What the evidence tells us about improving urgent care for older people

A literature review to support the independent Commission on Improving Urgent Care for Older People

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Summary of findings

There is no explicit consensus on what the term ‘urgent care’ means. There is also a need for clarity in the definition of urgent care. The coupling or conflation of urgent care with emergency care causes confusion for those accessing services. In addition it causes difficulty in establishing a clear and distinct evidence base for urgent care interventions and has a bias towards emergency care in hospital.

There is limited evidence relating specifically to older people in relation to urgent care. The review has found that there is a substantial and wide-ranging body of literature in relation to urgent (and emergency) care. Diving more deeply and despite a ‘wide net’ of search terms and key words, it emerges that the needs of older people are often combined with the needs of other patients and thus it is harder to establish the true degree of focus on older people.

There needs to be a proper evidence base to improve learning and share best practice, this is currently lacking. The literature is light in terms of robust evaluations and research of developments and initiatives that have a particular focus in relation to older people. Of significance is the need to consider the way in which initiatives to create improvement are evaluated so that the research and evidence base relating to urgent care and older people can be broadened and learning about best practice can be more widely shared and reviewed.

The majority of work looking at urgent care for older people is focused on admissions avoidance and proper discharge rather than prevention. The literature available tends to explore admission avoidance and effective discharge. While these two areas are of critical importance, there is much less that is helpful to understanding what works in relation to older person and urgent care. Nor does it provide examples of preventative work that can be undertaken in the community.

There is a definite awareness of the challenge of getting the right skill mix to deliver older people’s care well, and in doing so, building the right multidisciplinary teams across acute, primary, social and community care. Factors such as workforce/skill mix, competence in working with older people and awareness of their particular needs, integration, appropriateness of admission, pre-admission support, effective and safe discharge, the role of social care and capacity all feature highly as influencers upon the effectiveness of urgent care delivery for older people.

There is limited acknowledgement of the role that community services, including social care and ambulatory services, play in the relation to effective urgent care. The literature contains some discussion about the nature of urgent care and the extent to which much of it is delivered outside the hospital through primary care and whether the focus on the hospital minimises the work of non-hospital based practitioners and systems. The value and importance of the role and contribution of community-based services, including social care, the voluntary sector, ambulatory services and of nursing and residential care homes is sometimes overlooked.

Professionals need to be responsive to the needs of older people with multiple morbidities and/or complex social situations and the benefits of multi-agency and inter-professional responses. The review has found that a key factor in improvement is that of raising awareness among professionals of the particular challenges of meeting the needs of older people. There is an especially strong base for this, with a range of sources providing evidence in support of this area.

The literature strongly demonstrates that older people often have needs that are multi-factorial and as such are sometimes considerably more ‘vulnerable’ than younger people as a consequence of issues such as confusion, dementia, compromised communication and an underlying fear of treatment.
Introduction

The NHS continues to work in a challenging environment, with constrained financial resources, staff pressures and rising demand that stretches service capacity. As the population continues to age, the numbers of older people who require urgent care is likely to continue to grow. This demand must also be set in the context of the way in which the NHS works in partnership with social care, which as a sector is also facing significant challenges of resource and capacity.

The Five Year Forward View (FYFV) describes these challenges and sets out proposals for the NHS to meet them, including the new models of care programme. The FYFV makes specific reference to urgent care development:

"Across the NHS, urgent and emergency care services will be redesigned to integrate between Accident & Emergency (A&E) departments, GP out-of-hours services, urgent care centres, NHS 111, and ambulance services."¹

Urgent care, and in particular urgent care for older people has attracted growing focus as organisations seek to ensure improved access and outcomes. There were 18.5 million attendances at A&E departments, walk-in centres and minor injury units in England in 2013/14. The percentage of attendances among older age groups was consistently higher in 2013–14 than in previous years with 33.1 per cent (6.1m) of attendances for patients 50 and over, 14.9 per cent of attendances for the 65–84 age group and nearly a million attendances for those aged 85 and over.²

It is in this context that the NHS Confederation brought together a range of experts to form the Commission on Improving Urgent Care for Older People. Its aim is to find whole-system, workable and sustainable solutions for addressing the challenges of urgent care for older people.

At the same time NHS England, following the FYFV, invited NHS organisations and partners to apply to become vanguard sites for the new models of care programme. There are now 50 pilot sites, including eight which are developing new approaches to improve the coordination of urgent and emergency care services and reduce pressure on A&E departments.

Some of the more recent publications, some of which have been contributed to significantly by Commission members, have culminated in reports such as those from the Future Hospital Commission and the Health Service Journal’s Commission on Hospital Care for Frail Older People. Both these reports, alongside others, such as those from The King’s Fund, have assisted greatly in raising the profile of older people’s needs in relation to urgent care, as well as hospital care more broadly. Taken alongside the range of literature and other policy and strategic documents, it is clear that improvement in this area of provision is now seen as a key area of development, in terms of improving effectiveness, outcomes and efficiency.

The Commission on Improving Urgent Care for Older People has commissioned this literature review with the aim of identifying the key issues and themes that can be identified in relation to further improvement in this sector of healthcare. The aims of the literature review are to:

• identify current national policy and legislative imperatives for improving urgent care in both health and social care
• identify relevant national guidance in relation to urgent care for older people
• identify examples of research that has been conducted in to the delivery of urgent care for older people
• identify examples of best practice and innovation, particularly those that have been evaluated or are evidence based
• offer conclusions, based on the evidence reviewed, about what the literature says in relation to effective models of service for urgent care in relation to older people.

These objectives shaped the methodology adopted and have influenced the way in which our findings have been presented.
Methodology

The review of what the literature tells us has been undertaken through desk-based study and consisted of four main stages leading to this report.

Firstly work was done in conjunction with the library team at the Health Services Management Centre to identify the databases to be used for the initial search and to agree upon a set of search terms and keywords. Given the breadth of the subject area, it was decided to initially ‘cast the net widely’ in order to ensure that a range of literature could be located and reviewed. With this in mind, the search terms used were intended to reflect the range and nature of issues related to urgent care for older people.

The following is a selection of the keywords and search terms used:

- admission
- best practice in urgent care for older people
- care pathway(s)
- commissioning urgent care for older people
- effective discharge
- emergency care
- frailty
- geriatrics
- integration
- older people
- social care
- triage
- urgent care.

These search terms and keywords were used specifically in relation to urgent care but were also applied to search across the field of health and social care more broadly in order to gather other potential sources of information that might be cross referenced with urgent care.

An internet- and library-based search using recognised databases to establish publications, research and associated evidence that may approach the issues under review was then undertaken. These searches included relevant policy, research, think pieces, peer review literature, grey literature and relevant organisations’ websites.

Following the search process, a collation of extracts and abstracts setting out the evidence contained was drawn together to create a compendium of source material. The process included following sources not directly revealed by the database search but referenced in publications and papers that were identified in the first level search.

There then followed an analysis and review of the compendium of source material to establish an evidential narrative leading to conclusions about the research evidence, best practice examples and innovations that have been successful (or not) in improving urgent care for older people.

This report is based on an analysis of selected policy documents, commentaries and primary studies with high levels of relevance to the aims of the review to provide an overview of factors that deliver improved outcomes and success in the improvement of urgent care for older people.
A note on sources
In conducting the review of literature, we have drawn upon a wide range of sources using a number of recognised databases. We have found that there is a breadth of guidance and policy in relation to urgent (and emergency) care. Much of this is recent, building on service developments and priorities within the NHS that have emerged over the past few years, including those in current national policy and strategy.

There is also a good deal of literature that provides commentary and analysis of the current challenges relating to urgent care, but this tends to have been directed more towards urgent (and emergency) care more broadly, rather than the specific needs of older people.

A particular finding of this review has been the degree to which, despite utilising a suitably wide range of search terms and databases, it has proved difficult to locate primary research or robust evaluations of developments and initiatives that have a particular focus in relation to older people and urgent care. Furthermore those available tend to explore admission avoidance and effective discharge. While these two areas are of critical importance there is much less that is helpful to understanding what works in relation to older people and urgent care.

This review therefore seeks to outline the range of policy, commentary, analysis and the research evidence that exists currently while observing that there is a discernible gap in that evidence and how it relates to older people and urgent care.
Key findings from the literature

Holding the aims of the review in mind as we worked through the literature under review, a number of key themes emerged. We shared these with members of the Commission in our interim update as the work progressed and believe they have responded appropriately to the questions raised in the brief and reflect the strands we have discerned in the literature itself.

The population of older people

The growth in the number of older people in the UK is well known, but the range of that growth and its predicted increase bears repetition. The population estimates provided by the UK Office for National Statistics in 2015 show that:

“There are now 14.9 million people in the UK aged 60 or above.³ 11.4 million are aged over 65⁴ and three million are aged 80 or over.”⁵,⁶

“The number of people aged 60 or over is expected to exceed 20 million by 2030.⁷ By 2086 about one in three people will be over 60.⁸ The number of those aged 65 and over is likely to rise by almost 50 per cent by 2030 and the number of people aged over 85 is predicted to double in the next 20 years and almost treble in the next 30 years.⁹ Almost one in five people will now reach their 100th birthday.”¹⁰

Growing numbers of older people have an impact on the NHS. This was highlighted by Cracknell in his 2010 paper, Key issues for the new parliament – Value for money in public services:

“Average spending for retired households is nearly double that for non-retired households. In 2007/08 the average value of NHS services for retired households was £5,200 compared with £2,800 for non-retired.”¹¹

Cracknell goes on to state that:

“These averages conceal variation across older age groups, with the cost of service provision for the most elderly likely to be much greater than for younger retired people. The Department of Health estimates that the average cost of providing hospital and community health services for a person aged 85 years or more is around three times greater than for a person aged 65 to 74 years.”¹²

The Health Foundation reported on NHS finances in January 2015. Their briefing paper drew upon Cracknell’s earlier 2010 work and stated that:

“The average cost of providing hospital and community health services for a person aged 85 years or over has been estimated to be around three times higher than for a person aged 65-74 years. During the current parliament the population aged 65 and over will have increased by 10.7 per cent and the population aged 85 and over increased by 9 per cent.”¹³

In their April 2015 report, the NHS Benchmarking Network found that:

“The average length of stay for emergency admissions for all ages is 5.6 days. This LOS increases to 7.5 days for emergency admissions for ages 65-74, 9.3 days for ages 75-84, and 10.9 days for ages 85+.”¹⁴

When the cost of older people’s services in acute care was split in to the four different areas explored in their project, the NHS Benchmarking Network found that:

“65 per cent of expenditure on older people’s services was for care of elderly wards and inpatient care.”¹⁵

These population and spending figures clearly illustrate the scale of proportional change in the population in the coming years and how this will impact on the way in which services are commissioned, designed, delivered and paid for.
What do we mean by urgent care?
The importance of clarity in the terminology or definition of urgent care emerges as a theme in the literature reviewed and reveals the issue of potential confusion and misaligned focus. The range of ways in which urgent care is referred to in the literature reviewed highlights this.

In Guidance for the commissioning integrated urgent and emergency care, urgent care is defined using the Department of Health definition. This describes urgent (and emergency care) care as:

"The range of healthcare services available to people who need medical advice, diagnosis and/or treatment quickly and unexpectedly."\(^{16}\)

NHS Interim Management and Support defined urgent care as:

"Care needed the same day, regardless of who deems it necessary; the patient or a healthcare professional."\(^{17}\)

In their report, Time to act: Urgent care and A&E: the patient perspective, The Patients Association and The Royal College of Emergency Medicine provided a definition of urgent and emergency care as:

"Those (needs) that the patient perceives require a response on the same day that they arise."\(^{18}\)

These three examples are among many that appear in the literature that conflate emergency and urgent care. While this may be inevitable because of the linkage of the two in terms of service delivery, it nevertheless contributes to the potential for misunderstanding the nature of urgent care.

In addition, the focus of the literature tends to be on those interventions and services provided through A&E departments and hospitals. This was highlighted by The King’s Fund who stated in their recent work on the subject that:

"A&E is often seen as a service in crisis and is the focus of much media and political interest. But A&E is just the tip of the iceberg – the whole urgent and emergency care system is complex, and surrounded by myth and confusion."\(^{19}\)

This ‘myth and confusion’ hides the fact that urgent care is not solely delivered within A&E departments and does not highlight the extent to which a good deal of urgent care is delivered outside the hospital through primary care and in many cases by ambulance and other services. As The King’s Fund points out:

"A range of services are available in addition to A&E. These include walk-in centres, urgent care centres and minor injuries units. GPs also provide urgent care in their surgeries."\(^{20}\)

The role of primary care is regarded as significant in terms of the volume of urgent care that is delivered. In their paper, Urgent care in primary care, the Primary Care Foundation noted that:

"Approximately 95 per cent of urgent care is delivered in primary care."\(^{21}\)

This percentage is the most up to date that could be accessed in the literature reviewed and is widely quoted elsewhere. However, it may be borne out by the work of Fernandes for the Royal College of General Practitioners’ Commissioning Centre which stated that:

"General practice provides the majority of urgent care and small changes to improve overall access and a consistent approach to urgent care requests, especially to older people, is likely to have a significant effect."\(^{22}\)

Blackedge wrote in the Health Service Journal that:

"Across England’s 9,000 practices, around one million appointments are made every day, with about one-third of these same-day appointments."\(^{23}\)

Using Hospital Episode Statistics, Quality care for older people with urgent & emergency care needs, known as the Silver book, provides an important snapshot of the volume of urgent care in primary settings as opposed to that delivered in emergency departments:

"Around 300 million urgent care consultations are annually provided in primary care as opposed to 20 million encounters in emergency departments."\(^{24,25}\)
The complexity and terminology of urgent care as a system has led to concerns about how well people of whatever age can navigate the system and whether they are aware of or indeed wish to use the range of the urgent care services that are available. As Professor Bruce Keogh highlighted when launching his review in 2013:

“We need to review the increasingly complex and fragmented system of urgent and emergency care, so that sick, anxious and often frightened people can get what they need when they need it.”

This view is echoed in work produced by an independent commission report facilitated by Care UK, Urgent & important: the future for urgent care in a 24/7 NHS, which suggested that:

“Urgent care has become increasingly fragmented, delivered within a diverse range of settings and involving multiple players”.

As Dr Angelo Fernandes suggested in his guidance for the Royal College of General Practitioners:

“There is often confusion about the terminology used by users, providers and commissioners of urgent and emergency care.”

Urgent care means many things to different people. In considering how to improve urgent care, the literature highlights the importance of clarifying what is meant by the term itself.

The particular needs of older people

Older people are the main adult users of most NHS services including urgent care services but as the Silver book highlights:

“While most health and social care professionals come into contact with older people in a variety of settings, it is often in the acute situation, often out of hours or when traditional office hour services are not available, that the challenges are most pressing. Older people seldom have one single condition and often have multiple co-morbidities, often across the physical and mental health spectrum, with the sometimes added challenge of adverse social circumstances as the norm.”

Professor David Oliver highlighted the level of use of services by older people in his 2008 paper for the Journal of the Royal Society of Medicine:

“Older people are the main users of the NHS: around 60 per cent of admissions and nearly 70 per cent of hospital bed days are devoted to people over 65. They are not a minority.”

Older people may be more likely to be unable to navigate or access the healthcare system. As Khaldi’s research found:

“Less than half (46 per cent) of the elderly population have the confidence they know how to access the health and care system.”

A potential consequence of this was highlighted in a recent paper Making our health and care systems fit for an ageing population, where Oliver et al noted that:

“Older people are more likely to call an ambulance from home, more likely to be taken to hospital, and then more likely to be admitted than younger people.”

It might be expected that given the high level of use of urgent (and emergency care) use by older people, especially those deemed to be frail, it would not be hard to locate a plethora of guidance in relation to this area of work. However, as Lowthian et al found:

“There is a paucity of good quality evidence to guide the care for frail older people attending Emergency Departments.”

The literature highlights the particular needs of older people, specifically the issue of multiple long-term conditions, how older people are treated and how their needs may be overlooked by health professionals. This has been recognised for some time and not just in the UK. The Canadian gerontologist Dalziel, suggested that part of the reason for the gap in skills was that:

“Most of the training healthcare professionals receive unfortunately occurs only in acute hospitals where interns, nurses and other disciplines only see the sickest and worst 5 per cent of the elderly population...(there is) an inadequate knowledge base in what is known about care of the elderly.”

In their 2001 paper, Unmet need and older people, Cordingley et al highlighted the shift in assessment approaches and their effect:

“The past ten years have seen a move to incorporate subjective assessments of physical functioning and wellbeing. Although such scales may be useful in identifying older people’s perspectives, they may, paradoxically, have the effect of underplaying the extent of their needs.”

However, seven years later there appeared more to be done, as Oliver pointed out:

“Geriatric medicine does not feature prominently in the curricula of many medical schools, nor sufficiently highly in the core curricula for postgraduate medical training. Clinicians need to think differently about frailer, older patients.”

Conroy et al also describe this deficit in their 2015 paper:

“A key component of delivering high-quality care for frail older people are the appropriate behaviours alongside knowledge and skills; at present undergraduate and postgraduate curriculae in a range of disciplines are somewhat limited in their delivery of frailty competencies.”

Goel argues that the front line workforce needs to be better equipped to respond to and meet the needs of older people:

“The social and health state of the older population who need attention in health-related emergency situations can be improved only if ground level individual healthcare workers...are equipped with the knowledge, skill, training and sensitisation to the needs of their older patient.”

Alongside the identification and response to needs, the literature establishes the matter of complexity of that need by confirming that older people are much more likely to have a long-term condition. The Department of Health report in 2012, Long term conditions compendium of information: Third Edition, demonstrated that:

“Long-term conditions are more prevalent in older people (58 per cent of people over 60 compared to 14 per cent under 40) and in more deprived groups (people in the poorest social class have a 60 per cent higher prevalence than those in the richest social class and 30 per cent more severity of disease).”

People with long-term conditions frequently have more than one condition, with the chances of having more than one problem increasing with age. The British household survey of 2001 was prescient when it stated that:

“Around half of this population will have more than one major health problem, and around a quarter will have three or more problems.”

This growth is borne out in the figures provided in the Long term conditions compendium of information: Third Edition which highlighted figures that indicated that:

“58 per cent of those aged 60 and over report having an LTC, with 25 per cent of over 60s having two or more.”
The report also predicts that over 70 per cent of those aged 80 or over are likely to have at least three long-term conditions.

In 2013 the Office for National Statistics report on the General Lifestyle Survey found that:

“Among those aged 75 and over, 68 per cent reported a long-standing illness.”43

The complexity and co-morbidity of older people’s health needs was further highlighted in 2013 in JCP-MH commissioning guidance. Although focusing on mental health, it described the interrelationship between those needs and physical health and their combined complexity:

“As people grow older, their health needs become more complex, with physical and mental health needs frequently being inter-related and impacting on each other.”44

The Royal College of Physicians highlighted the complexity of assessment of older people in a range of settings in its acute care toolkit:

“The clinical assessment of frail older people is challenging as they often present non-specifically (for example with falls, immobility or delirium), which can make the immediate diagnosis obscure. History-taking may be challenging because of sensory impairment, dementia or delirium. Often, additional information and collateral history are needed, which may not be readily accessible in the acute setting. Time pressures may prevent staff from focusing on anything other than immediate problem.”45

In 2011 the General lifestyle survey showed that:

“An estimated 4 million older people in the UK (36 per cent of people aged 65-74 and 47 per cent of those aged 75+) have a limiting long standing illness. This equates to 40 per cent of all people aged 65 or over.”46

The Department of Health’s Compendium also showed that:

“The ageing population and increased prevalence of long-term conditions have a significant impact on health and social care and may require £5 billion additional expenditure by 2018.”47

The Office for National Statistics update published in March 2015 found that:

“In 2013, more than one in three adults in Great Britain (36 per cent) reported having a long-standing illness or disability. This had increased slightly compared with 2012 (34 per cent) but was in line with the levels seen over the 2005 to 2012 period. As expected, older adults were more likely to have reported having an LSI or limiting LSI than those in younger age groups. Those aged 75 and over were more than four times as likely to have reported an LSI than those aged 16 to 24.” 48

It is recognised that older people tend to see their GP more often than younger people. The Royal College of General Practitioners finds that:

“Older patients aged over 80 years consult more frequently – between 12 and 14 times a year in 2008/2009, compared with between 6 and 7 times in 1995.”49

Given that much of urgent care is provided by primary care, GPs in particular have had to adapt their approaches to seeing older people, more often than not doing so in the older person’s home:

“Older people are more likely than other age groups to receive a home visit by a GP. In 2006, 15 per cent of GP consultations for people aged 75 and over were undertaken as home visits.”50

Bowker and her colleagues found that:

“Around 20 per cent of general practice consultations are for elderly people. Of these consultations, about a third will need a home visit compared with less than 10 per cent of the general population. The trend for home visits is declining but older people remain the biggest user group.”51
In their 2009 report of their research on consultation rates in general practice, Hippisley-Cox and Vinograd found that:

“Consultation rates varied markedly by age and sex and the highest rates were found in the elderly. For example, in 2008, the highest overall consultation rates occurred in the age band 85 to 89 years for both sexes.”

These figures suggest that a confluence of an increasing older age population, a higher rate of long-term conditions, associated rises in costs and demand will require a clearer understanding of and response to, the particular needs of older people, especially in relation to urgent care.

In 2008, Cooke and Gakhal conducted a range of research into urgent care. Although its focus was not solely on the needs of older people it did highlight the fact older people had specific needs that should be responded to and provided an international perspective on addressing those needs.

“In the US, the more radical thinkers in this field have suggested the development of completely new models of emergency care for older people. Indeed, one hospital already has an emergency department staffed by geriatricians. In spite of the high proportion of older people in A&E populations, and the growing acceptance of their specialist needs, radical ideas do not appear to be under consideration in the UK.”

The Silver book suggests that it is necessary to more effectively audit performance in meeting older people’s needs and suggests that urgent care is one area that should be considered:

“Healthcare systems may wish to analyse...the proportion of urgent care encounters in primary care leading to a hospital attendance and separately hospital admission in people aged 65+/75+/85+.”

At least one study concludes that behavioural change in both patients and professionals will be needed, alongside other system change to ensure improvement but also to reduce reliance on the NHS.

As Bridges stated in her 2008 study Listening makes sense: Understanding the experiences of older people and relatives using urgent care:

“Greater understanding is needed of how best to deliver personal care to older people in ways that deal not just with the primary presenting problem, but that also address the wider range of needs that older people can have.”

Without that understanding that Bridges calls for, there may be an impact on the use of urgent care and of older people’s experience of it. As Parke and McCusker highlighted in 2007:

“Not only does this population require a different approach to care, their vulnerability to adverse outcomes and functional decline may perpetuate dependence on the healthcare system.”

Taking a more person-centred approach to interventions is seen to be of particular value. The Royal College of General Practitioners’ review of the evidence suggests that:

“Re-orientating the health and care system around a patient-centred approach has the potential not only to improve health outcomes and quality of life for patients, but also to reduce avoidable demand for health and care services.”

For those older people who do present at emergency departments the wider issue of the culture and design of those departments is reported to have an impact on the way in which interventions are delivered. As Skar et al found a micro-culture can exist within which:

“Findings on the ED value and belief level indicate that EDs are for urgent cases (not geriatric care), that older adults do not receive the care and respect they should be given, that older adults require too much time, and that the basic nursing needs of older adults are not a priority for ED nurses. Finally, finding on the assumptions level underpinning ED behaviors (sic) suggest that older adults do not belong in the ED, most older adults in the ED are not critically ill and therefore can wait, and staff need to be available for acute cases at all times. Efforts in the United
Kingdom to provide better access to care through the establishment of urgent care centers have the potential to reduce pressures in EDs and thereby reduce the perception that there is not enough time to look after the older adult. A systematic review on the effect of ED micro culture on the quality of geriatric care is warranted.58

The literature points to a need to ensure a fuller understanding of the range and complexity of older people’s needs and how to respond to them. Given that urgent care will most often be delivered across a range of professionals in different settings (including A&E) then the dissemination of understanding will need to be wide as well as deep.

Although there is a wide-ranging body of literature in relation to urgent (and emergency) care, diving more deeply it emerges that although older people are a focus of some of the literature, the needs of older people are often combined with the needs of other patients and thus it is harder to establish the true degree of focus on older people and thus the learning and development that may be drawn from it in enhancing approaches to the delivery of urgent care.

**Capacity**

The NHS faces a range of competing and ongoing pressures in its quest to provide high-quality, effective services. These imperatives, including limited resources, increasing demand and limited capacity, not only compete with each other, they are intertwined. This pressure is particularly prevalent within urgent care. As the Five Year Forward View highlights:

“The combined effect of these challenges is that organisations are focused on how best to develop and manage services that can respond to a range of needs, in a variety of ways, whilst at the same time demonstrating improved outcomes and value for money.”59

“Compared to five years ago, the NHS in England handles around 3,500 extra attendances every single day, and in many places, A&E is running at full stretch. The FYFV recognises that the 185 hospital emergency departments in England are only a part of the urgent and emergency care system. The NHS responds to more than 100 million urgent calls or visits every year.”60

The pressures on services are well recognised and have been the subject of media and public attention:

“NHS services outside of hospitals are struggling to cope with growing demand brought on by the ageing population, hospital bed shortages and staff cutbacks.”61

Professor Sir Bruce Keogh, Medical Director of NHS England conducted a comprehensive review into how urgent and emergency care services are organised and provided in England. The report of the first phase of that work was published in November 2013. The report highlighted some important facts:

“Every year there are 21.7 million attendances at A&E departments, minor injury units and urgent care centres. Attendances at hospital A&E departments (officially referred to as Type 1 and Type 2 A&E) have increased by more than two million over the last decade to 16 million. Each year there are 5.2 million emergency admissions to England’s hospitals. Emergency admissions to hospitals in England have increased year on year, rising 31 per cent between 2002/03 to 2012/13.”62

Professor Keogh concluded that:

“This growth in demand is set to continue as people live longer with increasingly complex, and often multiple, long-term conditions. These facts have led to an overwhelming consensus that our current services are unsustainable.”63

Keogh made a number of recommendations, including the statement that:

“We must provide highly responsive urgent care services outside of hospital so people no longer choose to queue in A&E. This will mean providing faster and consistent same-day, every-day access to general practitioners, primary care and community services such as local mental health teams and community nurses for patients with urgent care needs.”64
Demand for urgent care services is on the rise and this has placed additional strain on the system. A&E inevitably attracts particular attention but as Quality Watch made clear in their 2014 annual statement, Cause for concern:

“Other parts of the urgent care system are also showing signs of stress. In 2013/14, ambulance services only managed to respond to 74.8 per cent of the 2.9 million most serious calls within eight minutes; less than their target of 75 per cent (NHS England, 2014). In primary care, there are also concerns that awareness of, and satisfaction with, out-of-hours services, as measured by the GP Patient Survey, has fallen year-on-year since 2011; now only 66 per cent report that their overall experience of out-of-hours care was ‘good’, compared with 71 per cent in 2011.”

The challenge of capacity and meeting increased demand is of course associated with the rising population of older people and their particular needs as outlined earlier in the review. Those working in the field have highlighted the need to address the matter of capacity by ensuring effective strategies for timely urgent care and where possible community-based care that negates the need for emergency response. Professor George Alberti has stated that:

“Until we crack the problem of looking after frail elderly in the community with good preventative care we will have difficulty in both giving older people the quality of life they deserve and preventing unnecessary admissions to hospital.”

In the same publication Professor Ian Philp suggested that:

“Improved care for older people would lead to reduced demand for acute and long-term care services. Less pressure on acute services will create more space and time for staff to deliver better care and ensure that older patients are treated with the dignity and respect they have the right to expect.”

Since 2004 the necessary changes to the workforce have not developed, as pointed out by Imison and Bohmer:

“One of the biggest challenges for today’s professional workforce is that it was trained and developed to work in a model centred around single episodes of treatment in hospital. However, those placing the greatest demand on services, both now and in the future, are older people with multi-morbidities (both mental and physical), who need integrated, long-term health and social care. Workforce redesign is needed not only because of a potentially dwindling workforce, but also because the nature of healthcare work is changing and the skills of the current workforce are not well matched to future needs.”

The rising demand and associated pressures on emergency and other hospital care suggest that the need for effective urgent care remains a priority. If such provision is effective, given that much of it is provided in primary care, then it may have a positive impact on other areas of healthcare.

In a 2012 King’s Fund report Imison and her colleagues found that:

“2.3 million overnight stays could be prevented were there better organisation of urgent care, with GPs and other healthcare providers working together to prevent patients getting to the stage of crisis requiring hospital.”

The role of A&E in urgent care is not the only factor cited in the literature. The work of other services is also recognised. This was particularly highlighted by the University of York paper in 2013 which stated:

“Given current pressures on accident and emergency services, an important objective of urgent care services is to reduce inappropriate visits to emergency departments.”

The same briefing also suggested that:

“Effective urgent care depends on patients being able to access appropriate and timely primary care.”
In their evidence to the Health Select Committee in 2013 the Royal College of General Practitioners reinforced the central role of GP’s in the provision of urgent care.

“GPs play a vital role – both in and out of hours – in delivering safe and effective urgent care to millions of people every year.”72

The role of GPs is sometimes viewed somewhat separately from the rest of the healthcare system and the Royal College of General Practitioners has cautioned against this by stating that:

“General practice can and does play an important role in preventing unnecessary hospital admissions by supporting patients to manage their care in the community. We need to redesign services in a way that delivers better integrated urgent and emergency care, including better coordination between the NHS and social care, and promotes more effective self-care. Part of this solution must be a shift in investment towards primary care.”73

However, the pressure on general practice is also noted as a factor in the challenge of delivering and transforming urgent care. The Centre for Workforce Intelligence concluded that:

“The existing GP workforce has insufficient capacity to meet the current and expected patient needs. GP workforce numbers will need to be increased to more sustainable levels to meet future patient demand, taking into account demographic and other factors.”74

The literature also indicates that the availability of information for commissioners about service use is generally poor. As Turner et al found:

“The lack of national data on urgent care contacts with primary care makes it difficult to assess whole system demand for emergency and urgent care.”75

The capacity of urgent care centres, as a model for delivery is less well known, in part due to a reported lack of data. In 2013 the Primary Care Foundation reported that:

“Knowing how far away some services were from capturing such detail, we fear that such data is, as yet, rarely collected in urgent care centres.”76

The capacity of the NHS and of urgent care services to meet increasing demand, particularly among the older people population, is a central issue in considering where and how to make improvements. As the NHS Call to action stated:

“The population is ageing and we are seeing a significant increase in the number of people with long-term conditions...The resulting increase in demand combined with rising costs threatens the [financial] stability and sustainability of the NHS.”77

The picture that emerges from the literature is perhaps unsurprising and mostly resonates with the intuitive view that is regularly expressed across the system: that the various elements of the health service are under their own pressures in relation to capacity and that those pressures converge to impact more widely on the system. Urgent care is no different in terms of capacity, but can, if an effective part of the wider system, play a part in addressing capacity problems elsewhere in the health service.

**Workforce**

Planning, shaping and sustaining an effective workforce is a central part of delivering any form of healthcare. Achieving this is not without challenges:

“The NHS workforce, as a whole, is under considerable pressure with existing or predicted shortages in many professional groups.”78,79,80

In urgent care for older people the workforce needs may be different due to the particular needs of the older people population, as outlined earlier in this review. As Turner et al stated in their review:

“Any health system re-design will need to consider the implications around the workforce needed to deliver a plan. In the wider sense it will impact on the development of collaborative partnerships with services and specialities outside the immediate system but which will be crucial to improving care pathways.”81
Recognising this need for change is one thing, creating change in relation to older people’s care and more broadly can be more problematic as health and social care systems have found as has been highlighted in some strategic planning documents:

“The healthcare workforce can be relatively inflexible, with strong demarcation of roles and a working model often centred on single episodes of treatment. However, those placing the greatest demand on services – both now and in the future – are older people with multiple conditions.”

The debate about the composition and type of workforce has been ongoing but there is some consensus that it should be about more than simply the provision of medical staff. The journal, *Nursing Older People* noted that:

“A multidisciplinary, multi agency approach is essential.”

In their research into meeting the needs of older people, Wilson and Jenkins found that:

“A multidisciplinary team approach enabled complimentary expertise to address some, but not all, of the outcomes the service-user wished to achieve.”

The needs of older people will require specific skills and knowledge if urgent care is to be effective, in particular this is seen to require a differing approach as Beaumont et al have found:

“A positive attitude to managing... older people is a pre-requisite for implementing the appropriate knowledge and skills; healthcare professionals’ attitudes towards older people could be better, and ageism remains a problem in the health system.”

The role of nursing has been cited as important in relation to urgent care, including urgent care for older people. In 2013, NHS England states in their urgent and emergency care review that:

“Flexible use of the nursing workforce may prove a partial solution to shortages in other areas of the workforce.”

Drawing on wider evidence the review also found that:

“Specialist nurses, dedicated to particular areas of healthcare, can provide support and education to patients with long-term health needs, improving patient outcomes and reducing readmission rates. Evidence suggests that these roles are clinically and cost effective and they are strongly supported by the Royal College of Nursing, but educational preparation and provision is inconsistent across the country.”

In her work on professional roles in urgent care, Tracey Roeg has found that the nurse practitioner role is one that can be beneficial:

“Results showed that the care delivered by the nurse practitioner within a minor injury service unit was equal or better than the care provided by the physician in the traditional emergency department.”

The work of the ambulance service is cited as means of managing demand and the literature suggests their role has and will continue to change:

“The functions and capability of ambulance services has expanded so that they are now able to treat many patients at the scene, reducing the need to take people to hospital.”

However, as NHS England found in 2013:

“Ambulance services have the potential to meet a higher proportion of urgent and emergency care demand and prevent onward transportation to hospital; however ambulance services do not have sufficient clinically-trained staff to achieve this.”

The role of primary care, in particular the part GPs have to play in delivering urgent care has workforce implications:

“Providing more care out of hospital, including more senior clinician involvement in telephone access, will increase pressure on primary and community care. System re-design will need to carefully model the system needs, the likely impact of seven-day GP surgery opening on demand for out-of-hours urgent care and the whole system shifts in resource allocation needed to support out-of-hospital care.”
A recent study by the Royal College of General Practitioners reported that GP resources are already overstretched, making it difficult for services to deliver continuous care effectively. The study also reported that:

“The situation is likely to be exacerbated by an increasing proportion of individuals, who choose to work part time, becoming GPs, and the anticipated retirement of 13 per cent of the GP workforce within the next two years.”

NHS England’s own analysis highlights that:

“The GP workforce is under significant pressure in some areas, with insufficient capacity to meet needs.”

In addition the Royal College of General Practitioners has acknowledged the need to:

“Address the weaknesses identified in current GP training in relation to the care of ...those requiring urgent care.”

Given these pressures of workforce capacity, development and training, not just in relation to the delivery of urgent care, but as the literature has highlighted, in respect of the particular needs of older people, new workforce models will need to be developed and evaluated:

“Other workforce models with promise include emergency care practitioners (ECPs) and nurse practitioners. ECPs can reduce patient transport to emergency departments, though this appears dependent on the setting.”

Work conducted by Cooper et al found that:

“ECPs had a beneficial impact on the deployment of resources, especially relating to non-conveyance. Secondly, their training and education improved their decision-making repertoire and developed their confidence for a leadership role. Thirdly, inter-agency collaboration and cooperation was improved, and finally, care benefits were increased especially relating to immediacy of treatment and referral mechanisms.”

Research undertaken by the University of Sheffield in 2007 by Mason et al found that:

“Care provided by ECPs appears to reduce the need for subsequent referral to other emergency and unscheduled care services in a large proportion of cases. We found no evidence that the care provided by an ECP was less appropriate than the care by the usual providers for the same type of health problem.”

In their research Hill et al found that:

“Further evaluations should consider whether the beneficial impact of emergency care practitioners applies across settings and patient groups, and was not just a result of new investment in services.”

They also recommended research to better understand the qualifications, training and career pathways of emergency care practitioners.

In their review of evidence, the University of York cites work conducted by Tohira et al who undertook research into the effectiveness of the ECP role and found that:

“ECPs were less likely than conventional ambulance crews to take patients to the emergency department and suggests that deployment of ECPs is likely to reduce patient transport to the emergency department and increase likelihood of patients being discharged at the scene, but the magnitude of these effects is highly uncertain.”

The NHS Confederation further highlighted the issue of workforce in a briefing on urgent care in 2014:

“Urgent and emergency care would particularly benefit from workforce transformation, ensuring the right type of care at the most appropriate time and place.”
What the evidence tells us about improving urgent care for older people

The Royal College of General Practitioners has also highlighted the matter of flexibility on working, particularly out of hours:

"The need to provide better, more joined-up out of hours care should be balanced against the need to ensure that the workforce – including the primary care workforce – has the capacity to deliver this effectively."\(^{105}\)

The literature highlights the challenges of workforce development and capacity. This may best be summed up by Manley et al who stated that:

"There is no single workforce solution to address all the gaps and pinch points that will enable the achievement of a whole systems, integrated approach to urgent and emergency care."\(^{106}\)

The system and what works

The NHS and Adult Social Care face a range of competing and ongoing pressures in their quest to provide high quality, effective services. These imperatives, including limited resources, increasing demand and limited capacity, not only compete with each other, they are intertwined.

The Future Hospital Commission has suggested that:

"Management structures, financial models and leadership roles will be designed to support and enhance the delivery of high-quality non-elective and urgent care, and embed strong clinical leadership."\(^{110}\)

The need for integrated approaches and sharing of learning and expertise is a theme in both policy and literature. One example of this has been the development of urgent care boards though their value has been debated, as the NHS Confederation noted:

"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 and that they have failed to overcome a number of problems such as securing the right membership and setting a strategic focus."\(^{111}\)

However, some believe that such an approach to strategic planning is helpful:

"There is evidence that broad managed care programmes may reduce healthcare resource use, including unplanned hospital admissions and length of stay in hospital."\(^{112}\)

Alongside those urgent care boards, in response to the NHS England review led by Professor Sir Bruce Keogh, urgent and emergency care networks have developed:

"Urgent and emergency care networks now exist in many areas of England: in 2007, 96 out of the 152 PCTs (63 per cent) reported some network involvement in urgent and emergency care. However there was considerable variation in the organisation, scope, function and maturity of the networks."\(^{113,114}\)
Further plans for development of networks were outlined in recent NHS England guidance:

“Urgent and emergency care (UEC) networks will operate strategically, covering a footprint of 1-5 million (depending on population density, rurality, and local factors). Their purpose is to improve the consistency and quality of UEC (and) to address challenges in the urgent and emergency care system that are difficult...to address in isolation.”

These developments have been supplemented by further national guidance from NHS England which sets out a set of design principles for urgent and emergency care. These state that:

“For adults and children with urgent care needs, we should provide a highly responsive service that delivers care as close to home as possible, minimising disruption and inconvenience for patients, carers and families.”

NHS England has also initiated a series of vanguard sites related to a series of healthcare areas, including eight sites focused on urgent and emergency care:

“Each vanguard site will take a lead on the development of new care models which will act as the blueprints for the NHS moving forward and the inspiration to the rest of the health and care system.”

Of the eight sites, only one, Leicester, Leicestershire & Rutland makes specific mention of older people.

These vanguards will pilot and test new models of care, some of which appear to build upon initiatives and work that has been developed previously. One such example has been the creation of urgent care centres:

“Urgent care centres have the potential to significantly improve the way urgent care is provided and to enable greater integration of the wider unscheduled care system.”

Evidence of effectiveness within the literature is limited. Gnani et al noted that:

“Urgent care centres were implemented in the UK... without full evaluation, and proposed national evaluation has been hampered by access to data to identify the size of the effect, as well as wider organisational changes to the NHS.”

In their evaluation of a GP-led urgent care centre in Hammersmith, Gnani et al found that the urgent care centre had:

“Developed a model of care which can potentially safely manage the vast majority of patients.”

This is just one example however and the literature on the effectiveness of urgent care centres for older people is largely absent. More broadly there is some limited evidence, notably from Cooke and Gakhal’s work that raises questions about urgent centre effectiveness in terms of their impact on the wider NHS system:

“Several services that attempt to be substitutes for hospital care either by preventing admission or by hastening discharge have been experimented with. Many apparent substitutes for hospital care seem, in the United Kingdom, to increase overall demand for services, with little impact on overall hospitalisation or costs.”

The Primary Care Foundation found that:

“There are often a number of walk-in centres and minor injury units within each health economy. The evidence suggests that walk-in centres are not effective in reducing emergency department attendances except where they are co-located and integrated with emergency departments. Information for the public about opening hours and the range of available services is incomplete and unreliable. Information on costs and cost-effectiveness is insufficient to judge whether centres offer good value for money. There are unrealised opportunities for integration and joint working, especially where centres are co-located with other services such as GP out of hours.”
Increasingly telephone consultation for urgent care advice has emerged as a service development. NHS 111 is a free telephone service available in England and Scotland through which advice about non-emergency healthcare matters can be sought. Turner et al’s study of pilot sites found that:

“The provision of a telephone service which quickly guides people needing urgent care advice to the most appropriate service is sensible given repeatedly expressed concerns by the general public about confusion around which service to access when needing urgent care.”\textsuperscript{123}

This service has not been without its critics however. As Ham suggested:

“Even more important is the lack of integration of NHS 111 with other parts of the urgent and emergency care system, the fragmentation of which has been identified by NHS England’s chief executive, Simon Stevens, as a fundamental weakness that needs to be addressed. The answer to the problems facing the NHS lies in much greater integration of care both within the NHS and between the NHS and social care, as the Keogh review recommended in 2013.”\textsuperscript{124}

The University of Sheffield conducted an evaluation of the pilot sites for NHS 111. Turner and her colleagues found that:

“There was no evidence that NHS 111 changed perceptions of urgent care for recent users of emergency and urgent care (based on perceptions of 2,237 recent users of emergency and urgent care). The population surveys showed no change in satisfaction with urgent care or the NHS following the introduction of NHS 111 (based on perceptions of 28,071 members of the general population).

There was no statistically significant change in emergency ambulance calls, emergency department attendances or urgent care contacts/attendances.”\textsuperscript{125}

The then national clinical director for NHS 111 said in evidence to the Health Select Committee in May 2013:

“NHS 111 was not introduced to reduce use of NHS services. It was introduced to simplify and improve access to urgent care services for the public and patients.”\textsuperscript{126}

The final Sheffield evaluation was unable to reach a conclusion as to the likely impact of NHS 111 on the wider NHS urgent and emergency care system and no further evaluations of NHS 111 could be located for review.

The University of York’s review of evidence found:

“Little evidence to suggest that telephone consultation is less safe than standard care.”\textsuperscript{127}

The evidence remains limited but the York researchers point to a systematic review conducted by Purc-Stephenson and Thrasher in 2012, which examined the extent to which patients followed advice from nurse-led consultation/triage:

“The high rate of compliance with self-care recommendations suggested that telephone triage nurses were successful in diverting patients with less acute symptoms from using emergency services or visiting a general practitioner.”\textsuperscript{128}

As has been identified in this review, the need to identify and respond to the particular needs of older people should be a key element of urgent care services. The Silver book suggests that:

“All urgent and emergency care units should have accessible sources of information about local social services, falls services, healthy eating, staying warm, benefits and for carers of frail older people.”\textsuperscript{129}

Equally, urgent care should be seen as part of an integrated care pathway, as George et al have suggested:

“It is important that commissioners commission the complete pathway.”\textsuperscript{130}
The value of early understanding of the varied needs of older people has been found to be beneficial in ensuring better outcomes for them. As Melby and Ryan found:

“If the multiple needs of older people were addressed in the pre-hospital field, a reduction in readmissions and increased functional ability might be achieved.”

Current national guidance reflects this in stating that:

“Older people being admitted following an urgent care episode should have an expected discharge date set within two hours.”

The issue of integration of services (and professions) is highlighted in some of the literature reviewed. The Silver book guidance states that:

“Health and social care commissioners and those responsible for commissioning support arrangements must always reflect a joint approach across all disciplines which takes account of the multidisciplinary nature of care for and working with older people.”

The literature also suggests that integration is about more than co-location:

“While co-location of the urgent care centre and emergency department represents a degree of integration, a higher degree of integration could be achieved by having a single point of assessment (triage) with patients treated by primary care or emergency department staff as appropriate.”

The role of adult social care in responding to urgent care needs is also highlighted by Oliver et al who state that:

“Social work expertise and social care capacity are important elements in multidisciplinary initiatives such as rapid response, crisis response teams, and care-at-home services. As with primary care, appropriate social care services should be available out of hours, and should enable swift assessment of an individual’s care and support needs with the aim of stabilising the situation and assembling a care plan that avoids clinically unnecessary admission to hospital or to long-term residential care.”

As older people age and their needs increase, the demands on services also tend to go up:

“In England, 417,910 people aged 65+ received community-based care and support at home in 2012/13.”

“Approximately 30 per cent of people use some form of local authority funded social care in the last year of life.”

The Association of Directors of Adult Social Services has commented on the impact of social care within the wider care system and point to research by Bardsley et al who found that:

“It is often the case that the people who consume the most resources will have multiple health problems and be in contact with a wide range of interacting, and in some cases interdependent care providers. One area where this can be seen in England is at the interface between healthcare (provided by the National Health Service) and social care delivered by independent providers and funded either by local government or by people paying for themselves. The majority of people receiving social care will also be receiving healthcare and there are studies to show how these services interact so that receipt of one service reduces the need for the other.”

There are those who believe that the argument that better adult social care will be a panacea to reducing demand is flawed. The Health Service Journal’s Commission on hospital care for frail older people was clear in its assertion that:

“Improving community care may postpone the need for hospital care, but it will make frail older people neither invincible nor immortal: mostly, they will simply need the care later. It will never prevent older people and their carers from needing or seeking urgent care in emergency departments or in hospitals.”
What the evidence tells us about improving urgent care for older people

Others point to the need for a more holistic approach that is based on need rather than diagnostic criteria. As Oliver et al suggest:

“Transforming services for older people requires a fundamental shift towards care that is coordinated around the full range of an individual’s needs (rather than care based around single diseases) and care that truly prioritises prevention and support for maintaining independence. Achieving this will require much more integrated working to ensure that the right mix of services is available in the right place at the right time.”140

Integration between health and social care as a means to improve the quality of service older people receive is seen as part of the solution to the historical divide between the two sectors. As the Silver book makes clear:

“Commissioning evidence-based integrated health and social care systems that address care across the continuum will help deliver safe, efficient, effective and a high quality holistic care for frail older people in the years to come.”141

The combined skills and expertise of health and social care services are therefore central to ensuring better outcomes for older people:

“In managing older people with urgent care needs in the community, the first 24 hours of timely, effective health and social care support is crucial.”142

As Downes and Pearson highlighted in their paper to the board of NHS England in March 2013:

“Both health and social care have a central role in supporting people with disabilities and long-term conditions. The challenge for both services is to respond to the changing needs of the people of this country where an increasing focus will be on the growing number of people who need extensive health, care and support. There is an imperative to ensure that local services prevent or delay ill health and the need for services. At the same time the need to ensure coordinated, person-centred and consistent care for those who need it will be central at a local level.”143

The availability of literature that focuses on urgent care and older people appears limited, though there are some interesting examples of local work being undertaken across the country to improve services, some of which are specific to older people. One example in particular has been highlighted by the Health Foundation:

“In Sheffield they have taken a different approach. Building a deep understanding of how their urgent care services work (or don’t work!) for frail older people, they have recognised that the problem isn’t one of capacity but of flow. By tackling the factors that impede flow of patients through their services they have had a dramatic effect on length of stay, costs and – most importantly – outcomes.”144

Another example, part of the Commission on Improving Urgent Care for Older People’s site visit programme is the Pathfinder project in Cornwall where Age UK developed an innovative, invest-to-save service that integrated the care that the most vulnerable older people receive from the NHS, social care and the voluntary sector. The evaluation of the service showed a key need for:

“Building the multidisciplinary team as well as sharing learning and using informal social events is vital to ensure effective working and case management, developing shared outcomes and measures, commitment to finding solutions and empowering frontline practitioners to redesign services around the individual.”145

The emergence of new professional roles also has a part to play in improving urgent care. As Scott and Carney suggest:

“If we take the opportunity to develop staff (career progression) and at the same time create an integrated and clinically supported system, then patient care can be significantly improved.”146
What the evidence tells us about improving urgent care for older people

One notable development has been the creation of the urgent or emergency care practitioner (ECP) role:

“Emergency care practitioners are generic practitioners drawn from paramedic and nursing communities... (they) receive formal training to equip them to work across traditional boundaries in emergency and unplanned care.”147

Although not specific to older people in terms of effectiveness, Mason and her colleagues found that:

“ECPs provided an alternative service and were meeting their objectives in reducing the need for attendance at the emergency department.”148

One current example of an urgent care practitioner model can be found in Yorkshire where winter resilience money was invested with Yorkshire Ambulance Service to create the Urgent Care Practitioners (UCPs) programme. Four practitioners from Yorkshire Ambulance Service were employed to work alongside regular ambulance crews to accept referrals from nursing homes, community matrons, nurses and fellow paramedics. The service recruited a further eight UCPs in 2014:

“The practitioners work on a roving basis around the Vale of York. They are called to emergency 999 calls and calls from NHS 111. Typical referrals to UCPs include falls, chronic obstructive pulmonary disease (COPD), catheter problems, wound care and many more urgent care needs.”149

The University of York has drawn on a range of studies which suggest that:

“ECP services have been cited by have been implemented successfully in a variety of UK settings. There was support from staff and patients for ECP services. A number of studies of high methodological quality found care processes provided by ECPs to be equivalent to or better than those provided by practitioners with traditional roles. However, the authors noted that the evidence was insufficient to conclude that commissioning an ECP service is likely to be more productive than alternatives such as GP visits or paramedic treatment.”150

Studies have shown that up to a quarter of admissions to hospital of frail older people could be avoided:

“If there is an early review by a suitably qualified clinical decision-maker supported by responsive intermediate care services. Early expert intervention with multiagency support to manage older people may be more promising than other interventions that have been attempted.”151

The role of prevention has not been widely highlighted in the literature, but there is some evidence about the potential that improved awareness raising and preventative approaches might reduce demand for urgent care services among older people, but that this is not well developed within the NHS. As Craker found in his 2014 paper:

“Ensuring health services become more responsive to patients has been one of the main mantras of healthcare system reform for more than a decade. The National Health Service (NHS), however, still has much to learn about what influences patient’s choice in managing their non-urgent conditions.”152

Another area of preventative development and promotion of self-care has been the emergence of telehealthcare. There is a large body of positive evidence about the value of telehealth in supporting the management of long-term conditions and reducing the usage of health service resources. However, there is a significant minority of studies which indicate few if any benefits compared to ‘usual care’, and a small number of studies which appear to show some negative outcomes. The weakest part of the evidence remains the quality of economic evaluation. The results of this review are therefore ‘mixed’.

“The evidence for the positive impact of telehealth is promising, but mixed. Only a few studies showed any negative impact, yet about one-third reported that telehealth had made no positive difference over usual care. Of the two thirds of studies which did demonstrate positive benefits or trends, few could claim that their results were statistically significant.”154
There is a temptation to view telehealth and assistive technology as simply providing the necessary savings, though the evidence about this is in itself mixed. However the focus cannot solely or mainly be about cost savings:

“The evidence doesn’t support the view that large scale investment in expensive technology will generate significant revenue savings in the future. However, the evidence does support a view that judicious investment in telehealth, as part of broader steps to improve the management of people with long-term conditions in the community, can:

- improve patient clinical outcomes
- facilitate greater empowerment of patients and improve self-care
- generate productivity gains in the deployment of staff
- produce some modest reductions in secondary care usage.”

Shah et al found that telehealth (or telemedicine as it is described in their study) was especially effective for older people:

“The project demonstrated that high-intensity telemedicine services for acute illnesses are feasible and acceptable and can provide definitive care without requiring ED or urgent care use.”

Initiatives related to service improvement have tended to be ‘isolated’, in the sense that they have not always been part of a wider, co-ordinated programme of improvement. The development of urgent care networks and vanguard sites may help to reduce this isolation. However the NHS Urgent Care Commission found that:

“One of the most significant barriers we identified to achieving real change is the disjointed nature of the debate, with conversations taking place across government; the NHS; private and third sector providers; clinicians and in the media. An emphasis on delivering practical support for providers and clinicians to make quality improvements a reality is now needed.”

Collaboration and closer working between different parts of the NHS is one area to be further explored. This may include the relationship with pharmacies and the preventative role that they can play. As the Royal College of General Practitioners inquiry found in 2014:

“One area in which we see particular potential...is in the relationship between pharmacy and general practice. By encouraging more effective arrangements for collaboration, co-commissioning of pharmacy and general practice services could help drive increased uptake of support for self-care, and enable improved management of medication for patients with multimorbidity.”

Whatever service changes take place, either within vanguard sites or through other locally based initiatives the importance of addressing the needs of older people will be central. The literature is notably sparse in relation to specific examples of work to improve older people’s access to and experience of urgent care.

The NHS Confederation’s Commission on Improving Urgent Care for Older People has its own submissions of developments and service improvement from which to draw, but there does appear to be a need for further evaluation and research that is focused on older people and on specific service models and professional roles.
Conclusions

The key findings of this literature review reveal a range of issues, viewpoints and conclusions from papers, articles and other forms of literature has shown that improving urgent care and doing so specifically for older people is a complex topic, for which there are no easy solutions.

There is no explicit consensus on what the term ‘urgent care’ means.
There is a need for clarity in the definition of urgent care. The coupling or conflation of urgent care with emergency care causes confusion for those accessing services. In addition it causes difficulty in establishing a clear and distinct evidence base for urgent care interventions and has a bias towards emergency care in hospital.

Understanding the needs of older people and the impact of an ageing population are central to future improvement.
The growth of the older people’s population will place further demand on urgent care services and thus it will need to adapt to respond to that growth and the challenges it presents. The review has found that a key factor in improvement is that of raising awareness among professionals of the particular challenges of meeting the needs of older people. Older people often have needs that are multi-factorial and as such are sometimes considerably more ‘vulnerable’ than younger people as a consequence of issues such as confusion, dementia, compromised communication and an underlying fear of treatment.

There is limited evidence relating specifically to older people in relation to urgent care.
The review has identified a range current national policy and legislative imperatives for improving urgent care in both health and social care. Many of these are focused on urgent care as a broad subject and do not relate specifically to older people. Further research and evaluation of projects, service developments and initiatives is needed to establish a more comprehensive picture of what works for older people.

There needs to be a proper evidence base to improve learning and share best practice, this is currently lacking.
The literature comprises policy, think tank pieces, a range of studies and research as well as previous inquires and ‘taskforce’ reports. However, the literature is light in terms of robust evaluations and research of developments and initiatives that have a particular focus in relation to older people. Of significance is the need to consider the way in which initiatives to create improvement are evaluated so that the research and evidence base relating to urgent care and older people can be broadened and learning about best practice can be more widely shared and reviewed.

The majority of work looking at urgent care for older people is focused on admissions avoidance and proper discharge rather than prevention.
Examples of evaluated initiatives and the identification of best practice are especially limited and have tended to focus on admission avoidance and effective discharge. While these two areas are of critical importance there is much less that is helpful to understanding what works in relation to older person and urgent care. Nor are there examples of preventative work that can be undertaken in the community.

The role of urgent care centres and telephone support are central to the literature reviewed. The effectiveness of both remains a matter of debate from the material reviewed, but it does appear that where part of the wider system they have a good deal to contribute.

Without additional research there is a risk of further isolated and duplicated work, and a reliance on anecdotal experience rather than evaluated and evidence-based development.
National guidance provides little direct focus on the needs of older people in relation to urgent care.
The relevant national guidance is non-specific in relation to urgent care for older people. The majority of guidance since 2006 has been concerned with emergency care but the focus is changing. The imperatives in the Five Year Forward View and the creation of new models of care, alongside the establishment of vanguard sites will be key levers in creating change. However without a clearer focus on the needs of older people they risk the adoption of a one size fits all approach to urgent care delivery.

There is limited acknowledgement of the role that community services, including social care and ambulatory services, play in the relation to effective urgent care.
The literature contains some discussion about the nature of urgent care and the extent to which much of it is delivered outside the hospital through primary care and whether the focus on the hospital minimises the work of non-hospital based practitioners and systems. The value and importance of the role and contribution of community-based services, including social care, the voluntary sector, ambulatory services and by nursing and residential care homes is sometimes overlooked.

There is a definite awareness of the challenge of getting the right skill mix to deliver older people's care well, and in doing so, building the right multidisciplinary teams across acute, primary, social and community care.
Factors such as workforce/skill mix, competence in working with older people and awareness of their particular needs, integration, appropriateness of admission, pre-admission support, effective and safe discharge, the role of social care and capacity all feature highly as influencers upon the effectiveness of urgent care delivery for older people. In particular the need for professionals to develop new roles and expertise in working with older people will be necessary to appropriately support the delivery of effective urgent care to older people.

Professionals need to be responsive to the needs of older people with multiple morbidities and/or complex social situations and the benefits of multi-agency and inter-professional responses.
The review has found that a key factor in improvement is that of raising awareness among professionals of the particular challenges of meeting the needs of older people. There is an especially strong base for this, with a range of sources providing evidence in support of this area.

The literature strongly demonstrates that older people often have needs that are multi-factorial and as such are sometimes considerably more 'vulnerable' than younger people as a consequence of issues such as confusion, dementia, compromised communication and an underlying fear of treatment.
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