

Transforming urgent and emergency care services in England

**Urgent and Emergency Care Review
End of Phase 1 Report**

Appendix 3 – Summary of Engagement Responses

High quality care for all, now and for future generations



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Prepared by: Urgent and Emergency Care Review Team

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1. Introduction

Following the announcement from Professor Sir Bruce Keogh on 18 January 2013 of his intention to review the way the NHS responds to and receives emergency patients, an evidence base for improving urgent and emergency care and a number of emerging principles for the future organisation and delivery of these services in England were developed. Publication of these documents on 17 June 2013 opened a period of engagement with key stakeholders designed to:

- Present a very different review method by building the evidence base, and the shape of the objectives of the review in public;
- Establish buy-in to the review;
- Seek contributions to add to the evidence base, offer new ideas and service models;
- Obtain feedback, comment and support for the emerging principles; and
- Seek a mandate to commence work on Stage 2 of the review, which will develop a national framework for the commissioning of urgent and emergency care.

The engagement period ran for eight weeks from 17 June to 11 August 2013. A full description of the events and activities that were used to seek contributions from stakeholder groups during the engagement period is provided in Annex A. Over 1,000 responses were received throughout the engagement period. The questions posed in the online engagement exercise are at Annex B.

A number of responses (including 30 organisational responses) were received offline. The largest area of healthcare represented in responses was acute services (36 per cent of responses). Community-based care was the lowest area represented in responses (11.3 per cent). 27 per cent of responses received were from patients and the public. Additionally, a large number of contributions were received at the 6 August 2013 stakeholder engagement event and various meetings and events attended during the engagement period.

Following the period of wider engagement, this report:

- Provides a summary of the evidence base and emerging principles published for wider engagement;
- Describes key themes from the feedback and comments received during the engagement period through all engagement activities; and
- Identifies the Review's response to feedback and comments received during the engagement period and identifies where revisions to the evidence base and principles for urgent and emergency care have been made.

2. The evidence base

2.1 Summary of the evidence base

The evidence base for improving urgent and emergency care in England was produced by the Urgent and Emergency Care Review Steering Group, led by Professor Keith Willett, Director for Domain 3: Acute Episodes of Care, NHS England. The Steering Group had representation from clinicians and commissioners across the NHS, National Voices, and wider clinical and professional bodies.

The evidence base published for wider engagement aimed to review the urgent and emergency system in England and draw out evidence that illustrated the main challenges that the system currently faces. The document highlighted issues within each part of the urgent and emergency care system in order of the perceived levels of patient need that it addressed, these were:

- Self care and self management;
- Telephone care;
- Face to face care;
- 999 emergency services;
- A&E departments; and
- Emergency admissions to hospital.

Two final sections followed; one examined the capacity and sustainability of the current workforce, and the other outlined the potential of urgent and emergency care networks to create a whole-system approach capable of addressing many of the current issues.

The evidence base for change identified a number of areas for improvement within the current system of urgent and emergency care in England. In summary:

- More people are using the urgent and emergency care system to access healthcare, leading to mounting costs and increased pressure on resources.
- Overall fragmentation of the system means that many patients may not be able to access the most appropriate urgent or emergency care service to suit their needs, leading to unnecessary attendances and resource use.
- A patient's experience of healthcare is likely to have a bearing on the way they choose to access healthcare, and there is significant variation in patient experience across urgent and emergency care.
- Demographic change in the national population means that more patients need support managing long-term conditions; but provision and uptake of this support is variable. This can lead to increasing attendances at A&E departments and emergency admissions to hospital.
- Access to healthcare advice and information via the telephone is becoming increasingly popular and is less resource-intensive than face-to-face care. However some patients lack confidence in telephone advice and are likely to pursue a second opinion, which can lead to duplication of service provision.

- Early senior clinical input improves patient outcomes across urgent and emergency care; however there is variation in staffing levels across these services and significant workforce pressures.
- Emergency admissions are rising, and there is variation in outcomes for these patients. Reduced service provision, including fewer consultants working at weekends, is associated with this variation.
- There are wide variations in the way information is shared between providers of urgent and emergency care leading to duplication within the system causing delay and poor patient experience. Urgent and emergency care networks can improve patient outcomes and experience; however there is no consistency in the organisation, scope and functionality of networks across the country.

2.2 Key themes highlighted during the engagement period on the evidence base

Overall, 97 per cent of the respondents to the engagement questionnaire agreed that the urgent and emergency care system in England needs to change. Nearly 92 per cent of those completing the questionnaire had read the evidence base and between half and three-quarters agreed in full or mostly with the information contained in each section.

Over half (58 per cent) of respondents provided further comments on the document. Overall, there was no single, dominant area of the evidence base that respondents referred to, with comments covering a broad range of issues, spanning the whole document. The areas of the evidence base most commented on were:

- Effective urgent and emergency care networks (22 per cent);
- Urgent and emergency care workforce (19 per cent);
- Telephone care (19 per cent);
- Current provision of urgent and emergency care services (19 per cent); and
- 999 services and A&E departments (18 per cent)

Many individual respondents submitted comments relating to a range of issues covering several parts of the evidence base.

Current provision of urgent and emergency care services

19 per cent of respondents that provided additional comments on the evidence base referred to the section on current provision of urgent and emergency care services. A number of these comments referred to the quality of data around primary care, with some respondents submitting further evidence and information to support development of this section.

A number of respondents felt that the evidence base had not put enough emphasis on issues surrounding supply-led demand. About three per cent of further comments on the evidence base cited increased patient expectation and some patients' use of services that were not the most suitable to their needs as a reason for increased demand. There were a similar number of comments citing population factors, such as immigration and rising health inequalities as major reasons for increased demand for urgent and emergency care services. The London-wide GP Clinical Commissioning Council also highlighted the role that transient populations play in affecting demand for urgent and emergency care.

17 per cent of respondents that provided additional comments on the evidence base referred to issues surrounding patient experience. The majority of these comments supported the assertion in the evidence base that many people are unable to navigate their way through the urgent and emergency care system to the most appropriate service. Additionally, the Royal College of General Practitioners and the London-wide GP Clinical Commissioning Council supported the message that overall fragmentation generates confusion amongst patients and leads to over-use of the most expensive services. Some respondents attributed the inability to navigate the system correctly to a lack of public education and information available, but most supported the notion in the evidence base that the system is not intuitive enough.

Many respondents highlighted that patients are often unable to get straight forward problems dealt with and be treated (when appropriate) in one episode of care. A number of comments agreed with the assertion in the evidence base that A&E departments are understood and trusted by the public and therefore many patients will default to this service if they are in any doubt about who can help them. However some comments expressed concern that the evidence base did not adequately address the issue of patients who present to A&E departments with minor health issues. Several comments related to patients' expectations and the responsibility of the public to use services best suited to their needs. Many respondents attributed rising demand to a culture of over-reliance on clinical support to manage minor health problems.

A few respondents that provided additional feedback commented on the lack of direct evidence from patients and their experiences of urgent and emergency care in the evidence base. Some comments related to experiences of using primary care services, including: patients unable to see their preferred GP, inadequate GP support for the frail and elderly, and patients having to travel long distances to receive primary care treatment out-of-hours. The response from the Care Quality Commission drew attention to some recent patient surveys that may support the evidence base.

Self-care and self-management

16 per cent of further comments referred to the self-care section of the document. Many of these called for an improvement in information available to patients and highlighted that a lack of community education could mean that many people do not have the means to self-care. Some comments related to internet-based self-care support and concerns that it led to increased use of formal healthcare services; however a significant proportion of these comments felt that more needed to be done to support disadvantaged groups, who are unable to access self-care information effectively.

Telephone consultations and out-of-hours care

19 per cent of further comments on the evidence base related to telephone consultations and out-of-hours care. Some respondents, including representatives from patient groups, reported good experiences of the NHS 111 service. However there were also a number of concerns raised regarding:

- Patients' confidence in the call handler's ability to assess health issues;
- Inability of the service to offer advice and sign-posting to the appropriate services; and
- Perceived lack of clinical input.

A small number of these respondents felt that the evidence base was not critical enough of the implementation of NHS 111 services, particularly regarding lack of medical input. However, the

evidence base does address implementation of NHS 111, and greater medical input into NHS 111 services has been included as a possible implementation option in the emerging principles document.

Comments on GP out-of-hours services were received from around five per cent of the respondents that provided additional comments. The comments painted a mixed picture; with some very positive about the effectiveness of existing provision and others claiming services are too risk-averse, often referring patients to A&E unnecessarily. This supports the assertion in the evidence base that there is wide variation in the quality and provision of GP out-of-hours care. Some respondents that provided additional feedback felt that issues surrounding GP out-of-hours were not sufficiently covered by the evidence base. Similarly the response from the King's Fund supported the assertion in evidence base with regard to the variation in out-of-hours care and the rates at which people were sent to hospital.

Face-to-face care

17 per cent of respondents that provided additional feedback on the evidence base commented on issues relating to primary care access (including out-of-hours access). Most comments supported the assertion in the evidence base that people, who are unable to access their GP easily, will resort to using A&E services. Additionally, the Royal College of General Practitioners broadly supported many areas of the evidence base document, particularly the message that overall fragmentation generates confusion amongst patients and leads to over-use of the most expensive services. However several comments also suggested that there was too much emphasis on the connection between GP access and A&E attendances, as the issue of rising demand for A&E services is multifactorial.

Access to quality backup services

Three per cent of additional comments on the evidence base related to access to quality back up services. A small number of comments supported implementation of telemedicine to enable specialist support in more remote areas.

999 Services and Accident & Emergency Departments

18 per cent of additional comments referred to the 999 services and A&E departments section of the evidence base. There was no single, dominant issue raised within the comments but many respondents suggested that the evidence base had not sufficiently highlighted the link between patient flow within a hospital and A&E waiting times. The College of Emergency Medicine also highlighted patient flow through A&E departments as a key issue. The impact of patients presenting to A&E with conditions that were neither urgent nor life-threatening was a concern for many respondents that provided additional comments.

Some claimed that patients often present to an A&E department in order to obtain a second opinion, where the perceived or actual care by their GP has not been appropriate. Some comments made the assertion that many patients were admitted to hospital in order to avoid breaching the four hour standard.

Several comments related to the prevalence of parents presenting to A&E when their child had a fever; many respondents felt that the NHS is unable to adequately reassure this cohort without hospital assessment. This was supported by the Royal College of Paediatrics and Child Health's youth advisory panel who highlighted the need for a different approach to addressing urgent and emergency care for children and suggested that there are a number of

ways to manage this cohort outside of A&E. Additionally, several additional comments on A&E departments felt the role of liaison services had not been adequately covered.

Fewer of the additional comments on the evidence base related to ambulance services; the Association of Ambulance Chief Executives supported the evidence base with regard to highlighting the wide variation in conveyance rates between ambulance services and suggested the relationship between ambulance service workforce patterns and conveyance rates be explored. Other additional comments requested more evidence to support the expansion of 'hear and treat' and 'see and treat' services.

Urgent and emergency care workforce

19 per cent of comments related to workforce issues. The London Clinical Senate highlighted workforce challenges and the lack of alignment between acute and non-acute areas of health and social care as key issues facing urgent and emergency care. Key themes from the overall comments included recruitment and the supervision of emergency medicine doctor trainees. In particular, increased workload, meaning consultants have to focus on delivery of services instead of adequately supervising doctor trainees.

Evidence was also submitted to illustrate the reasons surrounding low uptake of emergency medicine doctor training posts; indicating the pressures of working in A&E departments and the impact on life outside of work as a major factor. This issue was also raised by the College of Emergency Medicine, along with the British Medical Association. Some respondents challenged the evidence base surrounding the impact of working patterns on weekend mortality rates and the impact of changing workforce patterns. Reference to weekend working patterns, which are inconsistent with those during weekdays, has remained in the evidence base as it is supported by a large body of evidence, which highlights the association with a detrimental impact on patient outcomes.

Several of the additional comments on workforce issues also expressed the need to expand capacity in primary care. Some challenged the assertion that GP numbers have increased because a significant proportion are thought to work part-time. There were also comments concerning training requirements for GPs in relation to paediatrics and patients with mental health problems. Some respondents felt that the evidence base lacked discussion surrounding the non-medical workforce such as paramedics, nurse practitioners, physiotherapists and health care assistants, suggesting that these groups could be used more creatively to address workforce issues. Expanding the role and raising the profile of paramedics and nurses, in particular, was something that several respondents felt the evidence base should outline in greater depth.

Effective urgent and emergency care networks

22 per cent of respondents that provided further comments referred to effective urgent and emergency care networks. Approximately seven per cent of respondents providing further comments on the evidence base highlighted the need for more information surrounding better integration of services. Many of these comments highlighted issues surrounding fragmentation of services and the need for improved information sharing between services. Multiple referrals and patients having to explain their symptoms repeatedly, because a service did not have access to their patient record, were frequently cited as major issues affecting patient experience and clinical outcomes.

Social care

12 per cent of respondents that provided additional feedback commented on an area of the urgent and emergency care system that had not been covered by the evidence base. Most of these were concerned about the lack of reference to social care, in particular poor access to social care being responsible for both emergency admissions and poorly managed discharge resulting in re-admission or delayed transfers of care. Although social care is beyond the scope of this Review, the evidence base now highlights this as a gap and refers to future work that will aim to address this.

Mental health

There were a significant number of comments related to mental health issues (14 per cent), with some raising concerns about the lack of psychiatric support to GPs and A&E departments. The response from the Royal College of Psychiatrists, from the faculty of liaison psychiatry highlighted the importance of liaison psychiatrist in A&E to provide leadership, rapid diagnosis and improving patient flow. A large proportion of engagement comments requested more information in the evidence base about mental health liaison services, with a large amount of additional information submitted to support this.

The treatment of patients presenting to A&E having self-harmed was of particular concern, along with patients who are detained by police services under section 136 of the Mental Health Act. Many respondents advocated the RAID (rapid assessment interface discharge) model of psychiatric liaison service and requested that it should be explored in the evidence base. Some respondents also commented on the lack of evidence surrounding the range of urgent care interventions relating to mental health, and a significant amount of additional evidence was submitted to support this.

The engagement process and documentation

10 per cent of additional comments related to the engagement process and the documentation provided. A small number of additional comments (six per cent) related to the overall quality of the document. Some of these respondents suggested that evidence had been used selectively to paint a simplistic picture of complex issues. The evidence base has developed since the version engaged on. It is acknowledged that some parts of the engagement base may have lacked evidence in particular areas, but relevant evidence has not been excluded deliberately. Where stakeholders have highlighted areas of weakness, additional evidence has been used to develop the document to show a more detailed picture.

Some respondents felt the document was not accessible enough to allow members of the public to contribute to the engagement exercise. An Easy Read version of the evidence base and emerging principles was developed, and the documents were available in different formats on request to ensure that they were accessible to all. In the revised evidence base, comments on the use of specific phrases have been addressed directly through rewording and the language of the document has been reviewed with efforts to remove jargon, over-complexity and ambiguity, where it has been identified.

3. The emerging principles

3.1 Summary of the emerging principles

Emerging principles for urgent and emergency care in England were developed by the Urgent and Emergency Care Review Steering Group, for the purpose of challenge during the engagement period. These suggested that a new urgent and emergency care system would be one that:

- Provides **consistently** high **quality** and **safe** care, across all seven days of the week;
- Is **simple** and guides good choices by patients and clinicians;
- Provides the **right care** in the **right place**, by those with the **right skills**, the **first time**; and
- Is **efficient** in the delivery of care and services.

Twelve system design objectives were also developed to outline the desired performance characteristics that any system of urgent and emergency care will need to deliver against the emerging principles. Some examples of possible implementation options were also included to help contributors appreciate the implications of accepting the principles and what achieving the objectives of the system in practice may mean.

3.2 Key themes highlighted during the engagement period on the emerging principles

Over 90 per cent of respondents completing the engagement questionnaire had read the emerging principles and 87 per cent of respondents agreed that any improvements and changes to the urgent and emergency care system needed to be based on these emerging principles.

During the engagement period, a stakeholder engagement event (see Annex A) was held on 6 August 2013 where a workshop session designed to gain further feedback on the emerging principles, system design objectives and examples of possible implementation options was conducted. Over 200 clinicians, commissioners and healthcare professionals from across the urgent and emergency care system, representatives from Royal Colleges and clinical bodies, patients and the public attended this event.

In keeping with respondents to the engagement questionnaire broad agreement with the four emerging principles was gained at the 6 August 2013 stakeholder event. The most common point raised was that the language of the emerging principles and system design objectives needed to be simplified and jargon removed so they could be understood by patients and the public as well as clinicians and healthcare professionals. It was also suggested that the content of the emerging principles, system design objectives and possible implementation options could be more patient-orientated.

Suggestions were made that there should be a narrative elaborating on each principle to explain the meaning in more depth. Taking this feedback into consideration, the possibility of developing supporting information for the principles and system design objectives to provide definitions and support greater understanding of their meaning will be explored during Phase 2 of the Review.

Emerging Principle 1: Provides consistently high quality and safe care, across all seven days of the week

A number of comments received during the engagement period suggested that 'seven days a week' should be changed to '24/7'. However, some feedback highlighted whether 'on demand' healthcare was truly deliverable within the means of the NHS. When considering these comments, whilst clinical opinion calls for safe care 24 hours a day, seven days a week, there is recognition that providing safe care 24/7 does not mean that the provision of services will be consistent throughout all 24 hours of the day. However, there is a need for greater consistency of services between weekdays and weekends. The College of Emergency Medicine supported this principle and recognised the move to seven day working needs to involve all services that support urgent and emergency care.

Emerging Principle 2: Is simple and guides good choices by patients and clinicians

Feedback received during the engagement period suggested that the phrase 'good choices' should be changed to 'informed choices'. This was because 'good choice' has many interpretations – a good choice from the patient's perspective may not be a good choice from the perspective of the healthcare system.

Emerging Principle 3: Provides the right care in the right place, by those with the right skills, the first time

Mixed feedback was received on this emerging principle, and there was no unanimous view around how this principle could or should be altered. Some comments highlighted confusion by the idea of 'first time' as the first time was when the patient chose to present, therefore there was no control over whether it was the right place or not for them to be treated. A link was made between this comment and system design objectives 6 and 7 (see section 4.1 of this report below), which highlighted the need to educate patients about settings of care within urgent and emergency services which are most suitable to their needs.

Emerging Principle 4: Is efficient in the delivery of care and services

Although few comments were received on this emerging principle during the engagement period, those that were received suggested that the word 'effective' was missing and suggested that the principle be changed to include this.

3.3 Key themes highlighted during the engagement period on the system design objectives

Broad support for the twelve system design objectives was gained with over two-thirds of respondents to the engagement questionnaire supporting in full or 'mostly' that the system design objectives would allow the emerging principles for the future delivery of urgent and emergency care to be met. There were suggestions that the system design objectives could be re-phrased to become more patient-centred.

Much discussion around the system design objectives took place at the 6 August 2013 stakeholder engagement event and overall broad support was gained. However, the practical deliverability of the system design objectives was questioned by some.

Feedback received during the engagement period suggested that the system design objectives were too lengthy and could be simplified and combined in places. Overall, many of the comments on the system design objectives focused on language and suggestions for replacement of certain words, such as 'support' and 'manage' to 'care for' and 'treat'. Terms

such as 'senior clinical input' were questioned, and there were suggestions that this be replaced with 'relevant senior input'. Also, feedback and comments highlighted that it was difficult to make the distinction between 'GP' and 'primary care team'. Taking this feedback into consideration, the possibility of developing supporting information for the principles and system design objectives to provide definitions and support greater understanding of their meaning will be explored during Phase 2 of the Review.

Empowering patients with information was a key theme raised within feedback and comments received on the system design objectives. Making good use of technology such as mobile phone apps to provide more information and support patients to self-care, as well as improved IT systems to help organisations share real-time data and patient records across the urgent and emergency care pathway, were also highlighted. The availability of relevant patient information to all areas of the urgent and emergency care system was identified as key to its success.

A number of comments highlighted that system design objectives 11 and 12 (training and patient experience respectively (section 4.1)) were confusing to read, and it was difficult to understand their true meaning.

3.4 Key themes highlighted during the engagement period on the possible implementation options

Over two-thirds of respondents to the engagement questionnaire supported the identified possible implementation options in full or 'mostly'. Closer working between GPs and secondary care clinicians (81 per cent) and improved IT and information sharing (78 per cent) were highlighted as the most common areas that would help to implement the possible solutions, along with closer working across organisations (78 per cent). An increased focus on clinical outcomes (57 per cent); and the establishment of urgent and emergency care networks (57 per cent) were also supported as areas that would help to implement the possible solutions.

Discussion on the identified possible implementation options at the 6 August 2013 stakeholder event brought mixed comments. Some highlighted that the possible implementation options should be more specific whilst others highlighted that possible implementation options should be designed locally to meet local needs. Also, there were suggestions that the possible implementation options addressed individual components of the system but did not address the need for a system-wide approach to urgent and emergency care.

Two consistent key themes emerged from discussions at the 6 August 2013 stakeholder event in terms of other implementation options that could be explored. Firstly, it was suggested that ambulance crews could provide more clinical input in rural areas to optimise the 'see and treat' approach. Secondly, it was highlighted that the definition of urgent and emergency care facilities – and the services they provide – should be standardised across the country. A range of examples were provided and other key themes included:

- Leadership and a clearly defined role for the newly established Urgent Care Boards;
- Innovative use of the workforce across the urgent and emergency care system, in particular, greater involvement of nurses and possible expansion of their roles;
- Greater integrated working;
- Improved access to mental health support and social care teams for A&E departments;

- Improved access to patients' GP surgeries;
- Awareness raising campaign for 'phone before you go';
- Greater information for patients and increased patient education; and
- Improved integrated IT systems across the urgent and emergency care system.

In terms of barriers to implementation, a culture of silo working across the urgent and emergency care system (77 per cent) and incompatible IT systems and data sharing issues (76 per cent) were most commonly highlighted in responses to the engagement questionnaire. There was also strong agreement that focusing on process rather than outcome could act as a barrier to implementation.

Additionally, nearly two-thirds of respondents highlighted that an insufficient workforce skill mix and the current 'Payment by Results' structure would also act as barriers to implementation. This view was also supported by the British Medical Association who highlighted the system as ineffective. In their engagement response, the Foundation Trust Network suggested more emphasis be placed on the impact of commissioning incentives and cost improvement programmes that often have a detrimental impact on the wider health economy.

During the 6 August 2013 stakeholder event a number of examples of barriers to implementation were highlighted:

- Cost of implementation;
- Tariffs and incentives that discourage integration;
- Information governance;
- Workforce implications for seven day working;
- Workforce shortages and recruitment issues across the urgent and emergency care system;
- A focus on seasonal planning and the pressures this brings which can hinder longer term planning;
- Supply-led demand – increasing the availability of primary care may increase demand for care without reducing impact on acute services;
- A suggested public loss of confidence in NHS 111; and
- Insufficient levers or incentives in the GP contract for increased access to primary care.

There were several themes that emerged strongly in the additional comments to the engagement questionnaire on the possible implementation options. Around 10 per cent of respondents that provided additional comments on the identified possible implementation options raised the issue of availability of the urgent and emergency care workforce – in terms of skills and numbers – particularly with reference to general practice and emergency medicine doctor training posts. Many comments also highlighted expansion of the roles of emergency nurse practitioners and nurses within general practice as possible implementation options.

Access to primary care featured strongly within the additional comments on the possible implementation options. Whilst respondents called for greater access which was consistent

across all seven days of the week, along with improved out-of-hours services, it was suggested that this needed to be balanced with sufficient funding and workforce to provide these services.

A number of respondents to the engagement questionnaire highlighted the need to strengthen the NHS 111 service to ensure it provided the single point of access that is intended. Whilst difficulties of implementing a new national service were recognised, some suggestions were made to provide greater clinical input and access to clinical opinion when needed, which would lead to greater success and improved outcomes for patients. There was also a call for a common, unified approach to triage and prioritisation with greater clinical input – across the whole urgent and emergency care pathway.

Furthermore, feedback suggested the need for early senior medical review in acute care. As highlighted in additional comments on the evidence base, a significant number of respondents that provided further comments on the emerging principles, system design objectives and possible implementation options raised the need for increased access to mental health services and in particular, liaison services for urgent care and A&E departments. It was requested that these be explored further as possible implementation options.

Whilst there was strong support for the identified examples of possible implementation options, some respondents to the engagement questionnaire questioned the affordability of implementation and the timescales required, with suggestions that short, medium and long-term solutions be identified. Greater clinical leadership and engagement with clinicians and patients and the public in the further design of implementation options was also highlighted throughout responses, along with the need for implementation to be led locally.

As with the structured self-select questions, respondents who provided additional comments indicated that implementation would not be possible unless there was integration across the urgent and emergency care pathway and a network approach. Alongside this, many respondents highlighted that information sharing amongst all providers, and ready access to this when required, was absolutely necessary.

A number of respondents also expressed the desire for greater patient involvement and engagement in the further exploration of implementation options and the design of future clinical models for England's urgent and emergency care system, which the Review team will action.

4. The Urgent and Emergency Care Review's response to feedback

4.1 Revisions to the evidence base

The evidence base for improving urgent and emergency care has been revised to reflect the feedback and comments received during the engagement period. The overall approach to developing the evidence base has also been updated to reflect the source of additional evidence used in the revised document.

Current provision of urgent and emergency care services

In response to feedback received during engagement, the statistical summary of urgent and emergency care activity has been updated. It is also noted that there has been no consistent national data available on GP consultations since 2008 and that the figure of 340 million is based on a straight line extrapolation of data collated up until 2008, as since then there have been no official estimates.

During the engagement period, a significant amount of feedback and supporting evidence was received concerning the increased complexity and volume in GP workload. In response to this, the evidence base has been revised to include more discussion about the increased pressure on general practice services.

Reference to the link between primary care access and A&E attendances has also been removed from this section but is described in more detail under access to primary care. In addition, the section on rising demand has also been revised to better distinguish between different types of A&E attendances.

Patient experience

Some concerns were expressed during the engagement period that the evidence in the 'patient experience of primary care' section took too little account of the interaction of various 'environmental' factors that impact practices, such as deprivation. In response to this, the impact of deprivation on general practice has been discussed under access to primary care. Additionally, the patient experience section of the evidence base has been expanded to include results from the recent Friends and Family Test. More evidence has also been included about patient ownership and responsible use of services.

Self-care and self-management

In response to further information received during the engagement period highlighting concerns that online health tools can increase use of NHS services, more evidence around the impact of online health tools on general practice activity has been included.

More evidence has also been included to highlight links found between socio-economic status and an individual's capacity to self-care. Feedback and further evidence received regarding telecare presented a mixed picture with both support for its use and concern that there is a lack of evidence to support its clinical and cost-effectiveness. In response to this, more evidence and analysis has been incorporated to reflect this view.

Telephone care

Feedback received during the engagement period queried the evidence behind the 'Doctor First' model. The evidence base has been revised to highlight research that reflects that the 'Doctor First' model, while demonstrating positive outcomes, requires broader analysis.

Face-to-face care

In response to further evidence received during the engagement period, the section on access to primary care has been expanded to describe the role of GP services in providing continuity of care and the difficulties services can face managing patients with mental health problems. The rise in demand for general practice has also been discussed in more depth.

Some feedback received during the engagement period expressed concern that health inequalities and the impact of deprivation on general practice were not sufficiently discussed. In response to this, a discussion covering health inequalities has also been included to add context to the key message stating that primary care can struggle to manage some patients with long-term conditions effectively. Additionally a section on home visits has been included discussing the impact of batching on emergency admissions.

999 emergency services and accident and emergency departments

Comments and feedback received during the engagement period highlighted the need to explore how different patient groups access A&E services. An additional key message has been included to highlight pressure from paediatric patients on A&E services, more information has been included to illustrate the impact of mental health patients and further discussion has been included on crowding and patient flow through A&E departments.

Access to quality back up services and support services

In response to feedback and additional evidence received during the engagement period, a section discussing mental health liaison services has been included. Mental health services and their role in the urgent and emergency care system have been researched further and the evidence submitted during engagement has been incorporated into the evidence base, where relevant.

During the engagement period, some feedback was received supporting the use of GPs in A&E departments to help manage patients with primary care needs more effectively. In response to this, further information has been included to evaluate the available evidence.

Emergency admissions to hospital

Further evidence was submitted during the engagement period around emergency admissions to hospital. This has been included to highlight concerns around the lack of alternatives to hospital admission available on the weekend. In response to feedback and additional evidence submitted during the engagement period, more information has been included about paediatric short-stay admissions.

Issues relating to patient flow through the hospital system have been further evidenced. In relation to variations in outcomes for admitted patients, further evidence received during engagement has been included to illustrate the benefits of consolidation of particular services.

Urgent and emergency care workforce

In response to feedback and further evidence submitted during the engagement period, more information has been included to highlight the need to expand the GP workforce and the recruitment issues faced by general practice. For emergency medicine, more information has been included to highlight the shortage of emergency medicine doctor trainees. Also evidence has been added to highlight potential recruitment issues facing the acute medicine specialty.

Further evidence received during engagement highlighted the role of nurses and their potential to address shortages in other areas of the workforce, which has now been included. Also, developing the role of the ambulance service workforce has been added to highlight the potential for more highly trained ambulance staff to deliver more treatment at the scene to reduce the conveyance rate to hospital.

Effective urgent and emergency care networks

Feedback received and evidence published during the engagement has been included to expand this section to highlight the complexity of urgent and emergency care networks and the difficulties that have been experienced previously when developing a shared vision.

The key messages within the evidence base have also been revised to reflect the changes made throughout the evidence base in response to the feedback and comments received throughout the engagement period. These are reproduced at Annex C.

4.2 Revisions to the emerging principles and system design objectives

The emerging principles and system design objectives for the future delivery of urgent and emergency care have been revised to reflect the feedback and comments received during the engagement period. These revisions are highlighted in figures 1 and 2; phrases have been changed where there was a common call to do so, and to use more patient-focussed language. Content in red reflects amendments made following engagement.

These revised principles and system design objectives will be used as a reference point to ensure that, as the Review progresses, any implementation options developed aim to achieve the principles and objectives for urgent and emergency care in England.

Figure 1: Revised principles for the urgent and emergency care in England

Principles for urgent and emergency care in England outline a system that:

1. Provides **consistently** high **quality** and **safe** care, across all seven days of the week;
2. Is **simple** and guides good, **informed** choices by patients, **their carers** and clinicians;
3. Provides **access to** the **right care** in the **right place**, by those with the **right skills**, the **first time**; and
4. Is **efficient and effective** in the delivery of care and services **for patients**.

Figure 2: Revised System Design Objectives

1. Make it **clear how I** or my family/carer access and navigate **the** urgent and emergency care **system quickly, when needed**.
2. **Provide me** or my family/carer **with information on** early detection and options for self-care, and **enable** me to manage my acute or long-term physical or mental condition.
3. Increase my or my family/carer's awareness and publicise the benefits of **'phone first'**.
4. **When** my need is urgent, provide me with guaranteed same day access to a primary care team that is integrated with my GP practice and my hospital specialist team.
5. Improve my care, experience and outcome by ensuring **the** early **input of a senior clinician** in the urgent and emergency care pathway.
6. Wherever appropriate, **care for and treat** me where I present (including at home and over the telephone).
7. If it's not appropriate to **care for and treat** me where I present, take or direct me to a place of definitive treatment within a safe amount of time; ensure I have rapid access to highly specialist **care** if needed.
8. Ensure all urgent and emergency care facilities **can** transfer me urgently, and that the transport is capable, appropriate and **approved**.
9. **Real time** information, essential to my care, is available to all those treating me.
10. Where I need wider support for my mental, physical and social needs ensure it is **co-ordinated and** available.
11. Each of my clinical experiences should be part of programme to develop and train clinical staff and ensure **development of** their competence and the future quality of services.
12. The quality **and experience** of my care should be measured **and acted upon to ensure continuing improvement**.

Annex A: Stakeholder engagement

Stakeholder groups targeted

On 17 June 2013 NHS England circulated a letter and press release from Professor Sir Bruce Keogh to key stakeholders, highlighting that the evidence base and emerging principles had been published for a period of wider engagement.

The Urgent and Emergency Care Review stakeholder engagement plan identified nine key stakeholder groups for engagement.

- **Patients and the public**

Voluntary sector and patient groups were contacted and sent background information on the Review and links to the engagement web page at the start of the engagement period. A banner and news item was uploaded on NHS England's homepage to attract public interest and signpost them to the questionnaire.

- **Provider organisations**

At the start of the engagement period, the NHS England communications team sent a letter containing background to the Review and links to the engagement web page to all Chief Executives and Communications leads at all NHS and Foundation Trusts in England.

- **Commissioning Organisations**

At the start of the engagement period, the NHS England communications team sent a letter to all CCG Clinical Leads, CCG Accountable Officers, NHS England Area and NHS England Regional Directors, to raise awareness of the engagement period and encourage them to participate.

- **Wider clinical body**

Steering group representatives from Society of Acute Medicine, Royal College of General Practitioners, Royal College of Nursing and the College of Emergency Medicine (as well as other Royal Colleges and organisations such as the British Medical Association) were asked to use their existing networks to raise awareness of the engagement period.

- **Political organisations**

Professor Keith Willett presented to the Health Select Committee on 25 June 2013 on the evidence base and emerging principles for improving urgent and emergency care, expressing the need for wider engagement.

- **Workforce and training organisations**

At the start of the engagement period, the NHS England communications team sent a letter containing background to the Review, along with links to the engagement web page, to Health Education England.

- **NHS Regulators**

At the start of the engagement period, the NHS England communications team sent a letter containing background to the Review and links to the engagement web page to communication leads at Healthwatch, the National Trust Development Authority, the Care Quality Commission and Monitor.

- **Health and Wellbeing Boards**

When the engagement period launched, regional NHS England communication teams were asked to send information and links to the engagement web page to the Health and Wellbeing Boards.

Stakeholder event on 6 August 2013, London

The stakeholder event formed an important part of the engagement period and was open to anyone that wished to help shape the future of urgent and emergency care in England. Over 200 delegates attended including clinicians, commissioners and healthcare professionals from across the urgent and emergency care pathway, representatives from Royal Colleges and clinical bodies, patients and the public.

The event included:

- Presentations from Professors Keith Willett and Jonathan Benger (National Clinical Director for Urgent Care, NHS England) to introduce the Review and outline the evidence base and emerging principles;
- A question and answer session on the evidence base; and
- A workshop session designed to provide the opportunity to discuss and collect feedback on the emerging principles, system design objectives and possible implementation options.

Online questionnaire

In order to capture structured qualitative feedback, an online questionnaire was available for anyone to complete when the engagement period opened on 17 June 2013. The questionnaire was designed to draw on the experience of patients and professionals in the NHS to test the documents and gather further contributions to the evidence base for change, emerging principles, system design objectives and possible implementation options. A paper version and Easy Read version of the questionnaire were also available for those who required it.

The full list of questions contained in the questionnaire is shown in Annex B.

Other events and meetings

- **NHS Interim Management and Support (IMAS) Regional Events**

Four regional events on urgent and emergency care were held by NHS IMAS in the following locations:

- Leeds (13 June 2013);
- Leicester (4 July 2013);
- Reading (17 July 2013); and
- London (18 July 2013).

These events were used as a platform for wider engagement from health care professionals involved in urgent and emergency care. At the event on 13 June 2013, Julian Hartley (Managing Director, NHS Improving Quality) presented an overview of the evidence base and informed delegates about the proposed period of engagement. At the other three events (4 July, 17 July and 18 July 2013) a video prepared by Professor Keith Willett providing the background to the Urgent and Emergency Care Review and giving information about

engagement and how to get involved, was also shown. Additionally, Professor Jonathan Benger gave an overview of the Review and a presentation on the principles and objectives for improving urgent and emergency care at the London event on 18 July.

- **Voluntary sector strategic partners (16 July 2013)**

The voluntary sector strategic partners are a group of 21 voluntary and community sector organisations collectively reaching around 500,000 health and social care organisations. Professor Keith Willett presented the evidence base for change and emerging principles to the strategic partners at their working day on 16 July 2013. The strategic partners were asked to disseminate the information about the engagement to the wider voluntary sector and encourage involvement in the engagement process.

- **London Regional Clinical Senate Forum (4 July 2013)**

This London Regional Clinical Senate Forum focussed on addressing the quality challenge in urgent and emergency care services in London. The event was used as a platform to publicise the Review and encourage those attending to give feedback on the engagement. Dr Andy Mitchell (Medical Director, NHS England (London region)) gave a brief overview on the Urgent and Emergency Care Review and provided a link to the online questionnaire as part of the introduction to the Forum. A link to the Review's webpages was also sent out electronically with the forum agenda before the event.

- **Commissioning Assembly (25 September 2013)**

At this event Professor Keith Willet outlined the work of the Review so far to an audience of Clinical Commissioning Group (CCG) representatives from across England. Although the Commissioning Assembly took place when the period of engagement had ended, this was an important opportunity to engage with CCGs and keep them updated with the progress of the Urgent and Emergency Care Review. The Commissioning Assembly will be used for further engagement and to provide input into the proposals during Stage 2 of the Urgent and Emergency Care Review.

Annex B: Online questionnaire

Urgent & Emergency Care Review - Evidence Base & Emerging Principles – Questionnaire

Overview

The urgent and emergency care system in England plays a critical role in the NHS, providing care for patients who need medical help quickly and unexpectedly. It's important therefore that we build a safe, more efficient and sustainable system for the future.

In January 2013 Professor Sir Bruce Keogh announced a review into the way the NHS responds to and receives emergency patients, called the Urgent and Emergency Care Review.

Why We Are Consulting

The Review has developed an evidence base for change, emerging principles on how a future system might be shaped, objectives which the new system would seek to achieve, and possible implementation options.

Please help us by commenting on the work so far, and by making suggestions which will help us to strengthen this work and the evidence base.

This is your chance to shape the future of your urgent and emergency care service. Your feedback sits at the heart of this Review.

Find below the weblink to all documents and the engagement questionnaire:

<https://www.engage.england.nhs.uk/survey/urgent-emerging-care>

Please find below an offline version of the questionnaire:

1. What is your name? (Required)
2. What is your email address? (Required)
3. What are the first three or four digits of your postcode? (these will help us to analyse results on a local and regional basis) (Required)
4. Are you providing a response as an individual, or on behalf of an organisation?
Choose from:
 - As an individual
 - On behalf of an organisation)
5. If you are responding on behalf of an organisation, which organisation is it? (Text box, 400 characters max)

6. Which of the following areas of healthcare are you representing?

(Required) (please tick all that apply)

Choose from:

- Commissioners of healthcare services
- Acute services
- Mental health services
- Primary care services
- Community based care
- Patients and service users
- Other
- None

If you ticked Other, please specify which organisation you are responding on behalf.
(Text box)

7. Do you believe that the current system of urgent and emergency care in England needs to change and improve? (Required)

- Yes/No

8. Have you read the full Urgent and Emergency Care Review evidence base? (Required)

- Yes/No

9. Do you agree with the evidence base presented for self-care and self-management (section 5 of the evidence base)?

- Yes/Mostly/Partly/No

10. Do you agree with the evidence base presented for telephone care (section 6 of the evidence base)?

- Yes/Mostly/Partly/No

11. Do you agree with the evidence base presented for face to face care (section 7 of the evidence base)?

- Yes/Mostly/Partly/No

12. Do you agree with the evidence base presented for 999 emergency services, accident and emergency departments, and access to back-up services (sections 8 and 9 of the evidence base)?

- Yes/Mostly/Partly/No

13. Do you agree with the evidence base presented for emergency admissions (section 10 of the evidence base)?

- Yes/Mostly/Partly/No

14. Do you agree with the evidence base presented for urgent and emergency care workforce (section 11 of the evidence base)?

- Yes/Mostly/Partly/No

15. Do you agree with the evidence base presented for urgent and emergency care networks (section 12 of the evidence base)?

- Yes/Mostly/Partly/No

16. Do you have any other comments on the evidence base, or is there any further evidence that you would like to offer to support improving the urgent and emergency care system in England? (Text box)
17. Have you read the full Urgent and Emergency Care Review emerging principles? (Required)
- Yes/No
18. Do you agree that any improvements and changes to the urgent and emergency care system need to be based on the emerging principles?
- Yes/No
19. Do the system design objectives outlined allow the emerging principles for the future delivery of urgent and emergency care to be met?
- Yes/Mostly/Partly/No
20. Do you support the identified possible implementation solutions?
- Yes/Mostly/Partly/No
21. What type of things would help with implementing the possible solutions? Please tick all that apply.
- Improved IT and information sharing
 - Increased focus on clinical outcomes
 - Urgent and emergency care networks
 - Closer working across organisations
 - Closer working between GPs and secondary care clinicians
 - Wider range of skills and increased training
 - Common commissioning framework
 - Better alignment of incentives/commissioning levers
- Other, if you ticked Other, please specify (Text box, max 2,000 characters)
22. What type of things might prevent implementing the possible solutions? Please tick all that apply.
- Incompatible IT systems/data sharing issues
 - Culture of silo working – not owning the whole pathway
 - Lack of secondary care support for GPs
 - Lack of awareness of how GPs can contribute to their patients care in hospital
 - Inability to risk share/ double-run systems in transition
 - Focus on process rather than outcome
 - Insufficient skills mix across workforce
 - Current Payment by Results structures
 - Contractual focus on penalties rather than incentives
- Other, if you ticked Other, please specify (Text box, max 2,000 characters)

23. Do you have any further comments about the emerging principles, system design objectives, or implementation solutions, or are there any other suggestions you would like to make? (Text box)

24. Would like to be involved in further work relating to the Review?

- Yes/No

Annex C: Revised key messages from the Evidence Base

Current services

- The number of GP consultations has risen over recent years and, despite rapid expansion and usage of alternative urgent care services, attendances at A&E departments have not reduced. This indicates either unmet demand across the whole system or supply induced demand: increased uptake as a result of increased provision of services.
- Growth in the number of people using urgent and emergency care is leading to mounting costs and increased pressure on resources.
- Overall fragmentation of the system and inconsistent service provision means that patients may not be able to access the most appropriate urgent or emergency care service to suit their needs, leading to duplication and over-use of the most expensive services, at significant cost to the NHS.

Patient experience

- There is significant variation in patient experience between GP practices. Data shows that some patients who have a good experience of their GP are less likely to use A&E departments.
- Patient experience of both the NHS Direct telephone service and pilots of NHS 111 has been found positive; however transition from nurse-led triage to calls answered by trained advisors, supported by experienced clinicians has led to some incidences of poor patient experience during the early implementation of NHS 111.
- The wide range of urgent care services available and lack of service standardisation and labelling results in patient confusion over how to access the right healthcare quickly; this leads to duplication, delay, increased clinical risk and poor patient experience.
- There are variations in the way patient experience is monitored and acted upon in urgent care and this falls short of what is achieved in other parts of the NHS.
- Consistently positive patient experiences of ambulance services, and confusion surrounding other areas of healthcare, are factors that may have contributed to an increased use of the emergency '999' number and ambulance services by patients with non-urgent healthcare needs.
- A&E performance (operational and clinical), and therefore patient experience, varies significantly between trusts, with a few performing far worse than the rest. Additionally, there are signs that overcrowding of A&E departments is causing a deterioration of performance and impacting negatively on patient experience.

Self-care and self-management

- Self-care for minor ailments and self-management of long-term conditions are effective at improving quality of life and reducing dependency on urgent and emergency care services. However there is a lack of awareness, particularly amongst patients in lower socio-economic groups, surrounding how to access support.

- There are a range of programmes available to support self-management of long-term conditions but provision and uptake of these is variable across the NHS.
- Variable management of long-term conditions in primary care may have contributed to a rise in the number of emergency admissions to hospital.
- Telecare may have the potential to improve health outcomes for some patients with long-term conditions; however there is little evidence to suggest this will reduce overall health costs.
- Community pharmacy services can play an important role in enabling self-care, particularly amongst patients with minor ailments and long-term conditions; however there is little public awareness of the range of services provided by pharmacists.

Telephone care

- Telephone advice can prevent many unnecessary attendances at NHS facilities. However it is sometimes difficult to accurately triage patients over the phone and, without clinical input, call handlers may sometimes over-triage if they cannot rule out a serious condition.
- Telephone consultations are becoming increasingly popular, are less resource-heavy for general practice than face-to-face consultations and their systematic use is linked to reduced use of A&E departments. However some patients lack confidence in telephone advice and are sometimes more likely to pursue a second opinion inappropriately, leading to duplication of service provision, in some cases.

Face-to-face care

- GP practices in areas of high deprivation typically deal with greater volumes of patients with more complex physical and mental health conditions, which can lead to greater practitioner stress and lack of capacity to manage some patients effectively. This may contribute to avoidable A&E attendances and emergency admissions to hospital.
- Access to urgent GP appointments across England is variable and, in urban areas where demand is high and transient populations exist, many may use an A&E department as their first point of urgent and emergency care.
- Most out-of-hours services work effectively to deliver a high standard of care to patients who need urgent care when their GP practices are closed. However there are variations in the standard of care provided and commissioners are not always able to hold providers to account effectively.
- The system of home visit services provided by general practice often means patients arrive at hospital when senior hospital staff have completed their working day. Responding more rapidly to requests for home visits, and ensuring a timely and effective system of patient transport, could reduce the number of emergency admissions to hospital and reduce overall healthcare costs.
- The fragmentation and diverse nomenclature of urgent care services across England causes confusion amongst patients and healthcare professionals in terms of services offered. This can lead to patients presenting at services that may not best suit their needs.

- Urgent care services are characterised by variation and a lack of standardisation and clear information. This contrasts with the strong identity of A&E departments. Variation in acceptance and quality of care provided can result in delayed treatment or multiple contacts and a poor experience of care, as well as inefficient use of expertise and resources.

999 emergency services and Accident and Emergency departments

- Appropriate staffing is integral to an effective A&E department; however doctors in training are relied on heavily to provide the service due to insufficient numbers of senior (middle grade and consultant) emergency medicine trained doctors.
- Consultant-delivered care and senior clinical input improves patient outcomes in A&E departments. However the shortage of senior emergency trained doctors is a problem for nearly all A&E departments and large variation in consultant 'shop floor' coverage is seen across England.
- Crowding in A&E departments is a growing threat to patient safety and can have a significant impact on all patients. Timely access is required from supporting specialties to enable appropriate admission and transfer of patients to improve patient flow within A&E departments.

Access to quality back up and support services

- To ensure high quality and safe care in an A&E department, access to inpatient beds and support from other specialities in the hospital or rapid transfer to the right hospital is required.
- Rapid access to mental health liaison services can improve care and conserve resources by reducing delays in assessment, treatment and discharge. However there remains significant variation in service delivery and availability across England.

Emergency admissions to hospital

- Growth in the number of emergency admissions to hospital has been associated with a large rise in short or zero stay admissions. The reasons for this are multifactorial but some studies have attributed it to a lack of early senior review, risk averse triage and A&E departments trying to avoid breaching the four hour standard.
- Reduced service provision, including fewer consultants working at weekends (in emergency medicine and acute in-patient specialties), is associated with England's higher weekend mortality rate. Consistent services across all seven days of the week are required to provide high quality and safe care.
- There are clear recommendations from the Temple Report that training needs to take place in a consultant-delivered service yet this is not practised across the majority of hospital services.
- Good patient flow through the hospital system can reduce costs and significantly improve patient outcomes; however patient flow is often impeded by inefficient hospital systems.

Workforce

- National workforce analysis highlights a growth in the GP workforce in England but there is unequal access to GPs between areas of high and low deprivation. Analysis highlights that the GP workforce is under significant pressure in some areas, with insufficient capacity to meet needs.
- The involvement of senior doctors 24 hours a day and consultant presence at times of peak activity seven days a week is required to ensure timely patient care and flow in an A&E department. Many A&E departments do not have the recommended number of emergency medicine consultants or middle grade doctors to support such a rota.
- Nurses can be used in A&E departments to provide greater clinical leadership and address issues faced by other areas of the urgent and emergency care workforce. This can result in better patient outcomes at less cost. However there is a lack of clarity and consistency in the roles they perform.
- Ambulance services have the potential to meet a higher proportion of urgent and emergency care demand and prevent onward transportation to hospital; however ambulance services do not currently have sufficient clinically-trained staff to achieve this.

Urgent and emergency care networks

- A networked approach to urgent and emergency care provision is supported by healthcare professionals, but the complexity and fragmentation in the current system poses a significant challenge to service integration.
- Urgent and emergency care networks can improve patient outcomes and experience; however there is variation in the organisation, scope and functionality of networks across the country.
- There are wide variations in the way information is shared between providers of urgent and emergency care leading to potential duplication within the system causing delay and poor patient experience.