The Government Response to the House of Commons Health Select Committee Report on Winter Pressure in Accident and Emergency Departments

Presented to Parliament
by the Secretary of State for Health
by Command of Her Majesty

July 2017

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The Government Response to the House of Commons Health Select Committee Report on Winter Pressure in Accident and Emergency Departments

(Third Report of Session 2016-17)

Introduction

Every year the NHS plans for winter as part of its year-round operational resilience planning, to ensure the health and social care system in England is fully prepared to cope with the increased pressures that time of year brings. For winter 2016/17, the NHS planned for winter earlier than ever before and the Department of Health worked closely with NHS England and NHS Improvement to ensure there were robust governance and operational arrangements in place so patients received the highest quality of care and timely access to services.

Cold weather in winter can adversely affect the health of elderly and very young people and those with pre-existing medical conditions, particularly through the seasonal increase in respiratory disease. In addition, there may be seasonal flu and adverse weather conditions, which can lead to increases in illness and injury. The change in demand winter brings is not simply about an increase in the numbers of people accessing urgent and emergency care, as the average daily number of attendances at A&E tends to be higher throughout the summer months than during winter. The change is about a greater proportion of people who attend A&E that are sicker and are subsequently admitted as an emergency.

It is this increase in emergency admissions that increases the demand for hospital beds, which is evidenced by the increased occupancy rates with highest levels during winter (quarter four) despite opening additional beds, and lowest levels during summer (quarter two). Consequently this affects the performance of A&E departments with the expected dip in performance during winter compared to summer. As this demand rises year on year, the NHS has experienced increased demand that has placed increasing pressure on hospitals and the wider urgent and emergency care system.

For winter 2016/17 we allocated £400m in resilience funding**,** £350m in CCG baselines so local health economies could plan and implement initiatives far earlier. The remaining £50m supported a number of national initiatives such as:

- Additional resilience funding for ambulance services.
- Additional resilience funding to support specialised commissioning.
- The expanded Emergency Care Improvement Programme (ECIP).
- The winter marketing/communications campaign.

Following winter, the 2017 Spring Budget announced capital investment of £100m for front door streaming at A&E departments, in line with a number of the best performing Trusts. This will help provide space for services to allow streaming, such as on-site GP facilities, to which non-urgent patients can be directed to access more appropriate care quickly and safely. We expect a large number of trusts to benefit from this new investment.

A review of winter 2016/17 is being undertaken by the NHS and lessons from this will be used in preparing for winter 2017/18 to minimise winter pressure on the NHS.

Data on emergency performance is published by NHS England on a monthly basis and is available at the following link: https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/

Evolving demand

1 **We are very concerned about the decline in performance of major emergency departments in England. We recognise that hospitals are managing ever growing demands, but the performance of emergency departments against the four-hour waiting time standard is a marker of much wider system pressure. (Paragraph 12)**

We know that the system faced a challenging winter, however we were determined to ensure that the NHS and social care sector focussed on delivering for patients and that national organisations supported them effectively to do this.

There was a 14% increase in attendances at A&E in 2016/17 compared with 2009/10; and a 25% increase in the number of emergency admissions via A&E during the same period. Demand for urgent and emergency care continued to increase in 2016/17, with over 451,000 more attendances in 2016/17 compared to 2015/16, and over 147,000 more emergency admissions.

In recognition of the need to improve emergency department performance the NHS' A&E Improvement Plan (2016/17) placed significant focus on new ways of working to reduce the broader system-wide pressures on A&E, including reducing demand at the front door and improving hospital flow, which has since been supported by the investment in streaming at the front door (supported by £100m capital), and at the back door through the recent social care funding settlement. Streaming at the front door by directing patients to ambulatory or primary care will help reduce waits in A&E departments and improve the flow through A&E by allowing staff to focus on patients with more complex conditions; whilst improving discharge aims to reduce unnecessary delays once treatment in the acute care setting is complete. The Plan also addressed wider system pressures besides A&E, including actions to improve the services delivered by NHS 111 and the ambulance service to ensure patients with the most urgent needs were seen in A&E whilst ensuring that all those who contacted NHS111 or the ambulance service received a clinically appropriate response.

As part of the A&E Plan, trusts were initially segmented on the basis of performance and severity of known issues with targeted support provided by the Emergency Care Improvement Programme and regional NHS England and NHS Improvement teams to unblock barriers and embed best practice. The building blocks for the A&E Improvement Plan included the best practice actions that senior clinicians from the strongest performing trusts reported as being the most effective interventions to improve performance. Trusts that already have these actions embedded are meeting the standard.

Good progress has been made on implementing the initiatives set out in the plan, however against increasing pressures, performance against the A&E waiting time standard – that 95% of patients wait for less than four hours before they are admitted, discharged or transferred to another hospital – did not recover. Therefore, alongside continued implementation of these initiatives, Jim Mackey, Chief Executive of NHS Improvement, wrote to NHS provider trusts on 19 December 2016 to set out four

key actions to ensure that patients are kept safe whilst A&E departments cope with winter pressures.

The 'Stay Well This Winter' public campaign provided simple advice on the evidence-based behaviours people should adopt to keep themselves as well as possible, thereby helping to reduce demand on A&E departments. It was designed to encourage those population groups who are at most risk of being admitted to hospital over the winter, particularly older people, people with long-term health conditions, pregnant women and parents of children aged 2-7 years, to take those actions that will help keep them stay well during winter, such as getting a flu vaccination, keeping homes warm and getting advice from a pharmacist at the first sign of illness. Initial findings show that spontaneous awareness of publicity around staying well last winter is significantly higher than in 2015/16, building on the high residual awareness of last year's campaign. In January 2017, recognition of the campaign was significantly higher compared to the same month last year with recognitions among the targets groups (those with long term conditions, individuals aged between 65-74 and individuals 75 and over) increasing, in particular, recognition increased from 50% to 77% for 65-74 year olds.

Early senior review of patients

2 Both the Nuffield Trust's and the Health Foundation's research support the case for early senior review of complex cases. The systematic review cited by the Centre for Urgent & Emergency Care Research, however, reported limited cost and patient outcome benefits from routine use of early senior review of patients. When redesigning systems and processes with the intention of improving patient flow trusts should assess how they are applied and whether they are effective in their local context. (Paragraph 22)

We agree that trusts should redesign systems and processes that work for their local context and can deliver the best patient outcomes for their population. The improvement approach taken by trusts should take on board the latest and best available evidence and best practice from research and leaders in the system, for example using the NHS' 'Safer, Faster, Better' guidance and accessing the skills of the Emergency Care Improvement Programme (ECIP), which has expanded in 2016/17, in terms of improving patient flow. The Centre for Urgent and Emergency Care Research's systematic review is therefore a welcome addition to the evidence base for early senior clinical review and can provide material to help clinical leaders make the right decisions for patients in their locality. The need for early senior review is already recognised in the clinical standards identified by the 'NHS Services, Seven Days a Week Forum' and other professional guidance – all trusts are required to achieve implementation of clinical standard 2 'Time to consultant review' by 2020.

ECIP recommends the use of Red: Green Bed Days as a management system to assist in the identification of wasted time in a patient's journey. The A&E Improvement Plan also advocated the use of the SAFER bundle to improve patient flow, which states that all patients should have a senior review to inform management and discharge decisions without delay. In addition therefore to supporting evidence from the Nuffield Trust and Health Foundation research clinical experts from across the system, including the NHS national leads responsible for developing the A&E plan, continue to recommend the use of early senior review of patients.

National policy interventions

3 It is welcome that the interventions designed for use by A&E Delivery Boards and individual trusts focus on the practical aspects of patient flow throughout a patient's stay in hospital. We support the whole system approach to providing a better experience of care to patients in the right setting at the right time. (Paragraph 27)

The Government notes this point and we will continue to emphasise the importance of the whole system approach to delivering safe and effective care for patients.

4 Ministers and senior officials should acknowledge the reservations expressed by the Centre for Urgent and Emergency Care and re-examine the evidence base for the initiatives being applied within emergency departments. (Paragraph 29)

We acknowledge the reservations expressed by the Centre for Urgent and Emergency Care. The evidence base for the initiatives being applied within emergency departments includes expert opinion and observational studies. We encourage rigorous evaluation and research to justify interventions. It is important also to take advice from frontline staff and senior clinicians who know best how to run effective emergency department services from extensive experience. The effectiveness of the initiatives has been demonstrated by 'doing' and it may take time before the research is able to evaluate the effectiveness of the interventions. Further the initiatives in the A&E plan were underpinned by the Urgent and Emergency Care Review work, led by the Medical Director at NHS England which is based on an extensive evidence base, and 'Safer, Faster, Better' is widely endorsed by professional bodies including the Royal College for Emergency Medicine. We will continue to keep the evidence for the initiatives under review and welcome attempts by research bodies to challenge and enhance the rigour of the evidence base in terms of the initiatives being applied within emergency departments.

NHS Improvement is part of a five-year partnership with Virginia Mason Institute and five NHS trusts to support them to develop a 'lean' culture of continuous improvement which puts patients first. Over the course of the five years, leaders and clinicians from the five trusts will receive a wide range of tools and hands on support to develop lean techniques, to accelerate improvements for patients through identifying waste and concentrating on the things that add value for patients and staff, leading to better, safer and more efficient care. Over time the trusts will be able to train their own staff to help create a sustainable culture of continuous improvement. To note that the evidence base for the initiatives which now form the Urgent and Emergency Care plan for 2017-19 were derived in part from the experiences of Pauline Philip, who was formerly the Chief Executive of Luton and Dunstable University Hospitals NHS Trust. This has been consistently one of the top performing trusts in England over recent years.

5 We recommend that NHS England and NHS Improvement set out how they intend to formally evaluate the effectiveness of the interventions that they have mandated and how they will be encouraging trusts to do likewise. Data collection and evaluation should be built into future programmes from the outset to improve research into the most effective interventions. (Paragraph 30)

We agree that ongoing evaluation of these initiatives is important and will seek to enhance the evidence base by improving the way it is used to monitor impact and by strengthening the

improvement support within the NHS to support and spread good practice. NHS Improvement has developed a comprehensive data dashboard to track the effectiveness of interventions on a very frequent basis. This will be used in conjunction with a robust oversight and support structure led by regional NHS England and NHS Improvement teams to provide challenge and support in understanding the impact of interventions and spreading those that work to other areas. This approach is integral to the urgent and emergency care programme and plan.

Practical improvement

6 The ongoing decline in performance of type 1 emergency departments against the four-hour target should be regarded as a matter of patient safety rather than a failure to meet a bureaucratic objective. (Paragraph 32)

The Government agrees with the Committee's conclusion that ensuring patients start their admitted care, are transferred or discharged from A&E Departments in a timely way contributes to individual patient outcomes and overall patient safety. Where this does not happen, A&E departments can become over-crowded, which is linked to worse outcomes for patients. That is why the Government is committed to the four-hour target and the A&E plan focuses on a return to the 95% standard where patient safety is optimal.

The NHS' approach to ensuring a return to the four-hour standard and patient safety is also recognised as being a broader challenge than type 1 emergency department performance. The whole system is expected to take responsibility for achieving the four-hour standard and a return to 95% performance. For example the governance arrangements for implementing the A&E plan required the establishment of Local A&E Delivery Boards which take a cross-system approach to planning and implementing A&E best practice and include senior leaders in trusts, local authorities and Clinical Commissioning Groups as members.

7 Through the improvement work they are undertaking with trusts, NHS England and particularly NHS Improvement should facilitate the development of the cultural approach we witnessed in Luton, where waiting times in A&E are seen as everyone's responsibility. (Paragraph 33)

We agree that the system can learn a great deal from Luton's approach and the experiences of their system influenced the development of the evidence base and best practice for the A&E Improvement Plan and wider implementation of NHS England's Urgent and Emergency Care Review (UECR). Besides sharing the example of Luton we are taking further steps to embed a culture of waiting times being everyone's responsibility through the governance arrangements for implementing the A&E plan. For example the national network of Local A&E Delivery Boards, which includes senior leaders from trusts, local authorities and CCGs, together take a cross-system approach to planning and implementing A&E best practice and to understanding better the connections between their services and the drivers of poor A&E performance.

The A&E Improvement Plan recognised that a turnaround and recovery mindset is required to deliver change; hence the targeted approach being taken with trusts segmented on the basis of performance and severity of known issues and tailored support provided by the Emergency Care Improvement Programme (ECIP) and regional NHS England and NHS Improvement teams to unblock

barriers and embed best practice. ECIP continue to work with some of the most challenged A&E systems and encourage a system-wide approach to resolving local problems through intensive work with system leaders. This attempts to build and strengthen local relationships and encourage a culture of shared ownership for A&E as has been shown to be the case in Luton. We will continue to emphasise the importance of developing the right culture in systems as a core pillar of the implementation of UEC and A&E Improvement Plan.

We are all in agreement that we should do all we can to meet the needs of our sickest patients. There are very clear guidelines and direction from the Royal Colleges in this regard and we are working with the relevant professional bodies on how best to give this more focus and prominence. For example, we expect to focus on 'time to see a relevant clinician' for key pathways (e.g. stroke percutaneous coronary intervention (PCI)), or time to start a bundle (such as sepsis six). We also believe that this will lead to better care for these patients, shorten waiting times, or guarantee that treatment commences within a shorter time frame. Included, as part of this, is a real effort to eradicate ambulance handover delays as we know that this is right for our patients. There is detailed and ongoing work to support these actions and other actions to improve patient care under the leadership of Pauline Philip, previously Chief Executive of Luton and Dunstable University Hospitals NHS Foundation Trust and now National Director for Urgent and Emergency Care across NHS England and NHS Improvement.

Flow & delayed transfers of care

8 It is an indictment of the existing state of adult social care provision that some acute trusts are having to establish domiciliary care services in order to improve patient flow through their hospitals and ease pressure in their emergency departments. This only serves to underline the perilous state of adult social care in England and the fundamental inadequacy of provision in some parts of the country. The Government should undertake an urgent review of the state of adult social care and its impact upon the NHS and the most vulnerable individuals who depend upon both. (Paragraph 41)

Adult social care is a key priority for this Government. This is why, against the context of tough public sector finances, steps have been taken to protect social care services. The Government understands the importance of strong and effective social care services in supporting people in their communities, helping avoid unnecessary hospital admissions, maintaining patient flow and getting people home safely and quickly after hospital admission. Recognising this and the financial pressures in social care, the Government has already taken action and at Spring Budget 2017 announced £2 billion in extra funding for councils in England, for adult social care.

Councils will use the funding for the purposes of meeting adult social care needs; reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready; and ensuring that the local social care provider market is supported. As this money is pooled into the Better Care Fund, councils will work with their NHS colleagues locally to consider how it can best be used. This includes implementing measures to help spread best practice in managing transfers of care.

In addition, the Care Quality Commission (CQC) will be undertaking a series of targeted reviews, initially in 12 areas in advance of winter, with a focus on the interface between health and social care, including delayed transfers of care.

An enhanced improvement and support offer will be available to all local areas, regardless of whether they have undergone or are due to undergo a CQC review.

Increasing bed capacity

9 Investment in 'step-up / step-down' community rehabilitation beds helps to relieve the pressure on NHS beds and can help to flex capacity at times of especially high demand. Nevertheless, acute trusts need to plan effectively for sufficient acute beds as well as access to community beds to improve patient flow. (Paragraph 53)

Local trusts and commissioners are expected to work together through accident and emergency delivery boards and STP footprint areas to ensure there is sufficient acute and non-acute bed capacity to deliver appropriate patient flow. The level of capacity in non-bed based services e.g. community teams is also key to this. Maximising bed capacity and reviewing escalation processes are part of routine winter planning arrangements and formed part of robust local planning to ensure the health and social care system was well prepared to cope with the increased pressures that winter brings when caring for patients. We know that difficulties with discharging patients can reduce the effective availability of beds for both emergency patients and those needing planned surgery. The extra funding made available for adult social care in the April 2017 budget can in part be used to reduce bed occupancy pressures on the NHS by funding increased social care packages. This investment, together with improved implementation of proven high impact discharge changes should help relieve pressure on NHS beds.

10 It is essential that the Government ensures that sufficient capital funding is available for trusts to develop the infrastructure that will enable them to meet performance levels demanded by Ministers. The first step will be an assessment of the infrastructure investment required to ensure that type 1 emergency departments are fit for purpose, which should be completed through the Sustainability and Transformation Plan process. Once that assessment is complete, NHS England and NHS Improvement will need to ensure that the available capital funding is directed accordingly—we call on the Government to review the real terms cuts to NHS capital budgets in the Spending Review and to protect the transformation element of the Sustainability and Transformation Fund. We emphasise the importance of evaluation of completed projects in order to guide future investment and identify and share best practice. (Paragraph 58

To help manage pressure on A&E services this coming winter, the Government announced £100m of new capital investment in A&E departments. This will help to ensure patients access the most appropriate care as quickly as possible by improving the space for assessing patients and providing on-site primary care streaming facilities. This investment will help support the delivery of primary care streaming and improve patient flow at hospitals, by making it easier to triage non-urgent patients to be seen by GPs. The expectation is that up to 100 hospitals in England will benefit.

In addition, the Government is investing £325 million worth of new funding to support locally-led Sustainability and Transformation Plans (STPs) over the next three years. This money will back the first set of NHS STPs which make the strongest case for investment, and deliver better, more joined up services which can bring real improvements to patient care. The funding will be ring-fenced specifically for STP capital investment and subject to HMT approval.

The investment will support regions with the strongest STPs to deliver their long term vision to improve patient services. There will now be a robust process established to assess which STPs have a strong case to receive this funding.

Supporting adult social care to maintain patient flow

11 We recommend that the Government should provide additional funding to increase adult social care capacity. This could substantially relieve pressure on trusts as exit block is a key contributor to winter pressures in areas lacking sufficient adult social care provision. (Paragraph 68)

Adult social care is a key priority for this Government, and we are giving councils access to further funding to manage adult social care pressures in their local area across the next few years:

- This year councils will be able to raise the adult social care precept by up to 3%, and 3% the year after (2018/19).
- The Government also created a £240m Adult Social Care grant in 2017-18, through recycling savings made from reform to the New Homes Bonus.
- In addition, in the Spring budget in 2017, the Government announced £2 billion in extra funding for councils in England, for adult social care. Councils will use the funding for the purposes of meeting adult social care needs; reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready; and ensuring that the local social care provider market is supported.

12 The national benchmarking exercise that has been undertaken by A&E delivery boards should inform an assessment of the impact that cuts in adult social care have had on the performance of trusts. We reiterate our frustration that the Department of Health has yet to undertake this assessment and consider it is vital that it does so at the earliest opportunity, particularly given its impact on the performance of the urgent and emergency care system. (Paragraph 69)

The Department's focus was on working with NHS England and NHS Improvement to support local A&E Delivery Boards in meeting the additional demands of winter and in doing so improve their performance against the 4 hour target. A&E Delivery Boards were best placed to bring local partners together to understand and address the causes of performance issues across the local health and social care system. All systems have been supported to implement best practice models to reduce delayed transfers of care and optimise patient flow, including through Discharge to Assess models of care and Trusted Assessor arrangements.

13 We believe that adult social care is underfunded and this is having an impact on the NHS. The performance of the NHS and social care cannot be viewed in isolation. Adequate funding of social

care and appropriate development of the social care workforce are worthy objectives in their own right, but the urgency of action on those two objectives is thrown into even sharper relief in the context of their contribution to the improved performance of the urgent and emergency care system. (Paragraph 70)

We accept that funding of Adult Social Care has an effect on A&E performance that is why in the Spring Budget 2017, the Government announced £2 billion in extra funding for councils in England, for social care. . Councils will use the funding for the purposes of meeting adult social care needs; reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready; and ensuring that the local social care provider market is supported. We acknowledge that high performing and accessible social care is an essential part of ensuring good patient flow through the system and ensuring that patients who do have to be admitted to hospital are able to leave in a safe and timely way when they are ready to go. However, we also know that performance of A&E departments and the arrangements for discharging patients after they have been admitted are issues for the whole system. Social care clearly has a role to play across the piece. Whilst delays in getting people safely out of hospital can occur for a number of reasons and may be the responsibility of the NHS or social care, we are committed to ensuring that social care continues to play its part. We are also committed to delivering world class primary care, NHS111 services and alternative emergency care streaming. The funding of local services is a key priority for this Government, and we are giving councils access to further funding to manage social care pressures in their local area across the next few years:

- This year councils will be able to raise the adult social care precept by up to 3%, and 3% the year after (2018/19).
- The Government also created a £240m Adult Social Care grant in 2017-18, through recycling savings made from reform to the New Homes Bonus.
- In addition, in the Spring budget in 2017, the Government announced £2 billion in extra funding for councils in England, for adult social care

Taken together with the funding announced in the autumn 2015 Spending Review, the Government believes that local government will have access to the funding it needs to increase adult social care spending every year in this Parliament. The spending review gave councils the flexibility to introduce a 2% adult social care precept on top of the usual council tax referendum principles, and access to additional funding for adult social care worth £1.5bn by 2019/20 through the Better Care Fund, starting in April 2017.

Utilising primary care to reduce demand

14 We would like to see further evidence that the Government's proposals for extended GP hours will limit the demands placed on emergency departments. (Paragraph 79)

The Government's mandate to NHS England "to ensure everyone has easier and more convenient access to GP services, including appointments at evening and weekends and over 75s will be guaranteed a same day appointment if they need it by 2019" was intended to deliver

transformational change to primary care, so that general practice plays a greater role in the delivery of emergency care and reduces the demands placed on emergency departments.

The evidence for this is being gathered via the GP Access Fund sites, which were implemented in two waves, collectively involving 57 schemes that cover 18 million people (a third of the country) and over 2,500 practices. The GP Access Fund sites are testing a range of measures to improve access, including: appointments on evenings and weekends; better use of telecare and health apps; more innovative ways to access services by video call, email or telephone; and developing more integrated services with a single point of contact to co-ordinate patient services. Data on the impact of extended access on emergency departments in the Access Fund sites are being collected and will be published in due course.

In addition, the 2017 Spring Budget announced capital investment of £100m for front door streaming at A&E departments, in line with a number of the best performing Trusts. This will help provide space for services to allow streaming, such as on-site GP facilities, to which non-urgent patients can be directed to access more appropriate care quickly and safely. We expect a large number of trusts to benefit from this new investment.

15 In the long term enhanced and properly resourced primary care shaped around the recommendations we made in our report of April 2016 on primary care will be crucial in helping to prevent the escalation of illness to an extent where emergency admission to hospital is required. (Paragraph 80)

The General Practice Forward View, published on 21st^{h} April 2016, developed by NHE England, Health Education England and the Royal College of General Practitioners, sets out investment and commitments to strengthen general practice in the short term and support sustainable transformation of primary care for the future. It includes specific, practical and funded actions in five areas – investment, workforce, workload, infrastructure and care redesign. On investment, it sets out NHS England's ambition to invest a further £2.4 billion a year by 2020/21 into supporting general practice services. This represents a 14% real terms increase – almost double the 8% real terms increase for the rest of the NHS. It increases the proportion of investment in general practice services by 2020/21 to over 10%.

The General Practice Forward View is not just about sustaining general practice. It is also about laying the foundations for the future, so that general practice can play a pivotal role in the future as the hub of population-based health care. Working at scale, with high uptake of new technologies and using the breadth of skills and capabilities across the medical and non-medical workforce, general practice will be better geared to support prevention, to enable self-care and self-management as part of creating a healthier population and a more sustainable NHS. Closer links with urgent care and out-of-hours services will be developed to support both on a day to day basis and also during winter.

16 We agree with the Centre for Urgent and Emergency Care Research that a robust evaluation is needed of proposed models of co-located of primary care with emergency departments. Further

research is required to understand the impact on patient behaviour, emergency department attendance and patient outcomes. In particular there needs to be much greater investigation into the risk of creating supply-induced demand. Given the shortfall in GP numbers, it is unlikely to be sustainable to operate several parallel systems for out-of-hours GP access and it is important that commissioners to consider the wider impact on primary care provision for patients as well as for A&E. (Paragraph 86)

We recognise the need for local flexibility and believe it is right that trusts and commissioners should have urgent and emergency care plans appropriate to their needs. A&E streaming is a model that has been effective in Luton and Dunstable University Hospital and we believe has wider applicability in a significant number of trusts. To help manage pressure on A&E services, the government announced £100m of new capital investment in A&E departments where we think it will work. This will help to ensure patients access the most appropriate care as quickly as possible by improving the space for assessing patients and supporting the delivery of primary care streaming in A&E departments. This investment will help provide space to allow GPs to be located next to A&E departments and improve patient flow at hospitals, by making it easier to triage non-urgent patients to be seen by GPs.

17 Equally, NHS England should be aware that co-location may not be a solution which enhances access in rural areas, and some trusts may simply not have the capacity to accommodate such a service or the capital resource to create it. Models will need to adapt to local circumstances and must be robustly evaluated. (Paragraph 87)

Co-location facilitates efficient patient streaming and the development of a service likely to meet the needs of the vast majority of patients in a single location, ensuring enhanced convenience and efficiency, particularly where general practitioners are present 24/7. We agree with the Committee that local healthcare economies should take a flexible approach when considering possible co-location of primary care with accident and emergency departments. However the implementation of various types of Multi-Speciality Community Providers (MCP), Primary and Acute Care Systems (PACS) and Accountable Care Organisations (ACO) arrangements locally, as identified in the Five Year Forward View (FYFV) may also present an opportunity for rural areas to improve access whilst reducing the capital burden, for example by increasing the scope and efficiency of services across primary, community and acute in new ways to deliver services to patients in dispersed locations.

If it is not practicable to co-locate facilities in rural areas, it may be necessary to develop and enhance services, including use of telemedicine where appropriate, so that more care can be delivered locally and fewer patients will need to be transferred to other facilities. For non-co-located Urgent Care Centres in urban areas consideration should be given to the role and purpose of the Urgent Care Centre within the wider Network, to ensure a consistent and efficient service and avoid unnecessary duplication.

The 2017 Spring Budget announced capital investment of £100m for front door streaming at A&E departments. This will help provide space for services to allow streaming, such as on-site GP facilities, to which non-urgent patients can be directed to access more appropriate care quickly and safely. We expect a large number of trusts to benefit from this new investment.

The ambulance service

18 Delayed ambulance transfers are an unacceptable waste of valuable paramedic resources and disadvantage patients living in neighbouring areas who may experience longer waits if vehicles are tied up elsewhere. NHS England should urgently address the level of variation to ensure that there is a timely handover of patients. (Paragraph 94)

We agree that ambulance handover delays are undesirable. The Government is working with NHS Improvement and NHS England to reduce delays. NHS Improvement has focussed on ambulance handover delays as a key driver of quality and safety and daily data on handover delays were a key feature of monthly performance management with acute trusts.

In December 2016, NHS Improvement and NHS England adopted a new joint approach to reduce handover delays, including:

- enhanced real-time escalation of delays as they occur, with regular regional review.
- the agreement of improvement plans between acute and ambulance trusts where required, and the review of weekly handover data to confirm plans are being followed.
- direct support to acute trusts to embed best practice handover management, to help address the causes of unacceptable delays in patient handover.

Additionally, systems that are successful in stemming handover delays have deployed other changes across the system, such as:

- Increased rates of "hear and treat", where 999 calls are resolved over the phone, initially through increased clinical advice in emergency operations centres and subsequently through the introduction of clinical hubs, which will provide access to a wide range of clinical advice to help resolve calls over the phone.
- Building the clinical capability of ambulance services so that they become mobile treatment centres, enabling them to increase the number of calls resolved at the scene or without transportation to A&E (known as "see and treat"). Paramedics will be further supported by direct access to the clinical hubs and an upgraded directory of service that will provide "live" information on onward destinations of care, other than A&E, when clinically appropriate
- Agreed protocols for ambulance services to take some patients directly to their admitting ward or a minor injuries unit/urgent care facility to reduce the bottleneck in emergency departments
- Effective escalation procedures within hospitals to respond in real time to surges in demand and prioritise handover of patients from paramedics.

Process redesign is also important, and trusts should consider how to learn from other industries where evidence has shown the ability to improve the process of handover, for example, using the pit-stop approach.[1]To ensure the NHS and social care services were equipped to deal effectively with the pressures of winter 2016/17, a jointly agreed NHS England and NHS Improvement A&E Improvement Plan was developed, focussed around improvement initiatives that all systems implemented, underpinned by national work programmes led by NHS England and NHS

[1] Catchpole, KR et al, 2007, *Patient handover from surgery to intensive care: using Formula 1 pit-stop and aviation models to improve safety and quality*

Improvement. The actions within the A&E Improvement Plan were those that the strongest performing trusts have reported as being the most effective to improve performance. Trusts that already have these actions embedded are meeting the standard.

ECIP

Over the past year, The Emergency Care Improvement Programme, (ECIP) have brought together system leaders across the country through a series of workshops to consider the problem and initiate both immediate and long term actions. The workshops had endorsement from the Royal College of Emergency Medicine and Association of Ambulance Chief Executives. From the workshops, systems were encouraged to develop concordats of agreement in which the systems would work together to address the issue.

Longer term

Urgent and Emergency Care Review - NHS England is leading implementation of its urgent and emergency care review, to achieve a fundamental shift in the way urgent and emergency care services are provided, delivering more care closer to home, where that is clinically appropriate. This will help ease the pressure on ambulance services and emergency departments. Actions include:

- Developing NHS111 so that it becomes an integrated urgent care service – the "front door" to advice, assessment and treatment.
- Faster and consistent same day, every day access to primary care and community services for people with urgent care needs.
- Better use of community pharmacists.
- Continuing to develop 999 ambulances, so they become more mobile urgent treatment centres, not just transport services. This will enable treatment to commence immediately, rather than waiting for the patient to arrive at A&E. In the future, ambulance services will be better placed to provide an integrated handover of care to A&Es, with treatment having started earlier and continuing past the A&E threshold. This will improve the quality of care during handover and potentially reduce delays in the handover process.

Ambulance Response Programme (ARP)

NHS England has explored improving patient outcomes and making the most use of resources through changes to the way that the ambulance service responds to calls. Results of the ARP pilots were due for publication on 13th July 2017, and demonstrate clear clinical benefits to patients.

The ARP aims to ensure consistent and rapid responses to those who require urgent attention; deliver an improved service through ensuring clinically appropriate responses to all patients; and end long 'tail waits'. The pilots had two elements:

I. **Dispatch on Disposition (DoD)** which gives call handlers more time to assess clinically all 999 calls that are not immediately life threatening (all calls bar Red 1) before a resource is dispatched, ensuring a more appropriate response based on clinical need.

II. **Clinical coding** - using evidence-based clinical codes that better describe the patient's condition and subsequently the most appropriate response/ resource requirement.

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NHS England intends to roll out the ARP to all ambulance service in England to create greater resilience in the ambulance service for winter 2017 and beyond.

Staffing

19 We recommend that NHS Improvement consider the steps which can be taken this winter to ensure that all emergency departments, but particularly those which are currently performing poorly, are able to recruit the staff which they need to get their performance to an acceptable level. (Paragraph 108)

Through NHS Improvement's annual operational planning round, all NHS providers consider the workforce requirements for their emergency pathways and incorporate workforce supply requirements into their overarching board approved workforce plans.

NHS Improvement's nursing directorate drove up its core support offer for challenged trust emergency departments through winter 2016/17, with a menu of support including direct support to providers, participation in rapid improvement collaboratives, and the development and publication of case studies so trusts can learn from best practice.

NHS Improvement's agency controls are aimed at helping trusts to manage their workforce in a more sustainable way, reduce reliance and expenditure on agency staffing, encourage staff back onto pay-roll, raise quality and improve the working environment for their staff. With regard to winter pressures, it is important to note that agency rules include a 'break glass' provision for trusts that need to override the price caps, maximum wage rates or framework rules on exceptional patient safety grounds. NHS Improvement's Workforce Efficiency Team has provided targeted support directly to trusts on their implementation of agency rules, identifying root causes and then offering expertise to assist trusts to plan and deliver an improvement programme.

In its improvement role, NHS Improvement has supported trusts buddying together to share resources and expertise in meeting staffing challenges. It has also highlighted areas of good practice directly with trusts, for example the Emergency Medicine Middle Grades scheme at Royal Derby hospital, has achieved significant success in recruitment and retention of clinical staff through, for example offering training, support, and education tailored to the need of the individual doctor.

NHS Improvement's Emergency Care Improvement Programme (ECIP), is working to improve the performance of 27 of the most challenged health and care systems across the country. This includes providing on the ground help and support to systems under the greatest strain including through advice on meeting staffing challenges, developing improvement tools and techniques, and sharing the lessons learnt with the rest of the NHS.

20 In the longer term, we recommend that Health Education England look again at the measures needed to improve staffing levels in emergency departments, and redouble its efforts to ensure that the supply of such staff is sufficient to ensure safe and timely care. It is in everyone's best interest for the prioritisation of the improvement of staffing levels to be the culture in every hospital. (Paragraph 109)

Medical Workforce

Between 2011 and 2016 the A&E consultant workforce grew by 50% from approximately 1,050 whole time equivalents (wte) to 1,570 wte – average annual growth of around 100.

So although A&E consultant numbers are up 50% compared with workload increases of 20% on the same period, there is a need, articulated by providers, to grow the Consultant workforce further.

In 2014, 2015 and 2016 Health Education England (HEE) invested explicitly in additional Emergency Medicine (EM) trainees to boost both current and future supply. HEE funded from identified national monies

- 2014: 75 additional programmes
- 2015: a further 75 in 2015
- 2016: a further 62 in 2016

When the run through option was introduced in 2014 this was offered also to existing EM trainees at Speciality Training (ST) levels years 2 and 3 (ST2 and ST3). Many took this option and as a result the number of trainees at ST4+ has been expanding.

Levels of historic growth and the forecast Certificate of completion of Training (CCT) output from the existing pipeline for the next few years suggest that the available supply of holders of the CCT are sustainable. If the introduction of the run through option in 2014 results in increased CCT output from 2022 onwards (which early signs indicate it will), growth in the available supply of CCT holders will accelerate.

A recommendation to "support Associate Specialist and Staff Grade (SAS) Doctors in their roles to ensure retention and increase work satisfaction" was put forward in a joint report published by Health Education England and the Royal College of Emergency Medicine. HEE are supporting a national rollout of the SAS retention toolkit to support Healthcare Providers to manage recruitment and retention issues.

Non-medical Workforce

Research conducted by Health Education England West Midlands identified a possible role for the Pharmacist in areas such as pre-discharge medicines optimisation in the ED and Acute Medicine Units, as well as within Clinical Decision Teams in the undertaking of medicines-related and common ailments. Such duties are currently undertaken by junior medical staff; staff who face significant demands on their time with emergency admissions.

HEE have also led a piece of work since January 2014 stemming from the Paramedic Evidence Based Education Project (PEEP), which recommended the introduction of a single point of education entry at degree level for paramedic training. This work is being carried out in partnership with the College of Paramedics. The Case for Change was presented to the HEE Public Board in Winter 2016.

Health Education England offers a number of Advanced Clinical Practitioner (ACP) Training Fellowships. The main purpose of these fellowships is to develop the ACP role across a variety of healthcare settings to help utilise a non-medical workforce and build a culture of improved outcomes for both the patient and the clinician. The Education Outcomes Framework (EOF) and Health Education England's (HEE) approach to quality will directly link education and learning to

improvements in patients' outcomes and will help address variation in standards and ensure excellence in innovation through high quality education and training.

The Emergency Care ACP Curriculum was co-produced by HEE and Royal College of Emergency Medicine and is endorsed by Royal College of Nursing. The curriculum was launched in August 2015 following a consultation period. The Curriculum provides an opportunity to set out specialty specific competences, standardise the range and level of competences acquired and achieve consistency across geographical boundaries.

HEE have commissioned a National Emergency department stocktake in collaboration with the Royal College of Emergency Medicine and endorsed by the Royal College of Nursing to develop a robust understanding of the baseline workforce numbers within the Emergency Department.

Funding

21 Rather than introducing a ring-fence on the winter resilience funding that is incorporated into the baseline allocation for CCGs, we recommend that NHS Improvement and NHS England take steps to ensure that there is transparency about the amount of funding which trusts and clinical commissioning groups direct to preparing for winter pressures. Thorough evaluation of the approaches to dealing with winter pressure will require transparency about how they are funded. (Paragraph 117)

Allocations were included in CCG baselines at the request of the system with the objective of facilitating the local deployment of funding as determined by local commissioners and providers. This aimed to move trusts away from last minute spending and to allow trusts to plan more strategically year-round for changes in demand. The current approach therefore allows greater time for trusts to recruit and train staff earlier, rather than rapidly during the winter months for example, by which time it may be too late. NHS England closely monitor operational and clinical performance and data collection over winter will indicate whether the winter resilience funding is being used effectively by CCGs and trusts.

22 Payment mechanisms should reflect the cost of providing care at each stage of the patient journey and incentivise ambulance and hospital trusts as well as community services to work together in the interests of patients. This means developing payment mechanisms which will suppress demand by encouraging prevention, facilitating early intervention, limiting the escalation of morbidity and helping to ensure that patients are seen by the most appropriate professional at the right time and in the right place. Tariff reform is long overdue and in responding to this report the Government should set out a clear timetable for it to be achieved. (Paragraph 121)

As part of the development of the New Care Models, NHS England and other ALBs are developing a new 'whole population budget', creating a single budget for the full range of services within the contract scope. This will help to ensure that the payment and contracting mechanisms facilitate transformational, system-wide change, and will align incentives in the health system to allow for a more flexible allocation of resources, directing funds to where they will have the greatest impact on population health care

Through Sustainability and Transformation partnerships, NHS commissioners and providers will work together with patients and the public, as well as local authorities and other providers of health and care services, to become Accountable Care Systems to support the full integration of these services. Accountable Care Systems will gain new powers and freedoms to plan how best to provide care, while taking on new responsibilities for improving the health and wellbeing of the population they cover.

Management of the system

23 We are concerned about the level of variation in performance between trusts in managing urgent and emergency care. We recognise the pressures hospitals face but there is much that trusts can do to improve flows within their own systems and to learn from the best performing trusts. We support the steps taken by NHS England and NHS Improvement to try to tackle variation. We encourage them to roll out this process as quickly as possible so that other trusts facing similar challenges can overcome their problems. (Paragraph 128)

Implementation of the five national initiatives of the A&E Improvement Plan sought to reduce the level of variation between trusts by embedding best practice to tackle inappropriate attendances, improve patient flow and facilitate faster discharge from hospital. The building blocks for the A&E Improvement Plan were the common actions that senior clinicians from the strongest performing trusts reported as being the most effective interventions to improve performance.

24 Performance management of trusts should not become more intense just because hospitals are operating under pressure. We recommend that the Department of Health should formally evaluate how the central management system which oversees performance against the four-hour target contributes to the maintenance of patient safety and the improvement of performance within trusts. (Paragraph 129)

Patient safety remains our top priority which is why we are absolutely determined to ensure the NHS is focused on delivering for patients and that national organisations support them effectively to do this. The A&E Improvement Plan was central to improving performance and maintaining patient safety. It took a different approach to performance management by segmenting systems into cohorts based on organisational scale and performance, applying best practice solutions bespoke to each set of identified local issues. This targeted approach aimed to ensure all patients have access to safe and effective care without unnecessary delay.

Performance management through the A&E Improvement Plan has also been beneficial to trusts in helping to identify some of the cross-system and cross cutting root causes of poor performance, such as the underuse of streaming at the front door, and opportunities to improve patient flow through the hospital by having more regular and earlier senior clinical review for discharge. It is therefore the information generated through this performance management process that is helping to highlight and share best practice which should benefit patient safety and improve clinical outcomes.

The Department will be working with both NHS England and NHS Improvement to lead and deliver UEC reform. We will assure progress through regular meetings providing challenge and supporting

the NHS to fully and swiftly implement agreed actions, escalating particular local situations as necessary. Strong national and local leadership is key and local leaders will need to be supported with NHS England and NHS Improvement working through regional and local A&E Delivery Boards to drive implementation.

Demand driven by alcohol consumption

25 Problem drinking is a significant contributor to the pressures in Accident and Emergency departments particularly at weekends and over holiday periods. The Government should take greater responsibility for policy decisions that would help to reduce the impact of excessive alcohol consumption on individuals, families and communities. Local authorities could be well placed to take action and we call on the Government to give them the levers to be able to do so by making public health and the impact on NHS services a material consideration in licensing and planning decisions. (Paragraph 137)

Alcohol-related attendances can be a significant burden on A&E departments, especially at weekends. A small number of people can have a disproportionate number of attendances. Local government has the responsibility to improve the health of their populations, including tackling problem drinking and commissioning alcohol treatment services. Despite an overall decrease in spending on public health, Local Authorities spending on alcohol services has increased. In 2014/15, LA public health expenditure on alcohol treatment services for adults was £201 million; this has increased to approximately £230 million in 2015/16. The Government is investing over £16bn in local public health services over the next five years.

The National Planning Policy Framework encourages local planning authorities to engage with relevant organisations when carrying out their planning function. This is outlined in planning guidance and includes Directors of Public Health, the Health and Wellbeing Board, the local Clinical Commissioning Groups, NHS England and the local community. Engagement with these organisations helps ensure that local strategies to improve health and wellbeing and the provision of the required health infrastructure are supported and taken into account in local and neighbourhood plan making and when determining planning applications.

Four-hour waiting time standard

26 We support retaining the four-hour waiting time standard in emergency departments. We recommend, however, that evidence-based standards of performance should be developed which allow for a better assessment of the performance of the wider health and social care system in relation to urgent and emergency care. (Paragraph 143)

This Government is absolutely committed to the 4 hour A&E standard. As set out in Jim Mackey's letter to NHS provider trusts of 19 December, the 95% standard is part of the NHS Constitution and will continue to be the headline indicator of the health system. We need to ensure that this accurately reflects what is actually happening on the ground, and in a consistent fashion.

We also want to ensure staff can stay focussed on quality of care and safety. With this in mind, NHS Improvement is looking to include a new, combined metric that aggregates waiting times, clinical standards, staff and patient experience into its oversight framework, to inform and drive its improvement and support offer.

NHS England has developed a set of new system-wide outcome measures to allow Urgent and Emergency networks to assess their effectiveness; we are currently running the second phase of a trial to test and improve these measures. As part of this, we will explore the linkages with other groups of measures that report the performance of A&E and the wider urgent care system. The system-wide outcome measures are intended to:

- Measure the performance of UEC systems over time, and highlight where levels achieved vary significantly from accepted levels;
- Make individual UEC networks / STP foot prints aware of potential issues about effectiveness in order to inform long term strategic planning and drive improvement;
- Foster development of UEC networks and network behaviour, particularly the smooth flow of patients and patient information across the urgent and emergency care service that an individual and their family receive.

Ambulance service targets

27 Reform of the existing target regime for ambulance providers in combination with tackling handover delays should be prioritised by NHS England. This would help to remove the practical barriers that limit the ability of ambulance providers to 'see and treat' patients without having to convey them to hospital. (Paragraph 148)

NHS England has been reviewing, evaluating and trialling a series of interventions to support changes in the existing target regime for ambulance services. This programme of work, the Ambulance Response Programme, was developed collaboratively with all the ambulance services in England, the Association of Ambulance Chief Executives, College of Paramedics and the National Ambulance Commissioners Network as well as an academic partner. The report's findings and subsequent recommendations from Sir Bruce Keogh (NHS England National Medical Director) were due for publication in July 2017.

The recommendations from the ARP include a set of ambulance metrics based on the clinical needs of patients whilst being operationally sensible. This piece of work, along with the enhanced skills expected of Band 6 paramedics, will help deliver care closer to home as more patients are treated through See and Treat and Hear and Treat interventions thus avoiding unnecessary conveyance to hospital.

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