



*Emergency Care Report*  
*2001–2002*

How the NHS and its partner agencies managed  
emergency services during winter 2001–2002

April 2002



# Contents

<b>Introduction</b>	by the NHS Chief Executive	2
<b>Chapter One</b>	Summary of performance	3
<b>Chapter Two</b>	Factors underpinning performance	6
<b>Chapter Three</b>	The “whole system”	8
<b>Chapter Four</b>	The year ahead	11
<b>Chapter Five</b>	Conclusions	13
<b>Annex 1</b>	Summaries of performance and comparisons with previous years	15
<b>Annex 2</b>	“Shifting the Balance of Power”	19

# Introduction by the NHS Chief Executive

This report describes how the NHS and its social services partners managed emergency services during 2001/02, especially the winter months. It also summarises some of the main conclusions we should draw from the experience if we are to continue making the progress of recent years.

The NHS was very busy, but again coped well thanks to better year-round capacity planning, extra investment, the dedication of staff and very good partnerships particularly with social services departments.

We recognise that these facts do not tell the whole story. Hospitals, GPs and their colleagues in social services all found themselves stretched at times as they worked to meet patients' needs and maintain the quality of services.

I'm impressed that, despite dealing with these pressures, the NHS stayed ahead of schedule in eliminating long waits in A&E. Throughout the winter about 75% of patients in A&E departments were admitted, discharged or transferred within four hours, in line with the milestone set in the NHS Plan for March 2002.

But there were times when some hospitals had real difficulty in coping. At those times the service provided to some patients was not acceptable to them, to staff, or to me. Those occasions were rare, but in future we must find ways to avoid them altogether.

That makes implementing *Reforming Emergency Care* (the Government's strategy for emergency care services, published last October) all the more important. The work is off to a good start but now it must be followed through to completion by local teams. More nurses in A&E, streaming in A&E departments to separate patients with major and minor injuries, better bed management throughout the system and better joint working can all improve patients' experience of emergency care in real and tangible ways.

Finally, I want to say "thank you" to everyone in the NHS, social services and other agencies who yet again worked so hard to deal with whatever winter threw at them. The spotlight of attention on the NHS is sometimes very harsh, but I can assure you that Ministers, my colleagues and I understand and appreciate what you achieve.

**Nigel Crisp**  
NHS Chief Executive  
10 April 2002

# Chapter One: Summary of performance

**While the NHS was very busy during the winter months, activity levels were close to what had been anticipated and planned for. Health and social services dealt with the situation well, supported by new investment and better year-round planning, and consolidated the general improvements in performance of recent years.**

## Getting services right for winter – a year-round task

- 1.1 Services this winter benefited from the general, year-round improvement to the planning and profiling of services. Trusts made a real effort to organise their elective work to make sure there was also enough capacity for emergencies. Health communities successfully invested in expanding general, acute, critical care and intermediate bed capacity so that in all cases it was higher this winter than last. For the second year the number of beds in NHS acute hospitals rose, reversing a 40 year trend.
- 1.2 This better planning has been coupled with major new investment, allowing the NHS to continue to rebuild and renew the service it provides. In 2001/02 the Government made available a total of £330 million extra to boost capacity in health and social care, including:
  - £40 million specifically to help the NHS prepare for winter;
  - £100 million to fund social care packages, reflecting the increase in NHS capacity;
  - £100 million to continue to fund social care packages put in place during winter 2000/2001;
  - £30 million to speed up and bring forward cases from waiting lists;
  - £50 million to fund more hospital cases, including better use of the independent sector to treat NHS patients; and
  - £10 million to fund more nurses in accident and emergency departments.
- 1.3 On top of that, from April this year another £200 million is available to reduce delayed discharges from hospital with £40 million more to support extra A&E nurses and enhanced management of emergency care.
- 1.4 How well hospitals provide emergency care depends partly on what happens more widely, across the “whole system” that includes primary and community care and social services. Good partnership working requires commitment throughout the year from all the agencies involved. Whole systems planning and working were stronger this year, including some good work across primary and secondary care, health and social services and human resource management.
- 1.5 ‘Flu immunisation reached 67.5% of the target population (against an objective of 65%) compared to 65% (against an objective of 60%) last year.

- 1.6 Met Office data shows that December was about one degree colder than average, but that January and February were very mild.

## Activity

- 1.7 Levels of emergency care activity remained consistently high throughout the year. Between November and February (when factors like severe weather or 'flu outbreaks can add to pressures) the NHS was busy, but not unusually so and activity kept broadly within planned-for limits. There are 179 NHS Trusts in England with A&E departments, and on average well over 30,000 people visit A&E every day. Significant problems were confined to a small minority of Trusts, each of which is receiving expert advice and intensive support to help prevent the problems recurring.
- 1.8 In December 2001 both elective and non-elective activity were slightly down on December 2000 and within the anticipated profile; in January both were slightly up on the previous year and slightly ahead of profile. Management information suggests that emergency admissions through A&E were also slightly up on last year, indicating that a higher proportion of non-elective activity is passing through A&E.
- 1.9 Despite the increases in bed numbers many Trusts reported running at nearly full capacity, making it harder for them to find beds for emergency admissions promptly and adding to the pressure on waiting times for admission through A&E.

## Performance

### Waits in A&E

- 1.10 Throughout winter the NHS remained in line with the March 2002 NHS Plan milestone of 75% of A&E attenders waiting a total of four hours or less for discharge, transfer or admission, although there were still significant variations in performance. Long waits remain a problem in a minority of Trusts.

### NHS Direct

- 1.11 The use of NHS Direct continued to grow very quickly, with nearly 40% more calls to 0845 4647 this winter than last. Once people have used NHS Direct they tend to use it again, which shows up in the high numbers of calls that it is still handling.

### Ambulances

- 1.12 Emergency ambulance calls are still increasing by about 5% a year, with peaks in winter. Despite that, ambulance Trusts are making good overall progress towards response time targets – provisional data indicates that 28 out of 32 have already reached the milestone of responding within eight minutes to 75% of calls to life-threatening conditions.

## Local government

- 1.13 Local government, in particular social services departments, played an important part in supporting emergency care. Most areas have good working relationships between the NHS and local authorities, with a shared understanding of the need to plan and monitor demand on a whole systems basis for the entire year. Links with other local government functions like housing and environmental services are getting better, as is the engagement of local authorities with primary care services so that they can help to take forward the broader agenda of preventing ill health and avoiding the need for acute care.

### **Delayed transfers of care**

- 1.14 The level of reported delayed transfers of care (where a patient is clinically ready to leave hospital but is waiting for suitable arrangements to be made for care at home or elsewhere) continued to drop. By the end of March it had reached the target reduction of 1,000, or over 20%, since September 2001.

### **Critical care and non-medical transfers**

- 1.15 Critical care services performed well and capacity has already increased to close to the NHS Plan target for 2003. In January 2002 there were over 3,000 critical care beds open, about 150 more than last winter and nearly 700 more than two years ago. Critical care transfers between hospitals for non-clinical reasons fell by nearly a half compared to last winter.

### **Paediatric intensive care**

- 1.16 This year the Government made an extra £8 million to expand bed capacity above last winter's additional beds and for a longer period. Even so demand over winter stretched the PIC service, but not beyond its capacity.
- 1.17 Annex 1 of this report contains some statistical summaries of activity and performance, and comparisons with previous years. Further information about the Department's work on capacity planning and emergency services is available at [www.doh.gov.uk/capacityplanning](http://www.doh.gov.uk/capacityplanning).

# Chapter Two: Factors underpinning performance

The main factor behind the NHS's successes this winter was, as ever, its highly skilled and committed workforce. Underpinning that was a whole range of activity geared to raising performance and improving patients' experience of NHS emergency care. This chapter describes some of those initiatives and the tangible difference they made to services.

## Helping NHS staff to help patients

- 2.1 This year the Government made available some £3 million specifically to fund local human resources initiatives that helped NHS staff to keep on providing care and treatment. Over fifty NHS Trusts used the extra money to benefit both staff and patients, including:
- **City Hospital, Birmingham** – £22,000 for an extra worker to maintain standards of hygiene and portering during busy periods in A&E;
  - **Hammersmith Hospitals** – £30,000 to improve the working environment of frontline clerical staff;
  - **Alder Hey Children's Hospital** – additional payments for extra intensive care unit staff hours;
  - **Peterborough Hospitals** – £40,000 for a discharge co-ordinator to manage waits for admission through A&E;
  - **Taunton & Somerset** – £10,000 to set up an emergency contingency team covering unexpected leave and exceptional pressures;
  - **Rotherham health community** – £7,000 for child care for frontline staff;
  - **Chesterfield Royal Hospital** – £7,000 for increased weekend working hours in the radiology department;
  - **North West Anglia** – £26,000 for two care assistants to support the nursing team; and
  - **Royal Liverpool & Broad Green** – £45,000 to help transfer, admission and discharge arrangements, freeing up qualified staff to deliver direct patient care.

## Using the independent sector for NHS patients

- 2.2 The NHS has developed its partnership with independent health care providers, using spare capacity in independent hospitals to treat more NHS patients. This winter the Government provided an extra £40 million for up to 20,000 NHS patients to get their treatment in the independent sector.
- 2.3 The NHS needs to continue working closely with independent providers all year round, particularly in local capacity planning groups, to plan in advance for the treatment of NHS patients.
- 2.4 Three NHS sites (East Kent, Portsmouth & Isle of Wight and West Sussex & East Surrey) used independent capacity abroad to offer their NHS patients quicker treatment. The first patients went to

France and Germany in January, and by April around 200 people should have been able to travel and get their treatment sooner than they would have done.

*“We were excited about piloting this new way to access capacity for the NHS. Using hospitals overseas will not help everyone, but we have found that it can work well for patients and help to ease pressure on the NHS locally.”*

Peter Huntley, Chief Executive of Channel PCG and the project manager of the pilot scheme.

- 2.5 The Department is also exploring the possibility of overseas providers establishing services here to provide treatment for NHS patients, without the patients having to travel abroad.

### ***Independent capacity web site***

To help the NHS to get the most out of the independent sector, a web site has been set up (at [www.pasa.doh.gov.uk/indhealth](http://www.pasa.doh.gov.uk/indhealth)) where independent providers publish details of acute procedures they can undertake for the NHS by location and by clinical specialty. The site is available to NHS staff, who should select “search” to go to the members’ login page. To obtain a user-name and password select “register”, complete details, request access to independent healthcare and submit. Users will be notified as soon as their access is cleared. Anyone with problems accessing the site can contact [suzanne.mew@doh.gsi.gov.uk](mailto:suzanne.mew@doh.gsi.gov.uk).

## Reforming Emergency Care

- 2.6 The *Reforming Emergency Care* strategy launched in October 2001 introduced radical changes to A&E departments. By 2004 there should be about 180 more A&E consultants as part of the overall expansion of consultants in the NHS Plan. The Government is making available a total of £40 million to fund 600 additional nurses in A&E and to support the introduction of basic streaming in A&E by March 2002 (full streaming should be in place by March 2003). “Streaming” means that patients are grouped according to their illness or injury, with separate staff dedicated to each stream. Experience in pilot sites shows that this can dramatically speed up advice and treatment for patients who don’t need to be admitted. It can also improve the speed of assessment and treatment in A&E for those who do need admission.
- 2.7 Emergency admissions to hospital via A&E have increased significantly over the last few years, as have acute and general bed occupancy rates. Research indicates that occupancy of more than 82% in an average sized hospital increases the risk of both waits of over four hours for admission and last minute cancellations of operations. The £50 million that the Government made available to the NHS this winter to free up capacity by funding operations in the private sector, combined with the drive to avoid unnecessary admissions and reduce delays in discharging patients, has begun progress towards the longer term goal of reducing occupancy to about 82%.

### ***Birmingham Heartlands NHS Trust***

At Birmingham Heartlands A&E patients with minor injuries or illness are treated in a dedicated area adjacent to, but completely separate from, the area where patients with major illness or injury are treated.

This separation, combined with a Medical Admissions Unit, has allowed the Trust to see, treat and admit or discharge about 95% – 97% of all A&E attenders within four hours of arrival, well ahead of the NHS Plan milestone. 99% of all patients requiring emergency admission are found a bed within four hours of a decision to admit.

# Chapter Three: The “whole system”

**To understand and improve NHS emergency care it is vital to recognise that A&E departments never work in isolation. Performance in A&E is influenced by what happens in the rest of the hospital, as well as outside the hospital in areas like social care, primary care and ambulance services – the “whole system”. This chapter looks at the contribution made this winter across the system.**

## Social care

*“In spite of the very real pressures on health and social care resources, the effective joint working between local councils and their health communities continues to develop and tackle the difficult and complex problems”.*

John Ransford, Director of Education and Social Policy, Local Government Association

- 3.1 Local government welcomed the announcement in October 2001 of the Building Capacity Grant as a significant step forward in developing services for elderly people and other vulnerable groups with their independent sector partners.

*“A relatively small amount of extra money direct to this authority has gone a long way in helping to maintain independent sector capacity through enhanced fees aimed specifically at those committed to achieving defined quality standards in pressurised financial circumstances.”*

Sukhdev Dosanjh, Social Services Business Manager, East Riding of Yorkshire Council

- 3.2 While some areas still need more local investment to develop community based services focused on preventing admissions to hospital, the Building Capacity Grant is already being used effectively up and down the country.

*“At times the pressure was on, but with the additional funding from the Building Capacity Grant, coupled with good whole systems working with our NHS partners we have achieved our target reduction on the levels of Southwark residents awaiting discharge from local hospitals. We can now plan to build on this success over the coming year.”*

Andy Nash, Assistant Director of Social Services (Adults), Southwark Council

- 3.3 This winter demonstrated a strengthened – and shared – understanding of the need to plan and monitor demand and provide a good service response on a whole systems basis, throughout the year. Local councils and their health partners are now more likely to focus on year round action to maintain the independence of older people and other vulnerable groups, preventing inappropriate admission to hospital and promoting timely discharge.

*“There is now clear evidence that a vision for promoting independence for older people is being realised. This goes beyond health and social care and embraces all the relevant public and non-public sector services at a local and national level – for example housing, environmental health and community safety – to reduce the likelihood of needing acute NHS services. Maintaining independence requires the development and proper resourcing of low-level prevention and support services. Though resources continue to be tight, the Cash for Change funding for the next two years has helped to maintain social care capacity.”*

Councillor Rita Stringfellow, Chair, Social Affairs and Health Executive, Local Government Association

## Ambulance services

3.4 Paragraph 1.12 summarised the progress that ambulance services are making towards response time targets. That progress, and progress in improving services more widely, is based on work being done across the country to establish and build on best practice. For example:

- **West Midlands Ambulance Service** – has introduced electronic wallboards into A&E departments to provide “whole systems” information about patient flows and the clinical condition of patients en route to hospital. They have also introduced an emergency nurse advisor in their control room to handle Category C (less urgent) calls arising in the home, helping to preserve front-line resources for life-threatening emergencies;
- **Essex Ambulance Service** – co-ordinated the winter capacity arrangements for the Essex health economy. It is also helping to make optimum use of the whole system by transferring non life-threatening calls to NHS Direct when appropriate, and by participating in a pilot project to reduce pressure on Colchester A&E by taking patients to a minor injuries unit when that would meet their needs; and
- **Greater Manchester Ambulance Service** – again provided the Greater Manchester Communication centre, in collaboration with the health authority. The centre records all emergency care activity and data and provides early warning if pressures begin to build in the whole system. Information is generated on the Manchester Emergency Care Website, which is also managed by the ambulance service. The process involves all acute NHS trusts, health authorities and Primary Care Trusts, and is now a year-round operation.

## Primary care

3.5 Primary care is an essential component of the whole system, one of the main gateways to emergency care and a provider of appropriate treatment for many patients who visit an A&E department.

### Improving access to primary care

3.6 The National Primary Care Collaborative – managed by the National Primary Care Development Team – is working with practices and Primary Care Trusts to help them modernise their services and better meet the needs of their patients. A priority for the Collaborative is improving access to primary care using an “Advanced Access” model. This helps to improve access and choice for patients, while giving clinicians and managers more control over their time and resources.

### ***Advanced Access (1)***

A north of England three-partner practice with 5,600 patients introduced Advanced Access in May 2001, and found it relatively easy to reduce their backlog by introducing a new appointment system over a three week period. The practice encouraged its staff to be adventurous and tested out some new ideas (on the basis that if the changes failed, the system could be returned to its original state). The practice also sought to include the views of its patients. Access to GPs and nurses is now routinely on the same day – 98% of patients are offered an appointment on the day of their choice.

### ***Advanced Access (2)***

A practice in southern England had more difficult issues to deal with. The practice, which has a list size of 11,600 and about six whole time equivalent partners, had an average twelve day wait for a GP appointment and a shortfall of about 200 doctor appointments a week. This was compounded when 2.75 wte doctors left the practice.

The Collaborative addressed the situation in a number of different ways. The partners systematically reviewed the frequency and nature of follow ups, agreeing protocols for common conditions, and introduced nurse telephone management of the demand for same day appointments. During the summer the practice cleared the backlog of appointments and recruited a locum to help cover the vacancies. On 1 October a new partner started and the practice implemented Advanced Access.

Since then home visits have fallen by 25%, missed appointments are less than 1% and the weekly consultation rate is down. 95% of patients see their doctor of choice, 99% see a doctor on their day of choice and 90% see a doctor at their time of choice.

## **NHS Walk-in Centres**

3.7 The Department is identifying different options for how WiCs can best be used to help modernise the NHS and relieve pressures on other services, including emergency care. The options being considered include:

- extending WiC services to some A&E departments, minor injury units and other healthcare providers;
- new WiC services targeted on deprived areas;
- new WiCs targeted on areas with the worst problems of access to services; and
- increasing the number of GPs, including GPs with special interests, offering specific services in WiCs.

### ***Harlow Walk-in Centre***

Harlow WiC, opposite the Princess Alexandra Hospital, opened in August 2000 and provides a fast, responsive and easy to use primary care service. Since then it has built an excellent relationship with the local A&E department, providing wound care and dressings, blood taking, minor injuries care and more. There are plans to expand the premises to allow better integration with GP out of hours services and to provide a base for community on-call staff.

# Chapter Four: The year ahead

**Investment and good forward planning are essential to handling pressures on emergency care. By next winter the NHS will have begun to look significantly different – the new strategic health authorities and health & social care regions will be up and running, realising the Government’s plan to shift the balance of power in the NHS from the centre to the front line. This chapter discusses how the NHS can use these changes to eliminate long waits and undignified conditions in A&E, reduce non-clinical transfers between hospitals and cancelled operations, and allow staff to practise their professional skills in an environment they can be proud of.**

## Shifting the Balance of Power

*“I want to make it more worthwhile for local health services to innovate in the way they deliver care to patients. I want to see a new culture of public sector enterprise in the NHS to rival the culture of private sector enterprise which has developed over recent decades. This requires more local discretion over how budgets are spent. It requires a greater emphasis on rewarding those who succeed and helping – rather than penalising – those who sometimes fail. And it requires organisational change to put the frontline first.”*

Alan Milburn, Secretary of State for Health, 25 April 2001

- 4.1 “Shifting the Balance of Power” is a programme of reforms empowering front line staff and patients. It will fundamentally re-shape the NHS around the needs of those it exists to serve – the patients. Important detail about the structural changes, and what they mean for the planning, commissioning and provision of emergency services, is set out in Annex 2.
- 4.2 The principles behind the changes build on the principles of the NHS Plan. Their success, and the consequent benefits for patient experience, depend on whether staff across the whole system are given the chance to work as effectively and creatively as their potential allows. Change needs to come from the bottom up, not just from the top down.
- 4.3 Staff who work day-in, day-out under great pressure often know that there could be better ways of delivering treatment and care. The common thread linking the most effective reforms of recent years is the harnessing of that know-how and commitment to improve care for patients. Now the task is to get that thread running through the whole NHS, including emergency services.
- 4.4 As a start Trusts should be considering how to give clinical teams greater control over budgets. The teams can then use their direct experience of patient care to decide how resources can best be used to improve patients’ experience of the NHS – for example, something as simple and relatively inexpensive as keeping a cleaner on permanent duty in A&E, or better communication with patients who do have to wait, could make a real difference to how people feel about their visit to the hospital.

## Focusing on quality

- 4.5 The process of planning ahead and getting best value from investment needs clear goals in line with the NHS Plan and the objectives of “Shifting the Balance of Power”. The NHS Plan sets out clear targets for total waiting time in A&E – at least 90% of patients waiting less than four hours by March 2003, rising to 100% by the following year – but these shouldn’t be allowed to limit the service’s ambitions.
- 4.6 Even isolated instances of very poor service can have no place in a modern NHS. Every Trust should now be focused on improving patients’ experience of A&E, and where necessary the first steps should include:
- acting to end, permanently and everywhere, waits of more than four hours in A&E – for example by using capacity in the independent sector to free up NHS beds;
  - reducing by half again the number of critical care transfers between hospitals for non-clinical reasons (for example by increasing critical care capacity in line with NHS Plan targets); and
  - rescheduling within 28 days at most any elective operations that have to be cancelled at short notice, and making sure that no operation is ever cancelled more than once, in line with the commitment in the NHS Plan.
- 4.7 All this is achievable and well within what patients have a right to expect. In fact most Trusts already reach those standards routinely, and there is nothing daunting or unduly burdensome about any of them. The support mechanisms of modernisation and improvement are there to be exploited, including more active bed management, the work of the Modernisation Agency and the empowering of staff throughout the system to develop and use their skills to their full potential.
- 4.8 Meeting those sorts of standards universally will not only be a significant step towards the more patient-centred services demanded by the NHS Plan and “Shifting the Balance of Power”, but will also make a big difference to the working lives of everyone involved in providing emergency care. The interests of service user and service provider overlap, and it is in the interests of both for local managers to deliver the improvements that are within their grasp.

# Chapter Five: Conclusions

**As the NHS strives to improve its performance it must never stop learning. The real gains it has made over recent winters won't be sustained, let alone extended, otherwise. This chapter sets out the four most important conclusions that can be drawn from this winter, and which the NHS and its partners need to address in time for next winter.**

5.1 The four main lessons that emerged from the performance described in the rest of this report are:

**A. Hospitals should not make patients in A&E departments wait longer than four hours.**

5.2 The NHS's achievement in reaching the March 2002 milestone early shouldn't be underestimated, but it is still only a milestone and not the destination. The key message is that it is no longer acceptable for any patients to wait very long periods or be kept in A&E in conditions that hinder their care, or that compromise their dignity or the professional standards of NHS staff.

5.3 Some Trusts may have further to go than others in eradicating long waits and improving patients' experience but there is no good reason why they should not all reach targets for improvement on, or ahead of, schedule. About one in five Trusts already deal with at least 90% of their A&E patients within four hours. To make sure that all Trusts first match then beat that performance they will need to maintain the levels of elective activity they reached during the winter throughout the year ahead, especially the spring.

**B. The use of hospital beds to meet clinical needs should be managed actively -and daily – and linked to resources elsewhere in the community.**

5.4 Good bed management is fundamental to preventing long waits in A&E. It should include control of all admissions – both elective and emergency – and planning of discharges, and use predictive analysis to make sure that enough beds are available for at least 24 hours ahead. Reducing bed occupancy and sustaining that reduction must be key objectives for the next year.

**C. Closer collaboration between local partners pays off in terms of more responsive care for patients.**

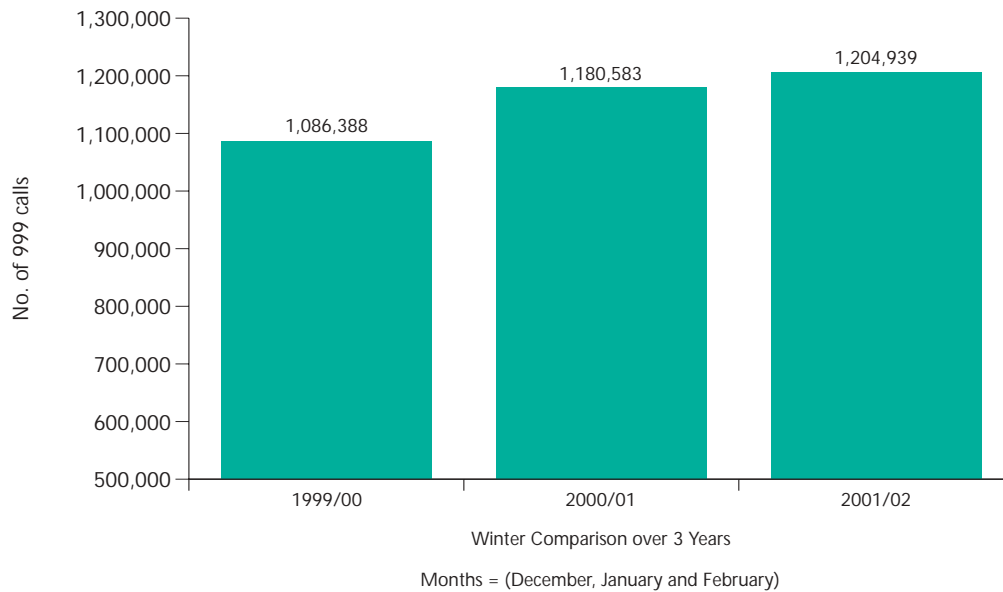
- 5.5 Trusts need to look imaginatively across their whole health and social care system for solutions to problems, not just inwards at their own procedures and processes. Problems often flare up at interfaces – for example, ambulance turnaround times (and their knock on effect on emergency response times) can be affected by a lack of collaboration between the acute Trust and ambulance service. Trusts can improve their discharge arrangements by developing bed management systems that use community beds as well as those in the acute sector.
- 5.6 Every Trust will appoint an emergency care lead and over the next few months they should establish networks that deliver appropriate care in a community. More details are available at [www.doh.gov.uk/capacityplanning/eclguidance.pdf](http://www.doh.gov.uk/capacityplanning/eclguidance.pdf).

**D. The clinical approach to A&E patients can be improved – implementing *Reforming Emergency Care* and looking at modern clinical practice both offer real opportunities for progress.**

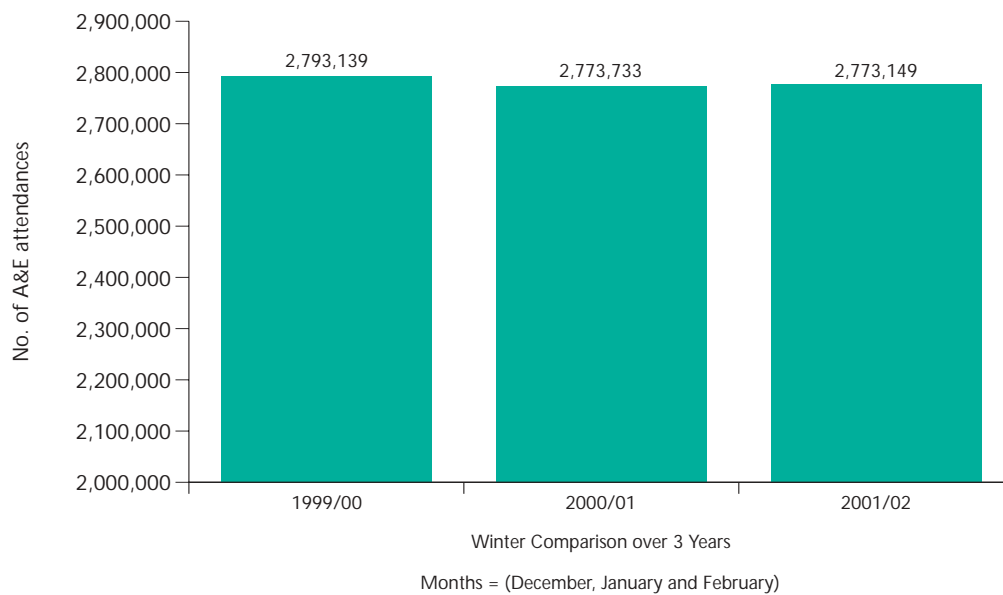
- 5.7 Work to implement *Reforming Emergency Care* needs to be followed through to completion. Streaming to separate people with minor and major injuries can cut waiting times in A&E (especially for those with minor injuries, who are currently most likely to be asked to wait). More information is available at [www.doh.gov.uk/capacityplanning/streamingguidance.pdf](http://www.doh.gov.uk/capacityplanning/streamingguidance.pdf). The move to network emergency care will also help to maximise capacity.
- 5.8 There are more new A&E nurses to be recruited, more consultants and more independent sector capacity to be used with the extra resources made available last year.

# Annex 1: Summaries of performance and comparisons with previous years

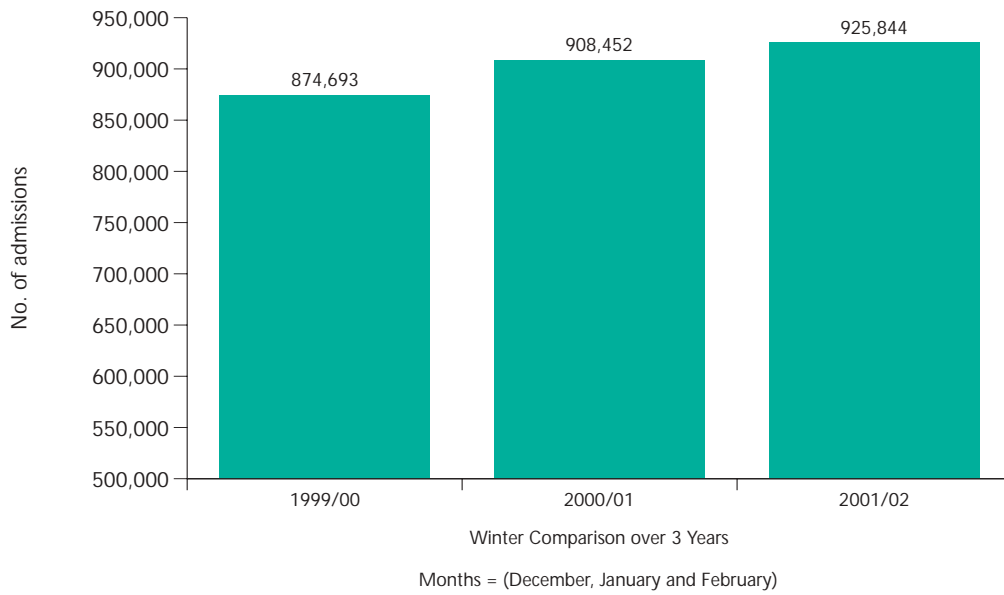
## Ambulance/999 (National)



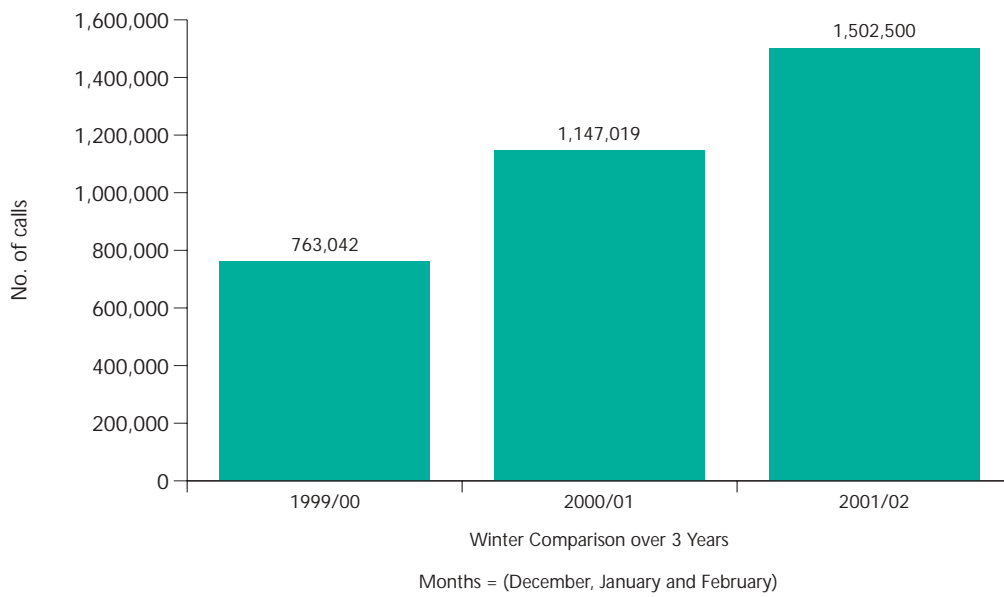
## Accient and Emergency (A&E) Attendances (National)



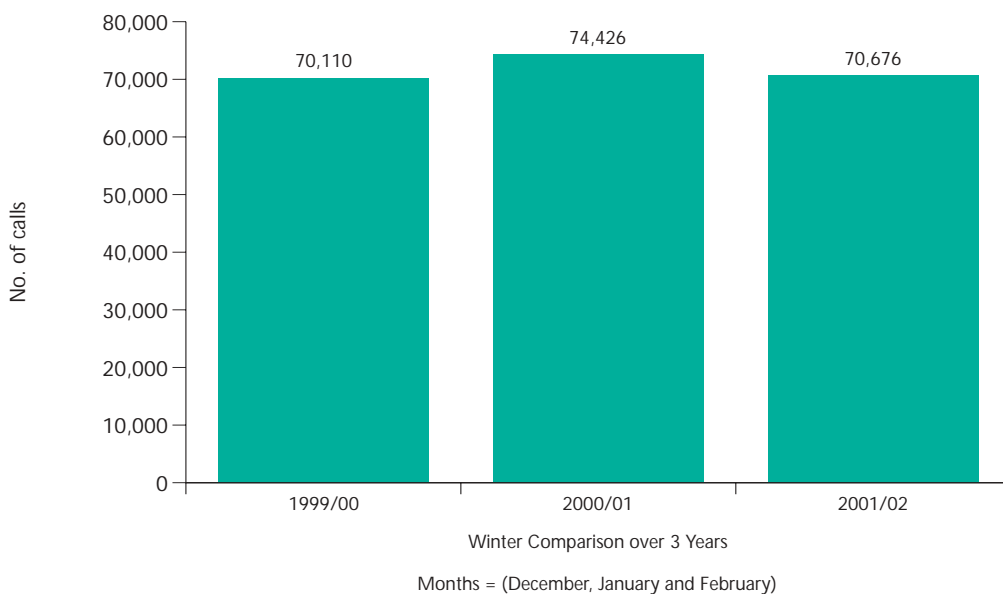
### Emergency Admissions through A&E (National)



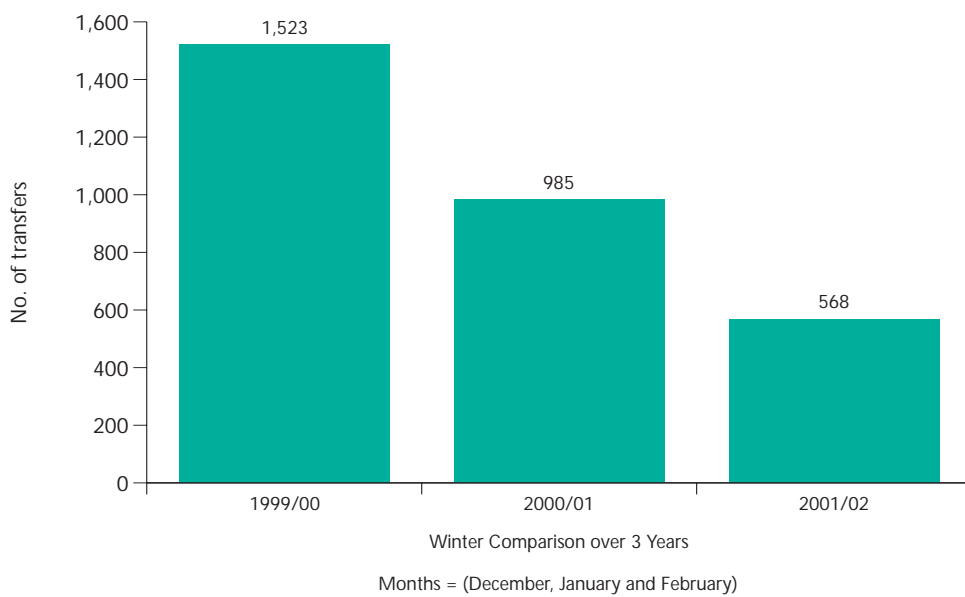
### NHS Direct (National)



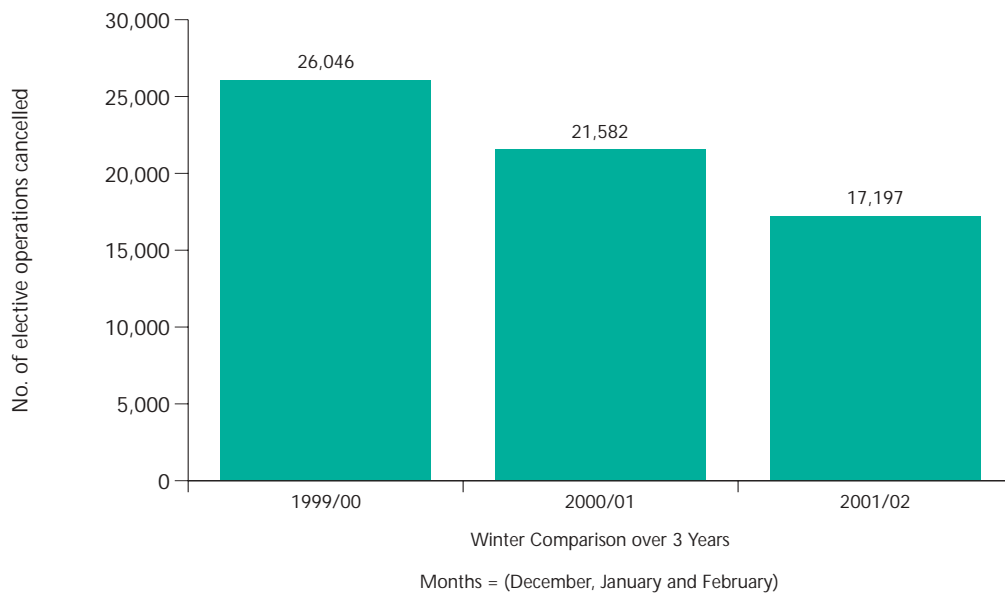
### Delayed Transfers of Care (National)



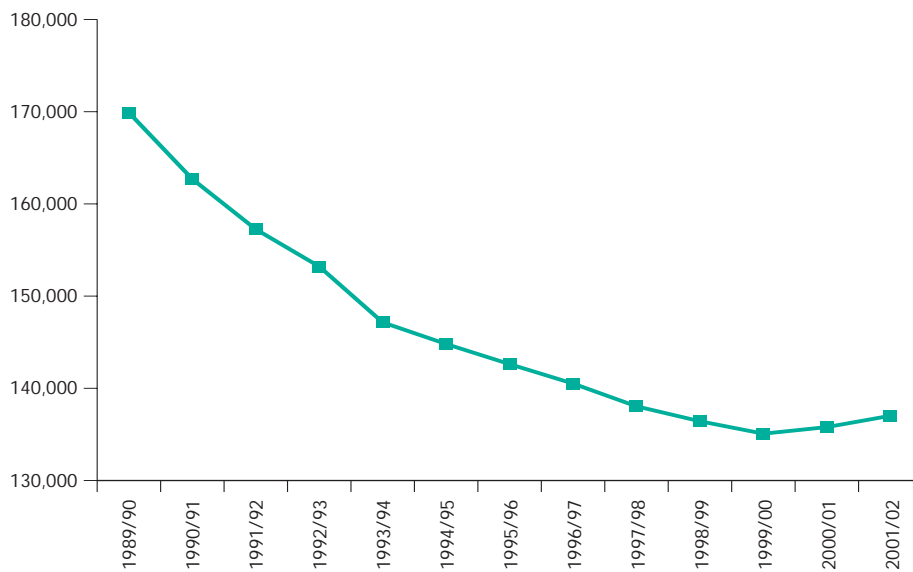
### Non Medical Intensive Care Transfers (National)



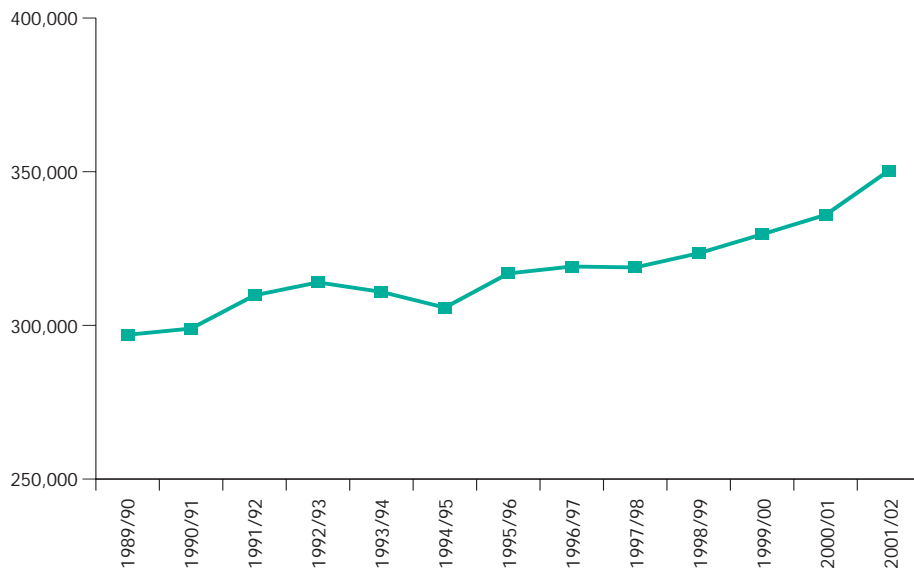
### Elective operations cancelled on the day of the operation (National)



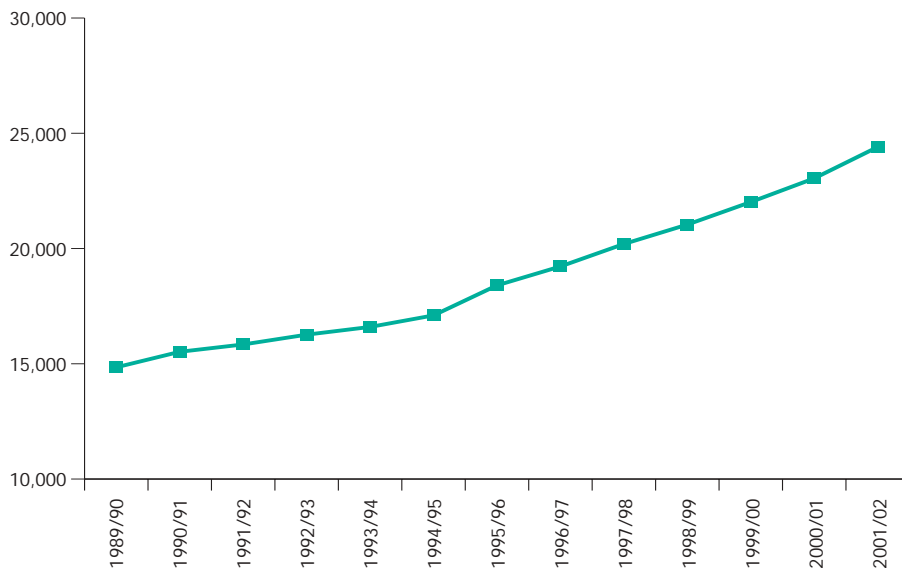
### NHS Capacity – General and Acute beds



### NHS Capacity – Qualified Nursing, Midwifery and Health Visiting staff



### NHS Capacity – Hospital Medical Consultants



NB: in some charts the vertical axis does not begin at zero so as to illustrate the year on year changes between very large numbers.

# Annex 2: Shifting the Balance of Power

- (i) On 1 April 2002 the 95 existing health authorities were dissolved, and most of their functions transferred to Primary Care Trusts. There will be over 300 PCTs in England forming the new cornerstone of the NHS, responsible for improving health, securing the provision of the full range of health services and integrating health and social care.
- (ii) There are also 28 new strategic health authorities, to create strategic frameworks and performance manage the PCTs and NHS Trusts within their boundaries.
- (iii) Existing NHS Trusts will now have their performance managed by the new strategic health authorities rather than by the Department of Health. They also need to work ever more closely in partnership with PCTs and their other partners to deliver local and national priorities – including the reform of emergency care. Internally, they need to review their systems and approaches to devolve more to clinical teams and frontline staff, and to increase the involvement of patients and the public.

## The impact on planning emergency capacity

- (iv) Health communities need to exploit this new structure to develop their year-round planning for winter and emergency care.
- (v) PCTs should now:
  - plan and commission emergency services for their local population in a full and positive partnership with primary care and local government;
  - work with their partners through Health Improvement Programmes and local strategic partnerships, and involve patients as decisions are made;
  - have combined plans for emergency and elective work, not separate ones;
  - promote health care, improve immunisation uptake, help to support people at home, develop intermediate care services, facilitate prompt discharge from hospital and avoid readmission; and
  - take responsibility for organising the care of people with primary care problems who present to A&E.
- (vi) Strategic health authorities should now:
  - make sure that PCTs, Trusts and workforce confederations co-operate to plan and provide effective services across wider health communities; and
  - develop dynamic capacity management systems across the whole community and prepare escalation plans for managing severe pressure above the level of individual NHS organisations.
- (vii) The Department of Health – working through four new regional offices of health and social care – will ensure the integrity of the whole system and provide a line of accountability from the front line to the centre. All the components of the system should work together to implement *Reforming Emergency Care*.





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