Department of Health

# Winter Report 2005–2006

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| Policy<br>HR / Workforce<br>Management<br>Planning<br>Clinical | Estates<br>**Performance**<br>IM & T<br>Finance<br>Partnership Working |
| **Document Purpose** | For Information |
| **ROCR Ref:** | **Gateway Ref:** 6323 |
| **Title** | Winter Report 2005–2006 |
| **Author** | DH/Programmes & Performance/ Recovery & Support Unit |
| **Publication Date** | 27 March 2006 |
| **Target Audience** | PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs, Medical Directors, Directors of PH, Directors of Nursing, GPs, Communication Leads Emergency Care Leads |
| **Circulation List** | Ds of Social Services |
| **Description** | This is a report into how the NHS performed during winter 2005–2006 |
| **Cross Ref** | Winter Report 2004–2005 |
| **Superseded Docs** | N/A |
| **Action Required** | N/A |
| **Timing** | |
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# Contents

# Foreword by the Secretary of State for Health

Winter in the past was synonymous with crisis in the NHS. Only a decade ago, we witnessed winters characterised by long waiting lists for operations, day-long waits in A&E departments, patients stacked on trolleys in hospital corridors, and NHS staff overworked to the point of exhaustion. The winter has brought great challenges in the past, and it is a credit to the perseverence of NHS staff that they continued to deliver patient care.

The contrast with the most recent winter, despite the severe weather and threat of flu, could not be more stark. This Winter Report shows that NHS staff performed magnificently as in previous winters, but this year their dedication was matched by the systems and resources to deliver first-rate care for patients.

We should be proud of the improvements in our NHS in recent years:

- the lowest waiting lists since records began – what patients told us was their top priority
- 19 out of 20 people seen in A&E within four hours
- more hospitals repaired and built than ever before
- since 1997 more lives saved – 43,000 lives saved from cancer; 60,000 lives saved from coronary heart disease
- more staff and better paid staff than ever before
- more choice for patients, including a choice from this year of at least four hospitals for operations
- innovations like NHS Walk-In Centres, NHS Direct, NHS Foundation Trusts and Independent Sector Treatment Centres (ISTCs) – all working to get better, faster care for patients.

This record has not come about by accident. It is the result of record funding in the NHS – a trebling of investment by 2008 – and a programme of reform which is starting to create a patient-led NHS.

We know that there is still a long way to go. We are half-way through our ten-year NHS Improvement Plan. We will introduce more choice for patients, get a firm grip on the NHS finances to wipe out the overspends which exist in a minority of NHS organisations, continue to modernise hospitals, clinics and surgeries, and achieve an 18-week waiting list target for patients from GP referral to operation. We need to move more care away from acute hospitals and into community settings and patients' homes. We need to tackle the unfairness in the NHS, which saw those in most need getting the worst healthcare.

Whilst being ambitious for the future of our NHS, we should celebrate its achievements in recent years. This Winter Report shows how far we have come in just a few years, and stands as a testament both to the programme of NHS investment and reform, and to the staff of the NHS.

**Rt. Hon. PATRICIA HEWITT MP**
**Secretary of State for Health**

# Executive Summary by Sir George Alberti and David Colin-Thome

Winter is traditionally a season when the NHS is under the greatest pressure due to an increase in respiratory ailments, influenza-like illnesses and accidents due to adverse weather. However, the efforts of those of you working in the service have ensured that this winter has been handled smoothly as part of the NHS' everyday business.

In our end of winter report last year, we identified some key areas where improvements were needed. These improvements have been delivered and were crucial to the better handling of winter this year.

The result is that out of hospital services such as out of hours general practice cover were effectively planned against known days of likely peaks in demand (for example bank holidays between Christmas and New Year) and hospitals planned elective operations much more effectively against predictable seasonal variations in emergency admissions throughout the year. Together this has ensured that, among other achievements, a greater percentage of patients than ever have been seen, diagnosed and treated within four hours of arriving at A&E.

Increased public awareness about the full range of services available has enabled patients to make a more informed choice about the care they need and where they can access it. A strong flu campaign meant that uptake in those over the age of 65 was maintained above 70%. These measures have helped to relieve pressure on primary care services allowing them to focus on those patients who really need their help.

There has been an increased focus on integrated working across the NHS. The *'NHS and Social Care Long Term Conditions model to support local innovation and integration'* continues to ensure that all those involved in delivering care work together effectively across traditional boundaries to improve quality of life for patients and reduce the need for stays in hospital. In addition, the recently published White Paper outlines further steps to be taken to ensure closer working between health and social care.

Success this year is not just a result of the NHS caring for more patients faster. It is the result of new services, new ways of working and new partnerships between healthcare organisations helping to keep patients healthy in the first place. As more reforms come on stream and the NHS becomes truly patient-led, we can be confident of maintaining high levels of performance and continued improvement in patients' care.

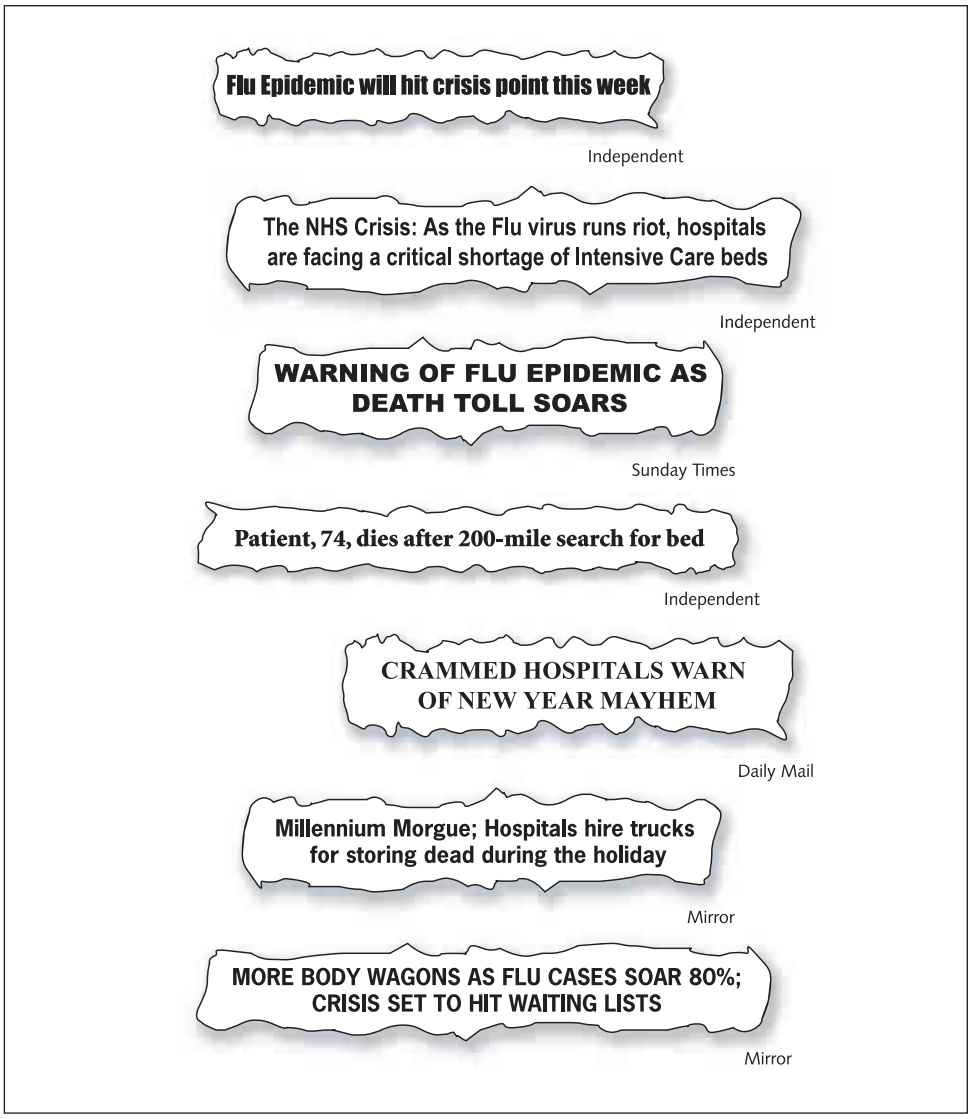
Finally, we would like to thank all staff in the NHS for their hard work and commitment this winter.

# 1. Winter Now and Then

## 1.1 Winter Then: 1999/2000

The winter of 1999/00 was the most challenging experienced by the NHS in recent years. It was not unusual for patients to experience trolley waits of up to or in excess of 24 hours. Unacceptable numbers of patients were having their operations cancelled as the service came under increasing pressure. An increase in respiratory illnesses during early January 2000 placed considerable, additional pressure on NHS services resulting in longer admissions to hospital and an increased demand for critical care facilities.

Despite media headlines suggesting the NHS was in the midst of winter "crisis", NHS and social care staff worked hard to ensure that patients received appropriate care.



Public information campaigns at the beginning of the winter period, coupled with the new NHS Direct service launched in 2000, went some way towards relieving pressure on other services.

However, there were a number of areas identified as requiring improvement if the NHS was not to face a repeat of this winter:

- An increase in uptake of 'flu vaccine
- An increase in critical care capacity
- Better management of the elective re-start following the Christmas and New Year period
- Avoiding unacceptably long waits in Accident & Emergency (A&E) departments
- Coping with problems posed by winter fatalities
- Pockets of poor performance in primary care
- A reduction in cancelled operations

## 1.2 Progress and performance in 2005–2006

Having addressed some of these key issues over recent years, NHS performance this winter has significantly improved, often dramatically, and dealing with winter has become part of everyday business for the service.

Noticeable improvements can today be seen in some of the areas that posed the greatest challenge during the winter of 1999/00:

- 'Flu vaccine is now freely available to anyone over the age of 65, those in residential care and people with underlying health problems. This has resulted in the highest ever uptake of 'flu vaccine with 75.3% of people over the age of 65 receiving the jab.
- Improvements in access to primary care have been sustained throughout the winter supported by a continued expansion of NHS Walk In Centres.
- Access to emergency care has been transformed since 1999/00. Well over 19 out of 20 people are now seen, diagnosed and either admitted or discharged within four hours of arrival at A&E. The majority are admitted or discharged within two hours of arrival. This has significantly improved the patient experience.
- The number of cancelled operations is significantly lower than during the winter of 1999/00. The small number of patients whose operation was cancelled were offered a rearranged date within 28 days.
- Better planning of operations over the Christmas and New Year period means that significantly fewer patients have had their operations cancelled and re-booked than in previous years.

## 1.3 Investment and reform in the NHS since winter 1999/00

These improvements could not have been achieved without the major investment and reform the NHS has benefitted from since the worst winter in recent history.

The *NHS Plan*, published in 2000, set out a vision of a health service fit for the 21st century. One designed around the patient, giving them more control and choice about their health and care. It set out a ten-year plan of investment – bringing health spending up to the levels enjoyed by our European neighbours – coupled with reform of the way the system and the people within it work.

With the foundations laid for more staff, more facilities and more services being delivered, the *NHS Plan* set out ambitious targets on the things that mattered most to patients – being able to see their doctor quickly, ending long waits for hospital appointments and making sure people are supported to live longer, with greater dignity and independence.

This direction of travel has been maintained and developed through the *NHS Improvement Plan* and *Creating a Patient-led NHS*. And now, just over half-way through our ten-year plan, we are well on course to meet our ambitious access targets. For example, today, patients are now guaranteed a maximum wait of six months for surgery.

The reforms have introduced new services, shaped around what is best for the patient, such as NHS Direct and Walk-in Centres. These have helped patients to receive the most appropriate treatment in the most convenient way. New staff roles, such as emergency care practitioners have enabled our workforce to make the best use of their skills and dedication, and ensured that patients get the very best care, when and where they need it.

The development of direct payments has empowered people with long-term conditions to take control of their own care, ensuring they get the support they need, when and where they need it, and helping them to stay out of hospital in the first place.

The reforms being embedded now – giving patients more choice, a wider selection of services, greater freedom for staff to shape services, and changing the way money moves through the system to reward efficiency and encourage services to focus on their patients needs – are further transforming patients experiences of the NHS.

The recently published White Paper *'Our Health, Our Care, Our Say'* further develops how these principles of a patient-led service will be applied to deliver the services people tell us they want delivered outside of hospital.

Transforming how the NHS manages winter is just one of the ways that the NHS has improved services for patients.

### Case Study: Transforming A&E: The Royal Surrey County Hospitals NHS Trust experience

Royal Surrey County Hospitals NHS Trust has worked extremely hard since the difficult winter of 1999–2000 to turn around the trust's performance in delivery of the four-hour A&E target. Key to this has been a change in mindset amongst all those involved at the trust, ensuring effective clinical engagement and also a great deal of collaborative working practices, with the acute trust working more closely with primary care, ambulance trusts, social services and other local hospitals to take ideas and reforms forward.

The trust has managed to reach and sustain levels of between 98–99%, a huge improvement from their earliest recorded performance of [66.9%].[1] Michael Wilson, director of clinical services said:

*"This achievement was largely realised because we've redesigned processes throughout the whole hospital, rather than just A&E and could not have been achieved without the hard work of the staff".*

Other practices and processes the trust has focused on to improve performance, and ultimately, standards of patient care are:

- Development of a walk-in centre on site, plus medical and surgical assessment units to ensure patients are streamed to the most appropriate areas on arrival
- On-site nurse practitioners in post 24 hours a day, seven days a week to ensure that patients are placed in the most clinically appropriate area
- A move back to specialty-based wards
- Introduction of a critical care outreach team to identify very sick patients and attend to them quickly and responsively
- Speeding up the discharge process to make it more efficient without compromising clinical care
- Executive leads regularly reviewing processes and the wider system, to see what is working well and what requires further attention and development.

1 Management Information: Sitrep data, four-week average, October 2001 (1-28 October)

## Case study: Record uptake of flu vaccine in England

The influenza immunisation programme protects those most at risk of serious illness or death from developing influenza. Since 2000, the Chief Medical Officer has recommended that flu vaccine be offered to all those aged 65 years and over and those aged over 6 months in groups defined as 'clinically at risk'. These risk groups include chronic respiratory disease, including asthma, chronic heart disease, chronic renal disease, chronic liver disease, diabetes and people with immunosuppression.

The annual monitoring of flu uptake in those aged 65 and over was introduced in the winter of 2000/01.

In the first year of monitoring (2000), a minimum 60% uptake was set as the national uptake target. In the following year, this increased to 65% and in 2002/03 the national target increased to 70%.

Flu vaccine uptake in those aged 65 and over has increased year on year (see table below). Data collection in those aged under 65 in clinical risk groups is now being collected for the first time. Final uptake data for 2005/06 shows that uptake in those aged 65 and over was 75.3%, and those under 65 (at risk) 48.0%. We will continue to encourage uptake in at risk groups next year and expect to see an improvement in uptake in line with over 65 uptake rates. We also promote vaccination in front-line NHS staff, although there is still some way to go in this aim.

| Year | Uptake in those aged 65 and over |
|---|---|
| 2000/01 | 65.3% |
| 2001/02 | 67.7% |
| 2002/03 | 68.5% |
| 2003/04 | 71.0% |
| 2004/05 | 71.5% |
| 2005/06 | 75.3% |

The consistent increase in uptake can be largely attributed to a comprehensive marketing campaign that targets those considered to be most 'at risk'. The campaign includes advertising – on TV, radio, press and on buses – and public relations activity using media and stakeholders to increase awareness and uptake. This national activity adds vital momentum to local NHS activity.

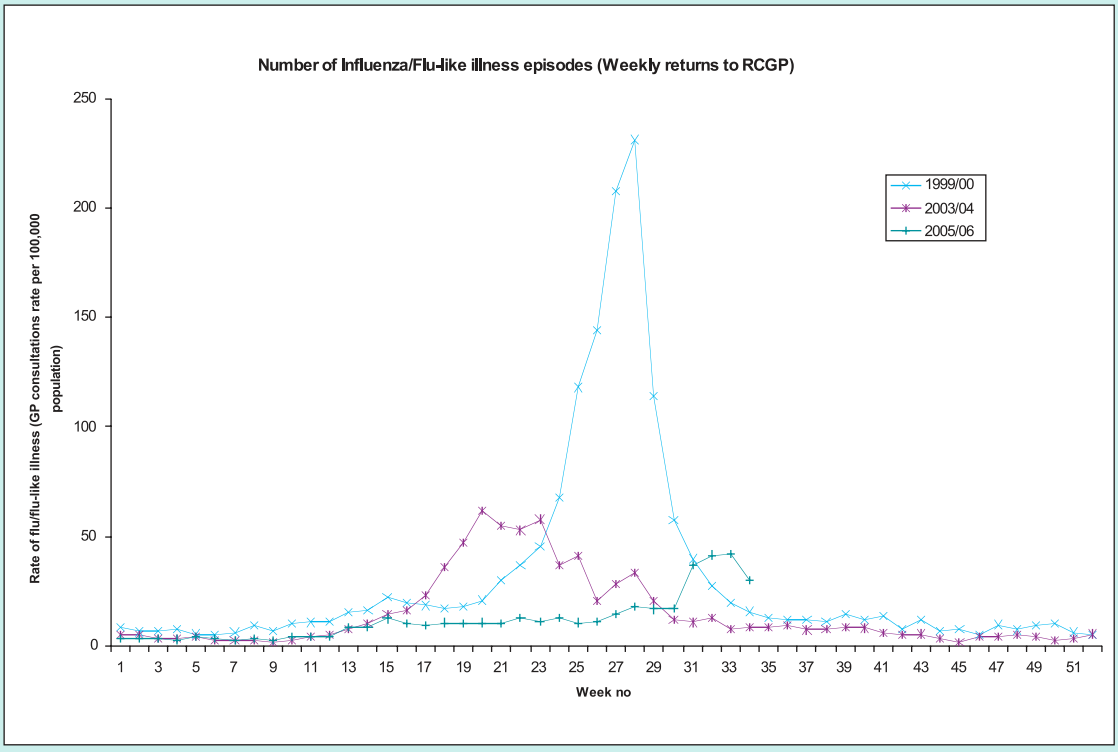
Campaign research from May 2005 suggested that two of the primary mechanisms for increasing awareness and uptake are word of mouth (either from a friend, family member or NHS professional) and advice from their clinician. Also, the role and effectiveness of a local NHS flu coordinator has a direct impact on uptake. This year's campaign worked to capitalise on these insights.

In 2004, Tower Hamlets PCT made the flu vaccination campaign a key priority and as a result increased uptake by an impressive 10% to almost 71% in just one year. This was a notable achievement given that much of the community may have found accessing primary healthcare difficult due to language and cultural issues. For example, over 30% of the local population is Bengali and many over 65s in the community are unable to read or write in English or in their own language. In addition, common perceptions across all communities such as many people over 65 not recognising themselves in phrases like 'vulnerable', or believing they could catch the flu by having the jab also posed a challenge to flu coordinators. Having identified these issues, the PCT led a proactive campaign that started early and took messages in to the community for example, by having regular question and answer sessions on a local Bengali radio station.

This year, the Department worked with Tower Hamlets PCT to produce a good practice case study and shared this with flu coordinators and NHS communicators across England. Many flu coordinators were not working with their Trust's communicator so we urged these two professions to work together to improve effectiveness. To aid front-line activity further, we ensured that central campaign resources, such as leaflets and posters and a communicators' toolkit, were available from July 2005 – much earlier than in previous years.

Speculation about the risk of avian/pandemic flu in 2005 contributed to the increased levels of media coverage and probably encouraged more people to seek immunisation. Despite concerns about the supply of flu vaccine, GPs and practice nurses ensured that all who wanted immunisation received the vaccine.

The incidents of flu over the last five years is shown in the table below:



# 2. Winter 2005–2006 in Detail

## 2.1 Winter Planning

Joint winter planning is central to the NHS' handling of winter and vital in being able to deal effectively with any challenges that this period can present. Although over recent years, the NHS has a proven track-record for successfully responding to additional winter demands, planning still played an important part in ensuring that this winter passed without any serious problems.

Strategic Health Authorities (SHAs), as local headquarters of the NHS, have the key coordination role to ensure that all organisations work together to manage services throughout the winter months. Effective winter plans focused around the seven major areas of; operational readiness (capacity, staffing, etc), out of hours arrangements, NHS/social care joint arrangements, ambulance service/primary care/A&E links, critical care services, preventative measures eg. flu campaign, and communications. Planned escalation procedures enabled the NHS to manage well when demand on services increased beyond normal operating levels.

Winter planning across the local health economies:

### Case Study: East Anglian Ambulance Service NHS Trust

The close working and early planning with the Strategic Health Authority (SHA), Emergency Care Network (ECN) and ambulance trust has been a critical factor in coordinating the SHA and health system's response to winter and other pressures as well as the provision of effective out of hour's arrangements and workforce developments.

East Anglian Ambulance Service currently operates the Norfolk, Suffolk and Cambridgeshire (NSC) Capacity and Monitoring System (CAMS), which monitor the bed capacity and working pressures of their eight acute units and community hospitals. This is updated on a two hourly basis and communicated on a widely available web based IT system.

The system has been implemented along with hospital ambulance inbound screens which allow hospital A&E, Emergency Admissions, Assessment units and operations rooms to see the status of all ambulance vehicles in their area and plan the receipt of patients accordingly. Extreme pressures are identified early on, which allows some cases to be diverted if other hospitals are under less pressure and avoids hospital congestion from developing.

Pre-planning of up to five weeks ahead is undertaken by the trust's contingency team (responsible for fleet coordination, supply, and scheduling with the trusts emergency, non emergency and primary care teams) to ensure maximum resources are deployed effectively.

A well-coordinated planning process and post-winter debriefing process ensures that:

- key lessons are learned
- better resourcing is achieved
- system management is put into place for the following year.

Through a major service modernisation programme, East Anglian Ambulance Service NHS Trust has significantly improved performance in Category A (emergencies which are immediately life threatening) response time from 53.0% in 2000-2001 to 76.5% in 2004-2005. Some of the more significant aspects are listed below:

- The implementation of demand-led rosters with staff defining the facilities expected nearer the centres of 999 activities.
- Major investment in control room and vehicle technology to ensure that the implementation of an hour-by-hour deployment plan could be fundamentally upheld.
- Closer working with the SHA and greater involvement in the three county Emergency Care Network (ECN); more recently expanding to include the Critical Care Networks too.

## 2.2 Weather

A cold winter combined with high levels of respiratory infections can have a major impact on cardiovascular and respiratory morbidity and mortality. Therefore, predictions that temperatures during winter 2005/06 were going to be significantly lower than previous years had to be carefully considered during the winter planning process. The Department and the NHS have, as in previous years, benefitted from regular updates and advice from the MET Office in order to be prepared for any bouts of severe weather.

The MET Office Winter Review on 3 March 2006, stated that England had a colder – than – average winter and was the coldest since 1996/7. Considering the associated increases in demand that cold weather often causes, the NHS has coped extremely well despite the particularly cold weather this winter.

## 2.3 Communications

In recent years, communications has become an essential element of the pre-winter planning process for NHS organisations.

This year's flu campaign outlined earlier in this report was supported by two additional public facing campaigns – Keep Warm, Keep Well and Get the Right Treatment.

The 'Keep Warm, Keep Well' campaign informed at-risk groups and older people of the need to take preventative action to reduce the risk of flu and other winter-related conditions and provided practical information on reducing fuel poverty. Campaign materials were available from September to ensure that communications were timely. Over two million information booklets were ordered by the NHS, GP surgeries, pharmacists, local authorities and voluntary organisations for distribution to their local communities. Over 14,000 calls have been received to date by the Winter Warmth Advice Line.

The aim of the 'Get the Right Treatment' campaign is to educate people about how to use healthcare services appropriately and to ensure that patients are aware of suitable alternatives to A&E and their GP – for example NHS Walk-in Centres and NHS Direct. National press advertising began in October and was supported by some regional radio advertising and public relations activity.

The advertising focused on promoting NHS Walk-in Centres, pharmacy services, and NHS Direct services. Resources were provided to local NHS communications leads to help them to extend the campaign locally.

## 2.4 Primary Care

Primary care is the first point of contact with the NHS. There are some 300 million consultations with general practice each year, and primary care accounts for some 90% of patient contact with the NHS. The five years since the NHS Plan was published have seen a major improvement in access to NHS primary medical care. This was sustained throughout the 2005-06 winter.

### 2.4.1 General practice

Many general practices now operate *'Advanced Access'*. This system has been developed and promoted by the National Primary Care Development Team through the Primary Care Collaborative which has involved more than 5,000 of the 8,300 practices. Other practices have adopted different approaches either on their own or working with their PCTs, but all have the common aim of ensuring that patients are offered better access to the services of GPs and nurses.

The *'NHS Plan 24/48'* hour access target, which sets out that patients can expect to see a GP within two working days and a primary care professional within one working day, has led to a focus on faster access for patients. However, further work is needed to ensure that this does not compromise other dimensions of the patient experience, including the opportunity to book appointments in advance at convenient times.

As highlighted in the recently published White Paper – *'Our Health Our Care Our Say'* – the newly negotiated GMS Contract broadens the scope of the 24/48 hour access target to include advance booking, telephone access and taking more account of what patients say in monitoring performance. The aim is that all patients will have the opportunity to get fast access when they need it, to book a GP appointment in advance or to be seen by a preferred GP.

A new independent national patient experience survey will be introduced in 2006/07, which, over time, will help the Government to improve its understanding, from the patient's perspective, of how well national priorities are being implemented. Patients' responses to the survey will trigger incentive payments to practices. The questions will address patients':

- opportunity to consult a GP within 48 hours
- opportunity to make advance bookings
- ease of telephone access to the surgery
- opportunity to be seen by the GP of preference.

### 2.4.2 NHS Walk-in Centres

There are now 73 centrally recognised NHS Walk-in Centres open, each seeing on average 114 patients daily. A further 16 are in development. Among these are seven new centres located at or near main railway stations whose services are focused particularly on the needs of the working and commuting population. Two of these – at Manchester Piccadilly and London Liverpool St Stations opened during the 2005/06 winter.

### 2.4.3 Out of hours care

The new out of hours services, introduced alongside the new general practice contract since 2004 are now maturing. Out-of-hours providers were able to draw on the experience of having already been through one winter, including the critical Christmas and New Year period. Providers used this experience to plan ahead and were much better placed to cope with peaks in demand. There were no reports of any particular problems with out-of-hours services over the Christmas and New Year period.

### 2.4.4 NHS Direct

NHS Direct is one of the new services that has been introduced in 1999/00 to improve and reform the NHS healthcare making it a modern, efficient and patient-led health service giving patients more choice and better access to their own healthcare.

The service provides access to confidential health advice and information, 24 hours a day, in a range of easy and convenient ways – the NHS Direct telephone service, NHS Direct Online website and the NHS Direct Interactive service on digital satellite TV service. As well as helping patients improve their health and look after themselves, their family and friends, NHS Direct helps patients access the right health service for their needs.

NHS Direct took a record number of calls over the four-day Christmas weekend. Figures show that the volume of calls over the Christmas period was 5% higher than last year. Usage of the 'NHS Direct Online' website increased even faster, with total visits up by 32% on the same period of 2004.

| | 1 Nov 2004–31 Jan 2005 | 1 Nov 2005–31 Jan 2006 |
|---|---|---|
| Calls answered | 1,770,923 | 1,783,210 |
| On-line usage | 2,058,942 | 3,392,404 |

The top five conditions accessed on the phone service and Online are listed in the table below.

| Calls to NHS Direct | Conditions assessed on NHS Direct Online |
|---|---|
| Abdominal Pain | Chicken Pox |
| Sore Throat | Rashes |
| Cough | Joint Pain |
| Toothache | Cold and flu |
| Vomiting | Diarrhoea |

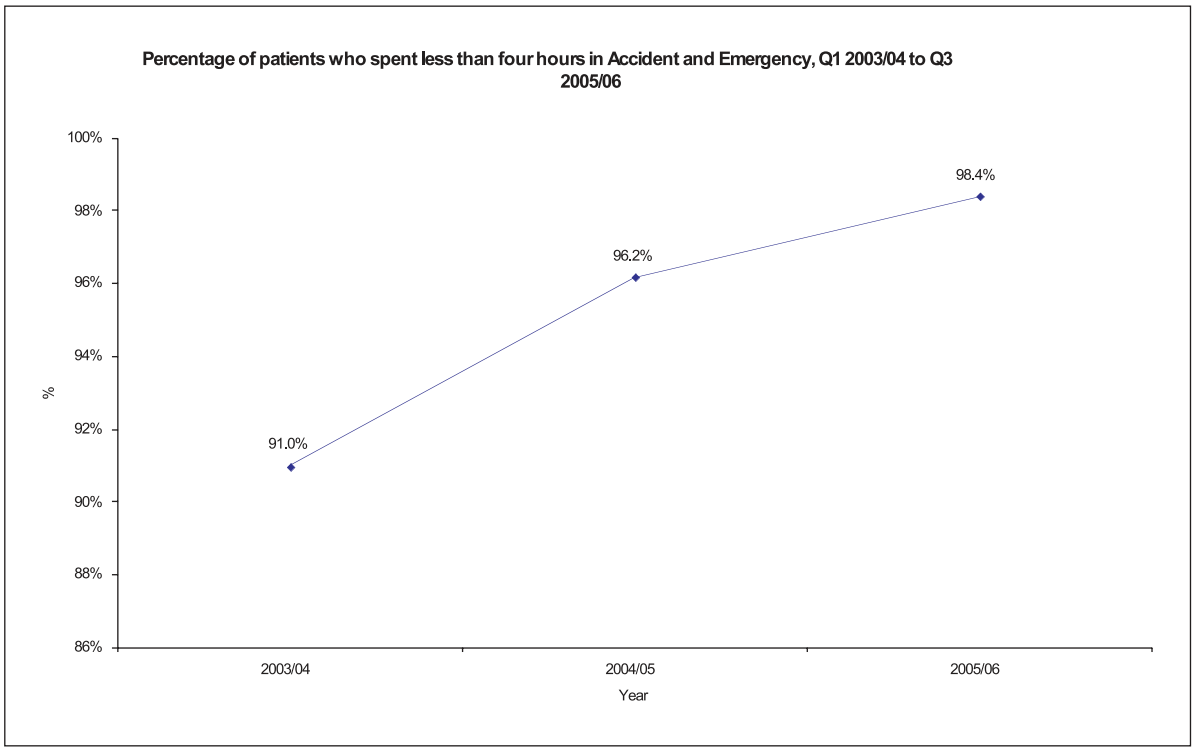
By providing expert advice for many of these patients, NHS Direct adds a popular and useful care capacity to current services.

NHS Direct is planning a range of measures to increase its capacity to respond to further increases in demand. These include:

- Harnessing national economies of scale which will give the service the ability to move calls seamlessly around the country, thus maximising the capacity of the service at busy times;
- Introducing call streaming, which will allow health advisors, with the use of a decision support system, to refer patients who need to attend A&E or receive an urgent medical assessment directly to the appropriate services, reducing patient waits and making better use of nurse capacity within the service;
- Continued marketing of the range of 'self-service' channels provided by NHS Direct – the NHS Direct Online website and NHS Direct Interactive service on digital TV– to allow patients to access information on self-care and local services directly.

## 2.5 A&E

The four hour target became an operational standard twelve months ago. The NHS has performed strongly against that standard, despite a rise in attendances over the last few years. 98% has been maintained for the nine months from April – December 2005.




The NHS has sustained performance this winter at higher levels than any previous winter. January is traditionally the period when A&E comes under greatest pressure. Despite this far more trusts have maintained 98% or above this year than last. This is no mean achievement. All but the most challenged are delivering a transformed service for patients.

There have been challenges. Some health communities have found maintaining 98% during the pressured winter period difficult. Those that managed to deliver 98% week in week out for patients through the winter share core characteristics – they meticulously plan inpatient and staffing capacity in advance against known peaks in demand and periods of NHS constraint (eg. public holidays).

While some trusts still have further to go, the national figures show – and patients tell us – that A&E has been transformed in the last two or three years:

*"I visited the department three times within two weeks. Although I saw a different doctor each time, the first two doctors I saw both came to find out how I was on my third visit, they were very caring. Overall I was very impressed, I had never been to A&E before and it wasn't at all like I imagined."*

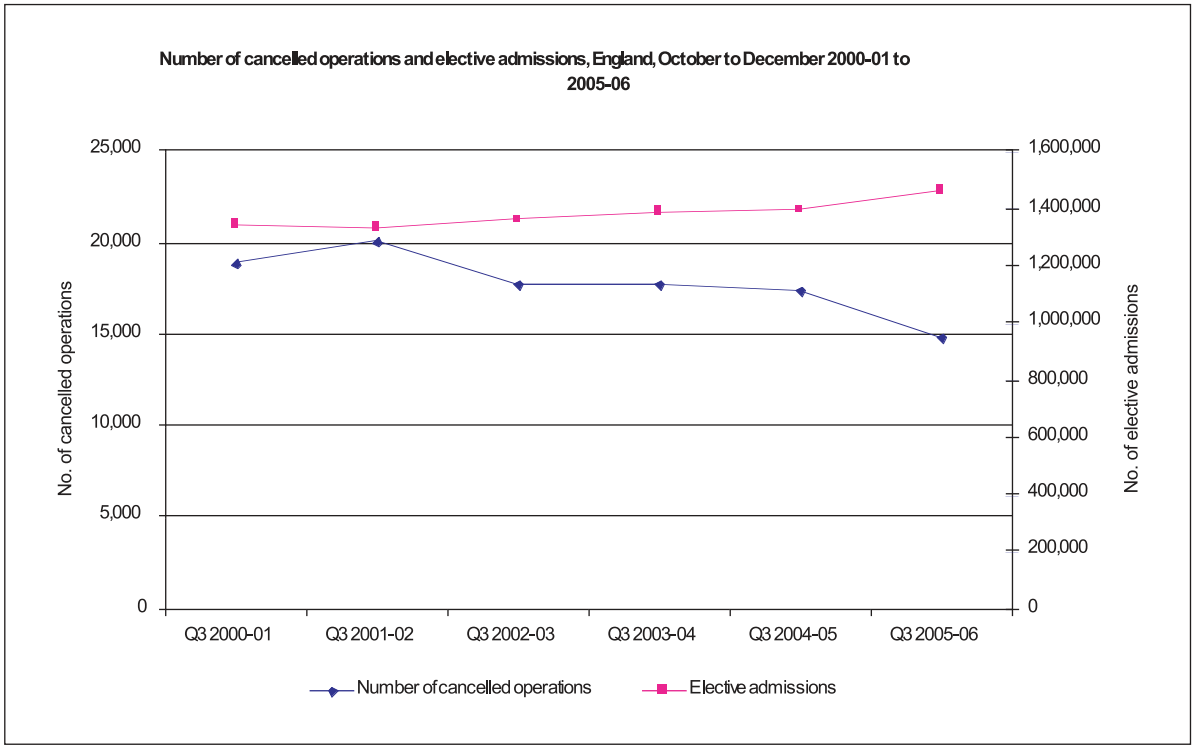
Quote from patient visiting Royal Surrey County Hospital

Well over 19 out of 20 patients are now seen, diagnosed and treated within four hours with the majority in and out in under two hours. Over the last twelve months the four hour target has moved from an ambition to an embedded professional standard that patients expect to be delivered and – crucially – the NHS expects of itself. It helps define NHS emergency care as world class – no other health system sets itself such a demanding standard.

# 2.6 Cancelled operations

'Last minute' cancellations are cancellations that occur on, or after the day that the patient was due to be admitted.

Number of last minute cancelled operations (for non-clinical reasons) in England: Quarter 3, 2000-01 to Quarter 3, 2005-06




Between October and December 2005 (Quarter 3, 2005-06), 14,818 operations were cancelled at the last minute due to non-clinical reasons (1.0% of all elective admissions). This is 14.8% lower than the same period in 2004-05, and 21.4% lower than the same period five years ago – despite an 8.6% increase in elective admissions over the past five years.

Under the NHS cancelled operations guarantee, patients whose operations are cancelled at the last minute (i.e. on or after the day of admission) must be offered a new date within 28 days. Failing this, they have to be offered the choice of treatment at a different hospital – paid for by the first hospital. Under the new system of Payment by Results, there are even sharper incentives for hospitals to avoid cancelling. Not only does the hospital lose income when a patient chooses to be treated elsewhere under the Cancelled Operations guarantee, hospitals also lose income when patients choose to go to another hospital with lower levels of cancellations.

# 2.7 Critical Care

Adult critical care services have overall, performed well this winter and have met demands for critical care beds. The latest critical care bed statistics indicate that on 16 January 2006, there were 3,233 adult critical care beds available in England. This is 1.3% more beds than six months ago and 37% more than in January 2000 when there were 2,362 adult critical care beds in England. This is the highest number of critical care beds reported since these statistics were first collected in January 2000. However, as in previous years, some areas have – from time to time – come under particular pressure and the number of critically ill patients who have been transferred between hospitals for non-clinical reasons continues to be higher than we would wish.

In October 2005, a forum of critical care stakeholders – including the Department of Health – published a guide to good practice in the delivery of critical care. This Guide *'Quality Critical Care – beyond Comprehensive Critical Care'* includes examples of good practice and provides a range of indicators that, if applied systematically and are regularly audited, will result in improved patient experience and outcomes and reductions in the length of stay in critical care.

In November 2005, Dr Jane Eddleston was appointed the first ever specialist critical care clinical advisor to the Department. Dr Eddleston, who is also Medical Director of Critical Care at the Manchester Royal Infirmary, will provide specialist clinical support on critical care matters. She will also be working with a range of specialist clinical and operational organisations on the development of guidelines on the care of acutely ill patients in hospital who are at risk of becoming critically ill or who require levels or care greater than that normally provided on general medical or surgical wards.

# 2.8 Social Care

Social care contributes in many ways to successful management over the winter period, for example by addressing ways in which admission into hospital can be avoided, and by effective discharge planning.

### 2.8.1 Living at home

The Planning and Priorities Framework 2005-8 target to increase, by March 2006, the number of those supported intensively to live at home to 30% of the total being supported by social services at home or in residential care, has already been exceeded. Improvements in intensive home care services have contributed to this success. In 2005, 32% of older people were receiving intensive support in their own homes.

### 2.8.2 Falls services

The national service framework (NSF) for older people published in March 2001 required integrated falls services to be in place locally by 2005. The NSF provides a detailed description of what an integrated falls service should look like, including the different elements and people required for integrated service planning and provision. Using the available evidence as a base, the practical approaches taken by local health and social care communities engaged in the National Primary Care Team's Falls Collaborative have significantly reduced the numbers of falls in the over-65s.

### 2.8.3 Discharge planning

The NHS and Councils work together, using the toolkit, *Achieving timely simple discharge from hospital*, to ensure that patients are discharged from hospital as soon as it is safe. Significant progress has already been made in reducing the number of delays.


Between June 2001 and December 2005 the number of people delayed in hospital reduced from 6,361 to 2,196 and the number of people over the age of 75 delayed in hospital reduced from 5,396 to 1,663. Delays in the acute sector have fallen since 2001 by over 65% by December 2005, releasing about 1.5 million bed days a year. This is continuing evidence of NHS and local councils, in terms of strategic commissioning of community services across health and social care, ensuring the correct range and capacity of services are available. Winter 2005-06 showed an improvement over last year. At December 2005, the total number of delayed transfers, as a proportion of the number of occupied beds, was 2.1%, and for December 2004 the figure was 2.3%.

### Case Study: Effective Discharge Planning: Trowbridge Hospital, Wiltshire

In Wiltshire, Trowbridge Hospital has successfully developed a project to improve patient discharge planning and promote independence. Project goals include: no care home placements from hospital, to meet and exceed target average length of hospital stay of 14 days, minimise delayed discharges: acute and community and reduce bed occupancy. Following a process mapping and redesign exercise by staff, a number of changes were made. An estimated discharge date was set within 24 hours of admission and prior to admission where possible, the multi-disciplinary team assessments to begin within 24 hours of admission, and the team having a daily handover. Additional investment in ward social work time was also made. As a result length of stay and re-admission rates have fallen, and the number of local authority funded placements has significantly reduced.

# 3. The Future

The NHS is changing rapidly. Real improvements have been achieved which everyone who works in the NHS should be proud of. But more needs to be done to make the long-lasting improvements we all want for our health and care services.

Further change is needed to make sure that the service meets people's expectations of a 21st Century service. One that responds to what it's patients want and offers care based around their needs and preferences rather than what is easiest to organise. There is a need to increase the focus on health improvement, keeping people out of hospital rather than in it. We need to offer patients greater empowerment and scope for self-care, partnership with their health professionals to better manage their ongoing needs. We must ensure that the system is geared to deliver the very best value for money and we need to make sure our staff are valued and supported, with time and freedom to do the best that they can for their patients.

Half way through the *'NHS Plan'*, the health service is in a crucial phase of reform and 2006 will be a year of considerable change.

During the year, many of the key elements of reform will become embedded as we continue to create a self-improving, patient-led health service. Payment by results will be extended in April. More trusts will begin to use the benefits of foundation status to benefit their patients. The roll out of practice based commissioning will put more control in the hands of those clinicians nearest to patients. The range of hospital options available to patients will increase as patients see the benefits of extended choice. Progress towards the 18-week referral-to-treatment pathway will require locally-driven service redesign – old methods of top down performance management will not be sufficient to deliver this. The service will undergo significant organisational change to develop PCTs as strong, effective commissioners, driving the very best services for patients and ensuring value for money, as well as changes in SHAs and ambulance trusts.

At the same time, following the publication of the *'Our Health, Our Care, Our Say* White Paper', we will see many of the principles of reform that are already driving improvements in secondary care, being introduced into community services. The White Paper set out a vision of changes to make sure that all these services also listen better to patients, are more flexible, put patients in control and provide services that suit their needs. We are bringing NHS staff – such as community nurses and GPs – and social care service closer together so that they work better as a team.

Complementary to these recommendations, are those published in Peter Bradley's review of ambulance services, *'Taking Healthcare to the Patient: Transforming NHS ambulance services'* which considered the long term direction and development of English ambulance services. The future vision ranges from delivering trauma services and urgent care through to supporting people with long-term conditions, on-scene diagnostic services and preventative health promotion.

**Focus on prevention** – *Our Health, Our Care, Our Say*, builds on the prevention agenda established by the *Choosing Health* White Paper. Key proposals include the piloting of NHS "Life Checks" to help people assess their own risk of ill health.

In addition, the *'Partnerships for Older People Projects'* (POPPs) are a £60 million scheme that will highlight preventative approaches to help older people lead active, healthy and independent lives. By helping people stay healthy, they will be less vulnerable to seasonal infections and illnesses.

Ambulance services have significant potential to contribute to health promotion and prevention of emergencies. Patients with diabetes or asthma are often seen by ambulance services. This provides an excellent opportunity for health promotion and advice on self care, as well as integrating patients' care with their primary care provider.

**Helping people control their own health** – People with long-term conditions will be better able to control and manage their own health, reducing the likelihood that they will be admitted to hospital in an emergency. This is because they will have greater knowledge and skills, allowing them to take more responsibility for their own health. We are expanding the Expert Patient Programme and, by 2008, people with long-term conditions will receive information prescriptions about their conditions. Increasing people's knowledge will allow them to do more self-care and reduce demand for NHS services.

**Care convenient to the patient** – People will find it easier to get help when they need it. GP surgeries will open at times to suit the needs of people and the new pharmacy contract means that pharmacies can be a good first point of call for minor ailments. There will be less likelihood of people not getting care when they need it.

There is an ongoing shift in the NHS towards community-based primary and secondary care services. Whether they need urgent or planned care, patients should increasingly receive advice, assessment, diagnosis, treatment and care in or close to their homes, particularly in rural areas where there may be greater difficulty accessing traditional secondary care services. As a mobile health resource, ambulances will in future be able to provide an increasing range of assessment, treatment and diagnostic services. The ambulance service should be playing a greater role in providing care closer to home.

**Close working between health and social care** – There is going to be closer working between health and social care through the establishment of joint teams, more joint commissioning and personal health and social care plans for people who need them. Such closer working will particularly help frail older people, who are most at risk during winter.

**New urgent care strategy** – In line with the new White Paper, urgent care will be planned and delivered on a whole system basis. It will be coordinated by the Urgent Care Networks, involving all the different partners as well as patients and the public. Out of hours services will work closely with ambulance services and nurse led out of hospitals. Care will be delivered as close to home as possible using mobile teams as well as Emergency Care Practitioners. There will be a new focus on preventative care so that fewer people will need to go to hospitals. Minor injury and illness will wherever possible be dealt with close to home and proactive care of the elderly and those with LTCs will become the norm.

By providing more care closer to home and working to improve the health of the nation, reducing the number of unnecessary emergency admissions will in the future help with the management of winter by allowing emergency care staff to focus their time on those who need it. We are confident that these reforms combined with the continuing hard work of NHS staff will ensure that the difficulties associated with the winter season can be handled even better and provide further improvement to services for all our patients.




274066 Mar 06
Produced by COI for the Department of Health

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