



Department
of Health

Government Response to
the House of Commons
Health Select Committee Report
into Urgent and Emergency
Services (Second Report of
Session 2013 – 14)



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the House of Commons
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into Urgent and Emergency
Services (Second Report of
Session 2013 – 14)

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

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Introduction

1. The Government welcomes the Health Select Committee's considered investigation into the NHS urgent and emergency care system. We agree with many of the Committee's recommendations and welcome the opportunity the report allows for us to explore and discuss the issues highlighted by the Committee in greater depth.
2. We believe the NHS is world class when it comes to the quality and ease of access to urgent and emergency care. However, as the Committee has identified, the system faces increasing pressure. This is part due to ever growing demand, and also due to growing complexity of the patients presenting at A&E departments.
3. To assist the NHS in coping with growing demand and winter pressures, we have provided an additional £500million over the next two years. NHS 111 will receive a £15million cash injection to increase capacity and allow the service to be prepared for any winter pressures.
4. In the longer-term, NHS England's Urgent and Emergency Care Review will help shape the future of urgent and emergency care services by developing a national framework to build a safe, more efficient system, 24 hours a day, 7 days a week. Associated guidance for clinical commissioning groups (CCGs) in 2015/16 will help them to commission consistent, high quality urgent and emergency care services across the country within the resources available. The review will ensure that long term changes are delivered to sustain urgent and emergency care in the NHS.
5. Alongside NHS England's review, the Department of Health will be publishing a plan for vulnerable older people, which will aim to set out some immediate priorities for urgent and emergency care for older people, so that rapid progress can be made from 2014/15.

Government response to the Committee's conclusions and recommendations

A&E PRESSURES

Growing demand

The Committee was surprised by the lack of clear evidence about trends in the level and nature of demand for urgent and emergency care. There is a pressing need for clearer information to be produced which can detail where urgent care cases present across the system and the case mix of urgent patient presentations; it is also important to monitor waiting times for urgent and emergency services in order to ensure that services are accessible to patients in urgent need of care. The Committee recommends that NHS England should ensure this data is collected and reported on a consistent basis across the country. (Paragraph 24)

Root cause analysis

The emergency and urgent care functions of the NHS are undoubtedly working under stress and there is insufficient resilience in the system. Availability of a hospital bed when required is a fundamental part of an emergency care system. Successful delivery of this basic requirement is, however, dependent on the ability of the system to understand the demands made upon it and to deploy its resources in the most effective way. Rising demand for hospital admissions may be as much a symptom of system failure (for example, failure to provide timely care in a patient's home) as it is of

an underlying rise of demand. Until these systems failures are addressed, hospital managements need to ensure that there is sufficient bed capacity available to meet current demand. (Paragraph 29)

The system cannot accurately analyse the cause of the problem, still less resolve it, if it continues to "fly blind". More accurate information about the causes of rising service pressures is not simply a management convenience; it is fundamental to the delivery of high quality care. (Paragraph 30)

6. The Government acknowledges the vital importance of gathering accurate information for analysis to establish the cause of current pressures on the urgent and emergency care system. As part of the NHS England's Urgent and Emergency Care Review, it has published an evidence base which details the pressures that the urgent and emergency care system is experiencing, as well as an assessment of some of the potential causes.¹ The evidence base has been used to generate emerging principles for change, some design objectives and possible options for how these might be implemented. These emerging principles and options are being tested and refined in a consultation engagement exercise that took place over the summer period with patients and all professionals in the NHS and across social care.

¹ *The Evidence Base from the Urgent and Emergency Care Review – NHS England* (June 2013) (www.england.nhs.uk/wp-content/uploads/2013/06/urg-emerg-care-ev-bse.pdf)

7. With regard to future data collection, NHS England is consulting on expansions to the hospital data currently collected nationally. Once implemented, these changes will significantly increase the range and breadth of data collected. NHS England is running a programme, Care.data, which is intended to increase the flow of data from other health and social care settings too, not just secondary care. Data provision and quality will be monitored to ensure consistency at a national level.

8. Finally, we agree with the Committee's recommendations concerning resource management. Local clinical commissioning groups and acute trusts must work together to ensure appropriate local bed allocation and demand management. Urgent Care Boards, as a network comprising representatives of the entire urgent care system, along with commissioners and providers, can make an important contribution, providing a platform for local discussion about the response to pressures in the urgent care system.

THE GOVERNMENT RESPONSE

Fragmentation

The successful provision of emergency and urgent care is a matter of life and death and therefore clarity in commissioning is vital. The Committee is concerned that the lines of responsibility and accountability for funding and managing services have been blurred. The Committee notes the concept of UCBs putting local clinicians and commissioners together to make practical changes and plan service improvement, but it is concerning that new structures are required so soon after the establishment of CCGs and Health and Wellbeing Boards. Health and Wellbeing Boards have made an uncertain start

but retain broad support and they are structured to bring all parts of the system together. The current problems should, theoretically, have provided them with an opportunity to develop their functions, but they appear to have been superseded by UCBs. (Paragraph 36)

9. We welcome the scrutiny that the Committee has brought to the local arrangements for addressing pressures on the urgent and emergency care system. Urgent Care Boards are in place across the country and are maturing. There is a clear distinction in membership, remit and structure between Urgent Care Boards and Health and Wellbeing Boards. Urgent Care Boards are local networks established through consensus, with locally agreed terms of reference. This follows good practice recommended by the Kings Fund and Emergency Care Intensive Support Team (NHS Improving Quality).

10. The responsibility for commissioning urgent and emergency care rests with CCGs. They commission all acute services, community based services as well as out of hours services. NHS England commissions primary medical services and GPs often provide urgent care in hours. Funding for social care rests with local authorities.

11. Health and Wellbeing Boards have statutory duties defined by Parliament and provide a forum where all commissioners can come together to jointly plan services to meet the health needs of local populations.

12. Urgent Care Boards (UCBs) are non-statutory organisations, intended as forums for stakeholders to come together and identify local solutions to urgent care issues. They support joined up and co-ordinated working and can only build a consensus of members who bring their own delegated authority. They cannot commit to funding or direct changes to services. Only organisations

with statutory responsibility can commit to spend, unless under delegated authority. Urgent Care Boards cannot replace or alter statutory organisational roles, responsibilities, powers or duties. NHS England recognises the importance of clarifying this and that the use of the term 'Board' may have led to misunderstanding of the role. As such, NHS England intends to issue further guidance and change the name of Urgent Care Boards to help provide clarification of their role.

13. Membership of UCBs is made up of: CCGs, acute trusts, ambulance trusts, community service providers, mental health trusts, social care, and primary care and out of hours providers (alongside other key stakeholders as agreed locally). Urgent Care Boards work across boundaries to improve patient experience and clinical outcomes making sure practical actions produce system wide improvements in urgent care.

Simplifying commissioning

We recommend that CCGs and Health and Wellbeing Boards explore the benefits of establishing single commissioning teams for out of hours care, ambulance services, 999, and NHS 111. A single commissioner can lead across CCG boundaries in the case of services which are most appropriately commissioned on a regional or subregional basis. Fragmented commissioning and provision results in a situation where patients are unaware of many available services or are unsure of the most appropriate service. The single commissioning teams for urgent care should take responsibility for signposting patients to available services. (Paragraph 39)

14. CCGs are responsible for commissioning all urgent and emergency care services in their local area. They retain accountability for the commissioning of services that meet the needs of their

population. Last year, NHS England published a framework for collaborative commissioning between CCGs. It can be used where two or more CCGs commission a single service and work together to ensure consistency in quality for their patients.

15. In some cases, a large number of CCGs might commission a single service that is organised across a large geographical area (such as ambulance services) and in other cases, a group of CCGs who are geographical neighbours may wish to work together on a contract with a single provider to which the majority of their patients flow.

16. To assist CCGs in developing robust agreements when working together with other CCGs, NHS England has published a model agreement that can be used and adapted as necessary. Further work is underway jointly with the Local Government Association (LGA) to support development of collaborative arrangements with local authorities and health and wellbeing boards. Discussions are also underway about the potential for legislative amendments which would enable CCGs to be members and bound by decisions of joint committees.

Funding

The Committee was disappointed with the evidence that was presented about the creation of UCBs. Ministers are relying on UCBs to implement short-term practical changes to improve hospital performance, but the composition, responsibilities and authority of UCBs remain unclear. There is little evidence that any form of national strategy exists beyond the creation of UCBs, and senior figures in NHS England could not tell us precisely how many UCBs have been established. (Paragraph 54)

The evidence presented to the Committee did not persuade us that the structures

existed to enable UCBs to implement reforms or influence local commissioning arrangements. The Committee believes that Ministers need to seek much greater clarity from NHS England about its plans for UCBs and ensure that they, or Health and Wellbeing Boards, are required to account for an Urgent Care Plan for their area in the winter and spring of 2013–14. The Committee recommends that NHS England should ensure that these Urgent Care Plans are prepared and agreed before 30 September 2013. (Paragraph 55)

It is concerning that UCBs appear to have been created without any senior figure in NHS England being clear whether they are intended to become permanent features in local health systems. We agree with several witnesses that UCBs meet an urgent need to introduce “system management into the system” If that is to be their role, we do not believe it should be regarded as either voluntary or short-term. (Paragraph 56)

17. There is no single operating model for Urgent Care Boards as their remit and structure is locally determined. This is to allow for greater effectiveness in their work across boundaries to improve patient experience and clinical outcomes in urgent care.

18. Urgent Care Boards play a key role in bringing together all the local organisations who sign off the local implementation of A&E system recovery and improvement plans. The key objective of the system recovery and improvement plans is to improve and build resilience in the delivery of the A&E standard all year round, including winter. The current plans are expected to be developed into fully assured final plans covering the winter by the end of September 2013, well ahead of the start of the winter period.

19. Urgent Care Boards are well placed to consider the following:

- The review and response to the full range of appropriate data concerning the local urgent care system, along with the communication and escalation of issues
- Ensuring the adoption of best practice
- The review of the effectiveness of primary care services, including out of hours and admission avoidance schemes
- The review of the effectiveness of ambulance services and also community services, including any walk in centres, minor injury units and how they integrate with secondary care
- Whether there are local plans in place to support the care of the key categories of patient who attend or are admitted frequently

20. NHS England considers that there will always be a place for local stakeholders to come together and discuss how they can best provide an urgent care system.

RESTRUCTURING

Specialist centres of care

The Committee accepts that a strong case has been made for the centralisation of some aspects of acute emergency care in regional specialist emergency units on the basis that substantial clinical benefits are delivered by focusing skills and resources in single locations. We are, however, concerned that this evidence is not abused; each proposal for service redesign should be reviewed on the basis of the evidence so that centralisation is justified only when the evidence supports it, not as an end in itself. For example, in rural areas the benefits of centralising care for some serious conditions could be negated by increased transport times. (Paragraph 62)

21. As the Committee recognises, there is compelling evidence which suggests that the concentration of skills and resources in regional centres can deliver both better outcomes for patients and more efficient delivery of services. We agree that centralisation of care can work effectively and improve outcomes for patients in some circumstances; however, we are also mindful that a 'one size fits all' approach is not suitable. Consequently, the second phase of NHS England's Urgent and Emergency Care Review will seek to develop a menu of clinical delivery model options to help build local solutions to match local needs.

22. A menu approach is required to support the building of sustainable local solutions that are appropriate for:

- Patient need (demography, age, inequalities and disease prevalence);
- Setting (rural/urban); and,
- Local and regional networks (e.g. so that sharing and use of facilities of nearby providers can be maximised).

23. However, the Committee is also correct to recognise that decisions to redesign services can only be successful if the local public understand the case for change and the evidence which surrounds it. The Government agrees that service design and reconfiguration proposals must be evidence-based, so that proposals demonstrate how changes will improve quality and outcomes for patients, and represent value to the taxpayer. We expect proposals to be clinically-led and be underpinned by a clear clinical evidence base and informed by patient insight and robust engagement. Where the evidence supporting different options for change is finely balanced, it is important that commissioners, providers and local authorities take into account the full

benefits and costs, including how to secure quality, sustainability and access.

A&E PERFORMANCE

The four hour standard

In a well-functioning health system the four hour waiting time standard would be met as a matter of course rather than as an objective of policy. The four hour standard retains its value as a basic measure of performance but it does not provide a full measure of service quality. It is prone to gaming and the key indicators of hospital performance should be based on a broader assessment of patient outcome and experience. Waiting times are certainly part of this, but not the whole of it. (Paragraph 67)

24. The Government agrees with the Committee's recommendation. The four hour standard is an important method of ensuring that patients receive care within the timeframe defined in the NHS Constitution. However, it does not record the full experience of the quality of care in A&E. It is for this reason that the Government introduced the suite of A&E Clinical Quality Indicators in April 2011. These indicators, when considered as a whole with the 4 hour standard, amount to a more rounded and multifaceted method of measuring performance that balance timeliness of care with other indicators of quality, including patient experience. They are designed to promote quality improvement through the collaborative working of commissioners, providers and other urgent care partners across the system so that improvement actions are not isolated to only one part of the system. This suite of indicators recognises that whilst timeliness of care is important, it is not the only measure of care quality.

Assessment of patients

Acute trusts must learn from best practice in the NHS. Patient flow studies by the Health Foundation have found that pressure on emergency departments can be relieved by restructuring the assessment of patients and changing working patterns. The management and boards of Acute Trusts should take responsibility for examining their own procedures and identifying whether they are in line with established best practice. In evidence Professor Willett told us that UCBs could help to examine best practice models. We agree that UCBs are well placed to undertake this role; successfully disseminating best practice across emergency and urgent care would help to establish the value of UCBs. (Paragraph 77)

25. Acute NHS trusts are key players in urgent care boards and in contributing to the development of plans to support the delivery of high quality emergency care services. Key to this is ensuring evidenced best practice delivery models are central to the development of patient flows through emergency care services.

26. We agree that best practice does need to be spread across the NHS, and by delivering against the mandate and outcomes framework. NHS England has a role to play, with its delivery partners, in the spread and adoption of best practice. Part of the work of NHS England's Urgent and Emergency Care review will be to determine the appropriate role for its innovation arm, NHS Improving Quality (NHS IQ) in terms of the spread and adoption of best practice in this area.

Accessing early senior review of cases can reduce duplication and accelerate the path of a patient through the system. Senior clinicians are better able to balance risk and make key decisions. We therefore recommend that trusts

assess the viability of implementing a rapid assessment and treatment (RAT) model. Additionally we recommend that Acute Trusts operating emergency departments explore the value of effective acute medical units (AMUs) which are designed to incorporate rapid access to senior specialist assessment and the swift development of care plans including a plan for discharge. (Paragraph 78)

27. The Government recognises the potential benefits to be realised through early senior clinical input. Further, as the Committee has seen through the evidence it has gathered, there are current examples across England of innovative senior-led delivery of care in Ambulance Services, Medical Assessment Units, Acute Medical Units, and Rapid Assessment and Treatment Arrangements.

28. Rapid Assessment and Treatment Arrangements and Acute Medical Units are recognised good practice which many trusts already employ, but in encouraging any particular type of model, it will be important not to constrain innovation which comes when trusts / lead clinicians introduce creative solutions to both manage patient flow and the deployment of a multi professional team.

29. A key outcome of the Urgent and Emergency Care Review will be to consider whether, and in what way, NHS England can support the adoption of ways of working and models of this type where this is appropriate. Again, however, it is important that models of this type are tailored according to patient need, setting, and local and regional networks if they are to be truly effective and gain traction.

Staffing

The Committee does not believe that attracting and retaining trainees is simply a question of improved remuneration.

Trainees will only join a specialty if they are convinced that it offers the prospect of a career that is both professionally and personally rewarding. It is important that Health Education England and Local Education and Training Boards address these issues in order to make emergency medicine an attractive career option.
(Paragraph 87)

30. The Government agrees with the Committee. Emergency medicine can be a rewarding career option for medical trainees but it is important that more is done to address the challenges of the profession and that trainees are given greater flexibility to enter the specialty.

31. In tackling recruitment in A&E, the Department and members of the College of Emergency Medicine (CEM) established the Emergency Medicine Taskforce in September 2011. This group published an initial report in 2012 that made a number of recommendations on the future clinician staffing of emergency departments.

32. Health Education England (HEE) has established the Emergency Medicine Workforce Implementation Group to take forward the recommendations in the report. The Group's work includes:

- Re-arranging the components of the Acute Care Common Stem (ACCS) Emergency Medicine Training Programme with the aim of improving early exposure of the emergency medicine component and to improve pass rates of the College membership exam.
- alternative training routes, providing more flexibility in the delivery of emergency medicine through developing a parallel run through training programme to be piloted across a number of Local Education and Training Boards (LETBs) for 2014 recruitment; and

- a pilot introducing flexibility for those with relevant competence or experience from other specialities to transfer into emergency medicine.

33. HEE is also looking to encourage a multi-professional workforce. Mid-level non-doctor clinicians, such as Advanced Clinical Practitioners (ACPs), Physician Associates (PAs) and paramedics are to form an increasingly important part of the future Emergency Department team. The Emergency Medicine Workforce Implementation Group has established working groups to look at the development of these roles and how LETBs may pilot and roll out the use of such roles within the Emergency Department.

Delayed discharge

The national data available on delayed discharges contradicts the evidence of clinicians and managers across the acute sector. The Committee believes that the data is incredible and we recommend that Ministers swiftly investigate the method of data collection in order to understand whether the available figures genuinely reflect the situation on the ground.
(Paragraph 94)

34. We welcome the Committee's attention on this matter. However, this is an area where statistics alone do not provide the full picture in terms of the effort and resources committed by hospitals in discharging their patients.

35. Delayed transfers of care data have been collected monthly from NHS providers since August 2010. This data is collected to national definitions that were developed and agreed with the NHS. The delayed transfers of care data undergoes central data assurance checks each month before being published as Official Statistics. Both

the Department of Health and NHS England are confident of the credibility of these Official Statistics.

36. These Official Statistics show that over recent years delayed transfers of care have remained at similar levels. During 2012-13 there were a total of 1,383,537 delayed days, which is 0.7% higher than 2011-12, and in quarter one of 2013-14 there were 346,313 delayed days, which is 2.4% higher than quarter one of 2012-13. Although the total level of delayed days has remained broadly similar, the underlying pattern of responsibility has changed. NHS responsibility has increased from 61% of delays in June 2011 to 68% in June 2013, while Social Care responsibility has decreased from 32% to 26% of delays over the same period.

More important than national data collection is the delivery of accurate information to local system managers. The Committee received strong evidence to suggest that delayed discharges were a significant threat to patient flow, and therefore to care quality. We recommend that NHS England should require each area's Urgent Care Plan to include an assessment of the impact of delayed discharges on patient flows and a plan to address the issue. (Paragraph 95)

37. We agree with the Committee that delayed discharge presents a challenge to patient flow. The delivery of accurate information to commissioners and providers is essentially for local management between CCGs as commissioners and providers under the NHS Standard contract. The local A&E system recovery and improvement plans now agreed by urgent care boards include actions that reflect all parts of the urgent and emergency care system to ensure:

- recovery of performance on standards where necessary

- sustained performance; and
- early and effective winter planning to assure continued resilience in this period.

38. These plans are intended to address all aspects of the urgent care pathway including care prior to A&E, patient flow within the hospital, discharge and out of hospital care. Urgent Care Boards are well placed to review and respond to this data.

Tariffs

The current arrangements for remunerating A&E departments with only 30% of the tariff for activity over 2008–09 levels is no longer viable. The baseline is five years old and does not account for, or reflect, the pressures that hospitals face. As part of its review of the marginal tariff, Monitor should seek options which minimise the twin dangers of perverse incentives and excessive complexity. Incentivising all providers to direct patients to the correct treatment option, however they come into contact with the NHS, should be the over-riding priority.

(Paragraph 99)

39. As part of their development of the 2014/15 National Tariff, Monitor and NHS England have conducted a joint review of the marginal tariff rule for emergency admissions, which was introduced in April 2010.

40. Since 2010/11, when the marginal rate was introduced and the 4-hour target was changed to 95%, the annual growth in emergency admissions has fallen from 4.4% to 1.0%. There is evidence that the marginal rate policy has had some positive effects, including incentivising the avoidance of emergency admissions, providing a mechanism to fund demand management schemes, and stimulating joint demand management planning in the local health economy. The absence of incentives for managing emergency care demand

could increase pressures on emergency departments and their funding in the long-term.

41. However, the review has found significant local variation, both in changes in emergency admissions and in the application of the marginal rate policy. As a result, there may be a number of health economies where the impact of the policy has not improved emergency demand management and may have an adverse financial impact on the finances of local urgent and emergency care services. The circumstances of each of these local health economies are unique, for example due to local differences in population growth.

42. Monitor and NHS England are considering all of the evidence and submissions in developing the policy approach for 2014/15. This will be set out in the National Tariff Document due to be published in the autumn.

43. Given the emerging consensus that management of demand for emergency and urgent care requires a whole system response, Monitor and NHS England will be aiming to develop new payment approaches for 2015/16 and beyond that, to support the findings of Sir Bruce Keogh's review into emergency and urgent care and ensure that quality care is sustainably delivered to patients.

ALTERNATIVES TO A&E

Primary care

The Committee strongly believes that primary care has an important role to play in delivering accessible, high quality urgent care. However the service structure required to deliver this objective is different from the structure required to deliver 'care to

patients with complex needs and deal with uncertainty in acute conditions'. The Committee does not favour a single blueprint from the Department or NHS England. The Committee recommends that NHS England (as the commissioner of GP services) should seek innovative proposals for the development of community based urgent care services in each area. These proposals should include consideration of step-up and step-down care and they should be properly integrated into the rest of the urgent care system in that area. NHS England should be open minded about how such a service should be provided.
(Paragraph 108)

44. The Government recognises the importance of primary care in delivering accessible, high quality urgent care. For instance, NHS England's Evidence Base for the Urgent and Emergency Care Review suggests that patients who are satisfied with access to their GP are less likely to attend A&E. Consequently, the Review's System Design Objectives recognise the importance of primary care within the urgent and emergency care pathway. These are fundamental considerations which will inform the design of clinical models that will flow from the Review.

45. The proposals for the vulnerable older people's plan suggest a stronger role for primary care, and particularly general practice, at the heart of integrated out of hospital services.

46. The Government's ambition for primary care is for services that provide stronger public health and prevention for the whole population, improved access and support for self-management, and proactive case management for the most frail and elderly vulnerable people. This ambition will require a shift in the way that services are provided.

47. NHS England wants to explore how best to stimulate innovation and quality improvement in out-of-hospital services and in GP services to improve outcomes, reduce inequalities and make the most productive use of NHS resources. This is likely to mean a strong focus on:

- more integrated services;
- a more proactive approach to supporting frail older people and those with long term conditions; and
- improving access to services.

48. NHS England wants to explore a range of ways in which it can support and stimulate improvement in services, including supporting clinically-led innovation (for example, through integration pioneers), using data and information to support improvement and give patients more choice and control, increasing the use of telehealth to help patients manage their own conditions (for example through the *3millionlives* programme), freeing up clinical time to focus on high-impact activities, improving incentives so that they focus on the key outcomes we want for patients.

Urgent Care Centres

The Committee welcomes the development of Urgent Care Centres on hospital sites and accepts the evidence that these units can improve the quality and efficiency of emergency care. We recommend that UCBs should actively consider the development of such centres on acute hospital sites where there do not currently exist, although we accept Professor Willett's warning that they can be a variety of reasons why the model does not fit every circumstance.
(Paragraph 114)

49. The Government recognises that the development of Urgent Care Centres on hospital sites is a potential model which

could be beneficial. However, it is important to be mindful that there will not be a 'one size fits all' solution which will work across the country, and so models of this type need to be capable of being tailored according to patient need, setting, and local and regional networks. The Urgent Care Board provides a platform for key stakeholders to meet and suggest innovative solutions which local commissioners can then consider taking forward.

The Committee also accepts that the warning of the College of Emergency Medicine that patients will continue to find the organisation of urgent care baffling if similar phrases mean different things in different places. Extensive application of the principles of Urgent Care Centres needs to be backed up by clear objectives, clearly communicated.
(Paragraph 115)

50. The Government accepts that the public and patients can potentially be confused by the differing terminology used to describe different urgent and emergency care services. One of the Emerging Principles of NHS England's Urgent and Emergency Care Review is that future organisation of the urgent and emergency care system must be simple and able to guide good choices by patients and clinicians. This is supported by one of the Review's System Design Objectives which suggests that organisation of the system must make it simpler for patients and their families / carers to access urgent and emergency care services and advice.

NHS 111

The decision to roll out NHS 111 was made before any evidence had been gathered to assess the strength of the service it could deliver. The service was shaped on patchy evidence despite the results from a small number of pilots

questioning the ability of the service to divert demand away from urgent and emergency care services. The Committee concludes that the national deployment for NHS 111 was undertaken prematurely and without a sufficiently sound evidence base. (Paragraph 122)

51. The Government acknowledges that there are lessons to be learnt from the rollout of NHS 111 for future national projects.

52. A full Impact Assessment was prepared by Department of Health Analysts using evidence from the Evaluation Report from the University of Sheffield of the initial four NHS 111 pilots. It outlined the economic case for NHS 111, assumptions of system impact of introducing the service, and the benefits to patients.

53. There were concerns raised about the speed of the rollout of NHS 111 which we addressed by offering a 6 month delay of the roll-out until October 2013, which would allow providers to spread out the final phase of launches and avoid launching services immediately prior to Easter. However, this option was only taken up by two areas.

54. There is widespread consensus that NHS 111 in principle is a good idea. It is disappointing that there have been problems with implementation, but these can and will be overcome.

Assessment

The Committee is concerned that NHS 111 did not apply the principle of seeking early engagement by a senior clinician, with the result that many calls took longer than necessary and some patients were advised to attend A&E but did not, in the event, need to be there. We recommend that, as part of its work stream examining the future strategic direction of NHS 111, NHS England attributes a higher

priority to the principle of early clinical assessment. (Paragraph 125)

55. As part of its on-going review into NHS 111, NHS England will run a Clinical Quality and Safety Work stream on NHS 111, led by Dr Mike Durkin. One of the key outputs of this work will be to review the procedures within NHS 111 and referrals to other services to ensure appropriate levels of clinical input are in place.

56. All NHS 111 providers use the NHS Pathways clinical algorithms, which are approved for use in emergency and urgent care settings, both on the phone and face-to-face. This product has been designed by senior clinicians and is governed by a Clinical Governance Group comprising members of Royal Colleges amongst others. The licence to use NHS Pathways mandates that there must be clinical staff working in the call centres at all times, to advise and take calls where necessary.

57. In addition, as part of its review of urgent and emergency care, NHS England will consider how to ensure early senior clinical input into the urgent and emergency care pathway, including in telephone triage where hospital transfer is recommended or for complex enquiries.

58. NHS England is also working to introduce processes to ensure patients with Special Patient Notes can be automatically identified, and routed to a clinician at the earliest opportunity. This will also allow the service to view specific care plans for patients.

The Committee accepts that a recognisable telephone led non-emergency service is useful but it is not yet convinced that the balance between "triage" and early access to a senior clinician is right. The Committee recommends that this balance should be

actively reviewed by NHS England as part of the on-going development of NHS 111. (Paragraph 127)

59. The Government acknowledges that there has been considerable concern about the length of the triage process within NHS 111. It is clear some of this concern has been generated by significantly increased call lengths during the early period of NHS 111 operating, and this has now reduced.

60. The NHS 111 Clinical Quality and Safety Work stream, and review of urgent and emergency care services in England, will both be reviewing the level of clinical input into NHS 111 calls to ensure that this is at the optimum point in any call.

AMBULANCE SERVICES

Ambulance services

Ambulance services must demonstrate a commitment to establishing a ratio of paramedics to technicians which ensures that ambulance crews are able to regard conveyance to an emergency department as only one of a range of clinical options open to them. We recommend that NHS England undertakes research to establish the precise relationship between more highly-skilled ambulance crews and reduced conveyance rates. (Paragraph 139)

Developing the functions of ambulance services

There is still a considerable variation in conveyance rates across ambulance trusts. NHS England should take the lead in reviewing the various staffing models used by different trusts to help understand which structures are most effective in reducing conveyance rates and putting patients on the correct pathway. This should establish an

evidence base for both urban and rural settings to help ambulance trusts determine how they organise their resources and workforce. (Paragraph 147)

61. The Government is supportive of ensuring that conveyance to an emergency department is only one of a range of clinical options available to ambulance services. Significant work has been undertaken by ambulance services over recent years to reduce emergency department conveyances – with encouraging results.

62. As part of the second phase of the Urgent and Emergency Care Review, NHS England will develop a menu of clinical model options that commissioners can choose from in order to help build local solutions to meet local needs. As part of this work, NHS England will give consideration to an enhanced role for the ambulance service, including the potential impact of more highly-skilled personnel than ‘standard’ paramedics. These staff would be potentially deployable (especially in rural and remote areas) to maximise treat-at-scene options. Whether this will involve NHS England commissioning research on the link between conveyance rates and staff skill, or using already established evidence-based approaches, will be considered as the Review progresses.

63. At the same time, we must recognise the benefit of a workforce skill-mix and the role technicians, emergency care assistants and emergency care support workers can, and should, play in treating patients alongside paramedics and other healthcare professionals. All ambulance trusts use a paramedic and technician / emergency care assistant / emergency care support worker workforce model, which the Government supports.

64. Ultimately, the Government believes that local commissioners and providers are best placed to make decisions about

ambulance staffing and skill mix, and these decisions will vary according to the needs of the local area. Local providers and commissioners are best placed to ensure that their workforce mix best matches local demand.

65. Collaboration between the emergency services has the potential to deliver improvements to public services and efficiencies. The Government is working with emergency services to enable them to achieve greater collaboration, where appropriate. There are some good examples of where ambulance and fire services collaborate but it is far from universal good practice:

- co-responding (e.g. Ambulance Services having agreements with the fire services to allow them to be first responders to certain less critical 999 calls, until an ambulance unit arrives).
- co-location (e.g. Ambulance Services using fire stations to post ambulance units to enable prompt responses to 999 calls).
- Joint call handling centres.

Ensuring that all ambulance crews have access to national patient data would increase the patient information available and allow for better decisions to be made regarding conveyance and care. The Committee recommends that UCBs take the lead in assessing access to the National Spine for all key parties in the delivery of emergency care and coordinate plans to ensure that the minimum patient record is made available. (Paragraph 148)

66. The use of Summary Care Records by Ambulance Trusts would give them access to the most critical patient information such as current medications, allergies and adverse reactions. We aim to extend in

2014 the Summary Care Record to include an additional information set, which would provide deeper insight into recent episodes of care.

67. The longer term vision for integrated digital care might extend the two-way sharing of information further but significant early improvement could be made with access to Summary Care Records. To achieve this, commissioners and local providers should assist in driving the use of the NHS Number as the primary patient identifier in urgent and emergency care settings to enable effective access to national services such as the Summary Care Record.

Incentives

The Committee believes it is vital that commissioners successfully introduce tariffs which encourage ambulance providers to 'hear and treat' and 'see and treat' patients. Such encouragement would provide ambulance trusts with further incentives to develop a skilled workforce predominantly made up of paramedics. This would be of particular benefit to patients in rural areas who have only limited access to services.

(Paragraph 151)

68. The Government acknowledges the importance of encouraging ambulance service providers to treat more patients on the telephone ('hear and treat') and at the scene ('see and treat'). We further recognise, as acknowledged elsewhere in this response, that clinical models developed as part of the second phase of NHS England's Urgent and Emergency Care Review, need to also be supported by appropriate levers and incentives to encourage adoption.

69. NHS England supports initiatives which allow ambulance trusts to move towards their stated intention of professionalising their workforces and increasing the number

of trained paramedics. However, decisions about ambulance staffing and skill mix are ultimately for local ambulance trusts and local commissioners to make, and will consequently vary according to the needs of the local area.

70. Ambulance services have national currencies and local prices. The currencies differentiate between ‘see and treat’ and ‘see, treat and convey’ as separate currencies. They were introduced in 2012/13. Some commissioners have used this currency model to incentivise see and treat, and this is something that the Government would like to encourage. However, evidence suggests that setting national prices for ambulance services would cause significant financial risk as the regional cost variation is large, but that ambulance providers are very willing to participate in agreeing local prices that create incentives to avoid taking patients to hospitals where possible.

71. In the longer term, the Monitor and NHS England will be working to consider the need to redesign the payment of all aspects of emergency and urgent care to ensure the system works as a whole. This could lead to new payment models to encourage partnership working across the system.

A service that is paid to transport patients will employ technicians to facilitate this; one that is paid to treat patients will invest in recruiting and training paramedics. The Committee therefore urges NHS England to closely monitor the relationship between the use of the new tariffs, conveyance rates and the balance between technicians and paramedics in ambulance trusts. (Paragraph 152)

72. As mentioned in paragraph 67, we recognise that the models emerging from the Urgent and Emergency Care Review will need to be supported by appropriate levers and incentives to encourage adoption.

73. Nevertheless, our view is that local providers and commissioners are better placed to assess the impacts of local service configuration decisions. Such decisions will consequently vary according to the needs of the local area and the nature of the service provided. It should also be recognised that conveyance rates will vary across different geographical areas and that this variation is appropriate as it reflects differently configured services.

74. The Department of Health will collect data on the use of the new ambulance currencies through the collection of Reference Costs. Clinical Commissioning Groups are best placed to understand the needs and requirements of their local populations and will be able to see and compare the activity and costs of the currencies to help them discharge this duty. 999 services will also be examined as part of the Urgent and Emergency Care Review.



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