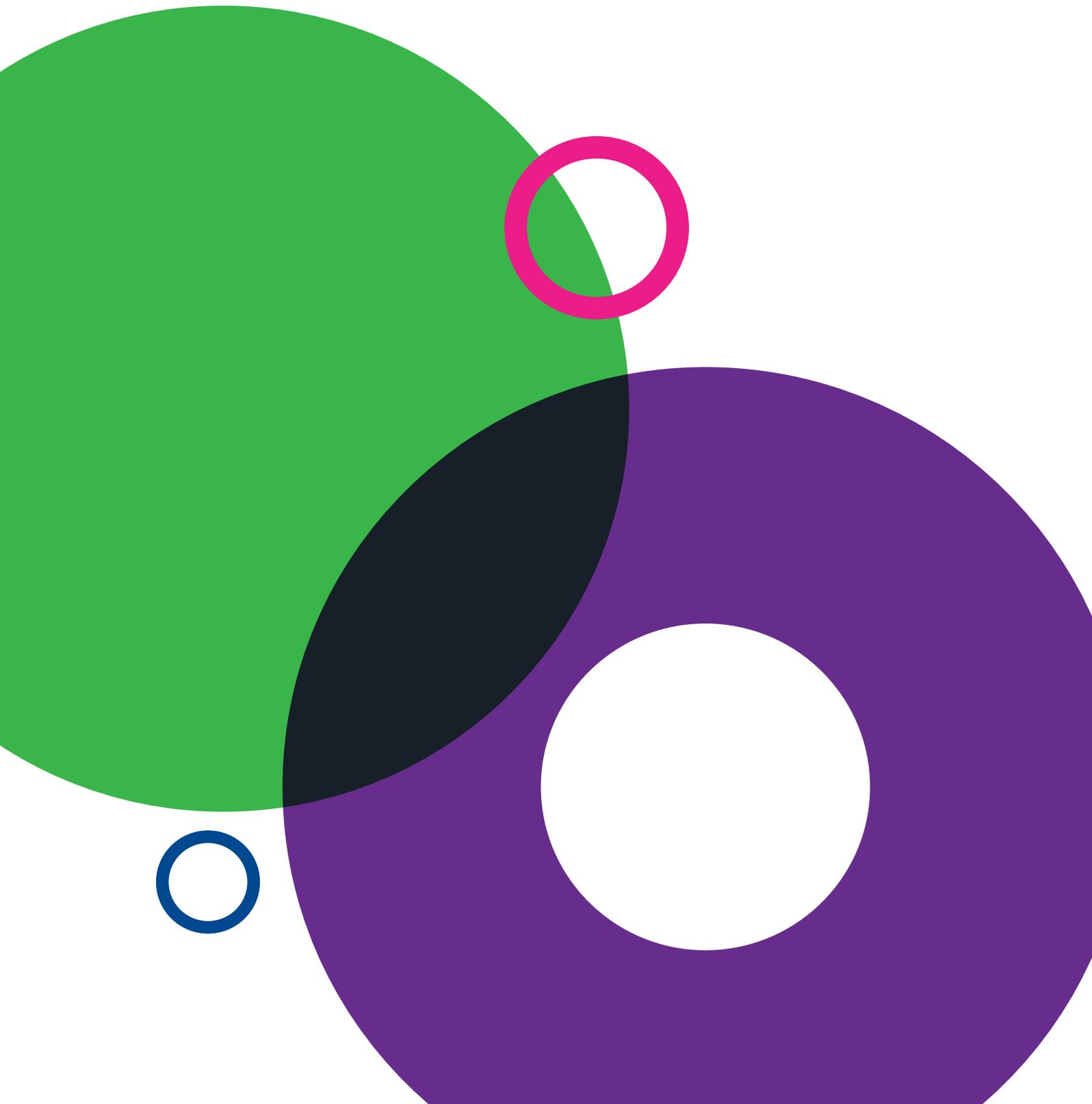




Rip off the sticking plaster now

Enabling the local implementation of sustainable
urgent and emergency care models in 2015/16



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Executive summary

Without immediate action, the NHS is set for a winter crisis in 2015/16. NHS organisations need to take rapid action now if we are to implement solutions that will prevent this from happening. Planning and policy guidance have been issued in disparate documents across a number of months, and have been affected by the electoral cycle. This report collates the guidance and urges immediate action from NHS organisations, national bodies and the incoming Government. We need to rip off the sticking plaster that covers emergency care systems now – winter is coming and we must be prepared.

Urgent and emergency care demand continues to be influenced by intertwined demographic, behavioural and capacity issues.

Sustained pressures throughout the past decades have made the healthcare system increasingly vulnerable to external shocks, such as slight increases in demand for urgent care. While urgent and emergency care pressures are most visible in A&E departments, they are symptomatic of systemic issues, which also affect ambulance services, primary care, community health and mental health, and need to be addressed by the system as a whole.

Many people who attend A&E departments could potentially have their needs addressed in community settings – if sufficient capacity existed – or could be supported to avoid a health crisis altogether. This must be a focus of health systems: to break the vicious circle resulting in increased pressures on A&Es, and ensure patients have access to the right care, in the right place at the right time. This will need to reflect the resources, needs and priorities of each individual area as set out in plans being agreed now – supported by Commissioning for Quality and Innovation (CQUIN) payments and incentives.

To design locally-appropriate solutions, and build capacity outside hospitals at the same time as maintaining sustainable A&E and hospital services, local areas will need strong collaborative urgent and emergency care networks of commissioners and providers. The NHS should not wait for further guidance and should develop these now.

The new models of urgent and emergency care delivery, as described in NHS England's urgent and emergency care review, and subsequently highlighted in the Five Year Forward View, offer a way forward.

Local leaders are expected to prioritise implementation of the urgent and emergency care review, if we are to avert an A&E crisis in 2015/16. To enable this, they need the national bodies and the incoming Government to prioritise support for local efforts to reshape care. They also need as much clarity as possible from national bodies on the process to follow and how this fits with other processes; and tools and guidance that will help them set up urgent and emergency care networks and reshape care.

“While urgent and emergency care pressures are most visible in A&E departments, they are symptomatic of systemic issues, which also affect ambulance services, primary care, community health and mental health, and need to be addressed by the system as a whole.”

These first steps toward a sustainable system will need to be boosted quickly. We recommend five key elements for a sustainable urgent and emergency care system that the incoming Government should work with national bodies, including NHS England, to enable and support:

1. Change must be locally led, with national-level support that is tailored locally
2. Direct investment towards the right services to have the most impact on overall sustainability – improving access to care in the community must be prioritised
3. Ensure access to a multi-disciplinary workforce, supported to work across primary, community, acute and social care
4. Embrace joint working between the NHS, social care and the independent and voluntary sectors, for a truly whole-system response
5. Avoid hitting the target and missing the point – system-wide, outcomes-focused measures must be our focus

In addition to the urgently needed support and guidance for local leaders, we ask the incoming Government to work with NHS England and others to:

- support local leadership of change
- allocate adequate funding to health and social care and make faster progress on developing new payment mechanisms that enable investment in the right places
- develop and support the workforce needed
- develop whole-system measures, aligned across health and social care
- enable the implementation of locally coordinated and shared information systems.

These themes are all reflected by the NHS Confederation and partners across health and care in the 2015 Challenge.

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Introduction

Pressures on the urgent and emergency care system have increased relentlessly over the past decade, and are no longer confined to the winter months.

Through our Urgent and Emergency Care Forum, the NHS Confederation has been emphasising:

- the need for long-term, whole-system solutions to the pressures on A&E¹
- the need for local areas to understand demand for urgent and emergency care across the whole system
- the workforce and system capacity challenges that need to be addressed.²

These are clearly mirrored in the case for change set out by the NHS Confederation and its partners across health and care, through the 2015 Challenge.³

One year on from our *Ripping off the sticking plaster* report, the pressures remain. NHS England's Five Year Forward View (5YFV)⁴ helpfully set out the need for locally-driven, long-term, integrated models of care that include more community-based capacity. We are pleased that the urgent and emergency care networks proposed in NHS England's urgent and emergency care review⁵ are an integral part of this vision. However, urgent and emergency care pressures were rarely out of the headlines during the winter of 2014/15 and many people expect 2015/16 to be worse. The need to implement more sustainable models is urgent.

As the countdown to winter 2015/16 begins, this report brings together:

- examples of new models that have been developed by different local areas, and their impact
- an assessment of progress and next steps in implementing the urgent and emergency care review
- an overview of the tools and resources that may help local systems to prepare
- recommendations for how the incoming Government, with national bodies, can support local leaders to implement the urgent and emergency care review.

In developing this report, we have re-assessed the statistical evidence on trends in emergency demand. We have also conducted semi-structured interviews with a cross section of 15 commissioners and providers, to explore their views on local areas' progress in preventing, or better managing, urgent and emergency care pressures, and on what support is needed. Finally, we have sought clarity on the existing and planned national support for local healthcare systems as they move to new models of care.

A snapshot: The urgent and emergency care landscape

Increasing pressures on the system

The last months of 2014 and beginning of 2015 saw the health system – with NHS 111, the ambulance services and A&E departments in particular – under unprecedented pressure. This pressure was vividly highlighted in statistics such as at least 15 hospital trusts declaring major incidents – a policy normally associated with major road accidents – in January 2015, or the A&E four-hour target being missed for 22 consecutive weeks in March 2015.⁶

‘Common sense’ might suggest that this increased pressure is being partly driven by an increase in attendances at A&E, but the figures do not bear this out. Attendances at A&E departments have actually slightly decreased in January–March 2015, compared to the same period in the previous year, while the volume and demographic make-up of A&E attendees is in line with previous trends.⁷

What has increased are emergency *admissions* from A&E.⁸ Acutely ill patients arriving in A&E are presenting with a higher level of complexity than observed in previous years, increasing the number of patients that need to be admitted. The majority of that increase are patients over 65, with a noted increase in over 85-year-olds.

While an increase in admission rates would seem to be tied to an ageing population, certain areas are also experiencing a growth in demand from people aged 16–64.

Increased complexity is shown to decrease the risk tolerance of clinical staff, especially junior clinicians, with a subsequent increase in decisions to admit patients.⁹ Often patients are ‘admitted to be assessed’, because they have multiple conditions and there are limited staff resources to allow for immediate diagnosis. In turn, as more people who are admitted to hospital have complex needs, the average length of stay increases and it is more often difficult to discharge people promptly. Difficult discharges are also due to the limited availability of community alternatives for intermediate or step-down care, or difficult coordination between the health and social care systems around discharges.¹⁰

The flow of patients within and between different services is becoming increasingly more drawn out and complex. Staff are spending more time trying to move patients through the system, which reduces staff capacity to efficiently assess new patients. It also increases the risk of poor quality care and chaotic management as staff resources are further stretched. All of this contributes to the ‘bed crisis’, and the vicious circle continues.

Over the last year, there have been continued attempts to identify the causes of emergency demand. These consistently point at the intertwining of long-term systemic issues with more recent patterns in demand. Reduced hospital bed capacity, the funding squeeze and fragmented services and workforce pathways combine with an ageing population and service users behaviour, decreasing the system capacity to cope with demand.^{11,12,13} In particular, having different services operating in ‘siloes’ within the urgent and emergency care system limits its capacity to flex. Because capacity is not available in the right part of the system, a relatively small increase or change in demand can cause a disproportionate escalation of pressures.

“Acutely ill patients arriving in A&E are presenting with a higher level of complexity than observed in previous years, increasing the number of patients that need to be admitted.”

Progress in implementing the urgent and emergency care review

Implementing urgent and emergency care networks

A vision for the future of urgent and emergency care was set out in phase one of the urgent and emergency care review, led by Professor Sir Bruce Keogh and published by NHS England in November 2013.

The vision described a future in which people with urgent but non-life threatening needs are provided with highly responsive, effective and personalised services outside of hospital. Through relieving pressure on hospital-based emergency services, this in turn would enable sustainable, high-quality care in hospitals to maximise the chances of survival and a good recovery for those people with more serious or life-threatening emergency needs.

Central to enabling the delivery of this reshaped care is the urgent and emergency care network model. Urgent and emergency care networks should logically build upon existing local and regional collaboration, such as system resilience groups (SRGs), which themselves evolved from urgent care working groups. They should bring together SRGs, clinical commissioning groups (CCGs) and a range of other stakeholders to address system challenges and responses that cannot be managed by a single local health economy. SRGs have the operational focus, while strategic urgent and emergency care networks will need to fulfil the role of coordinating, integrating and overseeing urgent and emergency care across

wider geographical areas and populations. Planning for this winter is set to be the first major test of this nascent model.

SRGs, in transitioning from urgent care working groups, expanded their role to include elective, as well as non-elective, care. SRGs are the forum where all the partners across the health and social care system come together to undertake the regular planning of service delivery and are normally chaired by a senior leader from the CCG(s) represented on the group. SRGs are a mechanism for whole-sector collaboration, rather than a statutory body, with members expected to hold each other to account for delivering on the plans agreed. They need to develop partnerships with other strategic planning mechanisms, particularly health and wellbeing boards, local education and training boards, and advisory groups including clinical senates. In most areas, SRGs already deliver the role envisaged for operational urgent and emergency care networks; and some areas have already established strategic urgent and emergency care networks by bringing together several SRGs.

Strategic urgent and emergency care networks will need to operate at a higher level (over perhaps a five-year timeframe) and a wider geographical area. It is logical that NHS England regional teams, with their role in specialised commissioned services, will need to work with CCGs and SRGs to form these networks.

How urgent and emergency care networks may look

<p>Operational level:</p> <ul style="list-style-type: none"> • smaller geographical area • approximately two-year planning horizon 	<p>Strategic level:</p> <ul style="list-style-type: none"> • larger geographical area • approximately five-year planning horizon
<p>In most areas, SRGs have developed to fill this role. They include all local CCGs and health and social care providers.</p>	<p>Could consist of SRGs working together as a strategic urgent care network.</p> <p>NHS England regional teams, CCGs and SRGs need to put these in place in preparation for winter 2015/16.</p>

The aim is to get urgent and emergency care networks in place and functioning as soon as possible, and certainly in preparation for winter 2015/16. Urgent care networks and the new care models programme are the first components of the 5YFV to be implemented.

CCGs were asked to prepare for this during 2014/15. NHS England's planning guidance, *Everyone counts*,¹⁴ indicated that CCG plans must include details of "how you will be ready to determine the footprint of your urgent and emergency care network during 2014/15, working with key partners and informed by a detailed understanding for your area of:

- a) patient flows
- b) the number and location of emergency and urgent care facilities
- c) the services they provide
- d) the most pressing needs for your population."

As expected, our members tell us that the transition to this new network model has not been uniform, with differences in structure, membership and pace across the different regions, reflecting inherent and historical regional differences. Members have also highlighted a number of issues that should be considered as these networks develop:

- are they duplicating, or can they be subsumed into existing structures that already work well?
- do the national bodies need to consider providing regionally-tailored support?
- how do the networks interact with some of the other developing collaborative networks of care set out in the 5YFV, especially those that would potentially plan and deliver all care for large, defined populations, such as multi-specialty community providers or primary and acute care systems?
- how will we ensure networks are able to sustain a focus on transforming the delivery of people's care and do not operate as another, duplicative performance reporting structure?

With urgent and emergency care networks working on a dual operational and strategic level, needing to be set up within what is already a complex set of structures and collaborative networks, and commissioners and providers raising a number of concerns and questions, support and guidance on developing effective urgent care networks is needed quickly. NHS England is planning to release written guidance on network formation, function and objectives, followed by a number of supporting documents on ambulance services, patient flow and other areas to support the effective functioning of urgent and emergency care networks. These must respond to the issues raised by our members, and be made available as soon as possible.

“Our members tell us that the transition to this new network model has not been uniform.”

Service changes to prevent and manage emergency demand: examples from around the country

The national picture of an emergency and urgent care system at crisis point is unfortunately a familiar one but it is not the whole story. Local health economies have been working hard, seeking local solutions to national problems.

There are key themes that run through the initiatives and new ways of working that are being trialled and implemented in local urgent and emergency care systems: increased partnership working and coordination, initiatives that focus on improving patient flow across the whole system, and an emphasis on providing integrated care.

Increased partnership working comes in many guises, from joint funding bids with local councils to set up intermediate care hubs, to community geriatricians working with CCGs. Local system coordination and strategic planning is also being carried out in a number of ways, from the use of urgent and emergency care networks, as described in NHS England's urgent and emergency care review, to dedicated working groups who bring together providers, commissioners and social care to discuss specific issues such as admissions avoidance.

The initiatives that focus on improving patient flow across the system are currently largely focused on increasing community capacity for rapid response and reducing in-house admissions and length of stay. For example, the West Midlands health economy has increased community higher acuity core capacity by 60–90 beds, working ten hours a day, seven days a week. Dedicated multi-disciplinary frail and elderly teams or units have also been set up across the country, addressing the needs of this care pathway by reducing both the need to admit and the length of stay, if patients are admitted.

The ultimate aim of these different ways of working is to move towards providing more integrated care, which in turn will support increased access to urgent care services in the community. A number of co-location schemes, focusing on improving the interface between primary and secondary care, are being implemented across our membership. For example, Wrightington, Wigan and Leigh NHS Foundation Trust has tendered out-of-hours GP services co-located with its A&E department. London Ambulance Service NHS Foundation Trust is also piloting a novel scheme in the borough of Hackney, where paramedics and GPs are jointly deployed in the community.

Primary and acute care systems, one of the 5YFV's new models of care to be implemented by 29 'vanguard' health economies, will further develop these models and expand collaborations to social care – such as in the Wirral health and social care economy. Wirral Community NHS Trust is part of this health partnership, together with providers and commissioners of acute, primary and social care, and mental health services. Based on its existing experience of urgent care provision, and acting on the assessed need for increased primary care access, the trust with partners has already started to redesign its walk-in centre model, an element of which will be part of a single 'front door' to co-located community, primary and A&E services. The trust is also strengthening its integrated community nursing and therapy provision, and capacity for rapid community response, with increased investment from commissioners including through the Better Care Fund.

To further illustrate the hard work that is happening locally to improve urgent and emergency care systems, a series of initiatives taking shape across different regions and organisations, and the progress they have made over the past year, are highlighted next.

Case study: Ambulatory care models reduce unscheduled admissions in Airedale – two years on

In February 2013, Airedale NHS Foundation Trust introduced a new ambulatory care model. Their ambulatory care unit (ACU), is adjacent to the acute medical unit and provides consultant-directed care supported by advanced nurse practitioners with out-of-hours support provided by the consultant on call for the AMU and senior nurses in the acute care team. The aim of the unit is to support inpatient admission avoidance, where this is in the best interests of the patient. In the first half of 2013/14, the ACU played an integral role in helping almost a third of cases to avoid admission to hospital.

Developments

Since the ACU's establishment, it has expanded its bed base (the unit now has 24 beds) and the scope of patients it is able to support, by adding a number of new pathways. This has been in reaction to the positive initial results and to an increase of 85 in the number of GP referrals in 2014. The ACU now also offers direct access to GPs, broadening the means through which it fulfils its aim of supporting the reduction of inpatient admissions.

This is part of a wider development of ambulatory care units, including the surgical assessment unit and the early pregnancy assessment unit. All of which aim to facilitate access to on-the-day advice and treatment, reducing the need for inpatient admissions, either through referral from A&E or bypassing A&E.

Outcomes

So far, the trust has seen 1,145 ambulatory care patients across the various ambulatory care units and pathways. The ACU has seen 581, with 46 per cent of those not having to be admitted overnight. The 46 per cent received the following treatments:

- telephone advice – 9 per cent
- same-day observation, assessment and treatment – 23 per cent
- same-day admission and discharge from the acute medical centre, following referral from the ATC – 13 per cent.

Based on the current level, it is estimated that over the year over 500 cases could be managed using ambulatory care and therefore possibly not require admission.

Next steps

The trust is co-designing with patients a business case to co-locate the ACU with the new emergency department, due to the advantages this could bring in staffing, referrals and admission avoidance. Overall, the trust's work on reducing in-house admissions is part of a wider plan to shift to a model based on population health. They are working with their CCG and have 'pioneer two' status to start work on the implementation of the Extensivist and Primary Care Plus Model.

Case study: Delivering joined-up care through a joined-up cabinet – three years on

In January 2012, South Devon and Torbay established a health and care cabinet – the ‘joined up cabinet’ – for the region. It brought together GPs, senior managers and clinicians from South Devon and Torbay CCG, South Devon Healthcare NHS Foundation Trust, South West Ambulance Service NHS Foundation Trust and representatives from social care and public health. The aim of the cabinet was to deliver high-quality, reliable and joined-up health and care that puts people first.

Developments

Three years on, the joined-up cabinet is still in place and is attended by senior leaders from across the system. Its key role is to showcase and debate innovative whole-system solutions to address urgent and emergency care by analysing data to develop earlier, integrated healthcare and support interventions to improve overall personal and population health and wellbeing through multi-agency care planning.

The cabinet is now complemented by a ‘joined-up board’ that was set up at the end of 2013 to manage a programme of projects to deliver integrated models of care. These include supporting development of the Integrated Care Organisation, a planned merger of Torbay Hospital and community health and care services, pioneer projects and extending multi-disciplinary working to include primary care across all localities. The joined-up board helps to turn ideas from discussions held at the cabinet into action as part of a planned joined-up programme of work.

Next steps

The joined-up cabinet has a whole-system design role in relation to urgent and emergency care alongside the SRGs. Given that membership of the SRG and the joined-up board is similar, the joined-up cabinet is looking at how closely these groups can be aligned while still maintaining their purpose and impact.

Case study: Supporting the provision of right care in the right place at the right time in the South West

In 2010, the South West Ambulance Service Foundation Trust (SWASFT) signed up to the Right Care, Right Place, Right Time initiative – a five-year funded agreement that committed the trust to reducing unnecessary emergency department admissions by 10 per cent through suitable conveyance to alternative settings. It is important to note the intention was to avoid conveyance to emergency departments, not the hospital itself. This target was achieved in SWASFT's east and west divisions, and the Right Care initiative became an effective tool to bridge the commissioner-provider gap, building a care system based on local needs and avoiding duplication. Joint planning has allowed for resources to be allocated in the most appropriate way, supporting prevention and treatment.

The Right Care model has been supported by strong CCG engagement, using feedback mechanisms on barriers that prevent ambulance clinical hub staff and frontline clinicians from making the most appropriate clinical decisions.

Developments

The Right Care 2 proposal, 'A Healthy System Productivity Offering in the Form of Right Care2', was produced by SWASFT as part of the 2014/15 contracting round in which all 12 CCGs in South West England invested. The proposal outlined a number of specific actions and schemes that would be implemented over two phases that built on the previous successes of the original five-year programme. The delivery is split into phase one (1 April 2014 to 31 March 2016) and phase two (April 2016 to March 2019).

What has been achieved?

The ambulance service is playing a key role in reducing any unnecessary urgent and emergency care demand on acute trusts, while working jointly with other local health and social care providers.

A significant emphasis of Right Care 2 is on SWASFT engagement with local stakeholders in order to develop and progress Local Right Care2 plans in each area. The Right Care team at SWASFT proactively manages the plans in partnership with all 12 CCGs, providing central support for locally delivered actions. The benefits are demonstrated with an improvement in shared knowledge, understanding and communication. Dedicated meetings have been held with each CCG to ascertain objectives and tailor plans to ensure a local dimension. Progress is tracked and reported to internally and externally by the project manager through monthly assurance reporting and additional workstreams, and actions are added as gaps and issues are highlighted through the staff feedback mechanisms.

This 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 emergency department and directly conveying to the computed tomography stroke pathway, angioplasty or major trauma centres, or direct surgical, medical or ambulatory ward admissions. This requires constant, direct communication and coordination with community-based and hospital emergency department staff, in order to discuss appropriate conveyance or arrange swift handovers.

This approach has been effective in reducing emergency admissions over five years, resulting in consistently positive outcomes and improved patient access. In 2014/15, SWASFT set out a further planned reduction in the percentage of patients they conveyed to an emergency department from 46.3 per cent to 45.6 per cent by 31 March 2015. This achievement is on course, which equates to an annual reduction in conveyances to emergency departments of over 8,000 patients across the South West. However, ultimately this means SWASFT staff are enabled to provide the Right Care with access to a wide range of local healthcare providers as a more suitable alternative.

Case study: Rapid access to 24-hour community-based services

Since 2013, Birmingham Community Healthcare NHS Trust has developed a model of care to enable rapid, 24-hour access to community services to reduce emergency hospital admissions.

The model

- a 24/7 single point of access for urgent and non-urgent referrals, giving professional advice and signposting to appropriate care
- a rapid response and advanced assessment at home within two hours for urgent referrals
- multi-disciplinary teams managing non-urgent referrals for community services, with a response time between four and 48 hours
- experienced community clinicians working within acute hospitals' emergency departments and on wards, preventing admissions from the front door and facilitating supported early discharges into community services.

Performance

- In the winter period of 2014/15, acute admissions in the emergency departments were prevented for an average of 139 patients per month, as well as an average of 54 supported early discharges. As well as being better for patients, this has generated significant cost savings:

Admissions avoided (annual)	Cost per admission	Estimated saving
1,668	£2,686*	£4,480,248

Bed days saved through length-of-stay reductions	Estimated cost per bed day	Estimated saving
3,758**	£200	£751,600***

- 100 per cent of urgent admission prevention assessments in patients' own homes have been delivered within two hours, seven days a week, for the previous 12 months.
- The model has coped with rising demand:
 - the volume of calls to the 24/7 single point of access for urgent and non-urgent referrals has increased 10 per cent per year for the last two years
 - an average of 47 per cent of patients referred for urgent care continue to be managed outside an acute hospital setting
 - the rapid response services have maintained response times while demand for them has increased 10 per cent year on year.
- Patients have been transferred into the intermediate care facilities on average 5.8 days earlier than in previous years.
- 91 per cent of patients were likely/extremely likely to recommend the rapid response service to a friend or family member. 64 per cent thought they would have needed to go into hospital without the service. A patient said it was "better treatment than hospital and less confusing".

Challenges

It has been challenging to manage the practical implications of demand and workload in other parts of the model following the decommissioning from March 2015 of the clinician-led telemonitoring service that was a core part of the original model. The telemonitoring service had been supporting up to 300 patients at one time, and an early review of the service by commissioners suggested that there was a reduction in the number of A&E visits, hospital admissions and bed days for some of the patient cohort.

It has been challenging to secure recurrent funding for piloted schemes, and there is a need to work with local CCGs to further develop a sustainable commissioning model for out-of-hospital urgent care so that the new service model is sustained over the longer term.

Future developments

Better integrated community services have been developed over the past two years to deliver care closer to home and make the urgent care system as a whole more sustainable, by both tackling demand for urgent care and offering new options for discharge from hospital. Examples include:

- developing a new purpose-built contact centre for the management of urgent care and referral management of community services
- piloting further alternatives to inpatient care, including 'virtual beds' and 'own bed instead' models that provide an extended home care package to patients who would normally move from an acute bed to residential/nursing home placements
- developing an integrated model with all health and social care partners to promote wellbeing. This includes a remote health coach service where patients are offered six phonecalls over six months to support them to achieve their health and wellbeing goals
- introducing a new community medical assessment unit, led by a consultant geriatrician and supported by advanced nurse practitioners, to provide a timely multi-disciplinary assessment as an alternative to acute hospital attendance
- working closely with health and social care partners to use technology system wide in order to embed the new models of care at pace and scale, including implementation of a central and shared care record.

Long-term success rests on the trust and CCGs developing a sustainable commissioning and funding model to move beyond a series of pilots.

* Based on 2013 CSU estimate of average admission cost for frail elderly admissions.

** Based on the winter pressures evaluation, it was established that patients were being discharged approximately 5.8 days earlier than they were prior to this investment, and this has been maintained; this equates to an estimated bed day reduction of 3,758.

*** This total is predicated on 100 per cent of bed days saved being excess bed days and savings to commissioners – in reality this is unlikely so productivity benefit would be split between commissioners and The Heart of England Foundation Trust.

Contractual and financial enablers

It will be vital that money flows around the system in ways that enable the transformation of care envisaged by the urgent and emergency care review.

Planning for winter 2015/16

The 2014/15 winter pressures funding has been rolled into CCGs' baselines for 2015/16. NHS England has also warned commissioners and providers that there will be no further in-year allocations during 2015/16. This approach is very welcome in that it allows a greater lead-in time for planning and preparation. However, it also places even greater pressure on SRGs and strategic urgent and emergency care networks to plan for and secure a resilient urgent and emergency care system. This brings to the fore the urgency of transforming at pace both our mechanisms for collaborative, strategic whole-system planning of urgent and emergency care, and the actual delivery of such care, so that enough has changed in time to cope with the increased pressure experienced in the winter months.

Looking at financial and contractual levers to facilitate implementation, the 2015/16 CCG quality premium and CQUIN framework both include significant incentives.

The 2015/16 quality premium for CCGs contains measures for urgent and emergency care that are worth 30 per cent of the overall quality premium. These would be worth £240,000 to a CCG with a population of 160,000.¹⁵ These cover three areas:

- avoidable emergency admissions
- delayed transfers of care that are an NHS responsibility
- increase in the number of patients admitted for non-elective reasons, who are discharged at weekends or bank holidays.

Similarly, the CQUIN guidance for 2015/16 also contains an urgent and emergency care menu that aims to incentivise an "increase in the number of patients with urgent and emergency care needs who are managed close to home, rather than in a hospital (A&E or inpatient) setting".¹⁶ The urgent and emergency care menu consists of four indicators:

1. Reducing inappropriate NHS 111 referrals to 999 and A&E:
 - a) reduction in the proportion of NHS 111 calls that end in an inappropriate 999 referral

- b) improve recording of A&E dispositions in NHS 111
- c) a reduction in the proportion of NHS 111 calls that end in an inappropriate type 1 or type 2 A&E referral

2. A reduction in the rate of ambulance 999 calls that result in transportation to a type 1 or type 2 A&E department
3. Reducing the proportion of avoidable emergency admissions to hospital
4. Improving diagnoses and re-attendance rates of patients with mental health needs at A&E:
 - a) an improvement in diagnosis recording in the A&E HES data set of mental health presentations so that there is a valid diagnosis code for at least 85 per cent of records
 - b) a reduction in the rate of mental health re-attendances at A&E.

The total weighting for the menu is 0.5 per cent. However, commissioners can choose one or more indicator and determine the weighting for each of the chosen indicators equating to a minimum total weighting of 0.5 per cent.

Beyond incentives: investment

The vision of expanded, consistent availability of highly responsive, effective and personalised services outside of hospital for people with urgent but non-life threatening needs, alongside sustainable, high-quality care in hospitals for those people with more serious or life-threatening emergency needs, cannot be realised without transition funding and reforms to payment mechanisms.

Work is underway nationally to develop the detail of how transition funding could work for the whole system, and urgent care is a key part of this thinking. Additionally, new payment models for urgent and emergency care are being trialled in this financial year.¹⁷ Nevertheless the need to start developing and investing in community-based urgent care services now, before these financial enablers are in place, represents a major challenge. We urge the national bodies to progress as fast as possible the development of new payment mechanisms that support and enable integrated, personalised care, and to put in place transition funding for service change as soon as possible in the new parliament.

Key elements of a sustainable urgent and emergency care system

Based on the evidence and data available, local circumstances and initiatives, and conversations with our members, we would urge any future Government with the national bodies, particularly NHS England, to focus on how to support the following five key elements to develop a sustainable urgent and emergency care system.

Local leadership of change

Local health economies, and therefore local urgent and emergency care systems, are not uniform; they differ in size, rurality, structure, history and relationships. This diversity is not an obstacle to improving the delivery of urgent and emergency care services; instead, local health economies need to be supported nationally to grasp the opportunities inherent in their local system and tackle the challenges.

There is wide consensus that the reshaping of the health and care system as a whole must be locally led, if it is to truly work for local people and use local assets well. This has been expressed through the 2015 Challenge.¹⁸ The next Government should work with NHS England to support local leaders to develop urgent and emergency care networks, and reshape urgent and emergency care pathways.

There are a number of ways that national level support can be tailored locally. The urgent and emergency care review, and now the 5YFV, set out a national vision for the delivery of urgent and emergency care and are now developing guidance for local implementation. It is paramount that national frameworks offer enough flexibility for the local implementation of such models, allowing them to complement rather than duplicate the coordination structures that already exist and are working well locally. This would ensure stability in the transition to new care systems, and 'head space' for local health leaders to implement change.

NHS 111 is an example where a balance needs to be found between clear and consistent national service specifications and local implementation. In order for

NHS 111 to fulfil its potential of facilitating access to the most adequate service in the system, it needs to be based on a comprehensive, up-to-date directory of services (DoS)[†], which in turn heavily relies on local coordination between providers and commissioners. How this is most effectively done will depend on the structure of the local health economy. The new NHS 111 service specifications include increased clinical input into the service, and in some areas progress has been made. For example, increased levels of clinical input into the service could be achieved by ensuring an effective link with, or co-location within, an urgent care clinical hub.

Invest in the right services to have the most impact on overall sustainability

Due to eye-catching headlines such as "A&E at breaking point", it can be easy for the public to assume that it is the acute sector and specifically A&E where investment will make the most impact. This, however, fails to place urgent and emergency care in its proper context, as a series of different, sometimes interlocking services from across health and social care, with the larger proportion of urgent care provided by community-based services.¹⁹ To make healthcare sustainable and truly patient focused, we need to see primary, community, acute and emergency care as a continuum, and consider where along this continuum initiatives and investment will have the greatest impact.

Investment should be directed to support people before their needs escalate into urgent and emergency care, or as means to provide 'step-down' treatment to patients that no longer have acute care needs, but still need medical support. Access to ambulatory care provided by Airedale NHS FT (see page 9), and rapid response teams operating at Birmingham Community Healthcare NHS Trust (see page 12), are practical examples of such approaches.

Sufficient funding should be therefore allocated to support a shift to out-of-hospital care, while ensuring that A&E departments and acute care remain

† The DOS is a national web-based directory developed by the Department of Health and populated locally, listing health, social care and third sector services.

sustainable during this transition. This will ultimately result in more sustainable and accessible local models for urgent and emergency care, addressing both physical and mental health needs.

Local partnerships have been established between the NHS – ambulance services in particular, local authorities, and the criminal justice system under the auspice of the Mental Health Crisis Care Concordat. Their emerging practice is now showing the positive impact of locally determined triage models and multi-agency working on mental health crisis prevention, support and rehabilitation.²⁰ If compared with the general population, mental service users have double the A&E attendance rate.²¹ It is therefore crucial to support and scale-up the implementation of the Crisis Concordat and other similar approaches.

New models of care need access to a multi-disciplinary workforce, supported to work across primary, community, acute and social care

While capacity and recruitment remain important issues, it is even more crucial to ensure that the right skills are in place to respond to current and future urgent and emergency care demand. This requires longer-term changes in education and training, consistently applied across the health and social care workforce.

The NHS Confederation, in partnership with 22 other leading health and care organisations, has been asking through the 2015 Challenge²² that the next Government initiate and resource a development programme that equips and supports today's workforce for the challenges of working in new ways, including working across and with different sectors and professions, engaging service users and supporting personalised care and support planning, shared decision-making and self-management. If delivered, this would make a vital contribution to the long-term success of the whole-system approaches to urgent and emergency care advocated in the review.

Meanwhile, the transition to new, established urgent and emergency care workforce models should aim to use differently the roles currently available, further developing their skills and with a focus on prevention and promoting population wellbeing.

Partnerships and collaborative models are crucial, including integrated approaches to prevent crisis points, in particular for populations at higher risk of emergency admissions, such as people experiencing mental health conditions, the frail elderly and people with one or multiple long-term conditions. Academic and practice-based evidence presented in this report highlights the benefit of community schemes reducing, or providing rapid response to, emergency demand,²³ and multi-disciplinary working models offering single access to care. Examples of these include: rapid response teams, co-location models, specialist professions based in ambulance control rooms (for example, midwives and mental health nurses) or enhanced use of community nursing. Rapid response and access to multi-disciplinary professionals are the key outcomes to be achieved, while actual workforce models should be determined by local needs.

Such enhanced offers in the community should also include a different use of ambulance service clinicians, providing access to alternative pathways of care through 'hear and treat' and 'see and treat' services, thereby appropriately reducing A&E attendances. This is already working effectively in some places, but in order to do so more extensively, paramedic education and career pathways need to be standardised and their skills appropriately developed to support such schemes.

Health Education England is implementing several programmes looking at developing advanced and specialist paramedics, and other healthcare practitioners' roles. We encourage these efforts to continue, with increased pace and scale. This should also be supported by a renewed national-local dialogue on workforce planning, equal pay considerations, and ensuring that workforce supply and deployment is based on local demand and population needs.

The provider-commissioner relationship remains essential, in order to ensure that new service and workforce models are delivered. The Association of Ambulance Chief Executives (AACE) and the National Ambulance Commissioner Network (NACN) are encouraging joint working across their respective membership at local level. They are also working together to promote key principles for urgent and emergency care transformation:

- local evaluation of 'see and treat' and 'hear and treat' initiatives, to demonstrate their cost effectiveness and contribution to urgent and emergency care quality improvement
- support standardisation of paramedic education
- joint development of longer-term workforce plans, based on a whole-system approach and working with partner organisations to understand skill mix needs, to support new models of providing truly integrated care for patients
- consistent messages in their respective communication with the local public and national policymakers
- ensuring the 'right' mode of conveyance depending on acuity every time.

Enable a truly whole-system response, through effective joint working between the NHS, social care and the independent and voluntary sectors

To unlock the potential of community assets and engagement and achieve more sustainable models of urgent and emergency care, multi-disciplinary working and new care models should include the voluntary and independent sector, especially if rooted at community level. Championing a comprehensive social response to health and wellbeing needs will generate formal and informal support from, and within, the wider community. This approach could also help engage patients and communities in articulating the answers they have.

The challenge lies in how local organisations can be supported and encouraged to redistribute power to the communities they serve so that they are empowered to achieve this, while avoiding the temptation of creating new structures and systems that are completely impermeable to the community they serve.

Consistent data sharing across health and social care services is essential to enable effective partnership working and integrated care. Some practical solutions are already available and need to be incentivised at local level. For instance in England, summary care records, which provide clinical staff with electronic access to up-to-date information about medications, allergies and adverse reactions, have been created for 50 million people in England.²⁴ This has been shown to improve efficiency and effectiveness of clinical decision-making and, importantly, increase patient safety.²⁵ The information is sent directly from the GP record and is available 24 hours a day, seven days a week.

The spine hosts the summary care records of over 45 million individuals, which are extensively accessed each week by care professionals in hospital pharmacies, accident and emergency departments and ambulance services. Summary care records are centrally funded: enabling access to view summary care records in those settings where it is not already available to carry no significant cost for an organisation. More fundamentally, NHS England's proposals to make all patient and care records digital, real-time and interoperable by 2020 are vital to the successful delivery of integrated, whole-system urgent and emergency care pathways.

“Consistent data sharing across health and social care services is essential to enable effective partnership working and integrated care.”

In 2011, Halton CCG embraced innovation and change and commissioned Wellbeing Enterprises CIC – a social enterprise member of the National Association of Primary Care (NAPC) – to design and implement Community Wellbeing Practices, a social model of health. Central to the development of this model was the evidence about promoting wellbeing, the need to tackle isolation and loneliness, reduce the inequalities gap and to address pressures on clinical and social care services. Community Wellbeing Practices was developed with support from Halton CCG and Halton Local Authority, and provides a wide range of wellbeing non-medical services wrapped around 17 GP practices, facilitated by the Wellbeing Enterprises team. At the core of the model are patient co-design of their wellbeing and health services, social inclusion and the use of local community access to increase patient access to alternative care models in their community – ultimately preventing their urgent and emergency care needs. Multi-disciplinary teams and GPs refer directly into the Community Wellbeing Practices service – addressing loneliness, isolation and any other practical social issues that are often the root causes for medical needs. For example, ‘John’, a frail and elderly community member, has been supported to get his boiler fixed – the real cause for recurrent medical admissions that clinicians could not diagnose – and supported to access opportunities to learn new skills and develop a hobby or interest. Wellbeing Enterprises CIC also offers primary healthcare staff training to promote people’s wellbeing, as opposed to purely curative medical approaches. The experience of Community Wellbeing Practices highlights the complexity of health demand and co-production strategies, and the importance of ensuring a plurality of views and resources.

Avoid hitting the target and missing the point

Current emergency targets remain important to understand service performance, but do not provide information on, or enable quality improvement of, the whole urgent and emergency care system. In order to do so, we need consensus on urgent and emergency care system outcomes at a national and local level, and a set of indicators that can assess the performance of the system as a whole and align across health and social care. This set of measures should be simple, pragmatic – based on available data – but also sufficiently inclusive, and thus reflect the contribution of different services within the urgent and emergency care pathway.

Politicians at national and local level have a vital leadership role to play in being candid with the public about the need to change the way we organise care. They must help ensure debates about the urgent and emergency care system are focused on the evidence about securing the best outcomes for people rather than on conserving individual buildings, and that targets are understood in their context, and not used simply to point the finger of blame at individuals and their organisations.

“Politicians at national and local level have a vital leadership role to play in being candid with the public about the need to change the way we organise care.”

Conclusion and recommendations

2015/16 is a critical year for urgent and emergency care. Pressures on the system are rising further still, money continues to be tight, and with no in-year bailouts available then planning must be better than ever before.

Urgent and emergency care networks will be central to both this immediate planning task of preparing for next winter and the 3–5-year task of local whole-system transformation of urgent and emergency care. It is therefore vital that local leaders prioritise establishing these networks at pace, and that the networks begin to function effectively in time to address the increase in pressure that will come with winter. This will be extremely challenging, and in many local areas there is much more to do.

Local leaders will need to make progress without sufficient guidance. This means that any tools and clear guidance that subsequently emerge must be permissive – local leaders making the right choices to take action should not be penalised by prescriptive post-hoc solutions. NHS England must test any additional guidance to ensure it helps local leaders and their urgent and emergency care networks to reshape care, and make this guidance available as soon as possible.

To break the vicious circle resulting in increased pressures on A&Es, and ensure patients have access to the right care, in the right place at the right time, efforts should focus on building an effective community offer. This will require adequate investment to transform primary, community and social care – while ensuring that acute and emergency care remains sustainable.

All parts of the system need to be included in a programme of change that will support self-care where appropriate, achieve a fundamental shift to enhance the delivery of the majority of care close to home in primary and community settings, develop the role of ambulance services and review provision within hospitals to ensure that patients achieve timely access to specialist care when they need it.

The examples of community models for urgent and emergency care implemented by our members in this report show what local areas can already achieve and gives some cause for optimism. These examples, and conversations with members, have highlighted five key elements that need to be the foundation of sustainable urgent and emergency care systems:

1. Change must be locally led, with national-level support that is tailored locally
2. Direct investment towards the right services to have the most impact on overall sustainability – improving access to care in the community must be prioritised
3. Ensure access to a multi-disciplinary workforce, supported to work across primary, community, acute and social care
4. Embrace joint working between the NHS, social care and the independent and voluntary sectors, for a truly whole-system response
5. Avoid hitting the target and missing the point – system-wide, outcomes-focused measures must be our focus

“Pressures on the system are rising, money continues to be tight, and with no in-year bailouts available then planning must be better than ever before.”

These elements are strongly consistent with the direction of travel set out in the 5YFV, and the system-wide consensus on the changes we need to make set out by health and care organisations in the 2015 Challenge.

Regardless of which Government is in place after the general election, key support from politicians and national bodies is required to create the right conditions for local leaders to shape sustainable urgent and emergency care systems:

1. Provide the stability and consistency required for local leaders to reshape urgent and emergency care: avoid major top-down reorganisation of NHS structures and one-size-fits-all models
2. Allocate adequate funding to health and social care – including transition funding – to enable urgent and emergency care transformation, and make faster progress on developing new payment mechanisms that support investment in community-based services

3. Ensure a workforce with the right skills to respond to current and future demand is in place, and they are equipped and supported to work in new ways
4. Develop a simplified outcomes framework and incentives that clearly align across health and social care
5. Enable the implementation of locally coordinated and shared information systems, underpinning urgent and emergency care networks

Supporting a whole-system response to the pressures within urgent and emergency care is a key priority for the NHS Confederation and its Urgent and Emergency Care Forum over 2015/16. We will continue working with NHS England and others to support and influence the implementation of the urgent and emergency care review, and working with our members to share learning from their experiences of implementing change, and advocate for action to address the barriers they face.

“Efforts should focus on building an effective community offer. This will require adequate investment to transform primary, community and social care – while ensuring that acute and emergency care remains sustainable.”

References

1. NHS Confederation (2013) *Emergency care: an accident waiting to happen?*
2. NHS Confederation (2014) *Ripping off the sticking plaster: Whole-system solutions for urgent and emergency care*
3. NHS Confederation (2015) *The 2015 Challenge. Our prescription for the election*
4. NHS England (2014) *Five Year Forward View*
5. NHS England (2013) *High quality care for all, now and for future generations: Transforming urgent and emergency care services in England*
6. Internal analysis of NHS England A&E attendances and admissions' weekly data and quarterly aggregate, www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity
7. *ibid*
8. *ibid*
9. O'Hara R, Johnson M et al. (2015) *A qualitative study of systemic influences on paramedic decision making: care transitions and patient safety*. Journal of Health Services Research and Policy
10. Blunt I (2014) *Focus on A&E attendances: why are patients waiting longer?* Quality Watch
11. Blunt I, Edwards N, and Merry L (2015) *What's behind the A&E 'crisis'?* The Nuffield Trust
12. The King's Fund (2015) *What's going on in A&E? The key questions answered*
13. The Royal College of Physicians, The College of Emergency Medicine, The Society for Acute Medicine, The NHS Confederation (2013) *Urgent and emergency care: a prescription for the future*
14. NHS England (2013) *Everyone counts: planning for patients 2014/15 to 2018/19*
15. NHS England (2015) *Quality Premium: 2015/16 guidance for CCGs*
16. NHS England (2015) *Commissioning for Quality and Innovation (CQUIN): Guidance for 2015/16*
17. Monitor (2014) *Reforming the payment system for NHS services: supporting the Five Year Forward View*
18. NHS Confederation (2014) *The 2015 Challenge Manifesto: a time for action*
19. NHS England (2013) *High quality care for all, now and for future generations: Transforming urgent and emergency care services in England*
20. Mental Health Network (2015) *Mental health and policing: improving crisis care*
21. 41 per cent of 1.5 million mental health service users in England visited A&E departments at least once in 2011/12, compared with 19 per cent of the general population over the same period (Health and Social Care Information Centre)
22. NHS Confederation (2014) *The 2015 Challenge Manifesto: a time for action*
23. Barnes S (2015) *'Walk-in centres reduce demand on A&Es, research suggests'*, Health Service Journal
24. <http://systems.hscic.gov.uk/scr>
25. <http://systems.hscic.gov.uk/scr/benefits>

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