

**HEALTH SELECT COMMITTEE INQUIRY
EMERGENCY SERVICES AND EMERGENCY CARE
EVIDENCE FROM THE KING'S FUND**

- 1) The King's Fund is an independent charity working to improve health and health care in England. We help to shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible care is available to all.
- 2) The King's Fund has published work on urgent and emergency care including regular analysis of performance data (Appleby *et al* forthcoming), a study of emergency admissions (Imison *et al* 2012) and an analysis of the urgent and emergency care system in NHS South of England (Edwards 2012).

Summary

- 3) This submission does not address each item in the terms of reference for this inquiry individually but makes the following conclusions.
 - While demand for accident and emergency (A&E) services has risen considerably over the past 15 years or so, nearly all of this is attributable to increasing activity in walk-in centres and minor injuries units and for the past two and a half years growth has slowed considerably – to just over 1 per cent per year (Appleby 2013).
 - However, there is evidence that the urgent and emergency care system is under pressure and performance on a number of important indicators, including the four-hour wait for A&E and ambulance handover targets, has been getting worse in recent months.
 - While the focus of attention has been on the pressures felt by A&E services, there is no single cause or solution to this problem. The pressures are caused by issues across the health and care system that prevent the flow of patients through the system and any solutions need to reflect this. These are complex issues that will not be solved just by short-term increases in funding. Financial disincentives that penalise hospitals for additional emergency activity over a baseline have not been effective.
 - To address the problems created by increasing demand on urgent and emergency care we need more strategic approaches that reduce the complexity of the system for patients; reshape primary care and chronic disease management; support patients in their own homes (including nursing and residential care homes); and provide flexible and timely community services that mean patients can be rapidly discharged from hospital. All of this requires leadership across a system rather than attempting to fix each individual component. We remain concerned that the fragmentation of commissioning and lack of strategic responsibility will make system-wide change more difficult to implement.

Urgent and emergency care services

- 4) There has been a rise of around 7.5 million A&E attendances (a 50 per cent increase) over the past decade. However, the facts about accident and emergency workload statistics are not straightforward and this increase is partly caused by changes in statistical collection (to include units not previously counted such as walk-in centres

and minor injury units) and a degree of 'supply-induced demand' as these new routes into emergency care have opened.

- 5) However, providers are reporting pressures on A&E services in particular. We recently surveyed NHS finance directors and when asked to pick just one immediate concern, 21 directors identified the four-hour maximum A&E waiting times target as their main problem at the moment. This concern is reflected in recent official data not just on the four-hour target but also the proportion of patients waiting more than four hours to be admitted to a hospital bed from an A&E department. In the last quarter, the proportion of so-called 'trolley waits' – patients waiting more than four hours to be admitted into hospital from A&E – reached nearly 7 per cent, the highest proportion since 2003/4. Nationally, more than 313,000 patients waited more than four hours in A&E departments in the last quarter – nearly 40 per cent more than the same quarter a year ago.(Appleby *et al* 2013).
- 6) Weekly data in the three weeks to the week beginning 5 May 2013 (and beyond the quarterly data period) show that performance has improved, with less than 5 per cent of patients waiting longer than four hours in the first week of May. However, it remains to be seen if this recovery continues. There is a similar recovery for trolley waits. Both may in part reflect a renewed focus on these performance metrics by hospitals as media attention has grown (Appleby *et al* 2013).
- 7) A&E targets have been in place for nearly a decade. The Prime Minister included A&E waiting times as one of his key pledges for the NHS in 2011. There is some evidence of a correlation between performance against the four-hour wait target and a relaxation of performance management by the government.
- 8) There is a huge range of advice on good practices that should be adopted by hospitals in managing the flow of emergency work, but our research found that they are rarely consistently and universally adhered to. Good practice is hard to sustain for a number of reasons, including a lack of attention to continuous monitoring and adjustment of the system; staffing pressures; and difficulties in changing job plans for doctors to ensure 24/7 cover. Systems are fragile and vulnerable to fluctuations in demand, changes in staffing or any hold up in the discharge process.
- 9) Provided that demand and capacity are in balance, there are a number of well-evidenced interventions for ensuring a smooth flow of patients through A&E services including:
 - creating separate streams for minors and majors
 - rapid assessment and treatment (RAT) for 'majors' patients
 - see and treat for patients with minor injuries and illnesses
 - reducing or eliminating triage
 - using College of Emergency Medicine guidance on capacity
 - robust job planning to meet demands on an hour-by-hour basis.
- 10) The pressures felt by A&E services are caused by issues across the health and care system that prevent the flow of patients through the system. Key to preventing long waits in A&E is making sure that patients flow quickly through the hospital and are discharged rapidly. There are a number of factors that prevent this, including:
 - misalignment of workflow between emergency departments and the rest of the hospital – hospitals still operate a five-day week for most of their activities which creates problems with the flow of patients. Our research found reduced diagnostic services during weekends and over lunchtimes impacted flow in emergency departments
 - efficiency and bed utilisation initiatives which have left hospitals running at high levels of occupancy and with reduced ability to respond to fluctuations in demand or to discharge patients

- delays in transfers to community or social services (see below).

Community health and social care services

- 11) The evidence suggests that for community health and social care services, focusing on facilitating discharge, rather than preventing admission, has a greater impact on creating flow of patients through services and reduces the likelihood of problems in emergency departments.
- 12) Our surveys have found that delayed transfers of care are a concern for many NHS organisations. However, more investigation is needed to discover why, despite these concerns, official statistics show a relatively stable picture on delays. Discussion with directors of acute hospitals strongly suggests that the official data for delayed transfers of care do not accurately reflect the number of patients who are delayed and waiting for discharge (Appleby *et al* 2013).
- 13) There is more that hospitals can do to achieve timely discharge of patients, either from hospital beds or from emergency departments. However, community services are also important and these need to work at the pace required by hospitals. Community health services are often commissioned using poorly drafted and inflexible block contracts, with response times measured in days, rather than the hours required by hospitals. In addition, community services can be complex and hard to navigate for emergency care staff, meaning that it can be easier to admit a patient than to find suitable support in the community at short notice. Our research suggests that to be effective, larger and more flexible community teams should be created that can provide an easy to access, 24-hour response and can respond to changing demand (Edwards 2013).
- 14) Timely access to social care services is also critical. Local authorities have tried to protect social care budgets, but net expenditure on adult social care has fallen in real terms for the past two years. The number of people receiving publicly funded social care through local authorities has also continued to fall – by 7 per cent in 2011/12 and by 17 per cent since 2006/7. Over the same period, the number of people aged 85 years and over has risen by more than 20 per cent. A recent survey of Directors of Adult Social Services by the Fund found that transferred NHS money is being used to promote the closer integration of care but in many cases it is being used to offset general service pressures and councils are finding it much harder to find savings that do not impact on the quality or quantity of care (Appleby *et al* 2013).
- 15) There is limited evidence that community-based interventions have been able to reduce admissions at a large enough scale to make an impact on the operation of hospitals. Schemes aimed at avoiding admissions and A&E attendance are generally very poorly evaluated, too small to make much impact, hard to manage and prone to creating additional demand (Purdy 2010). This adds to the very high level of complexity that is already present due to layers of previous projects, national initiatives and unco-ordinated service developments.
- 16) The evidence that does exist suggests that successful examples are likely to be large scale and integrated with other services. The integrated care service in Torbay remains the best example of community interventions that have reduced emergency admissions to hospital.

Primary care

- 17) Much attention has been paid to problems in access to primary care services, particularly out-of-hours. The data does not suggest a link between changes in out-

of-hours provision at the time of the renewed GP contract in 2003 and an increase in pressure in emergency departments.

- 18) There is a lack of understanding about the demand for primary care and no consistent data about how many emergency GP appointments are available in any given area and how many might be needed. Recent work with one strategic health authority revealed wide variation in the use of out-of-hours care and the rates at which people were sent to hospital. Crucially, this data did not appear to be readily at hand or used by commissioners (Edwards 2013).
- 19) There have been many attempts to divert people from A&E services over many years by providing alternative primary care type services. These schemes appear mainly to increase overall demand, particularly for minor injury and illness, and have also had the effect of creating a highly fragmented system which generates confusion among GPs and other referrers about how and where to access care. There is anecdotal evidence that patients are also confused and turn to A&E services as they have confidence in them and find them easy to access.
- 20) As with community health and social care services, the evidence base for interventions that can help to prevent hospital admissions is patchy. For example, evidence suggests that there are limitations on what can be achieved using case identification approaches (which use a range of algorithms to identify high-risk patients in the community), and some studies have found little or no effect. There is evidence that encouraging patient self-management can be effective (Purdy 2010).
- 21) Evidence suggests that a senior person able to make a definite decision about diagnosis and treatment as early as possible has been a key feature of successful urgent and emergency care services. The development of NHS111 services, which rely on less-experienced call handlers, does not reflect this evidence.
- 22) Nursing and residential homes are an integral part of the care system and are caring for increasingly frail patients. Improving the management of nursing and residential home patients is an important task for primary care in order to prevent unnecessary admission to hospital.

Commissioners

- 23) There are significant issues around how commissioners have operated to date in managing emergency activity. Some have taken adversarial approaches, while others have tried to implement overly detailed plans. In our research we found examples of questionable approaches to commissioning – for example, exploiting the difference between the community tariff and the hospital tariff. Commissioners we spoke to did not have a clear map of the system's capacity or of the flows between the different parts of it.
- 24) There is no evidence that the policy for hospitals to be paid only 30 per cent of the tariff rate on emergency admissions that exceeded 2008-09 volumes has provided an effective incentive.
- 25) In 2013 The King's Fund published a paper outlining the ten priorities for clinical commissioning groups (Imison *et al* 2013), one of which was managing urgent and emergency activity. In this report we emphasised developing an integrated approach to urgent and emergency care, particularly emergency medical admissions to hospital. This requires involvement, involving hospitals, and community, primary and ambulance services through joint service planning and sharing of clinical information across different agencies.

26) There are now multiple commissioners of urgent and emergency care: NHS England has responsibility for commissioning primary care; clinical commissioning groups commission acute and community services; and local authorities commission social care and housing. Urgent care boards, now being established across the country, may be a useful mechanism for developing system-wide responses, although it will be important to be clear about their role, leadership and accountability if they are not to become just another component in a complex system. We remain concerned that the fragmentation of commissioning and lack of strategic responsibility will make system wide change more difficult to implement.

References

Appleby J (2013). 'Are accident and emergency attendances increasing?'. Blog. The King's Fund website. Available at: www.kingsfund.org.uk/blog/2013/04/are-accident-and-emergency-attendances-increasing (accessed on 20 May 2013).

Appleby J, Humphries R, Thompson J, Galea A (forthcoming). *How is the health and social care system performing?* Quarterly monitoring report.

Edwards N (2013). *Urgent and emergency care: Improving Urgent and Emergency Care Performance across NHS South of England*. London: The King's Fund. Available at www.southofengland.nhs.uk/wp-content/uploads/2012/05/Kings-Fund-report-urgent-and-emergency-care.pdf (accessed on 20 May 2013).

Imison C, Thompson J, Poteliakhoff E (2012). *Older people and emergency bed use: exploring variation*. London: The King's Fund. Available at www.kingsfund.org.uk/publications/older-people-and-emergency-bed-use (accessed on 20 May 2013).

Naylor C, Imison C, Addicott R, Buck D, Goodwin, Harrison T, Ross S, Sonola L, Tian Y, Curry N (2013). *Transforming our Health Care System: Ten priorities for commissioners*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/articles/transforming-our-health-care-system-ten-priorities-commissioners (accessed on 20 May 2013).

Purdy S (2010). *Avoiding Hospital Admissions. What does the research evidence say?* London: The King's Fund. Available at: www.kingsfund.org.uk/publications/avoiding-hospital-admissions (accessed on 20 May 2013).