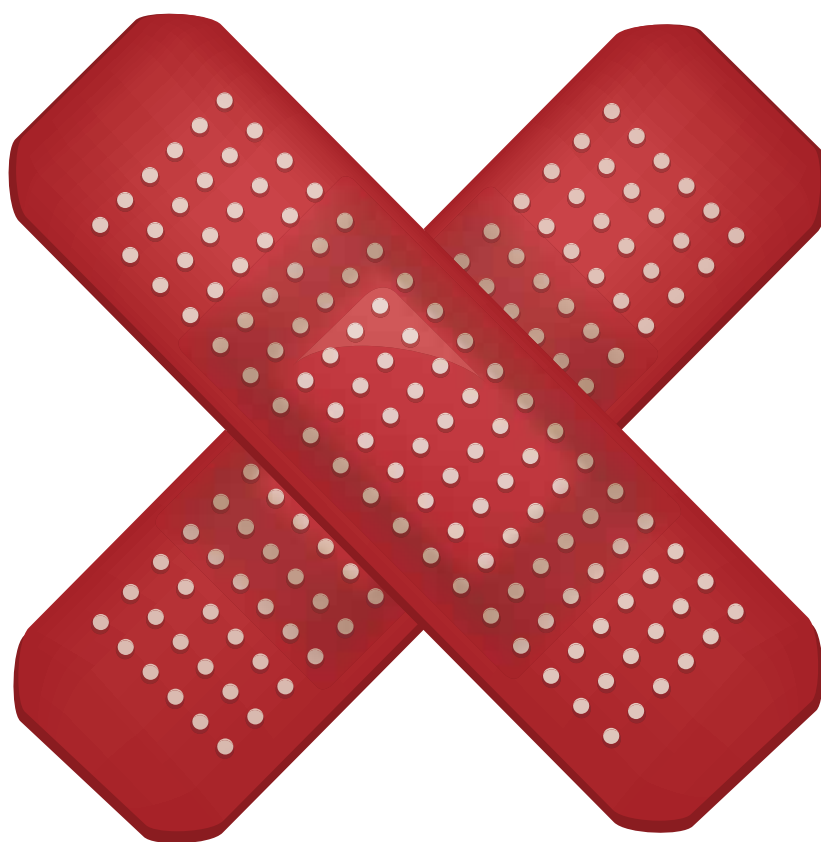




# Ripping off the sticking plaster

Whole-system solutions for urgent and emergency care



## Urgent and Emergency Care Forum

The NHS Confederation's Urgent and Emergency Care Forum brings together commissioners and providers of urgent and emergency care services to work in close collaboration with partners and stakeholders at a national level. The forum represents the whole healthcare system on issues of common interest relating to the delivery of urgent, emergency and unscheduled care.

For the benefit of our members, the forum seeks to influence government and regulatory policy; to develop ideas for service improvement and to raise the service profile of the many existing examples of excellent patient care.

For more information about our work, please visit [www.nhsconfed.org/urgentcare](http://www.nhsconfed.org/urgentcare) or email [viviana.olivetto@nhsconfed.org](mailto:viviana.olivetto@nhsconfed.org)

## The NHS Confederation

The NHS Confederation is the membership body that brings together the full range of organisations that commission and provide NHS services.

We bring together the views of each and every part of the healthcare system to provide a strong voice for the whole of the NHS in a way that no other organisation can.

We work with our members and health and social care partners to help the NHS guarantee high standards of care for patients and the public by:

- influencing health policy by representing our members' views to Government, Parliament, policymakers and the public
- making sense of the whole health system with our publications and information services
- championing good practice at events, in workshops and forums, and through partnerships
- supporting the health industry with the help of the NHS Employers organisation and the NHS European Office.

[www.nhsconfed.org](http://www.nhsconfed.org)

**For more information on our work,  
please contact:**

The NHS Confederation  
50 Broadway London SW1H 0DB  
Tel 020 7799 6666  
Email [enquiries@nhsconfed.org](mailto:enquiries@nhsconfed.org)  
[www.nhsconfed.org](http://www.nhsconfed.org)

Registered Charity no. 1090329

Published by the NHS Confederation © The NHS Confederation 2014  
You may copy or distribute this work, but you must give the author credit, you may not use it for commercial purposes, and you may not alter, transform or build upon this work.

# Contents

Executive summary	4
Introduction	8
Understanding demand	9
Emergency care networks	12
Improving access and navigation	14
A system and workforce fit for the future	20
Conclusion	25
References	26

# Executive summary

Mounting pressures on England's urgent and emergency care services have been well documented in local and national media over recent months. With headlines of "A&E in crisis" and "emergency services in meltdown" never too far from a front page, the topic has stimulated significant political and public debate. The task ahead for the NHS is to move beyond the headlines and handwringing and find practical whole-system solutions to address current pressures and avert future crises. Failure to find such solutions, and to act on them quickly, could have dire consequences for patients, and for the NHS as a whole.

The NHS Confederation's Urgent and Emergency Care Forum brings together organisations from across the whole health and care system to debate, develop and share ideas for improving urgent and emergency care. From the work of the forum we know that growing strain on the system is the result of multiple and complicated factors, often varying in different parts of the country.

The sheer scale of the challenge means that it cannot be tackled by NHS organisations working in isolation. Solutions hinge on change happening across the system, and leadership and shared responsibility that unites all parts of the service. Debate and attention has tended to focus on acute hospitals and their emergency departments, as they are often the point where the pressures become most visible. However, we believe that effective responses to these pressures require a whole-system approach that involves all commissioners and providers of hospital, ambulance, primary, community, mental health and social care services working effectively together.

In *Emergency care: an accident waiting to happen?* the NHS Confederation noted concerns from members that only sticking plaster solutions were being offered.<sup>1</sup>

This follow-up report acts as a roadmap to the fundamental changes required to create a sustainable and high-quality urgent and emergency care system that can meet the needs of patients now and in the future. While this destination is clear, the public and politicians will need to recognise that the journey to get there may vary in each area, according to the resources, needs and priorities in different communities. As the NHS Confederation's 2015 Challenge campaign sets out, we must ensure the health and care system has the freedom and flexibility it needs to develop solutions that will deliver the best possible outcomes for patients and the public.

The report draws on a review of the literature and evidence commissioned from the University of Sheffield's School of Health and Related Research (SchARR), and on the knowledge and experience of our members as shared through a programme of forum events, visits and steering group meetings.

It does not, and should not, claim to present all of the answers to how we address the challenges facing urgent and emergency care – they are to be discovered by local NHS organisations and their partners in local government, the voluntary and independent sectors, working with the communities they serve. Our members are already doing this, and there are many great examples of progress being achieved. A number of these are set out as case studies in the report, along with a series of recommendations to national policymakers and local leaders in three areas where we believe the need for action is most pressing: establishing emergency care networks; improving access to care; and developing an urgent and emergency care system and workforce that is fit for the future.

## Emergency care networks

Sir Bruce Keogh's review of urgent and emergency care services proposed the development of emergency care networks, which we welcome. Properly designed, the networks could provide sorely needed system leadership and coordination. To ensure their success, NHS England should set out the broad principles for how they will work but allow local areas the freedom to develop the networks to fit their circumstances. In particular, the networks must be able to innovate and develop bold solutions for effectively managing capacity and demand. This could mean networks considering different funding models and payment mechanisms, for example taking on the management of an urgent and emergency care budget at a network level.

NHS England will also need to learn lessons from the experiences of urgent care groups and boards. Some of our members have suggested their function is limited and that they have failed to overcome a number of problems, such as securing the right membership and setting a strategic focus. It is crucial that emergency care networks avoid these problems, complement existing architecture and avoid any potential for duplication.

We urge caution over NHS England's suggestion that emergency care networks should be based on the major trauma network model. Patients with life-threatening conditions requiring the services of specialist major emergency centres comprise the smallest proportion of the population requiring some form of urgent or emergency care. We are concerned that basing networks on a major trauma network model would risk excluding key parts of the system, such as community services.

## Access to urgent and emergency care

Accessing the urgent and emergency care system can be complicated; patients will often go 'where the lights are on' – somewhere convenient and accessible. Though understandable, this can lead to delays in accessing the most appropriate part of the system for their care needs.

The NHS cannot – and must not – simply label patients' decisions about where they access services as 'wrong'. Commissioners and providers need to fully understand the rationale behind individuals' decisions and work collaboratively with the public to help them access care and support in the most effective way. This requires improving awareness of local services and the care people can reasonably expect from the NHS. Local public and media campaigns are just one component of broader efforts NHS organisations need to take to engage with patients, service users and carers.

There also needs to be more information available to and used by GPs – in their role as gatekeepers in the local system – about the contributions that can be made by other services and agencies in the provision of preventative care and support for self-care across mental and physical health.

More needs to be done across the whole NHS to move towards a clear, single point of access for urgent and emergency care. It is crucial to establish effective and consistent triage to ensure people requiring both physical and mental health services are quickly directed to the correct part of the system, and there are a number of ways this form of triaging can be done. Patients could be encouraged to telephone before they visit an urgent care service (the so-called 'talk before you walk' approach). We recommend that NHS England promotes more widespread use of combined

urgent and emergency care centres that cater for all attendees. Here, patients are streamed to different parts of the centre on arrival and no condition is deemed inappropriate for treatment, advice or redirection.

The significant problems experienced in some areas with NHS 111 should not detract from the potential inherent in having one telephone number as a single entry point to improve access. The next phase of NHS England's review should consider how senior clinical involvement can be further integrated within NHS 111, as well as the development of an online counterpart to support access via all the different channels that people now expect to use.

In all action to improve access, triage, and care and support for those requiring urgent or emergency care, there must be parity in the responses to those with mental and physical healthcare needs.

## Getting the best from the urgent and emergency care system and workforce

Getting clinical professionals with the right skills in the right place at the right time will be vital to tackling pressures on the urgent and emergency care system. We recommend that emergency care networks play a role in coordinating how scarce specialist resources, including emergency medical consultants, are deployed across their local areas.

The NHS must continue to improve the education, information, engagement and support available to staff to enable them to decide whether a patient should be treated in an emergency department or a more appropriate alternative. Where work has been

**'We recommend that emergency care networks play a role in coordinating how scarce specialist resources, including emergency medical consultants, are deployed across their local areas'**

done to engage clinicians in finding solutions to manage capacity and demand, such as to better support paramedics in making decisions about when to convey patients to emergency departments, it has led to a decrease in 'inappropriate' attendances and admissions.

The NHS also needs to train a workforce that is fit for the future. We encourage Health Education England to continue to support the development of more community-based services through, for example, enhancing paramedic practitioner roles.

The wider system of community, primary, mental health and social care also needs to adapt and develop to ensure appropriate services are in place to help prevent the need for urgent and emergency care, and to provide alternatives to the emergency department.

## Our key recommendations

1. To ensure emergency care networks are successful, NHS England must set out the broad principles for how they will work but allow local areas the freedom to develop the networks to fit local needs.
2. Emergency care networks must innovate and be bold in developing solutions. For example, they could examine the feasibility of managing budgets for their whole system to maximise their ability to coordinate services.
3. Effective and consistent triage systems must be established in all organisations across an emergency care network, to ensure people requiring both physical and mental health services are quickly directed to the correct part of the system.
4. The next phase of NHS England's review should consider how senior clinical involvement can be further integrated within NHS 111, covering both physical and mental health.
5. NHS England should work to develop an online counterpart to NHS 111.
6. The service needs to understand the rationale behind individuals' decisions about where, when and how to use the NHS, and work collaboratively with the public to help them do this in the most effective way.
7. Emergency care networks should play a role in coordinating how scarce specialist resources, including emergency medical consultants, are deployed across their local areas.
8. Health Education England should continue to focus on supporting the development of community-based services through, for example, enhancing paramedic practitioner roles.
9. More information must be made available to, and used by, GPs – in their role as gatekeepers in the local system – about the contributions that can be made by other services and agencies in the provision of preventative care and support for self-care across mental and physical health.
10. The NHS needs to ensure parity of urgent and emergency care responses for those with mental and physical health needs.

# Introduction

Demand for urgent and emergency care continues to increase year on year and it has been evident for some time that the system for delivering this care must adapt to meet ongoing and new challenges.

The recent report of phase one of NHS England's Urgent and Emergency Care Review outlined five key elements at the heart of future service delivery:

- self-care
- right advice in the right place, first time
- more responsive out-of-hospital care
- the redesign of emergency treatment to maximise chances of survival and a good recovery
- ensuring the entire urgent and emergency care system "becomes more than just the sum of its parts".<sup>2</sup>

The NHS Confederation welcomed the review's framework for a future urgent and emergency care system and the positive story it told about the changes needed to achieve it.<sup>3</sup> We also recognised the immediate need for practical, whole-system solutions to support the establishment of an urgent and emergency care system that is fit for purpose.

Attempts to find solutions that deliver real impact need to be supported by a detailed understanding of the real issues facing local urgent and emergency care systems and, as far as possible, be evidence based. We have worked with the University of Sheffield's School of Health and Related Research (ScHARR) to examine a range of existing evidence on the factors driving increasing demand and effective responses to this, and to highlight areas where further consideration is needed.

This report draws on the evidence and makes a series of recommendations to support the implementation of NHS England's review. It showcases examples of whole-system initiatives to effectively manage urgent and emergency care demand already in use in several of our members' organisations. The report also forms an integral part of the NHS Confederation's 2015 Challenge campaign, a two-part challenge to politicians to create the space for necessary service change, and to the NHS to implement robust, cross-system plans for improvement and sustainability.

**'Demand for urgent and emergency care continues to increase year on year and it has been evident for some time that the system for delivering this care must adapt to meet ongoing and new challenges'**



# Understanding demand

A critical first step to managing demand for urgent and emergency care is understanding demand drivers and the reasons for changes.

While there has been significant public debate and postulation regarding the causes of pressures on emergency departments, NHS England and the Health Select Committee<sup>4</sup> have acknowledged the lack of clear and detailed information on whole-system demand in recent reviews of urgent and emergency care services. Without a comprehensive understanding of demand, including the characteristics of service users, there will be a lack of alignment between any proposed system responses and the actual underlying need. So what do we know?

- Growing demand for emergency department (ED) care is not a new trend.<sup>5</sup> First attendances at English EDs doubled in the four decades to 2006/07, from 6.8 million to 13.6 million – equivalent to an increase from 138 to 267 first attendances per 1,000 people each year.
- The rate of demand growth in first attendances at major (type 1) EDs has slowed since then, reaching 14.3 million in 2012/13. However, there has been a rapid rise in the use of type 3 facilities, such as minor injury units, with attendances growing by 46 per cent between 2006/07 and 2012/13, reaching 6.9 million.<sup>6</sup>
- There has been a marked shift in the proportion of older people attending EDs over the past 25 years. The workforce, skills and capacity required to care for frail elderly patients, typically with multiple long-term conditions, are different from those required for caring for 15–24-year-olds, who remain the largest group of attendees, but often with single conditions.

- There was a 26 per cent increase in emergency calls between 2007/08 and 2012/13.<sup>7</sup> While the proportion of patients transported to hospital declined during this period, there is a lack of thorough analysis of demographics and call characteristics.
- These demand patterns are not unique to England, with similar changes reported in other countries.<sup>8,9,10</sup>
- In England, a substantial proportion of urgent care is managed by primary care providers: according to a 2012 population survey, 60 per cent of urgent and emergency care service users contact their GP as the first port of call.<sup>11</sup>
- While there is no national data collection for urgent care contacts with primary care, an NHS 111 evaluation measured whole-system demand (excluding in-hours GP contacts) across seven former primary care trust areas. Costs associated with these contacts were found to have increased by around 4 per cent annually over the three-year period.<sup>12</sup>

## What are the reasons for increasing demand?

Our ageing population is often identified as the main cause of increases in demand for health services, and there is clear evidence of the impact of demographic change on the care system. In a recent survey of our members, which asked about their experiences as providers and commissioners of urgent and emergency care, this was the most frequently cited cause of demand growth.<sup>13</sup> However, the full story behind changes in demand is more intricate than is usually reported.

**‘A number of individually significant factors all combine into a complex whole to determine utilisation of urgent and emergency care’**

A rapid evidence review conducted on behalf of the Urgent and Emergency Care Forum in late 2013 highlighted a broad range of factors that contribute to demand, which are associated with both need and decision-making about where to access care. The evidence is available in detail on the NHS Confederation website, and is summarised in the box on page 11.<sup>14</sup>

What it shows is that a number of individually significant factors, including the changing health needs of an older population but also social factors such as deprivation and service factors like changing performance targets, all combine into a complex whole to determine utilisation of urgent and emergency care.

This underlines the need to understand the true reasons for demand growth if effective responses are to be found.

## **Tackling demand**

In the current financial climate, with year-on-year efficiency savings required of the NHS, urgent and emergency care services are unlikely to see significant and sustained extra investment, a solution that has been available in recent decades to help meet rising demand. If quality and access are to be protected, the only alternative now is to radically change the way care and support is provided to better cope with growing demand and the complicated, changing set of pressures being experienced across the NHS.

The NHS Confederation’s briefing *Emergency care: an accident waiting to happen?* summarised members’ views on the consequences of failing to tackle these pressures. Members were concerned that inaction could result in increased waiting times, put patient safety at risk and potentially push NHS organisations into financial failure.

The following sections set out the main areas where we believe change is required, and outline the actions needed to ensure the urgent and emergency care system is sustainable in the long term and better meets patients’ changing needs.

## Factors associated with increased use of urgent and emergency care

### Health needs and the ability to respond (services and patients):

- **Ageing population:** more frequent users; more people who suffer a fall; more complex conditions; less able to self care
- **Deprivation and social factors:** loneliness and lack of social support; access to transport; cultural differences and understanding of primary care services; public health-related problems
- **Changes to care provision:** for example, primary care access and social care eligibility
- **Performance targets:** for example, the four-hour A&E standard; Red 1 response times
- **Health promotion and public information campaigns:** increased awareness and expectations.

### Making decisions about accessing care:

- **Convenience and confidence:** understanding how the system works and where access is perceived to be easier, with shorter waiting times
- **Perceived limitations of primary care:** previous experience or belief that community options are too slow or duplicative; that only hospital doctors can rule out serious illness
- **Directed by other services:** NHS Direct/111; out-of-hours and in-hours GP services; professional risk aversion
- **Patient/public risk aversion:** uncertainty about seriousness; dislike waiting for call back; bystanders and family/carers more likely to contact emergency than urgent care.

# Emergency care networks

A robust and sustainable urgent and emergency care system requires both clear leadership and shared responsibility between all stakeholders involved. NHS England identified the need to “connect all urgent and emergency care services together so the overall system becomes more than just the sum of its parts” as an integral element of its review, and advocated emergency care networks as a means to do so. We believe there is good cause to endorse and support these networks, and have identified several practical issues for NHS England to consider as they are developed.

Clinical networks coordinating services for specific patient groups have worked successfully in the NHS. In 2004, a National Audit Office study suggested that a network approach had the potential to drive change in urgent and emergency care<sup>15</sup>, and a subsequent Department of Health review found a small number of well-functioning urgent and emergency care networks were operating by 2007.<sup>16</sup> **The evidence from these reviews points to a number of contributory factors to network success, which NHS England should consider when implementing its own recommendations.** It suggests that effective networks will have:

- clear network objectives and expected system outcomes
- board membership that reflects aims and objectives, but also includes a diverse range of commissioners and providers
- senior-level commitment and strong leadership, underpinned by providers and commissioners open to change and cooperative working
- a two-tiered model, with the board managing strategic issues and local groups ensuring implementation of agreed objectives
- dedicated funding for network management and information systems.

**‘The development of well-led and empowered networks might be the single most important factor determining whether long-term objectives for improving urgent and emergency care are met’**

An effective network should also ensure it has robust governance arrangements in place, takes responsibility for performance management and evaluates innovative solutions and best practice.

More recently, urgent care boards and groups have been introduced in an attempt to manage short-term system problems, but their role is not well defined and there is a lack of empirical evidence on their effectiveness. Some of our members have suggested their function is limited, as they have failed to overcome problems with: agreeing membership; maintaining strategic focus and direction; engaging stakeholders; developing a collaborative culture; and effecting change.

The development of well-led and empowered networks might be the single most important factor determining whether long-term objectives for improving urgent and emergency care are met. The variable success so far of urgent care boards underlines that localities must have the necessary autonomy to develop such networks in the most appropriate way for them to meet local needs. It will be crucial that they secure effective participation, complement the existing architecture for local decision-making and planning, and avoid duplication in system oversight.

**We urge NHS England to avoid any temptation to be prescriptive in the design of emergency care networks, and to adopt instead a principle-based approach. In particular, the networks must be able to innovate and develop bold solutions to local pressures.**

This could mean agreeing different funding models and mechanisms, or even managing an urgent and emergency care services budget at a network level, for example.

**We question NHS England's suggestion that emergency care networks should be based on the major trauma network model,** with responsibility for system delivery resting with major emergency centres. Patients with life-threatening conditions requiring the care of specialist major emergency centres comprise the smallest proportion of the urgent and emergency care population. There are questions as to whether assigning responsibility for system delivery and performance to the provider responsible for the smallest sub-set of patients is acceptable to the wider system, and whether such providers are best placed to manage the complexity of workforce and skill-mix deployment across primary, community and acute services.

As part of the work to develop emergency care networks, NHS England should:

- learn lessons from current network models in developing a **principle-based design approach**
- consider the development of **whole-system, outcome-based performance metrics** and evaluate the efficacy of performance targets for individual parts of the system
- examine how networks can play the most effective part in influencing commissioning strategies, and **informing commissioning decisions** so they are taken to benefit the whole urgent and emergency care system.

We do not underestimate the difficulties and challenges associated with developing a network model. It will require courage, vision, leadership and commitment to ensure progress is made on innovation and collaborative working across multiple sectors. The objective now is to find ways to move forward constructively and tackle the practical issues likely to arise. **NHS England should take the lead while ensuring our members and partners from across the system, including patient groups and social care commissioners and providers, are engaged throughout.**

# Improving access and navigation

NHS England's review recognised the need to improve access for patients to ensure they can easily navigate the system, citing "helping people with urgent care needs to get the right advice in the right place, first time" as one of its priorities.

Our members acknowledge that the variety of different ways to access urgent and emergency care, such as walk-in centres and minor injury units, can create confusion. Demystifying such a complex system for the public will be crucial in reducing the pressures placed on emergency departments. This will also ensure patients and service users are more quickly treated in the right place, which may often be in community-based settings rather than hospitals. Many of our members have already devised innovative local solutions to ensure the right care is provided in the right place at the right time (see case studies on pages 15, 18 and 21).

**We believe more needs to be done across the whole NHS to move towards a clear, single point of access for urgent and emergency care. Effective and consistent triage is essential to ensure patients and service users are quickly directed to the correct part of the system.**

Having one telephone number that provides a single entry point to the health service would help to address this.

## NHS 111

NHS 111 has the potential to act as a unique contact point and enable effective, consistent triage. Although there have been significant problems in some areas as NHS 111 has been rolled out – widely reported in the media – there are promising signs in other parts of the country.

The evaluation of the first four NHS 111 pilot sites highlighted some encouraging evidence, such as the high awareness of the service among disabled people and those with long-

term illnesses.<sup>17</sup> This indicated that it was reaching some of the people likely to have the greatest needs. The evaluation also showed that users were satisfied with the new service. However, researchers identified the need to review the relevance of questions asked and the advice given in some calls. Concerns about a lack of clinical input in call handling have also been raised.

A number of actions are needed to address anxieties surrounding NHS 111. We are encouraged that NHS England's review highlighted the need for early senior clinical involvement to tackle inappropriate emergency referrals and provide more self-help advice. Prompt GP telephone consultation can be effective in managing urgent problems out of hospital, and including clinicians in the NHS 111 service would help ensure there are no delays in transferring calls. Action also needs to be taken so that staff are fully trained on handling calls – including from people with mental health conditions – and can provide appropriate advice.

**The next phase of NHS England's review should consider how senior clinical involvement can be further integrated within NHS 111, covering both physical and mental health. We are also concerned that there is no online counterpart to NHS 111 and believe this should also be addressed.**

The NHS 111 pilot evaluation found some evidence of service integration prompted by its rollout. For example, some call advisers were able to dispatch an ambulance without further triage, and links in certain sites allowed appointments to be made with urgent care providers during the initial call. Nevertheless, there is clearly scope for further integration. Key to this is the alignment of NHS 111 with 999, which would help to join up efforts across the two services and better ensure that patients and service users do not fall between the cracks.

## **Case study: Collaborative care teams and ambulatory care reduce unscheduled admissions in Airedale**

### **Collaborative care team**

Airedale's collaborative care team (CCT) initiative was launched in 2008 to establish an integrated care team tasked with preventing unnecessary admissions and facilitating efficient hospital discharge. At the heart of the CCT approach lies the principle that patients should only be in hospital when this is of clear benefit to them. Board sign up was secured early on, with partner organisations demonstrating integration can be delivered without the need for a single organisation. The strong relationships between providers and commissioners in Airedale helped to address many of the common challenges inherently associated with developing a CCT model, such as organisational structures and line management.

### **What has it achieved?**

One of the key drivers for local authority engagement was to minimise the number of people requiring long-term care, particularly in the current financial climate. There has been a downward trend in long-term care cases since 2008 as a result of the CCT. Feedback from patients, carers and relatives has been extremely positive, with 100 per cent of patients for Airedale CCT and 98 per cent for Craven CCT reporting that the quality of services is "excellent" or "good" in the most recent patient satisfaction surveys. Moreover, patients report that they prefer the services offered to hospital care.

### **Challenges and lessons learned**

It was clear from the start that the CCT programme needed to be scaled at pace and that it offered patients clear alternatives to previous forms of care. Stakeholder involvement from the beginning was essential, as well as establishing appropriate financial mechanisms to ensure resources could be effectively moved around the system. Supporting the teams most impacted by changes in working through the transition was also a key challenge.

### **Ambulatory care**

A new ambulatory care model was introduced in February 2013 in response to a difficult winter, and built upon the foundations of the CCT. There was acknowledgement of the need for improved communication between GPs and acute clinicians. Existing ambulatory pathways were enhanced, fronted by doctors and with rapid diagnostics.

### **What has it achieved?**

In the first half of 2013/14, the ambulatory care unit (ACU) played an integral role in helping almost a third of cases to avoid admission to hospital. A significant cultural shift has also been achieved; acute consultants no longer contend an increase in inpatient beds is the answer to anxieties about capacity, regarding ambulatory care to be more effective. Feedback from primary care teams has been extremely positive and hospital patients also benefit from increased ward resources.

### **Challenges and lessons learned**

Ensuring the appropriate location of the ACU within the pathway and investing in sufficient numbers of advanced nurse practitioners and additional acute physicians are among the main challenges. Airedale is now aiming to co-locate the ACU with their ED and clinical decisions unit within the next two years to enable further progress.



There are lessons to be learned from the original procurement process for NHS 111. Where NHS 111 and 999 services are co-located, such as in the South West, they are reported to work well. While this may not be an appropriate solution everywhere, **we recommend that commissioners consider how to align 999 and NHS 111. This may mean bundling the services when they tender for them in future, or building requirements for integration into service specifications. There is unlikely to be a single right approach** and greater alignment will not happen overnight, but it is a direction of travel that will help improve care and service coordination.

It is paramount that NHS 111 providers, however they are organised and located, are able to both gather and share information among other local care providers and commissioners. An up-to-date directory of local services, which call handlers can use to help patients make the right choices across the system – including the full range of community and mental health services – is a crucial part of this endeavour. As one of our members described it, a comprehensive directory is “the engine in the vehicle” of 111. The directory can also be used by commissioners as a useful tool for identifying gaps in local urgent and emergency services.

**We recommend that emergency care networks be responsible for ensuring the directory of services for their area is updated and used effectively.** To maximise its effectiveness, the directory’s design will need to be locally determined.

## Changing expectations and behaviours

---

Our members know that people will often go ‘where the lights are on’ – wherever is convenient and accessible – when looking for care or advice. In many cases, the preferred destination will be an ED. While this is understandable, this default setting can often lead to delays in patients accessing the most appropriate care, as well as sub-optimal use of the specialist resources in services that are already under pressure.

**The NHS’s response to this cannot be to simply label people’s decisions as ‘wrong’. The service needs to understand the rationale behind individuals’ decisions about where, when and how to use the NHS, and work collaboratively with the public to help them do this in the most effective way. This involves improving the public’s general awareness of the full range of local resources and, more broadly, what care they can reasonably expect from the health service. It also means making it easy for people to make specific decisions about how to access care when it is immediately required.**

Our members have suggested that more public information should be made available at a national level to support this, and welcome initiatives such as NHS England’s recent *The earlier, the better* campaign, which aims to encourage more self-care or treatment within community pharmacies. However, evidence suggests that such public education campaigns will not be enough on their own to change expectations and behaviour.

There are a number of practical initiatives that could help to direct service users to the most appropriate point of access when care is required, such as a ‘talk before you walk’



system, where patients call before they visit an urgent care service. There are examples of such systems being used successfully in Denmark.<sup>18</sup> As already outlined, an effective 111 service is part of the solution within our existing model.

The expectations and behaviour of NHS staff also requires consideration, given that attendances at emergency departments are often the result of decisions made by clinicians, not of patient choice. **The health service needs to continue to improve training, information, engagement and support to enable NHS staff to question and decide whether a patient should be treated in an emergency department or a more appropriate alternative.**

A major part of the South West Ambulance Service Foundation Trust's *Right Care, Right Place, Right Time* initiative was improving the engagement of clinicians in work to reduce 'inappropriate' emergency attendances and admissions, and better supporting paramedics to make the decision whether or not to convey patients to an emergency department. This has led to around a 5 per cent reduction in the number of patients taken to emergency departments between April 2011 and April 2013 (see case study on page 18).<sup>19</sup>

When people do make the decision to attend an urgent or emergency care service – or are taken there by ambulance – triage, referral and appropriate treatment needs to be prompt and efficient. **We recommend that NHS England continues to encourage more widespread use of co-located urgent and emergency care centres that cater for all attendees, particularly in urban areas.** In this model, patients are streamed to different parts of the centre on arrival and no condition is deemed inappropriate for treatment, advice or redirection. There are examples of this working well in the Netherlands.<sup>20</sup> A recent review<sup>21</sup>

of the role of walk-in centres in the NHS has similarly recommended that they need to be better integrated with emergency departments if they are to have an effective role in demand management.

All such initiatives to change models of care and to influence how people access services must form part of broader efforts by the NHS to work in partnership with the public to shape the health service's future. NHS leaders, with their partners in local government, need to talk more to the public about their urgent and emergency care services. They have to use clear, accessible language to help raise public awareness about both the need for change, and the potential for things to be better. This should happen both locally and nationally, as part of a broader conversation on the future of the health and care system, something the NHS Confederation is leading through its 2015 Challenge campaign.

## Case study: Delivering the right care in the right place at the right time in the South West

With a predominantly rural population, high prevalence of frail elderly and long-term conditions, and a significant inequality gap, the South West has a history of collaboration in the delivery of healthcare, specifically managing urgent and emergency care pressures.

### Making change happen

South Devon and Torbay established a health and care cabinet for the region. It includes GPs, senior managers and clinicians from South Devon and Torbay Clinical Commissioning Group, South Devon Healthcare NHS Foundation Trust, Torbay and Southern Devon Health and Care NHS Trust, Devon Partnership Trust and South West Ambulance Service NHS Foundation Trust (SWASFT). Social care and public health representatives are also members.

The basis of the partnership is a shared vision to deliver high-value, coordinated and sustainable person-centred care, along with joint leadership, strong clinical input and shared information.

The cabinet is an effective tool to bridge the commissioner-provider gap, building a care system based on local needs and avoiding duplication. Joint planning allows for resources to be allocated in the most appropriate way, supporting prevention and treatment.

### What has it achieved?

Urgent and emergency care requires coordination, streamlined interventions and change delivered at pace to reduce or efficiently manage demand. This approach has been effective in reducing emergency admissions in the past three years, resulting in consistently positive outcomes and improved patient access.

In this framework, the ambulance service played a key role in reducing unnecessary urgent and emergency care demand on acute trusts, while working jointly with other local stakeholders.

In 2010, SWASFT signed up to the *Right Care, Right Place, Right Time* initiative, a five-year funded agreement that commits the trust to reducing unnecessary ED admissions by 10 per cent through appropriate conveyance. It is important to note the intention to avoid conveyance to EDs, not the hospital itself.

The Right Care model is supported by strong clinical commissioning group engagement, using feedback mechanisms on barriers that prevent ambulance clinicians from making the most appropriate conveyance decisions, such as quarterly Right Care joint meetings and bi-monthly contract review meetings. This mature commissioner-provider relationship allows for an open and constructive conversation on how to deliver the best needs-based care.

Referring patients to the right place sometimes means bypassing the ED and directly conveying to the computed tomography stroke pathway, angioplasty or major trauma centres, or direct surgical or medical admissions. This requires constant, direct communication and coordination with ED staff, in order to discuss appropriate conveyance or arrange swift handovers.

Detailed analysis of patient feedback over the past two years shows a direct benefit to patient experience, and a quantitative evaluation, in coordination with the Patients Association, is currently being undertaken. With a reduced call cycle for individual patients and lower conveyance costs, a financial balance has also been achieved.

**Keys to success**

Key elements for the success of this initiative have been:

- a cultural shift
- staff engagement
- clear and consistent cross-organisational communication
- clinical support
- tailored 'see and treat' paramedic training.

Communication between clinicians is paramount, in particular when there are negative experiences. SWASFT paramedics are supported through non-punitive serious incident reviews, and informal mechanisms are in place to resolve issues or discuss a medical incident with peer clinicians from other provider sectors. For example, in Somerset, a liaison group brings together lead clinicians from relevant minor injuries units and ambulance stations, enabling informal communication and learning, breaking professional barriers, and enhancing mutual understanding.

Issues remain and conflicting priorities across different sectors persist, but the Right Care initiative has demonstrated that they can be managed through open and up-front conversations and peer-to-peer support locally and nationally.

As one of 14 national pioneer sites, partners at South Devon and Torbay will be able to consider whole-scale transformation of the health, care, voluntary and community system over the next five to ten years.

# A system and workforce fit for the future

Building sustainable urgent and emergency care services will involve significant change to ways of working across the whole of the health and care system.

Supporting changes in emergency departments and ambulance services is necessary, but not sufficient if we are to create a system and workforce fit for the future. It is just as important that we develop community, primary, mental health and social care services so they can play their part in managing whole-system demand.

The final sections of this report examine a number of specific challenges concerning workforce and system capacity, highlight initiatives already underway from across our membership to overcome them, and identify recommendations to national bodies on what else needs to be done.

## Emergency medicine

A comprehensive 2013 assessment from the College of Emergency Medicine paints a worrying picture of the specialty, with 62 per cent of current emergency consultants reporting their job was “unsustainable in its current form”.<sup>22</sup> In each of the past three years, there has been a vacancy rate in emergency medicine specialist training posts of around 60 per cent. Surveys have found that while the majority of trainees enjoy their time in the ED, the number wishing to pursue a career in the specialty is on the decline, due to poor working conditions, the adverse work-life balance, a culture driven by targets and the absence of 24-hour support for the ED.

We are pleased that Health Education England has acknowledged the attrition rate and issued guidance to local education and training boards to ensure more trainees enter the

initial phase of acute training from 2014 in an attempt to mitigate the trend.<sup>23</sup> Sufficient support and engagement is needed with the trainees throughout the process, enabling them to devote appropriate time to their training.

**Health Education England should closely monitor progress on the implementation of its guidance to ensure it is delivering the necessary results.**

Recruitment and retention have proven to be particularly challenging for rural hospitals. However, the introduction of two levels of emergency centres, as proposed by NHS England, could help to address the issue of consultant deployment, **provided that emergency care networks can exercise the necessary autonomy around coordination to ensure the right staff are deployed in the right part of the system.** It is essential that both levels are configured to make them an attractive place to work, with links between the networks and deaneries crucial in this respect. The system also needs to ensure that the potential of roles such as advanced nurse practitioners and allied health professionals is realised.

## Ambulance services

A key element of phase one of NHS England’s review is “providing highly responsive urgent care services outside of hospital”. One of the main ways of making this happen is through more widespread recognition that ambulance services are well placed to do so. ‘Treat and leave’, whereby ambulance crews are able to provide appropriate care and support at the scene of a call, is already an option across ambulance services in England. **Conveyance rates do vary substantially, but further analysis is needed to understand the underlying reasons for variation, for example regional inequalities in morbidity and premature mortality rates.**

### Case study: Delivering seven-day care in Bassetlaw

In Bassetlaw, commissioners and providers have been working in partnership to enable consultant-delivered care seven days a week, reduce variation and improve clinical outcomes through a new model of care.

The drive to redesign the non-elective medical pathway at Bassetlaw Hospital was largely due to delays in assessments and treatment planning following admission. Evidence from a 2011 external audit highlighted higher weekend mortality rates and that 14 per cent of admissions to Bassetlaw Hospital were avoidable.

#### Making change happen

During 2011/12, Bassetlaw clinical commissioning group, primary and secondary care clinicians with community and social care providers worked jointly to develop the assessment treatment centre (ATC), a unit for medically ill patients with seven-day consultant-delivered care.

The ATC opened at Bassetlaw Hospital in November 2012 and receives patient admissions from A&E, GPs (in hours and out of hours), community services and ambulances. It has 21 beds with access to diagnostics, and enhanced pharmacy and dedicated social care support. An acute physician is present Monday to Friday, and a general physician at the weekends, resulting in consistent, high-quality seven-day consultant-delivered care. Additionally, the community rapid response service supports patient discharge over seven days.

The ATC also has a non-bedded ambulatory day care facility for patients with conditions such as deep vein thrombosis (which clinically do not require the patient to be admitted) to attend the unit for treatment and go home.

#### What has it achieved?

There has been reduced variability in patient experience, quality of care and outcomes, with a 12 per cent reduction in standardised mortality and a reduction in average length of stay of at least one day for non-elective medical patients since the ATC was established.

The skill mix and experience of staff supporting the ATC has improved due to a rotation system enabling them to gain a variety of skills as a part of a multi-disciplinary team. Improved staff morale, team working and training has contributed to an environment that offers ongoing development.

A&E is now supported with a clinically robust follow-on service. There has also been a reduction in locum staffing and a decline in inappropriate hospital stays.

#### Lessons learned

Early evaluation shows the ATC has improved clinical outcomes and patient experience, showcasing collaborative working with staff across health and social care boundaries to deliver high-quality care. Underpinning this collaboration has been a cultural shift among clinicians and managers with a focus on shared responsibility and leadership both at a system and organisational level.

The ATC is an evolving model that will continue to strengthen its cross-sector links to deliver a robust service, including the potential to co-locate and integrate A&E and ATC at Bassetlaw Hospital.

There is also good evidence that ambulance trusts can treat people effectively at home using paramedic practitioners, with reported high levels of patient satisfaction.<sup>24</sup> **We encourage Health Education England to continue to support the development of more community-based services through, for example, enhancing paramedic practitioner roles.**

While there is scope to increase specialist paramedic roles in this way, the right skills need to be extended to the wider workforce if the vision of more paramedic care in the community is to be realised.

Historically, the emphasis in paramedic training has been on dealing with life-threatening emergencies, but these cases now comprise only around 10 per cent of the overall workload.<sup>25</sup> The expectations, behaviours and skills of the workforce need to change, so that staff are comfortable treating and leaving more people at home or managing them in the community. New research on patient safety and decision-making for ambulance staff has identified a number of key issues that will need to be addressed if this agenda is to be taken forward.<sup>26</sup> In particular, it must be acknowledged that leaving people at home carries risk – paramedics need to be confident in their decisions or will continue to transport to hospital to mitigate this risk. Confidence is dependent on:

- good training to equip them with the skills they need to make sound decisions, underpinned by national standards
- availability of services to enable efficient referrals, with certainty that another professional will take over where appropriate.

**NHS England and Health Education England should do more to support the development of ambulance services as out-of-hospital providers by ensuring the workforce is properly equipped to play its role.** Emergency care networks could support the spread of good practice and may be best placed to consider where workforce investment would be most effective. The development of a range of sophisticated, whole-system outcomes-based indicators, akin to a balanced scorecard, would also help to ensure the assessment of ambulance providers' performance does not rest on response targets alone.

## Community services and primary care

There is a growing evidence base that demonstrates a significant proportion of patients in acute sector beds could be treated more effectively elsewhere in the system.<sup>27</sup> Members of the NHS Confederation's Community Health Services Forum have been piloting initiatives designed to address this by reducing avoidable emergency admissions. For example, a 'virtual ward' scheme enabling patients to receive ongoing care at home has recently been launched through a partnership between Norfolk Community Health and Care NHS Trust and The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust. The initiative is intended to help release 840 bed days each month at the hospital, freeing up crucial additional acute capacity during the winter.<sup>28</sup> We recognise that virtual wards have achieved mixed results to date in relation to reducing hospital admissions<sup>29</sup>, but **urge NHS England to use the learning from this and similar projects to inform the next phase of their review.**

Effective partnerships between statutory and voluntary sector health and social care organisations will be crucial to the success of such initiatives. A Department of Health-led programme encouraging partnerships between health, social care and the voluntary sector to improve the experience of older people reported a reduction in emergency bed days across all 29 project areas. In each locality, older people were involved in the management and design of the projects, for example acting as steering or programme board members. Researchers highlighted that for every £1 extra spent on partnership services, £1.20 was saved on emergency bed day costs, while the quality of life for service users was also found to have improved.<sup>30</sup>

Redesigning the urgent and emergency care system to provide more support outside hospitals will increase demands on primary care. To help ensure the system can respond accordingly, we urge NHS England to do more to support the scaling up of general practice federations and primary care networks. The latter should include pharmacy providers, community and voluntary sector services. Primary care professionals should be supported to work with these partners to develop innovative ideas for improving urgent and unscheduled care services, based on their understanding of local resources and needs.

GPs – in their role as gatekeepers in the local system – have a particularly important role to play in ensuring people are aware of the full range of care and support available. **More information should be made available to, and used by, GPs, about the contributions that can be made by other services and agencies in the provision of preventative care and support for self-care across mental and physical health.**

**'To help ensure the system can respond accordingly, we urge NHS England to do more to support the scaling up of general practice federations and primary care networks'**

We believe there should be more use within general practice of patient profiling and segmentation. This mechanism helps to identify those most likely to develop a particular illness or suffer deterioration in an existing condition. It can act as a powerful tool for early intervention across mental and physical health, supporting broader initiatives to reduce demand for urgent and emergency care in the medium and long term.

## Mental health crisis care

The NHS Confederation's Mental Health Network was among the signatories of the *Mental Health Crisis Care Concordat*, recently published by the Department of Health.<sup>31</sup> This has been developed as a response to the range of current challenges in the provision of mental health crisis care.<sup>32,33</sup> It aims to **ensure parity between urgent and emergency care responses for those with mental and physical health needs.**

**The concordat has a clear ambition for enabling mental health crisis care to be provided on a 24/7 basis, an ambition we wholeheartedly support.** Local commissioners have a responsibility to ensure appropriate services are available, working closely with their providers, and national bodies must support the system to achieve this. Other key initiatives under the concordat include:



- partnerships of health, criminal justice and local authority agencies to agree and deliver mental health crisis declarations in every locality in England
- liaison psychiatry services to be implemented with links between A&E and mental health services, as specified in the 2014/15 Mandate to NHS England
- NHS ambulance services in England to introduce a single national protocol for the transportation of patients subject to Section 136 of the Mental Health Act. This will provide agreed response times and a standard specification for use by clinical commissioning groups.

We will support our members as they implement this important agenda, and will help to spread best practice across the system.

**'The NHS workforce as a whole is under considerable pressure, and this can impact on the effectiveness of the urgent and emergency care system, which depends on collaborative partnerships with other services and specialties that are crucial to improving care pathways and outcomes'**

## Acute services

The NHS workforce as a whole is under considerable pressure, with reports of both existing and predicted shortages in many professional groups.<sup>34,35,36</sup> This can impact on the effectiveness of the urgent and emergency care system, which depends on collaborative partnerships with other services and specialties that are crucial to improving care pathways and outcomes. For example, there is some evidence that early assessment of frail elderly patients by geriatricians in the ED can improve outcomes<sup>37</sup>, but further development of such initiatives will depend on ensuring sufficient specialty capacity.

A move towards 'seven-day care' will also have an impact, with demand for staff groups already in short supply – such as radiologists and urologists – likely to increase.<sup>38</sup> The NHS Confederation supports the development of a seven-day care model to drive improvements in safety and patient experience, and has stressed it must be an approach adopted across the whole system. **We have already urged NHS England to provide clarity on what it will offer to providers most in need of support during the transition to seven-day services, in particular smaller providers who may not have the financial or human resources to implement this change.**<sup>39</sup>



# Conclusion

This report outlines an ambitious, but necessary, roadmap for the future delivery of urgent and emergency care services. There is plenty of work already underway among our members as they seek to rise to the various challenges we have outlined and to tackle mounting pressures with innovative approaches to supporting patients and service users. The recommendations we have made build on those initiatives, as well as phase one of NHS England's review of urgent and emergency care services, much of which we welcome.

Our members are clear that while the foundations for system redesign are laid

nationally, they should be empowered to lead the development of appropriate solutions at a local level. Most importantly, there is now widespread recognition that these solutions must involve the whole system working together towards a common goal.

We will continue to take this work forward in the year ahead as an integral theme within the NHS Confederation's 2015 Challenge campaign.

For more information on the issues covered in this report, please contact Sam Hunt, senior policy and research officer at [sam.hunt@nhsconfed.org](mailto:sam.hunt@nhsconfed.org)

## Acknowledgements

We would like to thank the following for their contribution to the production of this report:

- The University of Sheffield's School of Health and Related Research (SchARR)
- the organisations contributing the three case studies
- members of the NHS Confederation's Urgent and Emergency Care Forum Steering Group
- the chairs of the NHS Confederation's Urgent and Emergency Care Forum, Community Health Services Forum and Hospitals Forum.

# References

- 1 NHS Confederation (2013). *Emergency care: an accident waiting to happen?*
- 2 NHS England (2013). *Transforming urgent and emergency care services in England: Urgent and emergency care review, End of Phase 1 report*
- 3 NHS Confederation (13/11/13). *Keogh urgent and emergency care report reflects several Confederation 'asks'*
- 4 House of Commons Health Select Committee (2013). *Urgent and emergency services: Second report of session 2013-14*
- 5 Nicholl J and Mason S (8/7/13): 'Return of the "corridors of shame"?', *BMJ*
- 6 Department of Health, Total time spent in accident & emergency (up to Q1, 2011/12); NHS England, *Weekly A&E sit reps* (from Q2, 2011/12)
- 7 Health & Social Care Information Centre (2013), *Ambulance services, England – 2012/13*
- 8 Lowthian J, Jolley D, Curtis A et al (2011): 'The challenges of population ageing: accelerating demand for emergency ambulance services by older patients, 1995 to 2015', *Med J Aust.* 194: 574-578
- 9 Lowthian J, Curtis A, Jolley D et al (2012): 'Demand at the emergency department front door: 10-year trends in presentations', *Med J Aust.* 196 (2): 128-132
- 10 Lowthian J, Curtis A, Cameron P et al (2011): 'Systematic review of trends in emergency department attendances: an Australian perspective', *Emergency Medicine Journal.* 28: 373-377
- 11 Knowles E, O'Cathain A, Nicholl J (2012): 'Patients' experiences and views of an emergency and urgent care system', *Health expectations*, 15(1): 78-86
- 12 Turner J, O'Cathain A, Knowles E et al (2012): *Evaluation of NHS 111 pilot sites. Final report to the Department of Health.* University of Sheffield.
- 13 NHS Confederation (2013). *Emergency care: an accident waiting to happen?*
- 14 [www.nhsconfed.org](http://www.nhsconfed.org)
- 15 National Audit Office (2004). *Improving emergency care in England*
- 16 Turner J, Nicholl J, O'Cathain A (2007): *A preliminary study of emergency and urgent care networks. Report to Department of Urgent Care strategy team.* University of Sheffield.
- 17 Turner J, O'Cathain A, Knowles E et al (2012). *Op cit.*
- 18 Ørtoft M (2012). *Emergency medical services in the capital region of Denmark*
- 19 South Western Ambulance Service NHS Foundation Trust (2013). *Right Care SWASFT experience*
- 20 Thijssen W, Wijnen-van Houts M, Koetsenruijter J et al (2013): 'The impact on emergency department utilization and patient flows after integrating with a general practitioner cooperative: An observational study', *Emergency Medicine International.* 364659
- 21 Monitor (2013). *Walk-in centre review*
- 22 College of Emergency Medicine (2013). *Stretched to the limit: A survey of emergency medicine consultants in the UK*
- 23 Health Education England (2013). *Emergency medicine: Background to HEE proposals to address workforce shortages*
- 24 Mason S, Knowles K et al (2007): 'Effectiveness of paramedic practitioners in attending 999 calls from elderly people in the community: cluster randomised controlled trial', *BMJ*

- 25 Turner J, Nicholl J, O’Keeffe C and Dixon S (2006): *The costs and benefits of implementing the new ambulance service response time standards: Final report to the Department of Health*. University of Sheffield.
- 26 O’Hara R, Johnson M et al. (2013): *Decision making and safety in ambulance service transitions*. University of Sheffield (NIHR report under peer review).
- 27 For example, Dr Foster Intelligence (2012), *Fit for the future? Dr Foster hospital guide 2012*; or The King’s Fund (2012), *Older people and emergency bed use*
- 28 Norfolk Community Health and Care NHS Trust (2014), *50 patients cared for at home in new virtual ward*
- 29 Lewis G et al (2013), *Impact of ‘virtual wards’ on hospital use: a research study using propensity matched controls and a cost analysis*, NIHR.
- 30 Windle K, Wagland R, Forder J et al (2009): *National evaluation of partnerships for older people projects: Final report*. University of Kent.
- 31 Department of Health (2014). *Mental Health Crisis Care Concordat – Improving outcomes for people experiencing mental health crisis*
- 32 Mind (2011). *Listening to experience: An independent inquiry into acute and crisis mental healthcare*
- 33 Her Majesty’s Inspectorate of Constabulary, Care Quality Commission, Her Majesty’s Inspectorate of Prisons and Healthcare Inspectorate Wales (2013). *A criminal use of police cells? The use of police custody as a place of safety for people with mental health needs*
- 34 Imison C and Bohmer R (2013). *NHS and social care workforce: meeting our needs now and in the future?* The King’s Fund.
- 35 Royal College of Nursing (2013). *Running the red light*
- 36 College of Emergency Medicine. Op cit.
- 37 Conroy S, Stevens T, Parker S, Gladman J (2011): ‘A systematic review of comprehensive geriatric assessment to improve outcomes for frail older people being rapidly discharged from acute hospital: ‘interface geriatrics’’, *Age and ageing*. 40(4): 436-43.
- 38 Healthcare Financial Management Association (2013). *NHS Services, Seven Days a Week Forum: Costing seven day services*
- 39 NHS Confederation (18/12/13). *Viability of seven-day services and urgent and emergency care reforms rests on system working as integrated NHS*

# Ripping off the sticking plaster

Mounting pressures on England's urgent and emergency care services have been well documented in local and national media over recent months. With headlines of "A&E in crisis" and "emergency services in meltdown" never too far from a front page, the topic has stimulated significant political and public debate. The task ahead for the NHS is to move beyond the headlines and handwringing and find practical whole-system solutions to address current pressures and avert future crises. Failure to find such solutions, and to act on them quickly, could have dire consequences for patients, and for the NHS as a whole.

This report acts as a roadmap to the fundamental changes required to create a sustainable and high-quality urgent and emergency care system that can meet the needs of patients now and in the future. While this destination is clear, the public and politicians will need to recognise that the journey to get there may vary in each area, according to the resources, needs and priorities in different communities. As the NHS Confederation's 2015 Challenge campaign sets out, we must ensure the health and care system has the freedom and flexibility it needs to develop solutions that will deliver the best possible outcomes for patients and the public.

## Alternative formats can be requested from:

Tel 0870 444 5841 Email [publications@nhsconfed.org](mailto:publications@nhsconfed.org)  
or visit [www.nhsconfed.org/publications](http://www.nhsconfed.org/publications)

© The NHS Confederation 2014. You may copy or distribute this work, but you must give the author credit, you may not use it for commercial purposes, and you may not alter, transform or build upon this work.

Registered Charity no: 1090329

Stock code: BOK60071



## NHS CONFEDERATION



The NHS Confederation  
50 Broadway London SW1H 0DB  
Tel 020 7799 6666  
Email [enquiries@nhsconfed.org](mailto:enquiries@nhsconfed.org)  
[www.nhsconfed.org](http://www.nhsconfed.org)

Follow the NHS Confederation on Twitter:  
[@nhsconfed](https://twitter.com/nhsconfed)