Foundation Trust Network

EMERGENCY CARE AND EMERGENCY SERVICES 2013

VIEW FROM THE FRONTLINE

The emergency care system has been under huge pressure over the last few months and although recent weeks have seen performance stabilise, there is a danger the system will fail unless each local health economy plans effectively for the coming winter. It is important that any actions taken to stabilise the system in the short term should be consistent with the longer term changes that are needed, as this a complex, whole health and social care system, issue.

The FTN has surveyed its members operating at the frontline on the urgent and emergency care pathway. Our survey shows that acute, ambulance, community and mental health have different perspectives but there are also some clear common messages. We share some of our initial findings here.

KEY MESSAGES

CAUSES OF PRESSURE

The current pressures on the urgent and emergency care pathway are the product of systemic failure. Poor hospital performance against four hour A&E wait targets and ambulance call answering targets are only a proxy for system wide performance failures. Although the precise balance will vary in each local health economy, the principal reasons for the pressure on A&E Departments – "the biggest operational problem facing the NHS"[1] – are:

- Increasing demand.
- Increasing acuity of patients given an ageing population and greater prevalence of long term conditions and multiple co-morbidities.
- Failures in other parts of the system to manage demand, particularly GP surgeries and doctors out of hours services (recognising that these services are also under extreme pressure themselves).
- Slow progress in investing in community facilities for out of hospital care closer to home.
- A broken hospital emergency care funding system.
- The inability of many trusts to recruit and retain the right staff for this specialty.
- The uneven introduction of the new 111 system.
- Issues discharging patients in a timely and effective way due to problems in social care.
- Poor patient signposting.
- Failures by some acute hospitals to manage their patient flow as effectively and efficiently as they could.

IMMEDIATE SOLUTION FOR WINTER 2013

NHS England, Monitor and the NHS Trust Development Authority have recently announced a good first step for planning for next winter[2]. However, to be successful, the plans created by Urgent Care Boards need to be built from bottom up. To make the required long lead time decisions, the right level of funding to support these plans must be consistently made available by end June 2013. The plans must also be part of the long term solution rather than a temporary "stop gap".

SHORT TERM FUNDING AND WORKFORCE SOLUTIONS

The 30% marginal rate policy is fundamentally flawed and should be replaced as quickly as possible. There is little evidence that the 30% marginal rate is facilitating more effective demand management. The NHS also needs to quickly solve the shortage of middle grade doctors – an area where the current Government's immigration policy is having a significant effect.

WHOLE SYSTEM LONG TERM SOLUTION TO REDESIGN THE URGENT AND EMERGENCY CARE PATHWAY

The wider NHS system is not working effectively. Our research indicates that at least 25% of patients currently attending A&E Departments could and should be treated by other parts of the NHS (fig 3). Therefore a whole system approach is needed to tackle these issues longer term. This requires

1 Secretary of State Jeremy Hunt speech to Age UK conference, 25 April 2013 https://www.gov.uk/government/speeches/will-we-rise-to-the-challenge-of-an-ageing-society

2 http://www.england.nhs.uk/2013/05/09/sup-plan/

fundamental re-design of the whole pathway, including appropriate investment in primary, community and social care services and much better patient signposting to these services. The FTN believes that an effective, universally available, high quality, 111 service is a key part of this mix. Sir Bruce Keogh's review of the urgent and emergency care pathway is the obvious place for this future design work to be undertaken.

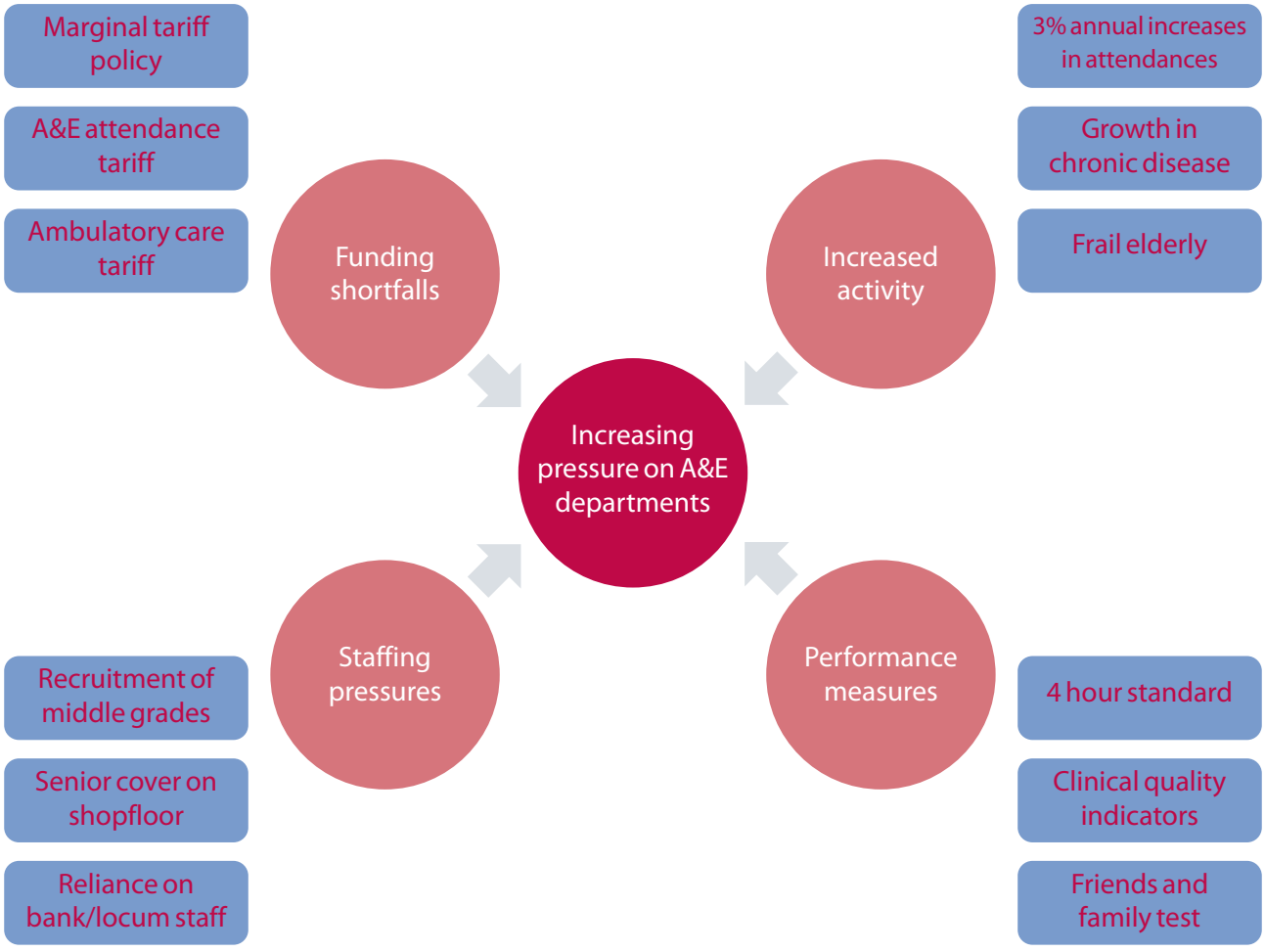
THE STRATEGIC FUNDING AND CHANGE CONUNDRUM

The NHS therefore faces a strategic funding and change conundrum. The NHS needs up front investment to develop the long term, community, out of hospital services that are required. But we must also ensure A&E Departments have the funding they need to treat their growing volume of patients safely in the meantime. This financial 'double-running' is very difficult to deliver at a time of major financial challenge. The FTN believes that any long term work on the urgent and emergency care pathway must find an effective solution to this key question.

FTN FINDINGS

Part 1 focuses on the headline results from the FTN's survey of its members. Part 2 provides the FTN's response to the cross cutting theme of how to meet increased emergency demand.

FIGURE 1: PRESSURES FACED BY A&E DEPARTMENTS[3]



3 In October 2012, FTN carried out a benchmarking study which brought together 11 acute trusts operating A&E services ranging from major specialist trauma centres to primary-care-led urgent care centres. This diagram represents the findings from this study.

PART 1 – HEADLINE RESULTS FROM FTN SURVEY

Pressure on the emergency care system is growing and the reasons are numerous and complex as outlined above. In May 2013, FTN surveyed its members to gain a full understanding of the issues faced by those providing services on the frontline. We received 105 responses, largely from acute, ambulance and community trusts. These are summarised in Figure 1 on the previous page.

SUMMARY OF SURVEY RESULTS

The accident and emergency system is at a tipping point.

On a scale of 1 to 5 (with 1= tipping point, 3= neither tipping point nor sustainable, 5 = good sustainable model)

72% of FTN members assessed the system to be currently at or near tipping point (1 or 2).

A&E performance is likely to worsen next winter.

There was widespread agreement among respondents that:

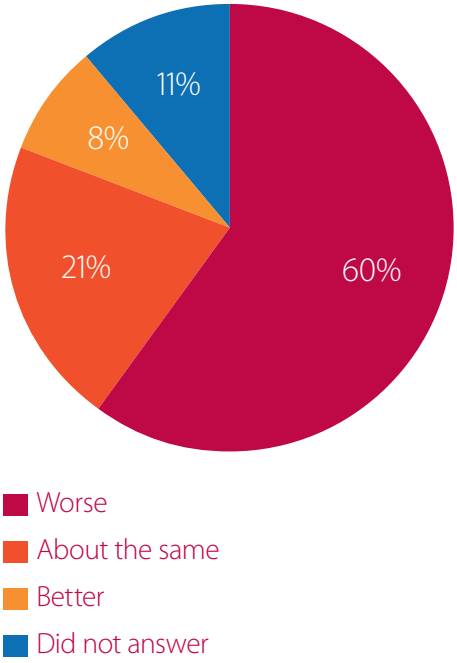
The position for the coming winter (2013–14) is very likely to be worse than the 2012–13 winter (fig 2).

When asked to list the **reasons for current system pressures** 62% of survey respondents highlighted increased demand as a current difficulty in their local system. 42% cited increased acuity of patients as a factor. These combined with failure of primary and social care services (32%) were the most commonly identified reasons for the current pressure on the system.

While the majority of respondents said they are engaging with commissioners to address the pressures, the overall feeling is that these discussions are taking a long time to translate into real change or are being frustrated by a lack of incentives for commissioners to fund a new and different model.

Respondents saw the role of **community and primary care** as fundamental to reducing demand on the A&E system. However, the majority lamented the **lack of commissioner investment in out of hours, community and primary care services**. The overall view was that until primary care was able to operate a 24/7 structure to match that of A&E, little would or could change.

FIGURE 2 EXPECTATIONS FOR NEXT WINTER

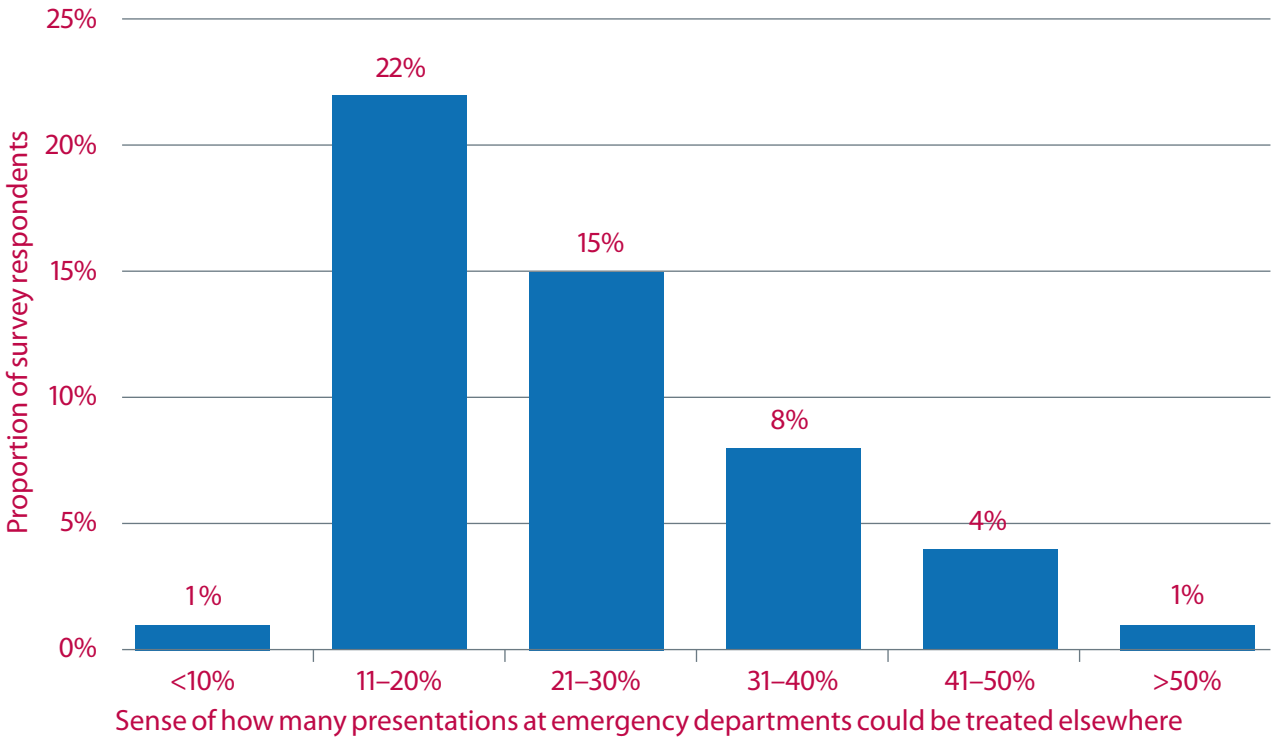


Respondents reported that on average, **25% of patients** presenting at Emergency Departments **could be treated elsewhere** in the health system (fig 3).

Ambulance Services could, and are willing to, play a bigger role in managing demand by ensuring that patient referrals are more evenly spread across trusts and throughout the day; by redirecting more patients to community services (which relies on the existence of such services) and by increasing the provision of "See & Treat". While the Ambulance sector does a great job already, to be even more effective it needs more support.

On the **move towards clinical effectiveness measures and away from response times**, 68% of respondents were broadly supportive. However reservations were expressed over the complexity of such targets and the justification for removing response time targets altogether. Approximately 17%

FIGURE 3 PATIENTS PRESENTING AT EMERGENCY DEPARTMENTS WHO COULD BE TREATED ELSEWHERE



were against the move. There is, anecdotally, strong support for the 95% A&E wait time target as a good and effective barometer of the overall health of the whole emergency and urgent care pathway (i.e. not just hospital A&E performance).

Where respondents had experience of **111 services**, many pointed to an initial spike in A&E referrals in April. Others said it was too early to assess their experience of 111 services so far due to delay in roll out or lack of time to embed. Only three respondents had a good experience to report.

Five strong themes emerged as the **reasons for delays in transfer** between care environments. They were:

- Lack of integration.
- Excessive bureaucracy.
- Issues with capacity.
- Lack of Available Funding / Financial Incentives.
- Lack of Social Services capacity.

Approximately 64% of respondents expressed a view that current consultative requirements on service change were not wholly effective. 31% held mixed views on its effectiveness whilst 5% felt that they were currently effective.

PART 2: MEETING INCREASED EMERGENCY DEMAND

The FTN believes that any solution to how the NHS can meet increased and increasing emergency demand, as well as the increased acuity that comes from an ageing population with higher prevalence of long term conditions, depends on four key elements:

- An immediate solution for the coming winter.
- Creating the right funding mechanism and solution to current A&E workforce shortages.
- Re-designing the urgent and emergency care pathway longer term, using a whole system approach.
- Solving the strategic funding and change conundrum of how to keep the system afloat in the short term whilst investing in the long term shift to out of hospital community care.

Each of these elements is explored below.

KEY MESSAGE

In the short term, urgent action is needed to ensure that the A&E system is able to function effectively this coming winter. While we welcome the recent focus on developing local plans, these need to be fully supported financially, drawing on funding from NHS England's commissioning risk pool, with funding levels agreed by the end of June 2013.

The recent announcement on creating local Urgent Care Board plans is a good first step in planning for the coming winter[4]. However, more clarity and certainty is urgently needed. The FTN believes:

- Each Urgent Care Board plan must be created bottom up, not top down. The job for NHS England Local Area Teams is to support and enable the creation of these plans, not lead this process.
- NHS England's key responsibility, as the overall risk manager and funder of the commissioning system, should be to ensure that each CCG has the financial wherewithal to support each local plan. NHS England has announced that the withheld 70% funding from the operation of the 30% marginal tariff should be used to fund these plans. However, some CCGs were effectively being forced by financial circumstance to use this money to support their mainstream budget, despite the national planning guidance.
- The FTN believes that the money withheld by CCGs from emergency readmission penalties should also used to fund Urgent Care Board plans.
- Urgent confirmation of the total aggregate amount across the NHS and the amount to be committed to each local plan is needed by the end of June. With only four months to go till next winter, providers and other parts of the NHS need this certainty now, so they can start making the long lead time decisions that are needed.
- Confirmation is needed that this money will come from the NHS England overseen commissioning risk pool and will not be at the expense of ambulance, community, mental health and elective activity. At a system level, we cannot reach the end of 2013/14 and find that yet another £1 or £2 billion has been returned to the Treasury and the urgent and emergency care pathway has not received the funding it patently needs.
- Each Urgent Care Board local plan should not be seen as a temporary "stop gap" solution only. Rather it should, wherever possible, progress the long term move to out of hospital care.
- The operation of local Urgent Care Boards sets an important step for the future. So it is vital that they embody the culture of local ownership, collaboration and integration within the NHS and across health and social care that are required for the long term.

4 http://www.england.nhs.uk/2013/05/09/sup-plan/

KEY MESSAGE

We must create the right funding mechanism to support rather than penalise NHS providers. The 30% marginal tariff is fundamentally flawed and needs to be replaced as quickly as possible. The NHS also needs to quickly solve the current shortage of middle grade doctors – an area where the current Government's approach to immigration policy is having an adverse effect.

As the FTN has continually stated, the NHS must urgently abandon the policy of paying emergency admissions above 2008/09 levels at a marginal rate of 30% of the tariff. The aim of this policy was to incentivise admission avoidance and the delivery of care closer to home. However, admissions have risen in more than two thirds of hospitals since 2008/09, by as much as 35% in some trusts. This is losing some hospitals between £5 and 6 million a year and the sector as a whole an estimated £300 to £400 million a year[5], on top of the already stretching 5% Nicholson challenge.

The marginal tariff provides no incentive for primary care to take shared responsibility for emergency admissions since urgent and emergency care patients can be treated in hospitals for 30% of the cost of treatment. Hospitals are simply earning less for the work they undertake, despite the long term improvements they are making to their A&E services and the costs of temporarily re-opening wards and employing extra staff to cope with short term extra demand.

Furthermore, the financial impact of the marginal rate is reducing the ability of providers to implement admission avoidance initiatives to support care closer to home. For example, initiatives in the South West to provide geriatric specialist support in emergency departments and comprehensive geriatric assessment of frail older patients have not been fully rolled-out due to lost income from the marginal rate. Similarly, pilot initiatives in East of England to offer acute geriatric support to nursing homes have reduced emergency readmissions to hospital significantly, but with only a small pool of consultants that limits the roll-out of the initiative to more local nursing homes due to lack of funding.

We welcome the recently launched NHS England and Monitor review of the 30% marginal tariff. We need the review to quickly conclude that major change is required, agree a new approach and have it in place for 2014–15. We recognise that changes to the tariff do need to strike the balance between stability and change, but this is an area where change has been overdue for several years.

VIEW FROM THE FRONTLINE:

"If we had access to the 70% monies we could increase ambulatory day unit capacity and we could invest in a revised older people assessment and liaison service to prevent admissions in the first place."

"... one of the biggest problems with the current system is that the incentives are wrong. Emergency tariff is too low to create an incentive amongst commissioners to do something about it. "

ACUTE NHS FT

5 FTN internal analysis, based on CHKS data

Another area requiring short term solution is recruitment and retention of career-grade mid-level A&E doctors that are the centre of the A&E department shop floor, and ensuring there is sufficient senior consultant cover seven days a week[6]. Members reported that staff shortages were having a range of impacts from potentially increased risk to patient safety to higher admission levels than necessary as junior doctors, due to lack of experience, ended up admitting more patients than experienced consultants.

"Acute shortage of middle grade doctors and non-trainee doctors is having a huge impact. Consultant and junior contracts have to change and we need more doctors on the floor to do the work."
Acute NHS FT

KEY MESSAGE

The wider NHS urgent and emergency care pathway is not working effectively. Our research indicates that at least 25% of patients currently attending A&E Departments could and should be treated by other parts of the NHS. Therefore a **whole system approach is needed to tackle these issues longer term**. This requires fundamental re-design of the whole pathway, including appropriate investment in primary, community and social care services and much better patient signposting to these services.

THE NEED FOR A WHOLE SYSTEM APPROACH

Effective operation of the urgent and emergency care pathway requires all the different parts of the NHS and the wider social care system to perform their allotted task. Failure to do so just displaces problems to other parts of the pathway with A&E Departments currently acting as a default back stop.

THE FAILURES CAUSED BY THE LACK OF A WHOLE SYSTEM APPROACH

For example, while A&E and ambulance services operate 24/7, many other services on the pathway do not. If a patient with mental health needs attends A&E, the provision of expert psychiatric services is generally excellent between 9am and 5pm, but these services are often not commissioned by CCGs outside normal working hours. This places the strain squarely on A&E departments to deliver clinical care and manage referrals for these patients.

A similar situation exists in relation to the increasing number of older patients presenting at A&E because of inadequate out of hours GP services. One NHS Foundation Trust has recently completed a three year project to examine patient flow and develop ways in which capacity can be better matched to demand. Their project found significant improvements could be made through changes to their hospital's own working and staffing practices[7]. However their project also identified that:

"the presentation of older frail patients out of hours means that they often get admitted for safety/compassionate reasons rather than for a clear clinical concern. If these cases presented earlier in the day, many could be managed outside of hospital by our community teams (who we also manage here) or by their own GPs".[8]

While there are many examples of excellent partnership working between ambulance and acute services, including clear and well-used early warning and escalation policies, and sharing of staff between services, delayed ambulance handovers continue to be a key issue on the pathway. One member provides a good illustration of the system-wide nature of the problem. When GP home visits were done in batches late in the day, ambulance urgent referrals were arriving at peak times of A&E demand. Alternative

6 The FTN is working with its members to make sure that these recruitment difficulties are reflected in workforce planning models and government's Shortage Occupation list. We are also influencing both the future shape of medical training and the current talks on possible changes to the consultant contract, particularly around defined career pathways for junior and middle doctors (SAS) and that these grades are clearly not attractive compared to other specialities and the GP route.

7 The Kings Fund's recent report for NHS South lists all the key improvements that acute trusts should be making to improve patient flow within their A&E Departments: http://www.southofengland.nhs.uk/wp-content/uploads/2012/05/Kings-Fund-report-urgent-and-emergency-care.pdf

8 South Warwickshire NHS Foundation Trust, 15 May 2013

services to A&E were switched off for the evening, community services were not funded adequately to arrange a night-sit for elderly patients, and there was insufficient bed capacity to process incoming admissions (in part due to lack of community beds to discharge to). The ultimate result was patients queuing in A&E and patients queuing in ambulances to get through the front door of A&E. It is only system-wide changes at a local level that can smooth out peaks in demand – for example acute trusts, clinical commissioners, and GPs working together to arrange staggered home visits to smooth out peaks in A&E referrals.

VIEW FROM THE FRONTLINE:

"We have the ability to refer patients to local services or transport them to services other than A&E if they exist. The issue is that the only place to take them is A&E, which clogs up the A&E departments creating waiting time issues and the really urgent patients then have a delayed response because we are stuck at the hospital."

AMBULANCE NHS FT

"Improved population of the Directory of Services, better weekend and evening service cover, more integrated commissioning of primary, secondary and ambulance sector services."

AMBULANCE NHS FT

"Ambulance Service should provide 111 services. Huge benefits from ability to pass calls from 111 to 999 and vice versa seamlessly. Development of Directory of Services – huge task to maintain – affords opportunity to direct patients to most appropriate service and keep patients out of Hospital. But it needs commitment from all whole system working together – e.g. GP's, Hospitals, Out of Hours Providers and Social Services."

AMBULANCE NHS FT

"111 – if resourced properly and integrated with the Ambulance Service has enormous potential benefits for the Health Care System as a whole."

AMBULANCE NHS FT

Many hospitals are also facing an urgent and growing problem of not being able to discharge patients in a timely and effective way because of problems in social care stemming from funding cuts due to reduced local authority budgets. FTN members report problems with "hospital back door" discharge, leading to longer stays and higher bed occupancy rates. This rapidly leads to problems coping with "hospital front door" A&E admissions as beds are not available. Small increases in patient acuity – such as a 1% or 2% annual rise – can lead to increased admission levels that hospitals find it very difficult to absorb when they are running at or close to capacity.

VIEW FROM THE FRONTLINE:

"Discharge – this in my view is one of the biggest causes of the current A&E problem. Reductions in social care budgets leave older frail patients in hospital. The longer they stay the more their care packages or support mechanisms fall apart. So they stay even longer, sometimes then contract infections, or have falls due to their unfamiliar circumstances."

ACUTE NHS FT

"…cuts to Social Care budgets having massive impact on delayed transfers once patients are medically fit."

ACUTE NHS FT

"The fragmented system of care is causing delays in supporting the discharge of the most vulnerable patients. Much of the delay in discharge is linked to the challenge of social care funding and delays in setting up packages of care and placements."

ACUTE NHS FT

"[We need] Integrated service models with social care. "

COMBINED COMMUNITY & MENTAL HEALTH NHS FT

Our survey showed that on average 25% of presentations at emergency department could be treated elsewhere in the healthcare system.[9] Greater investment in out of hours primary and community services is therefore a key part of the long term solution to these problems.

"I think 15–20% of admissions could be avoided with greater access to alternatives e.g. access to acute clinics, diagnostics, rapid access to social or community nursing care." Acute NHS FT

"At least 10% of patients in hospital are awaiting care in a different setting." Acute NHS FT

"Everyone is working very hard but in silos with conflicting agendas and cultures resulting in patient delays.[10]" Acute NHS FT

"Our different regulators and financial systems get in the way of true joint working."[11] Combined Acute & Community NHS FT

Those local health economies that have already invested in these approaches are seeing considerable benefit. For example, the benefits of rapid response community teams and "See & Treat" ambulance services are both clear and impressive. Investment in out of hospital facilities covering mental health and addiction has significantly reduced frequent A&E attendances by the same patient.[12] Ambulance services also have an important role to play here. One ambulance trust has developed a falls referral form which is transmitted to community falls teams, GP triage systems, and then turned into a patient-specific ambulance anticipatory care plan which is held on the

9 Foundation Trust Network Survey of 105 Foundation and NHS Trusts, May 2013

10 FTN Survey of members on emergency care, May 2013

11 FTN Survey of members on emergency care, May 2013

12 Foundation Trust Network Briefing: Driving Improvements in A&E Services, October 2012.

despatch system. This has helped identify and stratify patients such as elderly fallers, so that community and falls teams can see the most at risk patients as urgently as possible. As a result, more patients are being treated safely at home rather than being conveyed to emergency departments and admission units.

THE NEED FOR A PLANNED RE-DESIGN OF THE ENTIRE URGENT AND EMERGENCY CARE PATHWAY

All of this evidence points to the need for a re-design of the entire urgent and emergency care pathway. Sir Bruce Keogh's review is the obvious place for this future design work to be undertaken and we are encouraged by early conversations with Sir Bruce and his team on the development work that has already been done. We also welcome the Secretary of State's recent announcement in the Queens Speech debate to place this review in the broader context of creating the right NHS delivery model to manage increasing numbers of frail elderly and those with long term conditions. We wouldn't wish to prejudge the outcome of Sir Bruce's Review but assume that it would need to contain the following elements:

- A long term approach to investing in community facilities closer to home, including more investment in higher capability ambulance services, so that A&E Departments are only used to treat those patients requiring acute care.
- Ensuring that GP surgeries and out of hours services are able to meet their share of demand – this may, for example, require revisiting of the GP contract.
- Ensuring that 111 services fulfil their potential. The FTN believes that NHS ambulance trusts are best placed to run these services.
- Identifying an appropriate model for A&E Departments which is likely to involve reconfiguration so that appropriate elements of specialist care are increasingly rationalised and centralised where possible, as the NHS has done to great effect with stroke care in London.
- Much greater attention to and investment in effective patient signposting so patients know where to go.

This work needs to be completed as quickly as possible. It is likely to involve difficult decisions in the run up to a General Election but we cannot afford to wait for the redesign that is so patently needed.

VIEW FROM THE FRONTLINE:

"Wholesale reform of the system… requires rebalancing particularly for the frail elderly and those with long term conditions. [This] requires patients and families to have more faith in community packages and out of hours schemes so they do not see A&E as the default position"

ACUTE NHS TRUST

KEY MESSAGE

Political and system commitment is needed to address the strategic funding conundrum that the NHS faces. While up front investment is needed to develop long term, community out of hospital solutions, we also need to ensure A&E departments have the funding they need now to treat their growing volumes of patients safely. How this conundrum can be addressed against a backdrop of major financial challenge is both an immediate and long term challenge. The FTN believes that any long term work on the urgent and emergency care pathway must therefore also find an effective solution to this key question.

The Foundation Trust Network (FTN) is the membership organisation and trade association for NHS acute hospital, ambulance, community and mental health service trusts. The FTN supports these foundation trusts and trusts in delivering high quality, patient focussed, care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate. The FTN has 220 members – more than 90% of all NHS foundation trusts and NHS trusts – who collectively account for £70 billion of annual expenditure and employ more than 630,000 staff.

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