

## Summary

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### Growing demand

The failure of emergency departments to meet national waiting time targets in the early months of 2013 reflected the ever greater demands that are being placed on the emergency care system. Whilst growth in attendances at emergency departments has been limited, admissions have grown substantially placing more pressure on hospitals and restricting the ability of emergency departments to manage the flow of patients. Beyond this, however, analysing the growth in demand is more problematic. Evidence regarding the profile of patients presenting at A&E is contradictory and there is a pressing need for clearer information which can detail where cases present across the system and the case mix of such presentations.

The problems that have manifested themselves within emergency care cannot be attributed to any one factor or failure within the system. The Committee notes that reduced bed capacity is an important factor in limiting the flexibility of hospitals, but neither this, nor problems with out-of-hours care, or the failures associated with NHS 111 can sufficiently explain why emergency care is operating under such sustained stress.

What we can identify is a broader failure resulting from fragmented provision of emergency and urgent care and a structure that is confusing to patients. A&E departments remain the default option for many patients and hospitals must ensure that they have the flexibility to meet demand by providing sufficient bed numbers.

### The Government response

#### *Urgent Care Boards*

The Government's response to the pressure in emergency and urgent care revolves around improving local system management in the short term and restructuring care for the medium term. Urgent Care Boards (UCBs) have been created to implement emergency care improvement plans in local areas. Additionally, local oversight appears necessary to restore a degree of system management removed as a result of the reforms implemented in April 2013. However, the evidence we heard in relation to the Government's proposals did not persuade the Committee that UCBs will be able to implement reforms and influence commissioning. From the evidence presented by NHS England it was unclear whether UCBs are voluntary or compulsory, temporary or permanent, established structures or informal meeting groups. We believe UCBs have potential to provide local system management but they have no executive power and no clear direction.

The improvement plans which UCBs determine are intended to be funded through the 70% of the emergency care tariff for work over 2009 levels which is not paid to hospitals and, instead, retained by the commissioner. Commonly known as the marginal tariff, this money is already at work and as a result the Committee believes that UCBs will have to identify opportunities for disinvestment elsewhere to fund the appropriate plans. UCBs will be challenged by the fact that they have no statutory role but must exert authority over

Clinical Commissioning Groups in order to deploy resources to support the improved delivery of emergency and urgent care.

We do not believe that the local re-organisation of care can be successfully managed in such a fashion. As they stand, the Government's plans to improve emergency care and support local changes to the delivery of care require further refinement. Ministers should seek much greater clarity from NHS England regarding their plans for UCBs and either UCBs or Health and Wellbeing Boards should be held to account for plans to improve local emergency and urgent care. We recommend that local Urgent Care Plans should be in place by 30 September this year.

### *Commissioning*

An overall lack of authority in local commissioning is concerning. Lines of responsibility and accountability for funding and managing the system have become blurred by the presence of UCBs. They feed in to a system which is already built around multiple commissioners and budget holders commissioning providers at regional and sub-regional levels. Allowing providers to work with a single commissioning team can simplify the process, establish key relationships and, importantly, bring providers together to work collaboratively.

### *Restructuring*

The bulk of the evidence we received made a strong case for centralisation of treatment for patients with certain conditions such as stroke care, cardiac care and major trauma. When implemented successfully, the creation of specialist centres enhances clinical skills and concentrates resources, with demonstrably improved outcomes for patients. Centralisation, however, is by no means a universal remedy for the ills of emergency care. Service redesign must account for local considerations and be evidence based. Some rural areas would not realise the benefits from centralising services that London has, therefore the process must only proceed on the basis of firm evidence. The goal is to improve patient outcomes – centralisation should not become the end in itself.

## **Improving A&E performance**

### *The four hour standard*

Performance failure against the four hour waiting time standard has prompted public concern and the eventual publication of proposals to improve emergency care. In this sense the four hour target maintains a degree of intrinsic value as it can highlight when pressure is growing and performance is suffering. Nevertheless, the Committee is clear that the target is not a useful indicator of the quality of care received by a patient.

### *Patient flow*

The smooth flow of patients through hospital from their initial attendance at the emergency department to eventual discharge is fundamental to the operation of an

emergency department.

Smooth patient flow can be aided by early senior review of cases. Evidence suggests that the constant assessment and reassessment of patients by junior staff in emergency departments and medical assessment units only breeds duplication and delays authoritative decisions regarding treatment, transfer or discharge. It is imperative that Hospitals learn from best practice in the NHS in order to implement practical reforms that can improve the operation of emergency departments. Increasing the availability of consultants and developing systems of early senior review of patients is at the heart of this.

### *Delayed discharge*

It is evident that one of the major contributory factors to the breakdown in patient flow is the inability to discharge patients from hospital. The Committee heard that this is often because places are not available in social care to accommodate patients who have no medical need to stay on a ward. Anecdotal evidence from clinicians and hospital managers identifies this as a fundamental problem which inhibits patient flow, but the official data says fewer bed days are being lost to lack of social care rather than more. The discrepancy between the evidence of people working with patients and the formal data is striking and we find the data incredible. Methods of data collection must be reviewed to ensure that such data provides an accurate picture of the relationship between hospital discharge and social care. Most importantly, data collection must provide system managers with accurate and useable information so they can shape services appropriately.

### *Staffing*

Staffing levels in emergency departments are an area of considerable concern to the Committee. They are not sufficient to meet demand, with only 17% of emergency departments managing to provide 16 hour consultant coverage during the working week. The situation is even worse at weekends and consultant staffing levels are nowhere near meeting recommended best practice.

Emergency staffing at all levels is under strain and a 50% fill rate of trainees is now resulting in a shortfall of senior trainees and future consultants. Emergency medicine is not seen as an attractive specialty by young doctors considering their long-term futures. The working environment is uncertain, the conditions are stressful, there is an unsatisfactory balance between work and personal life. Health Education England and local education and training boards must take steps to ensure that emergency medicine is both professionally and personally rewarding.

### *Tariffs*

The way in which hospitals which operate emergency departments are remunerated for the services they provide only adds to the challenges that they face. The marginal tariff has failed to encourage the delivery of care outside of emergency departments and penalises them for being open and available to all patients 24 hours a day, 7 days a week. Existing tariffs can provide perverse incentives and do not reflect the need for providers of different services to work together to make sure patients get the best treatment. It is imperative that

tariffs are designed to reward all NHS providers for putting patients on the correct pathway at the first time of asking; however they come in to contact with the health service.

## **Alternatives to A&E**

### *Primary care*

It is apparent that a significant proportion of emergency department work could more appropriately be classified as primary care and undertaken by GPs. However, we found no evidence that primary care has the capacity to absorb additional work. Walk-in-Centres certainly cater for demand outside of A&E and traditional GP surgeries but the evidence suggests this demand was induced by the provision of additional services.

In principle urgent care can be delivered in primary care but not without substantial restructuring of existing services. No blueprint drafted in Whitehall can deliver a solution for each local health system, and Ministers should look to clinicians to understand what works well and can be replicated elsewhere. The Committee is particularly keen that a new model of integrated primary care should account for the needs of elderly patients. In particular, this would address clinical responsibility for out of hours care, relationships with social care and other providers, and high-quality end of life care. The elderly are too often failed by existing services and many older people end up in emergency departments without any genuine clinical need for this type of treatment.

### *Urgent Care Centres*

One way of beginning to instil efficiency and clarity in the provision of emergency and urgent care services is to co-locate Urgent Care Centres with emergency departments on hospital sites. This can offer considerable organisational and patient benefits by concentrating resources and providing a system for quickly directing patients to the correct level of care. We recognise that this model is not appropriate for all locations but UCBs should consider the benefits of this when putting together their improvement plans. The plethora of titles for similar units offering similar services is highly confusing and the purpose of UCCs must, therefore, be clear to patients.

### *NHS 111*

It is clear from the evidence presented to the Committee that Ministers rolled out NHS 111 without attempting to interpret the evidence from pilots, which themselves were limited in scale and scope. NHS 111 was launched prematurely without any real understanding of the impact it would have on other parts of the NHS including emergency and urgent care.

NHS 111 is based around triage by a call-handler who is not clinically trained. Call-handlers use the NHS Pathways IT system to assess patient symptoms, but this was regarded by witnesses as excessively risk-averse. In the view of the Committee, NHS 111 does not embody the principle of early assessment by a clinician qualified to a level where they can appropriately quantify and balance risk. We understand the principle of creating a highly recognisable non-emergency telephone service, but believe the process of triage may be so off-putting to patients that they prefer the option of going directly to A&E. In its

current configuration we do not believe that NHS 111 will help to keep people from inappropriately attending A&E. In light of this, NHS England should review the balance between triage and clinical assessment.

### **Ambulance services**

Like the emergency departments they often work with, ambulance services are meeting ever increasing demand. In order to enhance the overall system of emergency care in England, ambulance services should be regarded as a care provider and not a service that simply readies patients for journeys to hospital. Increasing the number of fully qualified paramedics can help achieve this. Skilled paramedics can treat more patients at scene, reduce conveyance rates to emergency departments and make difficult judgements about when to by-pass the nearest A&E in favour of specialist units.

Treating at scene and reducing conveyance rates would contribute to alleviating some of the pressures in emergency departments and offer a better service to patients. Particularly in those rural areas where journey times are long and a major consideration, highly skilled paramedics can play a significant role in providing emergency and urgent care. The precise relationship between the development of more highly skilled ambulance crews and conveyance rates and should be investigated thoroughly by NHS England to help ambulance trusts further develop their workforces.

There is more that can be done to support ambulance services in improving the provision of care to patients. UCBs should ensure that ambulance services in their areas have access to key patient data – such information can be crucial in putting together a swift and accurate assessment of a seriously unwell patient. The local implementation of newly developed tariffs designed to reward treating patients over the phone or at scene is similarly important. NHS England should monitor the use of such tariffs in order to understand whether they do provide genuine encouragement to Ambulance Trusts to invest in more high skilled paramedics and treat and discharge patients rather than transporting them on to emergency departments.

Ultimately, the ambulance service has the potential to coordinate other elements of the emergency and urgent care system and lead integration of services. Changing the staff mix, reforming tariffs and ensuring access to patient information are important elements of a process of developing ambulance services in-to care providers in their own right.

