Improving Emergency Care in England

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL
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Summary

1 A visit to accident and emergency (A&E) is many people's only contact with the NHS hospital sector. There were some 12.7 million visits to these major A&E services in the last year, and in around a fifth of these, patients were admitted to hospital. Emergency admissions both through A&E and direct to hospital wards in 2002-03 totalled 4 million; by comparison non-emergency admissions were 3.7 million[i]. A&E departments are only one in a variety of NHS emergency care providers which include: ambulance services; GPs; primary care trusts; out-of-hours services; NHS Direct; and open access minor injury centres[ii].

2 In 2000, the Department of Health (the Department) set a range of emergency care access targets in The *NHS Plan*.[1] Patients had identified the reduction of A&E waiting time as the improvement they would most like to see and the Department gave a high priority to ensuring that, by December 2004, no-one would spend more than four hours in A&E[iii]. The *Reforming Emergency Care* policy document[2] of 2001 set the targets in a wider context of modernisation, envisaging increased capacity, reduced fragmentation, wider access and consistency of services as well as new professional roles and ways of working.

3 We examined (Appendix 1) whether there had been progress against the key target for maximum total time spent in A&E as well as with the wider modernisation of emergency care. We found that:

- in A&E departments there has been a significant and sustained improvement in waiting times and also improvements in the environment for patients and staff. There are, however, groups of patients such as people requiring admission (often older people) who still have a higher risk of spending longer in A&E than the four-hour maximum, and the worst performing trusts are some way behind the rest (Part 1);
- these beneficial changes have come largely through improved working practices and local investment within A&E departments. Further major improvements in care and patients' experience within A&E departments will depend on further improving the way the whole hospital and other health and social care providers work to manage the flow of patients. There is also a need to ensure that staffing and infrastructure for A&E departments are adequate for modern care provision (Part 2);
- amongst other providers of emergency care, there are good examples of services becoming more patient-centred, but full integration of services has not yet been achieved. The provision of new sources of emergency care has had a positive response from patients but is mainly addressing previously un-met demand rather than taking pressure off existing services (Part 3);
- as a means of securing necessary integration of services, local emergency care networks are a promising development. Many networks are still in their infancy and lack the authority and funding to bring about co-operation across the various providers of emergency care (Part 4).

i *Includes waiting list, booked and planned cases, but excludes day cases.*

ii *Such as Walk-in Centres and Minor Injury Units, referred to by the Department as Type 3 A&E departments.*

iii *The Department has announced that from April 2005 the four-hour maximum total time in A&E will no longer be considered a national target but will be part of the framework of health and social care standards that organisations and health economies will be expected to meet, and performance will be assessed by the Healthcare Commission along with the other standards.*

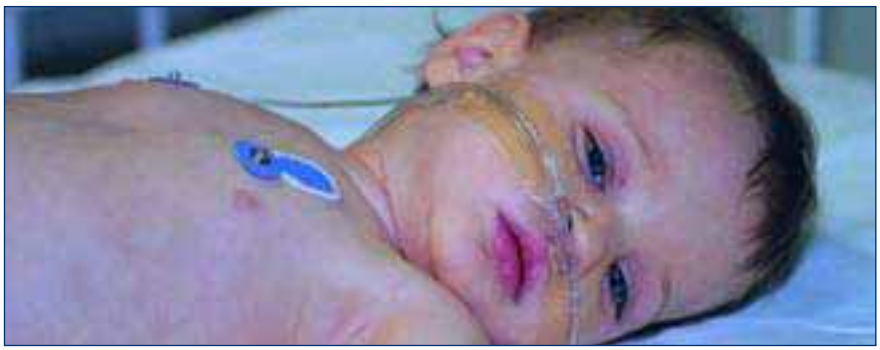
Improvements in time spent and patients' experience in A&E departments

4 Since 2002, all trusts have reduced the time patients spend in A&E, reversing a previously reported decline in performance. In 2002, 23 per cent of patients spent over four hours in A&E departments, but in the three months from April to June 2004 only 5.3 per cent stayed that long[iv]. Some trusts now treat nearly all their patients within four hours and the variation among trusts has reduced significantly. The Department's use of financial incentives, active management of performance and support for trusts has helped achieve this.

5 The four-hour target focuses on reducing long stays in A&E. However, there is a risk that undue focus on meeting the target could mean less attention being paid to the timely completion of treatment for patients who could in fact be safely managed in far less than four hours, or those who had already exceeded that threshold. We noted some risks to arrangements for accurately measuring and reporting patients total time. The Healthcare Commission is carrying out work in 2004 to assess the quality of the data on performance against the target and has yet to report.

6 The reduction in total time spent in A&E does not appear generally to have been achieved at the expense of other key objectives. For example many trusts have been able to sustain significant reductions in time spent in A&E while also reducing numbers of cancelled operations.

7 These notable achievements overall in improving time spent in A&E mask differences for specific groups of patients. Very few children and "minor" patients[v] now spend longer than four hours. But there remains some room for improvement as regards patients with more complex needs (who include many older people and some with mental health needs). For example, 23 per cent of the patients needing admission to hospital, many of them older people, still spend more than four hours in A&E.



8 There is evidence that reducing the time patients spend in A&E has led to increased patient satisfaction. The Department has also funded physical improvements to the environment in A&E to help reduce stress for both patients and staff, and this contributes to an improved perception of the quality of care.

9 Measurement of the quality of clinical care and national benchmarking has been much more limited. A full range of formal measures/care pathways, which would help staff, patients and the Department judge the quality of care provided, has yet to be put in place for A&E. Not all trusts contribute to national audit of trauma care. However, work on quality measures is now beginning to gain momentum.

iv In all types (1, 2 and 3) of A&E department.

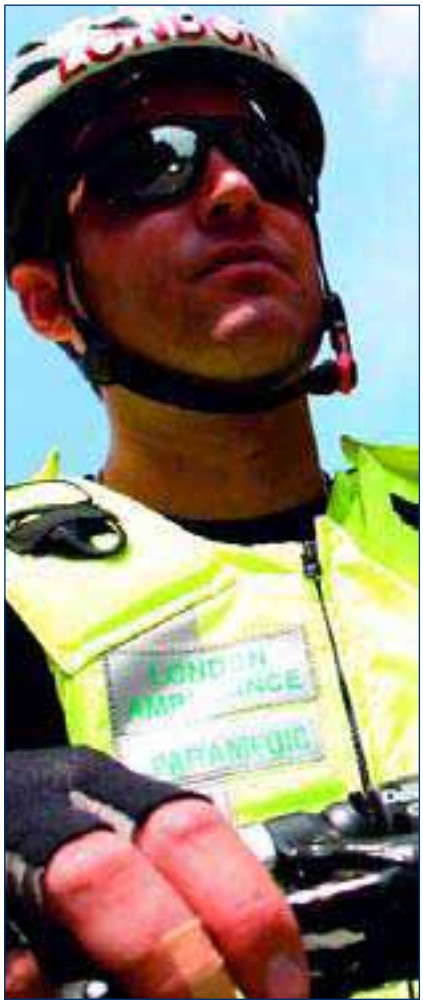
v Patients who can be treated and discharged relatively quickly, often following a simple diagnostic assessment. These patients often have a minor injury or illness.

Modernising A&E departments, and the remaining obstacles

10 The Modernisation Agency's Emergency Services Collaborative (the Collaborative) ended as planned after two years, in September 2004. The Collaborative encouraged A&E departments to work with other parts of the system to identify their own causes of delay and trial practical solutions. The improvements that have occurred cannot be attributed to any single solution, but rather have resulted from numerous changes to traditional working practices. Key improvements include: separating patients into parallel streams with dedicated staff; and improving access to diagnostic services, this despite a national shortage of radiology, radiography and pathology staff. Many changes have been relatively low in cost though there has also been central and local funding for modernisation.

11 The bottlenecks which still cause delay, in particular for patients in A&E who need to be admitted to the hospital, go beyond those working practices under the control of A&E departments and reflect constraints in the health and social care system as a whole. These include:

- avoidable peaks and troughs in the availability of beds, caused by the way non-emergency admissions and discharges are managed;
- delays in accessing a specialist opinion, caused by conflicts with specialists' elective work, and difficulties in obtaining authority to admit patients to wards;
- gaps in liaison arrangements with psychiatrists or delays in accessing psychiatric beds for patients with mental health needs (estimated numbers are variable but these patients may average 1.5 per cent of A&E department users[3]).



12 The NHS workforce is growing across the board. However, we found that obtaining sufficient suitably qualified staff remains a problem for many A&E departments and there is no accepted model for staffing them. More than half of the trusts we surveyed reported shortfalls in consultants or other medical staff and a quarter were concerned about recruiting or retaining the right mix of experienced nurses to support new working practices. The problem is complex, as modern approaches focus on using staff in a better way, rather than increasing numbers, and various studies have failed to show a direct relationship between staff numbers in A&E and delays to patients. There are, however, clear gaps in the provision of staff with the specialist skills needed to deal with children, vulnerable older patients and patients with mental health needs.

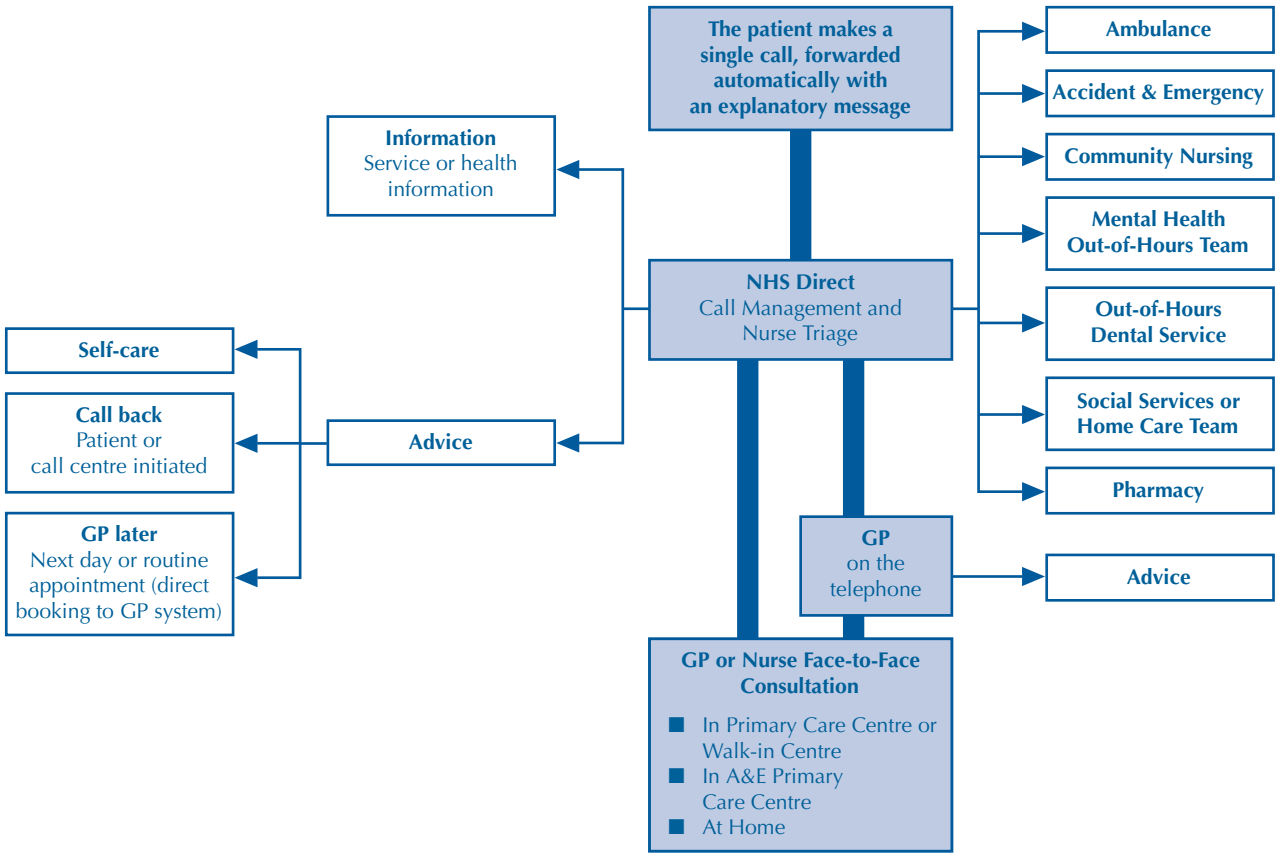
13 Buildings cannot be modified as quickly as working practices and the design of A&E buildings often reflects now outdated arrangements. Most trusts were less than satisfied overall with their buildings and facilities, particularly those built in the 1980s. Even some new buildings did not always reflect good design practice, which had a negative effect on the flow of patients through the department and the quality of care provided.

Modernisation of wider emergency care services around patients' needs

14 A&E is not the only source of emergency care, nor the most appropriate for all patients. The public continue to expect to be able to access unscheduled care via A&E and recorded attendance at major (Type 1) A&Es remains high. The Department stated in *Reforming Emergency Care*[2] that NHS staff should not consider any patient attending A&E as "inappropriate", but that its aim was to provide the most appropriate type of services at the location most convenient for patients.

15 The Department in 2001[4] envisaged all services linked through a single point of access in NHS Direct **(Figure 1)**. Some progress has been made towards this in areas where NHS Direct is integrated with local GP out-of-hours services and the department plans to extend such integration across the whole of England by December 2006. The revised arrangements for NHS Direct to provide locally-commissioned services, as well as the recent changes in responsibility for GP out-of-hours services, provide an opportunity for primary care trusts to integrate emergency care services better. The implementation of these changes also presents risks, but the Department's Out-of-hours Exemplar Programme provides a set of models of out-of-hours access to draw on.[vi]

1 The Department's vision for access to emergency care



Source: Department of Health, 2000

vi The 34 different service models in the Out-of-hours Exemplar programme cover 20 per cent of the population of England.

16 With its increasing emphasis on unscheduled care, the Department has brought in a range of new open-access minor injury and illness providers, of which the programme of 81 Walk-in Centres has the highest profile. These were introduced to complement GP and A&E services for patients with minor injury or illness. Patients' response has been generally positive and attendances continue to rise: 1.6 million people used Walk-in Centres in 2003-04. More recently, some Walk-in Centres co-located with A&E are helping to manage demand at these sites. However, the Department consider that the initiative is in many places satisfying a demand that was previously un-met, and the impact in terms of reducing attendance at A&E nationally is minimal.

17 Locally there are examples of practitioners and organisations redesigning the way they work around patients' needs. There are also examples of re-routing ambulance callers or A&E patients to a more suitable provider. Some ambulance trusts have taken the lead locally to glue the whole system together, particularly through the development of the Emergency Care Practitioner who has autonomy to treat and make decisions about patients. Ambulance trusts already have the freedom to avoid taking patients to A&E if there is a more appropriate option. By giving local health economies the freedom to set local standards for non-urgent (Category C) calls from 1 October 2004, the Department is aiming to encourage greater flexibility in the way they manage demand.

18 We noted initiatives, both locally and under National Service Frameworks[vii], to manage chronic disease in primary care and to improve mental health services for people at risk of psychiatric crisis. Locally, these have achieved reductions in attendances at A&E by specific groups of patients. More generally, the reductions in waiting times for planned hospital treatment mean that patients are being treated more quickly and may also help in some cases to reduce the need for emergency care.

Promoting joint working in emergency care through stronger emergency care networks

19 In line with its view of emergency care as a whole-system issue, the Department in 2001 advocated emergency care networks[2] (cross-organisational and multi-disciplinary groups) to take a leading role in developing local delivery - and provided some funding to pay for clinicians' time in the development of these networks. There is a clear need for improved joint working but many networks are still in their infancy. Unlike, for example, those for cancer services, emergency care networks do not usually have dedicated managers or have any direct control over funding of services, and we found they lacked a well-defined role in influencing decision-making. Few could point to truly cross-organisational successes.

vii *There are currently eight National Service Frameworks, covering Coronary Heart Disease, Cancer (The Cancer Plan), Paediatric intensive Care, Mental Health, Older People, Diabetes, Renal Services and Children. A framework for Long Term Conditions is being developed. Each framework sets out national standards and strategies to drive improvement in a defined service area or group of patients.*

Recommendations

20 The Department and the NHS have made significant and sustained improvements in A&E waiting times, though more needs to be done. Achieving the Department's vision for whole-system modernisation of emergency care will require greater integration and more effective joint working.

Achieving and sustaining further improvements in time spent and patients' experience in A&E:

1 Avoidable peaks and troughs in inpatient numbers, which are one of the main causes of delays for patients awaiting admission to a bed, can be identified using simple bed management tools. The Department provides one; there are others. All **acute trusts** should use them to reduce the significantly higher incidence of delays to A&E patients requiring admission. The *Wait for a Bed* Checklist and the NHS Modernisation Agency's *Making Best Use of Beds* programme should also be used by trusts to improve the flow of patients.

2 To help reduce any remaining delays caused by A&E access to diagnostic services, **acute trusts** should draw on approaches such as widening traditional staff roles and greater use of information technology and remote access, always ensuring that these are properly risk-assessed. This should be a key part of the NHS-wide programme of improvements to diagnostic services scheduled to be completed by 2008.

3 The four-hour total time is a measure of the maximum time any patient should require in A&E or a minor injury service. Many patients, particularly those with minor injury or illness, require much less time in A&E. **All service providers** should monitor their processes and performance and make use of local benchmarking, to ensure that no patient spends more time there than is clinically necessary.

4 To contribute to modernisation of working methods in A&E, and to improve the experience for patients, **acute trusts and primary care trusts** commissioning any emergency care new-build or refurbishment projects should incorporate the latest good design practice which has been developed by NHS Estates. They should include as matter of course consideration of patient safety aspects and effective consultation with staff and users.

5 **Primary care trusts** should use the setting of objectives and allocation of funding to require both A&Es and minor illness/injury providers to sustain and build on achievements in reducing time spent by patients, and to encourage organisations to work together.

6 There is now considerable evidence of what works well in the management and staffing of A&E departments, but trusts felt that they needed more central assistance in obtaining the right number and type of staff. **Strategic health authorities/ Workforce Development Confederations** should promulgate as soon as possible the results of trials of the A&E department workforce planning model. They should also agree plans to address the shortfalls in skilled staff through workforce planning.

Improving the integration of emergency care services around patients' needs:

7 In view of the particular needs of children, older people and patients with mental health needs in A&E, **acute trusts** should assess their services for these groups against the requirements of the National Service Frameworks in terms of facilities, specialist advice and staff training, and set in train action plans to meet any shortfalls.

8 **Emergency care networks** should analyse the care pathways of vulnerable patients, including frail older people, children and those with mental health needs who attend A&E to identify improvements to the clinical quality, safety and experience of their journey through the emergency care system. Improvements may involve design of new working arrangements between partner organisations or making better use of existing systems.

9 To contribute to the aim of patients being treated by the most appropriate professional and in the most cost-effective setting, **emergency care networks** should achieve maximum flexibility in the range of emergency care providers to which ambulance services transport or refer patients, working within clinically appropriate pathways and guidelines. They should eliminate any real or perceived barriers to achieving this.

10 Given the key role envisaged by the Department for NHS Direct in routing patients to emergency care, **emergency care networks** should involve NHS Direct fully in local emergency care planning, drawing on the lessons learned from the Out-of-hours Exemplar Programme. This will be key in achieving the plan for full integration by 2006.

11 Increasingly, emergency care practitioners are delivering emergency care in settings in and out of hospital. The range of models of this role in use, however, makes it hard for practitioners to transfer from place to place. **The Department** nationally should now draw together and publish the evidence on the contribution of these practitioners and clarify the skills and competencies of the role to provide a greater degree of consistency nationally.

12 The standard for "call-to-needle" time before administration of thrombolysis to a heart attack patient is one example of a whole-system quality measure. **The Department** should support the development by emergency medicine experts of performance indicators, care pathways and associated measures for emergency medicine. These should cover at least the main emergency care groups of patients.

13 **Health economies**, when introducing new emergency care facilities such as Walk-in Centres, should make explicit their financial and quality of service assumptions and objectives, and model the likely impact of the new service on all local healthcare organisations. The modelling should ensure value for money is being achieved by drawing on best practice and current evidence. They should set a timescale for evaluating the actual impact and validity of the assumptions.

Improving joint working in emergency care

14 Where they have not already done so, **emergency care networks** should clarify by April 2005 their role in supporting primary care trusts and strategic health authorities in relation to emergency care commissioning, accountability, governance and performance management. Neworks should agree any resource implications with all partners.

15 The objectives of emergency care networks should reflect national delivery and quality standards but focus on local priorities for the whole of the emergency care system of the health economy. **Emergency care networks** should agree measurable network objectives, which support delivery of the Local Delivery Plan, with all partner organisations at board level, and publish these for staff and patients.

16 **The Department through strategic health authorities** should maximise opportunities for the dissemination of good practices by supporting links between the individual networks both within strategic health authorities and across England.