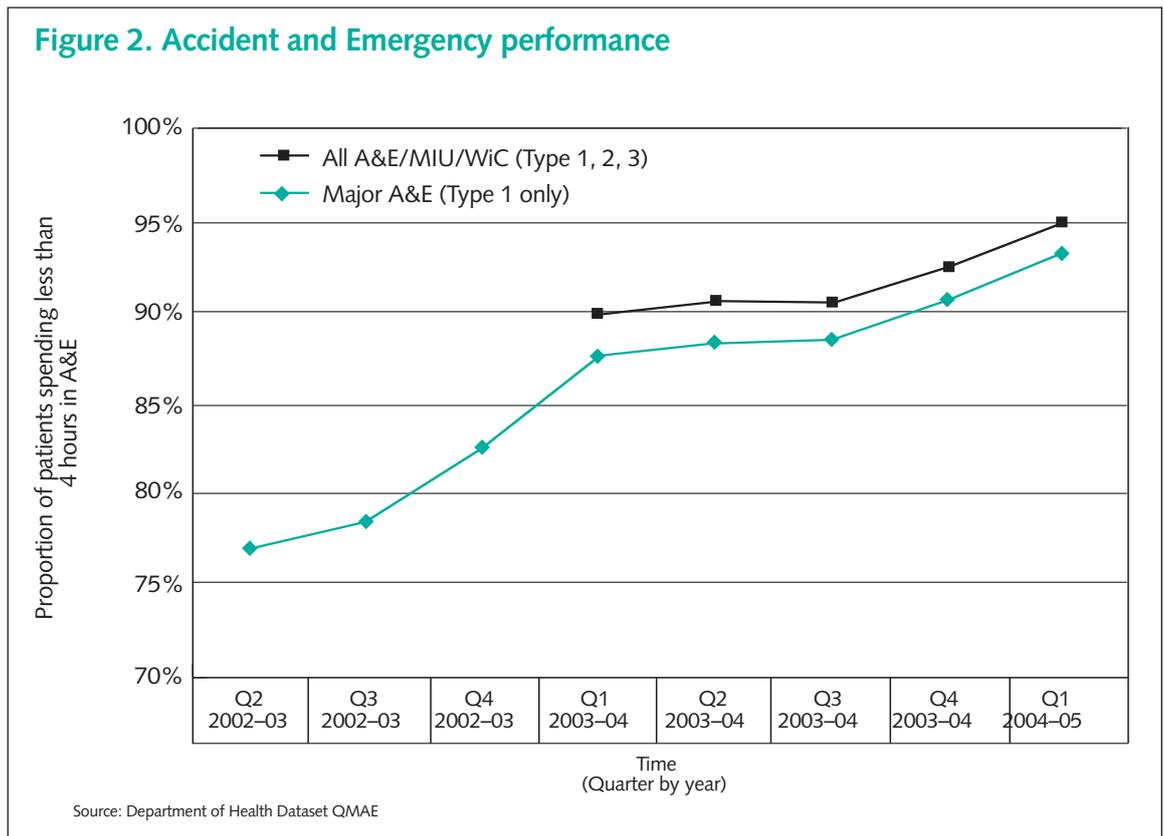
Improvements in A&E performance

The demand for emergency care services has continued to increase. In 1992 the attendance figure for new and follow-up attendances was 13 million. By 1999 this had risen to 14.6 million and to 16.5 million in 2003/04. The rise since 2002/03 has been mainly in Type 2 and 3 departments such as Walk-in Centres and Minor Injury Units. The rises are largely due to:

- increased use and availability of Minor Injury Units and Walk-in Centres;
- inclusion of Type 2 and 3 attendances in official figures and performance ratings;
- increased public satisfaction with A&E services.



Despite this there has been a really remarkable improvement in A&E performance throughout the NHS since 2002. In the second quarter of 2002/03 77% of patients spent four hours or less in A&E (measured from time of arrival to time of admission, discharge or transfer). By the first quarter of 2004/05 this had gone up to 94.7%. Since then the trend has continued to improve, and is now over 96% and still rising.



By international standards, this performance is outstanding. Long waits are an enduring problem for healthcare systems around the world. In the summer of 2004 a survey revealed that 84% of Australian patients waited over eight hours for a bed following the decision to admit them. The Canadian Association of Emergency Physicians has described their emergency department overcrowding as a ‘national epidemic’ and reports that the situation is getting worse. In 2002, for instance, 6% of Canadian patients waited over 24 hours for their admission. In the USA a study in 2002 found that 28% of their patients spent over four hours in the emergency department, and there was no sign of this improving.

Two years ago, a Commonwealth Institute report on emergency care included England as one of the countries in which waiting was a fundamental challenge – together with the United States, Canada, New Zealand and Australia. This year, at the 10th International Conference on Emergency Medicine, long waits were highlighted as a continuing issue around the world. By contrast, however, the approach of the NHS in England was hailed as an exemplary success.

As a result, there is very high international interest in the achievements of the NHS. For example, on a recent visit to study the modernisation of emergency care in England

Professor David Ben-Tovim, Director, Clinical Governance and Clinical Epidemiology at Flinders Medical Centre, Adelaide commented:

'I cannot overstate the importance of what our small group from Australia gained during our visit to you. It was a rare privilege to realise that we had seen a new paradigm for healthcare in action. It is no exaggeration to say that we left seeing the healthcare world through new eyes.'

Professor Christopher Baggoley, the Chairman of the National Institute of Clinical Studies in Australia, added:

'The timeliness of care in English emergency departments is becoming the envy of the world.'

Improvements in patient and carer experience

Healthcare Commission surveys show that there is a strong link between the length of time patients spend waiting in A&E and how they rate their experience overall. The reduction in waiting times, as judged against the four hour target, has clearly gone a long way towards improving the patient and carer experience.



Significant improvements have been made to other aspects of how patients experience emergency care. To ensure the appropriate level of leadership and co-ordination, Jonathan Asbridge was appointed in September 2003 as the first National Clinical Director for Patient Experience in Emergency Care. The Department of Health also made available £2 million to help improve information for patients, make physical environments cleaner and more pleasant, and introduce better facilities for children. However, as always, frontline staff were responsible for many improvements – for example:

- in North Cumbria matrons organised an improved, separate paediatric area, as well as TV and video, air conditioning and special chairs for elderly and disabled patients;
- in Southport and Formby – based on the results of her patient survey – the modern matron introduced pagers for patients, so they can leave the department while they wait for blood test results. This is not only better for the patients, but also helps to ease congestion in the waiting area.

In 2003 the Patient Environment Action Team (PEAT) inspections were extended to cover A&E. These contribute directly to a trust's performance ratings. The 2004 results are still being analysed, but indications are that A&E now ranks equal to, or slightly ahead of, other ward areas in the categories that patients identify as key to their experience of care.



The Healthcare Commission patient survey for the ambulance service was carried out for the first time in 2004. Overall, the results are very encouraging, 98% of patients are overwhelmingly satisfied with the service they receive. Ambulance trusts will continue to ensure they have mechanisms in place to maintain these positive results. They will also ensure that those issues highlighted as needing improvement are addressed. For example, the survey found that patients would like ambulance crews to improve their explanations of care and treatment as well as do more to help control pain.

Improvements in expanding the workforce and skill-mix

The workforce is the most valuable part of any healthcare system and emergency care is no exception. There has been a significant improvement in the number of doctors and nurses in A&E over the last five years. There are 159 more A&E consultants than in 1999, representing a 36% increase, and the pool of nurses from which A&E specialist nurses can be drawn has increased by around 66,700 since 1999.

At a local level individual organisations are making decisions about appropriate staffing levels to best meet the needs of the population. While staffing levels in A&E have increased and are increasing, more still needs to be done. Health economies will need to make further investment in the consultant workforce and Emergency Nurse Practitioners in particular to provide a high quality 24 hour, 7 days a week service.

In addition to extra numbers, more GPs are working in A&E, and nurses and allied health professionals (AHPs) are performing expanded roles ensuring that patients get more timely access to specialist care.

Improvements in ambulance performance

The ambulance service now reaches more patients more quickly than ever. The objective in *The NHS Plan* was to improve ambulance response times so that ambulance services respond within eight minutes to 75% of 999 calls involving life threatening emergencies (Category A). Latest information for 2003-04 shows that this was achieved in 75.7% of Category A calls. This compares with 74.6% in 2002-03.

This improvement is despite the rising demand for the ambulance service. The latest figures for 2003-04 show an increase on the previous year of eight per cent in the number of calls made, with a seven per cent increase in incidents attended.

Total time for patients who arrive at A&E by ambulance is counted from 15 minutes after the arrival of the ambulance. This has provided a strong incentive for ambulance services and A&E Departments to work together to speed up the transfer of patients from the care of the ambulance crew to the A&E team. Improved performance against the four hour target has enabled patients who arrive by ambulance to receive an early assessment in A&E and for the ambulances to be freed up to respond to their next call more quickly.

Peter Bradley, the National Ambulance Advisor and Chief Executive of London Ambulance Service, commented:

'We are witnessing a rapid change of role for the ambulance services. No longer are they seen as only providing critical care and transport services. Today, ambulance trusts, working closely with other unscheduled care services, provide tailored care to meet the needs of the wide range of patients they see. The current ambulance review will ensure that the ambulance service continues to be at the centre of providing high quality care to patients.'

Case study 1

Airedale NHS Trust has achieved consistently outstanding performance against the four hour target: it currently sees, treats and discharges 98% of patients within four hours.

The Trust has underpinned this performance by restructuring around patient flow. ‘Service working groups’ focusing on one patient flow, such as emergency care, have been established, replacing the traditional departmental groups.

This faster treatment has also improved patient experience of emergency care. A range of new ideas and processes has been key to this success:

- all senior nurses in Accident and Emergency are trained as Emergency Nurse Practitioners so that they can see and treat patients instead of patients having to wait to see a doctor. Airedale Trust has worked with Huddersfield University to develop an academic training programme for this Emergency Nurse Practitioner role. The course has received such academic acclaim that other NHS Trusts are adopting the training package;
- processes in the department have been improved to:
 - speed up assessment
 - prioritise patients needing immediate or urgent treatment; and
 - reduce waits for treatment or further referral;
- the trust is working with the Primary Care Trust (PCT) so that patients who attend A&E out of hours with primary care problems can be treated by primary care nursing practitioners and GPs on the same hospital site.

Steve Tomlinson, Service Manager for Urgent and Critical Care commented:

‘The key to the department’s success is the committed group of staff. There is a constant drive for improvement and all staff are involved in suggestions for improving the way the service is provided. This leads to excellent team work and team encouragement.’

Case study 2

Royal United Hospital Bath NHS Trust has seen a dramatic improvement in performance against the four hour target. In the summer of 2001 the hospital's A&E department saw, treated and discharged only around 50% of patients within four hours. In August 2004 this figure had risen to 98.5%. Together with the successes of the minor injuries units, the overall figure reached 99.4%. Performance since has been sustained at above 98%.

Key to delivering this improvement has been:

- involvement across the hospital system, including, pharmacy, diagnostics, portering, transport, nurses, doctors, therapists, practitioners and managers;
- empowerment of the site team together with senior nurses from the emergency department, medical assessment unit and surgical assessment unit to drive through changes; and
- close involvement of consultants and Senior House Officers (SHOs) with proactive management of discharge planning and improved documentation and information for patients.

Jenny Barker, Royal United Hospital deputy chief executive and director of operations commented:

‘Our success has been about whole systems and not the actions or roles of just one organisation. It has been a community-wide collaboration between health and social care which will need to continue if the trust is to sustain progress. To achieve the turnaround the four hour target was made a top priority for managers and clinicians across the whole trust and supported by strong executive leadership. Site managers and senior nurses were empowered to resolve issues preventing achievement of the target and there consultants were closely involved. These measures, together with new facilities in the emergency department and a new medical assessment unit, have really helped make the difference.’

Case study 3

Between April and June 2004, 95.3% of patients at Swindon and Marlborough NHS Trust were seen and treated, admitted or discharged within four hours of arrival at A&E. Performance has continued to improve, with current average performance sustained at over 98%. This is a tremendous improvement for the trust against a background of just over 65% of patients seen within four hours in Summer 2003.

This dramatic turnaround has been achieved by strong executive leadership, key frontline staff leading improvements and a structured approach to implementing changes. There has been commitment from the whole health and social care community. Front line clinical and managerial teams were empowered to make changes to the way the system worked with a constant focus on improving care for patients. Numerous changes were by made by staff, including:

- Implementation of a support team to manage discharges; and
- Emergency Nurse Practitioner (ENP) rotas matched to demand.

The Trust used the rigorous improvement methodology of the Emergency Services Collaborative as the approach to delivering the improvement locally. Changes were tested on a small scale first to allow clinical teams to understand the impact on patient care before a change was fully implemented.

Jill Brewer, Emergency Services Collaborative programme manager at Swindon and Marlborough, was the driving force behind this change programme. Sadly Jill died shortly before the publication of this report. Jill's work will be a lasting legacy for both the patients and staff of Swindon and Marlborough NHS Trust.

3 The strategy

How was such a radical transformation achieved? It was built upon a strategy with five key elements:

- *The NHS Plan* and the four hour target;
- *Reforming Emergency Care*;
- the Carson Report;
- the Emergency Services Collaborative; and
- whole system co-ordination/five point plan.

The NHS Plan and the four hour target

The government's first response to the challenges facing emergency care was *The NHS Plan* (2000). This set out firm, clear targets to make sure all patients could have access to high quality, prompt NHS care in or out of hours. The target set for A&E was that, by the end of 2004, all patients should be admitted, discharged or transferred within four hours of arrival. An interim milestone of 90% was set for 31st March 2003.

This target was groundbreaking and more ambitious than any international equivalent. It differed crucially from any previous measures: it covered all patients for all the time they were in A&E. It recognised that patients care about the total time they spend in A&E, not just their initial wait.

Mike Hayward, Professional Nurse Advisor for Emergency Care, Royal College of Nursing commented:

'There is absolutely no doubt that the four hour target has been the single most important catalyst for effective change within emergency care. Although at times the journey has been tough, clinicians have worked together innovatively and collaboratively to directly influence and improve the delivery of patient care and experience. Emergency care teams have risen to the challenge and demonstrated how pushing the boundaries has revolutionised the emergency patient's journey.'

New money to recruit an extra 600 A&E nurses accompanied the target. Emergency care was made a key national priority in the NHS Priorities and Planning Framework. Emergency care was now higher up the NHS agenda than ever before and a higher priority for local funding decisions.

Reforming Emergency Care

A ten year strategy, *Reforming Emergency Care* (October 2001), is driving the changes in emergency care. The strategy is based on six key principles:

- services should be designed from the patient's point of view;
- patients should receive a consistent response, wherever, whenever and however they contact the service;
- patients' needs should be met by the professional best able to deliver the service;
- information obtained at each stage of the patient's journey should be shared with other professionals who become involved in their care;
- assessment or treatment should not be delayed through the absence of diagnostic or specialist advice; and
- emergency care should be delivered to clear and measurable standards.

This has served as a blueprint for the radical overhaul of the emergency care system. The effect of *Reforming Emergency Care* was that, for the first time, emergency patients and staff were given the priority and focus that they deserved with strong support from professionals, patient groups and management.

The Carson Report

In 2001 the Department invited Dr David Carson to review GP out of hours services and make recommendations. The review team's report, published in July 2001, recommended a new model for providing out of hour services, based on:

- a prompt response for any patient needing services at night, or at the weekend, whether they need:
 - a doctor to call;
 - to visit an out of hours centre;
 - to go to A&E; or
 - to have telephone advice from a nurse;
- consistent, professional handling of calls to out of hours services;

- telephone access, through which patients can be referred to other services without making a second call;
- integrated planning of out of hours services across Primary Care Trusts; and
- further integration between GP out of hours services, NHS Direct and A&E departments.

Emergency Services Collaborative

Alongside these policy initiatives, the Department of Health allocated £30 million to the NHS Modernisation Agency to fund a national service improvement programme, the Emergency Services Collaborative, targeted at frontline clinical teams.

Every acute trust with a 24-hour, consultant-led A&E department participated in the Collaborative programme. Each trust put together multi-disciplinary and multi-professional teams. Doctors, nurses, receptionists and porters all worked together, using quality improvement techniques, to enhance the delivery of care for patients. Representatives from across the hospital and across primary and secondary care joined forces to tackle the different problems that they were facing. The Collaborative brought together the teams from across the country, and enabled local teams to learn from each other in a way that they had never done before.

Don Berwick, President and Chief Executive Officer of the Institute of Healthcare Improvement and one of the world's leading health improvement experts, said of the Emergency Services Collaborative:

'This programme is the most ambitious, accelerated and successful that I have ever seen in any field (not just health care) in the world.'

Whole system co-ordination/five point plan

Recognising that time was critical and performance had levelled off, the Department of Health identified a need to ensure that the momentum for reform continued and that key elements for delivery were brought together.

In a five point plan agreed in January 2004, the Department of Health:

- clarified the four hour target and the 98% operational standard which took into account the issue of those patients who might have to remain in A&E for clinical reasons, e.g. severely ill patients needing continued resuscitation;
- introduced an incentive scheme to encourage NHS trusts to improve performance;

- brought together the Intensive Support Team, who provide expert on-site support to challenged organisations, and the Emergency Services Collaborative to provide more co-ordinated support to NHS trusts;
- focused on improving the patient journey and developing solutions for key causes of delay;
- identified and implemented the leadership and performance mechanisms associated with a radical programme of change.

A project team, made up of key policy and modernisation teams, has worked to put the five point plan into action. This provides support to organisations facing challenges as well as working with local health communities to improve access for, and care of, patients needing emergency assessment and treatment. The five point plan will continue to operate until the four hour target is delivered.

4 The lessons – successful approaches and solutions

Summary

This strategy laid the foundations for improvement. The dedication and hard work of individual organisations and front line clinical teams making the improvements have delivered the results. The NHS's desire and commitment to provide the best possible standards of care for patients have transformed the delivery of services.

But it has not been easy, and many lessons have been learnt. The first is that improvements in emergency care must start with the challenge and not the solution. Each health and social care community faces its own set of issues, and each needs to tailor solutions to meet its own specific set of needs. The second is that improvements must not be limited to the A&E department, but made across the whole hospital and whole health and social care community. Many of the approaches taken follow principles outlined in the *NHS Modernisation Agency's 10 High Impact Changes for Service Improvement and Delivery* document, launched in August 2004.

The successful approaches and solutions are described in this section under the following headings:

- identifying local problems;
- improvements across the hospital;
- improvements across the whole system; and
- improvements for specific patient groups.

Identifying local problems

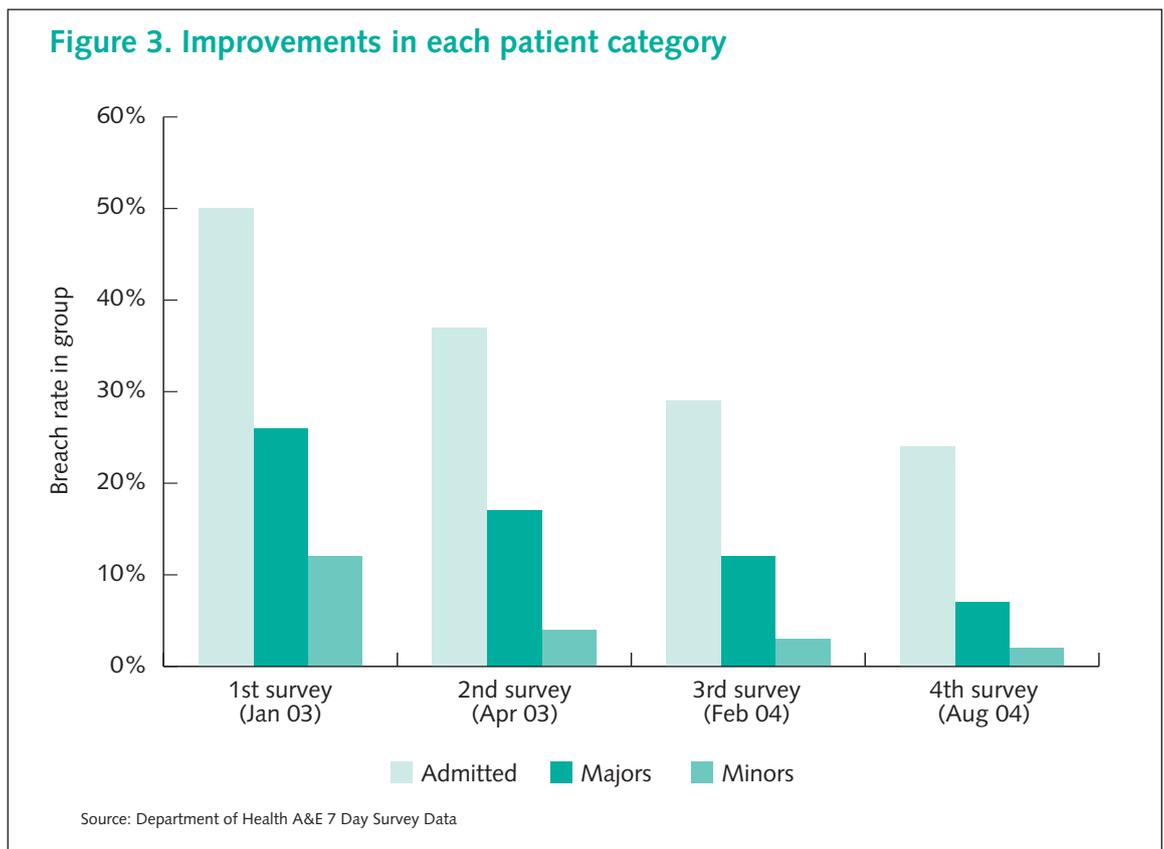
One of *Reforming Emergency Care's* central features has been supporting health communities in pinpointing the main causes of delays in A&E. In early 2004, the Department of Health made available a diagnostic tool to help health communities better understand where they needed to focus their efforts in service improvement.

The diagnostic tool allowed trusts to break down delays in A&E into seven main causes. The four most common are waiting for:

- assessment;
- a specialist;

- a bed; and
- diagnostic tests.

All Trusts in England performed this diagnostic analysis. The common themes that emerged helped the Department of Health, NHS Modernisation Agency and NHS to develop a set of common solutions to the causes of the delays. The chart below shows the reduction in breaches to the four hour target over four snapshot survey periods. The chart shows the impact that the implementation of these solutions had on patients' access to emergency care. It breaks the figures down according to whether patients had minor problems, had major problems or were admitted.



Improvements across the hospital

‘See & Treat’

‘See & Treat’ is an innovation that has transformed A&E departments in England. It is probably responsible for the largest overall reduction in waiting times.

The key principle is that a senior decision maker who can start treatment sees a patient first. Skill mix is also important, with many ‘See and Treat’ models using a variety of skilled clinicians including Emergency Nurse Practitioners (ENPs).

The aim of ‘See & Treat’ is to assess and treat patients with minor complaints as soon as they arrive. It works on the principle that the first clinician to see the patient is able to assess, treat and discharge that patient. Appropriate clinical staff are dedicated to ‘See and Treat’ and they see patients as they arrive. Delays inherent in patients queuing for triage are therefore removed. Because each patient only takes a short amount of time to treat, queues do not build up. At the same time, another team of clinicians deal with more serious cases as they arrive.

The Emergency Services Collaborative rolled out the principles of ‘See and Treat’ throughout A&E departments in England. As a result, 98% of patients with a minor injury or illness are now seen and treated within four hours. Most are treated within two hours.

Tackling delays in access to beds

The availability of beds for patients, whether in emergency or elective cases, has always been a critical issue for the NHS. Until recently the approach to bed management was based on the assumption that, as emergency care flows were unpredictable, demand would sometimes exceed capacity resulting in long waits for patients needing admission to hospital. The standard response to this was simply to try to manage any mismatches as and when they occurred.

Meeting the four hour target for emergency care required a different approach. Extra support was given to all hospitals in June 2004 to help them understand why delays in access to beds were occurring. This revealed:



- most problems were restricted to in-day problems in bed management – almost all patients needing a bed were admitted by the end of each day;
- decisions about when patients were discharged from hospitals were often driven by non-clinical factors, resulting in many patients staying longer than necessary;
- day-to-day variations in admissions were often caused by the number of elective patients being admitted rather than emergencies; and
- the number of emergency cases presenting to a hospital changed daily but could be predicted to a degree of certainty so that problems do not occur.

These discoveries provided the basis for the recommendations in the *Wait for a Bed Checklist*, which made a number of practical recommendations including:

- set a discharge date for all patients on admission;
- whenever possible discharge patients earlier in the day. This frees up beds for those who need them urgently as well as allowing patients to go home at a more convenient time;
- effective pre-operative assessment to allow patients to be admitted for elective surgery on the day of surgery (rather than the day before), thus saving a night in hospital for both the patient and the NHS; and
- ensure that patients needing quick diagnosis and treatment are admitted to a specialised short stay unit.

This approach was endorsed by the Presidents of the Royal College of Physicians and the Royal College of Surgeons and Sir George Alberti in a joint document *The Emergency Department: Medicine and Surgery Interface Problems and Solutions*.

Further help from the *Making Best Use of Beds Programme* has allowed hospitals to develop plans and the ability to manage how patients flow across the system, for example, between primary care and hospital.

Further support and advice is provided in the toolkit *Achieving timely, simple discharge from hospital*. Liz Lees, Consultant Nurse at Birmingham Heartlands and Solihull Hospital NHS Trust, commented:

'I was encouraged by the positive reception at a recent away day with twenty experienced matrons. Even though the discharge toolkit may at first appear prescriptive, it provides a sound starting point to help the trusts to use their local knowledge and experience to tailor discharge processes to suit their needs, as well as tools for measuring their own progress. One of the matrons left the away day saying 'exciting times lie ahead.'

By making these changes, NHS hospitals have succeeded in actively managing patient flows in ways that have improved the experience of thousands of patients every day.

Tackling delays in access to specialist doctors

Patients with major emergency medical or surgical conditions are normally referred to the medical or surgical team who are responsible for acute emergency admissions at that time. In the past a Senior House Officer would see such patients first, discuss them with a Specialist Registrar and a consultant would review the case. The whole process could take several hours, leaving patients waiting for significant periods of time in between different phases of their treatment, depending on the availability of busy senior clinicians.

The *Wait for a Specialist Checklist* recommended that this problem could be solved if the following principles were adopted:

- senior doctors responsible for emergency assessment should be free of other duties when scheduled to assess emergency patients;
- senior doctors should see patients first, thus ensuring prompt diagnosis and access to treatment; and
- there should be enough clinical staff to meet anticipated demand. For instance, there should be enough senior doctors available early in the evening when many hospitals have large numbers of emergency patients.

The Royal College of Physicians and Royal College of Surgeons support these principles. They recommend that any referred patient should be seen by a senior decision-maker within one hour of referral and also that, in some circumstances, A&E consultants should be able to send patients to the most appropriate ward without waiting for 'permission' from the receiving team.

Hospitals have adopted various solutions to help overcome these problems. The majority of acute trusts now have Assessment Units or Wards, typically run by Acute Physicians, to which patients can be transferred quickly. Acute Physicians are a new and growing group and the Royal College of Physicians has recommended that by 2008 there should be three in every acute trust.

Case study 4

Brighton and Sussex University Hospitals NHS Trust has quickly improved access to a specialist for patients attending A&E using the 'Wait for a specialist' checklist. The number of patients waiting more than four hours in A&E due to delays in getting a specialist opinion has gone down from 15 to 4 a day (a reduction of 73%).

The trust identified exactly which patients were waiting for a specialist opinion and the time of day and week that delays occurred. They were then able to work with the appropriate specialties to ensure that patients had prompt access to an appropriate decision maker.

The trust is continuing to refine the 'Wait for a specialist' approach, to deliver continued improvement to allow all patients to be managed within the four hours. The total number of patients being seen and treated, admitted or discharged within four hours has increased from 70% to over 96%.

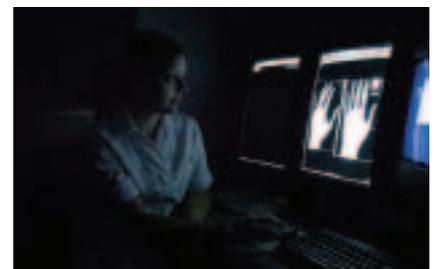
A further development has been the introduction of Clinical Decision Units (CDUs). Where patients need more than four hours for assessment or treatment to enable a decision about their care to be made, some trusts have found it useful to group patients in a CDU or similar.

Tackling delays in access to diagnostic investigations

A vast array of diagnostic investigations are required by emergency patients and these include blood tests, plain x-ray, ultrasound, CT and MRI scanning, ECG and echo cardiography and emergency endoscopy.

Waiting for these procedures is an additional burden for patients. Existing processes, which are usually designed around the efficiency of individual departments and resources, can often inadvertently cause delays for the patient whose pathway takes him or her from one department to another. By viewing all processes from the perspective of the patient, and in particular, by examining how departmental routines and practices fit together as an overall system, significant improvements have been made.

Processes have been redesigned, for example Point of Care Testing and the use of protocols to enable Allied Health Professionals (AHPs) to refer patients for diagnostic procedures at the most appropriate time in the patient pathway of care.



Staff have been developed, and expanded roles including practitioner roles in radiography, nurse requesting of x-rays and nurse interpretation of x-rays have been introduced.

The introduction of new technology, including Picture Archiving and Communication Systems (PACS), has also reduced the amount of time that patients have to wait for tests.

Case study 5

Changes within the radiology department at South Tyneside Healthcare NHS Trust have led to enhanced patient care and improved A&E performance. Traditionally a patient would arrive at A&E, see a doctor, wait to be x-rayed, wait for the doctor to see the x-ray and then, up to two weeks later, receive a final report from the consultant radiologist. This led to delays in patients receiving their care.

The skills of staff have been expanded and new working roles and processes established:

- the Emergency Nurse Practitioner can now refer a patient on to the x-ray department, rather than wait for a doctor to make the referral;
- the consultant radiographer can now also report on x-ray images and provide written opinions to allow a rapid diagnosis to be made; and
- the patient, where appropriate, can now proceed directly to x-ray, returning to A&E with either a consultant radiographer's report or radiographer opinion, allowing for immediate diagnosis and treatment, including discharge or direct admission to an orthopaedic ward.

Since these changes, patient waiting times in A&E have fallen by more than one hour to an average of one hour and fifty minutes. Quality has also improved; for example, missed fractures in A&E have decreased in two years from 7.3% to 1.7%.

Lee Whitfield, Clinical Nurse Leader, Accident and Emergency, South Tyneside Health Care NHS Trust commented:

'Developing new roles and partnerships between Accident & Emergency and Radiology has produced streamlined pathways of care, shorter waiting times and fewer misdiagnoses. This empowering and innovative partnership continues to challenge boundaries, promote change, celebrate success and embrace risks in order to drive forward sustainable developments in emergency care practice and develop our staff with flexible and responsive educational support. The incentive for us all has been the satisfaction gained by improving the emergency care experience of our patients, their carers and our own staff across the organisation.'

Improvements across the whole system

Developing Minor Injury Units and Walk-in Centres

Over the last two years Minor Injury Units (MIUs) and NHS Walk-in Centres (WiCs) have increasingly helped improve access to emergency care. They are now established and valuable parts of local health care systems.

MIUs and WiCs tend to be run by nurses. In the past MIUs focused on injuries but now also deal with minor illnesses. NHS WiCs were set up to provide convenient access for people with less serious and primary care complaints. They typically offer access from 7am until 10pm, 365 days a year. Some NHS WiCs are now providing a full 24-hour service by acting as care centres out of hours. MIUs are typically open for more limited periods.



Changing out of hours provision

Out of hours medical services used to be provided by individual general practices. There was then a trend for practices to join together forming co-operatives that covered specific geographical areas. Standards were set to make sure that patients received a guaranteed quality of service.

The opportunity offered by the new GMS contract has led to these co-operatives joining with other unscheduled care providers to provide integrated out of hours health services for local populations. For example, in Nottingham the GP co-operative is working with the local NHS WiCs to develop nurses' range of skills. These nurses now operate in an integrated clinical team in the out of hours primary care centre, offering high quality and appropriate clinical care. They both support out of hours GPs and reduce the need for them.

Improving ambulance services

The ambulance service now delivers more care to more people faster than ever before. This has been achieved by:

- improved response times;
- a more skilled workforce delivering more healthcare interventions to patients; and
- referring patients along more suitable care pathways, using, for example, the closer links forged with mental health crisis resolution teams.

Ambulance trusts' improved integration with the rest of the NHS means that they are now seen as major players in emergency care networks. They help ensure a whole system approach, as well as assisting the delivery of emergency and urgent care. A number of ambulance trusts now lead the provision of out of hours services.

Ambulance trusts have embraced new ways of working. For example, many paramedics are training to become Emergency Care Practitioners and work in the community by, for example, being based in GP surgeries. There is also the potential for ambulance staff to play an increasing role in the care of patients with long-term conditions.

The need for improved processes for dealing with calls that do not require an emergency ambulance response has been recognised. Often these are genuine calls in that some form of help or care is needed but not necessarily an emergency ambulance. Many are simply because the caller is in panic or not aware of better alternatives. The Department of Health made it clear in guidance issued in 2002 that there is no absolute requirement to send an ambulance to every 999 call and, where the conditions clearly do not warrant the attendance of an ambulance or paramedic unit, they should not be sent. Individual ambulance trusts are developing clear local protocols and policies for dealing with and recording such calls. Many ambulance trusts have run local campaigns aimed at re-directing these callers to the NHS resource that most suits their needs.

The Improvement Partnership for Ambulance Services (IPAS) was launched in September 2003. The aim of the programme is not only to help improve performance, but also to spread good practice and provide support in key areas such as leadership development. IPAS is helping break down the traditional boundaries between ambulance trusts and the wider NHS, to help ensure they can make their full contribution to the delivery of the NHS Plan.



Case study 6

The Greater Manchester Unscheduled Care Network has embraced the national Emergency Care Practitioner (ECP) initiative as one of its key work streams.

The initiative trains and develops healthcare professionals to use their clinical skills in a range of different environments, rather than within traditional boundaries.

The Network directs the Greater Manchester ECP programme while the Greater Manchester Ambulance Service acts as the managing agent. A&E departments, in-hours and out of hours primary care providers are closely associated with the project. For example, as part of their training ECPs work in each area on a three to four month basis. This approach promotes greater understanding of each service and how it fits into the wider system. It also enhances communication between partners. The ECP programme increases staff skill sets and provides simpler career transition from one part of the system to another.

The project is accessible to all registered healthcare practitioners with experience in urgent or emergency care. The first stage of the project consisted mainly of paramedics and A&E and community nurses. However, the project is now actively seeking other allied health professionals, and will develop to offer assistant and advanced ECP roles.

This initiative will deliver the following key benefits:

- a single practitioner will, in certain patient pathways, manage the patient throughout their journey. The ECP may complete the patient episode either at their home or, when the situation or facilities do not allow, transfer the patients to an Urgent Care Centre, provide treatment and then return the patient home again;
- key stakeholders are taking a joint responsibility for the development of the workforce. The whole system will be able to respond quickly to changes and pressures within an individual part by using this generic workforce in a more flexible and responsive way; and
- the ECP will help avoid unnecessary visits to A&E departments by ensuring patients receive the most appropriate care. Signposting patients to any health and social care service within the whole system will ensure they receive the right treatment, in the right place, from the most appropriate practitioner, at the right time.

Mr DP Walter, Clinical Director and Consultant in Emergency Medicine commented:

'This is a catalyst bringing the different unscheduled care providers in Primary Care, the Emergency Departments and Out of Hours together in co-operation; an effect far wider than just extra bodies on the front line.'

A strategic review of the ambulance service is underway. The review, led by Peter Bradley, the Department of Health's National Ambulance Advisor, is looking at a number of issues including:

- the ambulance service's future role;
- how best to clarify clock start/stop times to ensure transparent and consistent measurement of response times; and
- how to make longer term improvements to ambulance staff education and training.

The review has already started to deliver: local Strategic Health Authorities, Primary Care Trusts and ambulance trusts are now responsible for managing and monitoring how local services respond to non-urgent 999 category C calls. This means trusts will no longer have to send a speeding ambulance to a caller who may have a cut finger. Instead they will be able to provide a more appropriate response, tailored to the caller's needs. Whilst this could still be a double crewed ambulance it could alternatively, for example, be clinical telephone advice, or an Emergency Care Practitioner attending.

Developing staff roles

The roles of emergency care staff are being extended to make the best use of their skills, for example:

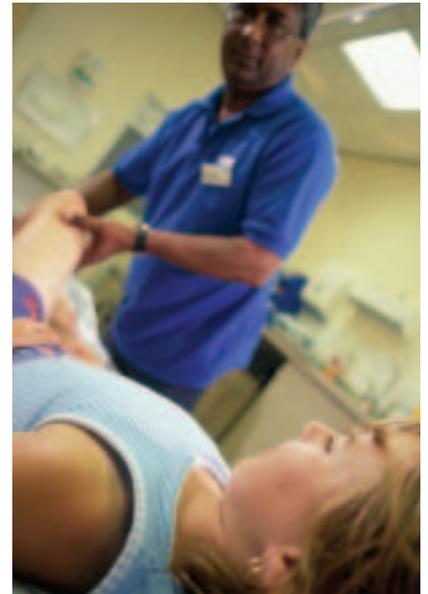
- nurses are leading chronic disease teams, running Minor Injury Units and managing assessment units;
- community pharmacists are working alongside other primary care professionals, using their skills to deliver quality urgent care services to patients; and
- ambulance staff are delivering more healthcare interventions at the scene of an incident. For example, a number of trusts have improved their coronary heart disease care through the use of twelve-lead ECG machines as well as the administration of thrombolytic drugs.

Barriers have been removed to allow this to happen. A key example has been the extension of the range of medicines included in the Nurse Prescribers Extended Formulary.



Lynda Holt, Chair of the Royal College of Nursing Emergency Care Association commented that:

‘The four hour target has made us look at how we work, and at who does what. For nurses, and many other health professionals, it has been a catalyst for role development and greater clinical freedom to use our expertise more fully. This has had a number of benefits. For patients it means quicker access to someone who can make decisions, and, in many cases, manage all their care needs. For nurses it has created some training opportunities, but more importantly has increased job satisfaction by allowing people to work to their full clinical potential. For the NHS it means we are using the expertise we have within the emergency care environment, and reducing artificial role boundaries. We need to continue to challenge our practice to ensure patients’ needs are met, but the four hour target has given us a significant kick start.’



New Emergency Care Practitioner roles are being trialled across the country where practitioners can:

- support general practices;
- support out of hours services;
- support ambulance services and emergency departments; and
- see, treat or refer patients with the minimal need to refer to other professionals.

Pilot studies have shown that Emergency Practitioners are a valuable addition to the emergency care team, and their work within multi-disciplinary teams can reduce pressure on A&E and ambulance services.

Improvements for specific patient groups

Improving services for children

The Children's National Service Framework was published in September 2004 and makes a number of recommendations for emergency care. There is a strong role that emergency care networks can play in helping to improve care for children and young people. A checklist for unscheduled care of children and young people is under development for release early in 2005.



Improving services for older people

Older people often have complex medical and social needs. 48% of older people who attend A&E are admitted to hospital, compared to 20% of all patients. The early involvement of old age specialist teams improves outcomes, reduces lengths of stay and inappropriate admissions. There is now a clear focus on multidisciplinary assessment and care

planning. This requires effective co-operation between acute, primary care and social services.

Professor Ian Philp, National Clinical Director for Older People's Services, commented:

'Older people are a key category of patients for emergency care. The four hour target has helped to identify some of their complex needs. These are being addressed so we can deliver the care they deserve. In future, people with transient ischaemic attack, strokes, falls or acute confusion, should be able to be transferred directly to the relevant specialist service in both hospital and community settings, in many cases avoiding the need to go through the emergency department.'

Improving services for patients with mental ill health

Patients with mental ill health form a small but important minority of those attending emergency care departments. The complexity of some of their problems and the response they need requires a whole systems approach to planning and delivering local services.

The Department of Health has made available a new checklist for local staff to help them improve access to care for patients with mental ill health who, too often, wait longer than four hours. The checklist was updated in September to include more examples of good practice and an analytical diagnostic tool.

The Department of Health has also included access for patients with mental ill health as one of the measures in the current incentive scheme for trusts. Mental health trusts are currently working to qualify for £200,000 incentive funding. They will achieve this by demonstrating progress in developing effective 24-hour crisis services for people with mental ill health. This will encourage mental health trusts and emergency departments to continue working together to deliver a better service to patients.

Crisis resolutions teams have been established as part of the whole system of effective 24-hour crisis care for people with mental ill health. In July 2004, there were 174 crisis resolution teams designed to respond to crises and to provide intensive home treatment instead of inpatient admission whenever possible.

Professor Louis Appleby, National Director for Mental Health at the Department of Health commented:

‘The Mental Health checklist provides the basis for mental health providers and emergency care services to work in partnership to improve processes for the benefit of the patients. Mental health is an important area of work for Emergency Care Services and we need to continue to strengthen these links.’

Improving services for patients with coronary heart disease

Coronary heart disease (CHD) emergency treatment, driven by the National Service Framework for CHD, has improved significantly in the last four years with developments such as:

- a ‘door to needle’ time target for thrombolytic treatment;
- the redesign of services for patients with heart attacks. Ambulance, hospital and primary care teams now work together to improve patients’ journeys of care;
- in many parts of the country paramedics now administer thrombolytics, resulting in faster access to treatment for patients; and
- in many hospitals heart attack patients are now fast tracked, having received thrombolysis either on their way to hospital or immediately on arrival in the Emergency Department.

5 The future for Emergency Care

In 2005 we will develop a clear strategy for delivering a comprehensive, patient centred emergency care system that transcends the conventional boundaries between primary, secondary and social care.

Summary

Tremendous progress has been made in the provision of emergency care. The NHS in England is at the forefront of transforming its delivery. Our aim is to build on recent successes to design an integrated, patient-focused approach to emergency and urgent care. We want to produce a system of emergency care that will provide the greatest benefit to patients; one where waiting is no longer an issue. This needs to be done in the face of continuing high demand, using strong partnerships working across the system.

Six principles of patient-centred care

How does the system need to change? Building on the principle from *Reforming Emergency Care* that services should be designed from the patient's point of view, the focus must be not on primary or secondary care but *patient* care. The patient must be placed in the centre. In the future, this system of patient-centred care will be based on the following six principles:

Personal, individual, high quality service

Patients will receive high quality care, wherever it is delivered, according to their needs.

No unnecessary delays

Patients will experience no unnecessary delays.

Simple access

Patients will have easy to follow and understandable journeys of care, no matter where they enter the system.

Convenience

Care will be provided where it is most convenient for patients. 24/7 care, where appropriate, will be available in hospital and community settings.

Emergency prevention

Patients will receive care as early as possible. This will help prevent their problems from becoming more serious or even happening at all.

Integrated whole system care

Patients will be able to move from one part of the system to another, without barriers, delays or having to start again.

Delivering the future

We are working with care providers and users on five strategies to help achieve the goal of patient-centred care:

Emergency Care Networks

Empowered, effective Emergency Care Networks are central to delivering the future of emergency care. They will ensure that care is developed around patient needs as never before. They will develop cross-boundary working and integrate Primary Care Trusts (PCTs), acute trusts, social services, local authorities, ambulance trusts, pharmacies, mental health trusts, patients, the public, the voluntary sector, Strategic Health Authorities, NHS Direct, out of hours providers and all those who provide emergency care. A key challenge for Emergency Care Networks will be to break down existing boundaries. New integrated staff roles will be developed to support the new integrated structure. In the longer term PCTs may commission Emergency Care Networks to deliver the full range of emergency care services.



Photograph Courtesy of Airedale NHS Trust

The development of these networks will particularly improve the provision of care for older people. Older people make up more than half of the medical admissions to acute hospitals and often need simultaneous care from a number of providers. Emergency Care Networks will rebuild the provision of care around each patient, rather than each patient having to move from one provider to the next.

Simple local access

Any future improvement to urgent and emergency care will take advantage of the National Programme for IT (NPfIT) to help simplify patients' access through the system.

Minor Injury Units and Walk-in Centres

Local blueprints for Minor Injury Units (MIUs) and Walk-in Centres (WiCs) will be developed, with appropriate staffing and equipment, to increase choice for patients. These already exist in many parts of the country and will be developed to form an important nurse-led service. Some will operate next to acute Trusts, others in separate locations, depending on local preference. They will provide quick access to clinical opinion, and to diagnostic investigation facilities, for example, plain film x-rays, PACS, ultrasound and a number of other simple laboratory tests. Where needed MIUs and WiCs will be open 24 hours a day, seven days a week. Where possible they will be in the same place as out of hours GP services. A number of Emergency Care Practitioners are being trained to work alongside nurses. Many of these have a paramedic or nursing background. They have particular skills in first contact care and can provide urgent care where it is needed, whether at the patient's home or in WiCs.

Out of hours care

The new General Medical Services (GMS) contract has helped to develop new solutions to the delivery of out of hours care. These will match the patient with the clinician most suited to their needs. Depending on the local configuration of services the co-location of primary care centres, local surgery or an NHS Walk-in Centre will help provide an integrated user-friendly services.

Emergency prevention

Emergency Care Networks will drive the provision of integrated care. This will improve support to patients, particularly those managing long-term conditions such as chronic respiratory disease, to patients with significant co-morbidities (often older patients) and to patients with mental ill health.

Pre-emptive regular care has been shown to reduce drastically the number of admissions and to improve greatly patients' quality of life. This finding comes from the use of case managers who check regularly on patients most at risk, coordinate multi-agency care and respond to urgent needs. Several pilot programmes are in place in England and are showing significant benefits. Pre-emptive care fits with the new emphasis on long term condition management as outlined in *Choice, Responsiveness and Equity in the NHS* (2003).

The vision of care for the future is ambitious and challenging. The work to achieve the emergency care targets marks a beginning not an end. It provides a strong platform for delivering a radical new service that truly places the patient at the centre of the provision of care.

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Useful resources:

For further information on emergency care policy please visit:

<http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/EmergencyCare/fs/en>

A series of emergency care checklists and toolkits and toolkits have been developed, which include:

- Emergency care networks checklist
- 4-hour checklist: reducing delays for A&E patients
- Faster access: checklist – wait for a specialist
- Faster access: checklist – wait for a bed
- Faster access: toolkit – wait for bed, further guidance
- Mental health care checklist
- Patient information toolkit
- Achieving timely ‘simple’ discharge from hospital – a toolkit for the multi-disciplinary team
- Emergency assessment unit checklist
- Implementation Guide for reducing Waits for Assessment
- Implementation Guide for wait for a specialist

These are available at:

[www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/EmergencyCare/
EmergencyCareChecklists](http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/EmergencyCare/EmergencyCareChecklists)

The Emergency Services Collaborative website gives access to guidance, case studies and other information to help trusts implement the emergency care reforms and meet the 4-hour A&E target

<http://www.modern.nhs.uk/emergency>

National Electronic Library for Health's (NELH) emergency care specialist library – contains a range of guidelines, toolkits and other resources targeted at the emergency care community

<http://www.nelh-ec.warwick.ac.uk/>

The website for the Improvement Partnership for Ambulance Services (IPAS) provides information about the objectives of IPAS, current work and resources for ambulance trusts

http://www.modern.nhs.uk/scripts/default.asp?site_id=60

Glossary of terms

A&E – Accident and Emergency

AHPs – Allied Health Professionals

BAEM – British Association for Emergency Medicine

CDU – Clinical Decision Unit

CHD – Coronary Heart Disease

DH – Department of Health

ECP – Emergency Care Practitioner

ENP – Emergency Nurse Practitioner

FAEM – Faculty of Accident & Emergency Medicine

GMS – General Medical Services

GP – General Practitioner

IPAS – Improvement Partnership for Ambulance Services

MIU – Minor Injury Unit

NAO – National Audit Office

NHS – National Health Service

PACS – Picture Archiving and Communication Systems

PCT – Primary Care Trust

PEAT – Patient Environment Action Team

RCN – Royal College of Nursing

REC – Reforming Emergency Care

Type 1 A&E department – A consultant led 24 hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients.

Type 2 A&E department – A consultant led single specialty accident and emergency service (e.g. ophthalmology, dental) with designated accommodation for the reception of patients.

Type 3 A&E department – May be doctor led or nurse led with designated accommodation for the reception of accident and emergency patients. A defining characteristic of a service qualifying as a Type 3 department is that it treats at least minor injuries and illnesses (sprains for example) and can be routinely accessed without appointment. Type 3 service includes all NHS Walk-in Centres and other open access treatment services offering at least minor injury/illness services, whether located alongside a main A&E department or at another location.

WiC – Walk-in Centre



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