Transforming urgent and emergency care services in England

Urgent and Emergency Care Review

End of Phase 1 Report

High quality care for all, now and for future generations

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Transforming urgent and emergency care services in England

Urgent and Emergency Care Review

End of Phase 1 Report

High quality care for all, now and for future generations

First published: November 2013

Prepared by Urgent and Emergency Care Review Team

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Letter to the Secretary of State for Health and the Chairman of NHS England

Dear Secretary of State and Sir Malcolm,

Earlier this year, I agreed to conduct a comprehensive review into how we organise and provide urgent and emergency care services in England. We all shared the same anxiety that, up and down the country, A&E Departments, the hospital services that support and sit behind these departments and our ambulance services were under intense, growing and unsustainable pressure. This pressure is very real and whilst the NHS is coping, it needs addressing urgently so patients can continue to receive high quality urgent and emergency care in the future.

This letter and accompanying report present the findings from the first phase of my review. The report sets out proposals for a fundamental shift in how and where we meet the urgent and emergency care needs of people in this country. I am confident that, if fully implemented, within a few years we can create a service that is more responsive and personalised for patients and delivers even better clinical outcomes. It is essential that we transform the whole urgent and emergency care pathway, from end to end. This system-wide approach is the only way to create a sustainable solution and ensure that future generations can have peace of mind that when the unexpected happens, the NHS will still be able to provide a rapid, high quality and responsive service, free at the point of need.

Our Vision

Our vision is simple. Firstly, for those people with urgent but non-life threatening needs we must provide highly responsive, effective and personalised services outside of hospital. These services should deliver care in or as close to people's homes as possible, minimising disruption and inconvenience for patients and their families. Secondly, for those people with more serious or life threatening emergency needs we should ensure they are treated in centres with the very best expertise and facilities in order to reduce risk and maximise their chances of survival and a good recovery. If we can get the first part right then we will relieve pressure on our hospital based emergency services, which will allow us to focus on delivering the second part of this vision.

The case for change, opportunities for improvement

The reasons for the growing pressures our A&E departments are experiencing have been well rehearsed. Two things in particular are often cited. Firstly, an ageing population with increasingly complex needs is leading to ever rising numbers of people needing urgent or emergency care. Secondly, we know that many people are struggling to navigate and access a confusing and inconsistent array of urgent care services provided outside of hospital, so they default to A&E. While both these things are true, they arguably underplay the fact that A&E departments have become victims of their own success. The A&E brand is trusted by the

public and, despite increasing pressure, continues to provide a very responsive service with an average wait for treatment of only 50 minutes and the overwhelming majority of patients being treated within 4 hours. So, we should not be surprised that people choose to go to A&E.

But, the reality is that millions of patients every year seek or receive help for their urgent care needs in hospital who could have been helped much closer to home. The opportunities for bringing about a shift from hospital to home are enormous. For example, we know that 40% of patients attending A&E are discharged requiring no treatment at all; there were over 1 million avoidable emergency hospital admissions last year; and up to 50 per cent of 999 calls requiring an ambulance to be dispatched could be managed at the scene. To seize the opportunities these numbers present, we will need to greatly enhance urgent care services provided outside of hospital. This forms a key part of our proposals.

The second part of our vision relates to those people with the most serious or life threatening emergency care needs who do require treatment in hospital. In the 1970s most A&Es and their hospitals could offer people the best treatment of the day for most conditions. Clinical practice has taken great strides forward in the last four decades, and this is no longer the case.

Take heart attacks for example. In the 1970s, heart attacks were treated with bed rest. The hospital mortality rate was about 25 per cent. Today, as a result of advances in medical science, we now mechanically unblock the culprit coronary artery which was causing the heart attack. This treatment has seen mortality rates fall to just 5 per cent. But this improvement has required very expensive diagnostic equipment and cardiologists with special skills. This highly effective, advanced treatment of serious heart attacks cannot be provided by every hospital; it is currently delivered by half the hospitals in England, with about a third providing a comprehensive 24/7 service. We have very good results by international standards because the diagnosis can be made in the ambulance and the right patients are taken to the right hospitals for the most advanced treatment. This means that for paramedics to get patients to the best and most appropriate services, they will sometimes drive past the nearest A&E to get the patient to the right place. This is a good thing. The recent national reorganisation of major trauma services which resulted in the designation of 25 major trauma centres has produced, in its first year, a 20% increase in survival despite increased travel time for patients who now bypass A&Es that previously treated only a handful of these very serious and complicated cases.

Similarly, the treatment of strokes which occur when the blood supply to part of the brain is blocked, has evolved. Effective treatment requires rapid transfer to a highly specialised unit with expensive diagnostic scanners and clinical expertise so that drugs can be given to minimise the brain damage that occurs. Stroke services in London have been reorganised to offer this high level treatment, but this required redirecting patients with suspected strokes from 32 admitting hospitals to only 8. The end result is that London has the best stroke services of any capital city in the world, saving more lives and returning more patients to independent living.

We have made good progress on treating heart attacks and strokes, although there is still more to do in these and other areas in order to reduce risks and improve outcomes. Advancing science has directed the way we deliver services to achieve the best results, but it also exposes the illusion that all A&Es are equally able to deal with anything that comes through their doors. We now find ourselves in a place where, unwittingly, patients have gained false assurance that all A&E's are equally effective. This is simply not the case.

We also know that the likelihood of recovering from a particular illness or injury varies considerably between hospitals. Despite the best efforts of the staff who work there, many hospitals and their A&E departments do not have consistent consultant presence overnight or at weekends. The support services available also vary considerably, with 1 in 7 lacking at least one "essential" on-site service, such as critical care, acute medicine, acute surgery or trauma and orthopaedics. As you know, I have also been leading the NHS Services, Seven Days a Week Forum which has been considering potential solutions to some of these issues and will report shortly.

So, A&E departments up and down the country offer very different types and levels of service, yet they all carry the same name. We need to ensure that there is absolute clarity and transparency about what services different facilities offer and direct or convey patients to the service that can best treat their problem. Most importantly, we need to ensure that anywhere that displays a red and white sign is a place that will provide access to the very best care for the most seriously ill and injured patients, 24 hours a day and 7 days a week. A place that can resuscitate, make a diagnosis, start treatment and ensure rapid transfer to the right place if it can't offer the very best care.

The Future of Urgent & Emergency Care Services in England

The challenges facing our urgent and emergency care system are clear, as are the opportunities for improvement. We now need to take action. Our report sets out our proposals for the future of urgent and emergency care services in England. There are five key elements, summarised below, all of which must be taken forward to ensure success:

- **Firstly, we must provide better support for people to self- care.** This is by far the most responsive way of meeting people's urgent but non-life threatening care needs. Millions of people already do this, but millions more could be better supported to take control of their own health. To achieve this, we will need to provide better and more easily accessible information about self-treatment options so that people who prefer to can avoid the need to see a healthcare professional. We will also need to accelerate the development of comprehensive and standardised care planning, so that important information about a patient's conditions, their values and future wishes are known to relevant healthcare professionals. This way, patients will be better supported to deal with that condition before it deteriorates, or if additional help is required.

- **Secondly, we must help people with urgent care needs to get the right advice in the right place, first time.** To achieve this, we will greatly enhance the NHS 111 service so

that it becomes the smart call to make, creating a 24 hour, personalised priority contact service. This enhanced service will have knowledge about people's medical problems, and allow them to speak directly to a nurse, doctor or other healthcare professional if that is the most appropriate way to provide the help and advice they need. It will also be able to directly book a call back from, or an appointment with, a GP or at whichever urgent or emergency care facility can best deal with the problem.

- **Thirdly, we must provide highly responsive urgent care services outside of hospital so people no longer choose to queue in A&E.** This will mean providing faster and consistent same-day, every-day access to general practitioners, primary care and community services such as local mental health teams and community nurses for patients with urgent care needs. It will also mean harnessing the skills, experience and accessibility of a range of healthcare professionals including community pharmacists and ambulance paramedics. By extending paramedic training and skills, and supporting them with GPs and specialists, we will develop our 999 ambulances into mobile urgent treatment services capable of dealing with more people at scene, and avoiding unnecessary journeys to hospital.

- **Fourthly, we must ensure that those people with more serious or life threatening emergency care needs receive treatment in centres with the right facilities and expertise in order to maximise chances of survival and a good recovery.** Once we have enhanced urgent care services outside hospital, we will introduce two levels of hospital emergency department – under the current working titles of Emergency Centres and Major Emergency Centres. In time, these will replace the inconsistent levels of service provided by A&E Departments. The presence of senior clinicians seven days a week will be important for ensuring the best decisions are taken, reassuring patients and families and making best use of NHS resources. Emergency Centres will be capable of assessing and initiating treatment for all patients and safely transferring them when necessary. Major Emergency Centres will be much larger units, capable of not just assessing and initiating treatment for all patients but providing a range of highly specialist services. These centres will have consistent levels of senior staffing and access to the specialist equipment and expertise needed to deliver the very best outcomes for patients. We envisage there being around 40-70 Major Emergency Centres across the country. We expect the overall number of Emergency Centres (including Major Emergency Centres) carrying the red and white sign to be broadly equal to the current number of A&E departments.

- **Fifthly, we must connect all urgent and emergency care services together so the overall system becomes more than just the sum of its parts.** Building on the success of major trauma networks, we will develop broader emergency care networks. These networks will dissolve traditional boundaries between hospital and community based services and support the free flow of information and specialist expertise needed to achieve the delivery of patient care in the most appropriate and convenient setting. Major Emergency Centres will have a lead responsibility for the quality of care and operational performance of

services across the network they support, including linked Emergency Centres. These networks will also support the introduction of an efficient critical care transfer and retrieval system so that patients requiring specialist help reach the best possible facility in a timely fashion.

The system-wide transformation of urgent and emergency care services we envisage is a major undertaking. There will be many challenges along the way. Traditional barriers and vested interests will need to be tackled and broken down. We know that many parts of the system are already coping with sustained pressure and multiple demands, particularly GP practices which have themselves experienced significant increases in patient consultations in recent years. So, it will be important that we create the right conditions and environment to allow the new services to be developed safely. But, the truth is that if we don't change the whole urgent and emergency care pathway, from start to finish, we will simply repeat the mistakes of the past: timid, limited or disjointed initiatives will be insufficient.

Let me be clear that there is no simple solution. This report sets out some principles. How they are developed locally will, and must, vary to suit local circumstances and wishes. We will need different approaches in metropolitan, rural or remote areas. The majority of people needing urgent care do not have life threatening problems so we must focus our attention on bringing the best care to people as close to home as possible, wherever they live. When patients have serious problems we must equally ensure they are treated by clinical teams that offer them the best chance of recovery.

I would like to thank Professor Keith Willett for the vision and clinical leadership he has provided to this review as well as the thousands of people, particularly patients and their representatives, who have engaged with us and helped get us to this point. The second phase of the review will now focus on implementing their vision and the proposals set out in this report. The NHS belongs to us all. Many people will have many ideas, some will have fears. We will listen and continue to conduct and build this review in public and will report again on progress in Spring 2014.

Professor Sir Bruce Keogh KBE, MD, DSc, FRCS, FRCP
National Medical Director

Foreword

I have been a consultant trauma surgeon for over 20 years, and believe passionately in providing my patients with the most responsive and professional urgent and emergency care the NHS can offer. I therefore relish the opportunity to lead this review knowing that, for the many reasons Professor Sir Bruce Keogh has outlined, we must transform services now to ensure that we and our families can absolutely rely on the NHS whenever and wherever we may need help urgently.

I also appreciate, as an NHS doctor and now as a Director in NHS England, just how often in the past we have been told what was right for us and our patients without reference to those of us who live and breathe these issues on a daily basis, or experience services as patients or carers. I fully understand how important urgent and emergency care services are to local people, and how strongly NHS staff strive to secure the best results for their patients. It is for those reasons we have set about this review very differently; we have built it in public, and will continue to do so as the review progresses.

We started the first phase by compiling the evidence of what works from published research and, building on the views of patients and clinicians from the frontline of urgent services, drafted a set of core principles and objectives that we felt everyone should expect any new system to meet. Importantly we then put all of our findings out into the public domain with an expectation that they would be discussed, criticised and improved, and they were. Over 1,000 people, including members of the public, NHS staff, commissioners of services and organisations representing patients and professionals, have taken their time to give their views and help us improve the review.

We have listened to everyone who sent us their feedback, either on our website, by letter, or at events that we conducted. The resulting evidence base (Appendix 1) and the principles and objectives (Appendix 2) are a part of this report. Powerfully, almost everyone in our engagement exercise (97% of respondents) accepted that things had to change. Indeed, many said change needed to be fundamental with no more tinkering at the edges. People described how NHS urgent care has become disjointed between GPs and specialists, between the community services and hospitals - resulting in many patients feeling they had no control and confused as to what they should do and where they should go. Urgent care has become out of step with how people live their lives.

I am confident that we are now harnessing the combined clinical wisdom and experience of the NHS and its patients, and that we can address these issues. Indeed, we owe it to the staff working in our urgent and emergency care system and each and every one of our own family members to get this right.

We have good evidence to guide us, and working examples of the key components of a new urgent and emergency care system. This report outlines the changes we intend to make in our community, general practice, ambulance, and hospital services. These changes range from improving the ability of patients to self-care for minor illnesses, all the

way through to priority access to specialist services for life-threatening emergencies. The report clearly recognises the need for end to end whole system transformation. It also describes the importance of a supporting network, so no patient or clinician is consulting in isolation.

Phase 2 of this review will take these proposals and determine the commissioning, workforce and cost implications of the new clinical models, developing the tools and guidance that will support successful implementation. We will specifically test to ensure that our proposals offer effective care for children, for those who are elderly or frail, and for those with mental health needs. As we progress, it remains essential that we continue to explore every aspect in public because there are important issues of quality and sustainability that can only be resolved through the engagement and cooperation of clinicians, commissioners and patients.

These are vital times for urgent and emergency care in the NHS. Change is required now, right across the system, and we must all work together to deliver it. I look forward to you joining me on this journey.

Professor Keith Willett FRCS
National Director for Acute Episodes of Care, NHS England

Chapter 1: Introduction

The fundamental principles upon which the NHS is founded - the provision of a comprehensive service, with access based on clinical need not ability to pay - are at their most precious when we or someone we care about needs urgent or emergency care. Every year, the NHS responds to hundreds of millions of contacts from members of the public with such needs. At one end of the spectrum these contacts relate to people seeking help and advice around options for self-care. At the other end, they relate to people needing life-saving treatment for the most serious conditions such as major trauma and heart attacks.

Whilst we should celebrate the fact that the fundamental principles upon which the NHS was founded still endure, it is concerning that the way in which we organise and provide urgent and emergency care services today still resembles the system put in place over five decades ago. We now have an outdated model, too focused on 'bricks and mortar' rather than the provision of services where and when patients need them. It is struggling to cope with ever increasing demand and changing patterns of disease and which, in some instances, has failed to keep pace with advances in medical science and technology as well as changing public expectations.

An emergency service at its limit

The demands being placed on our urgent and emergency care services have been growing very significantly over the past decade. Over the last three years alone, attendances at all types of urgent and emergency care facilities (officially termed type 1, 2 and 3 A&E departments) have risen by one million. NHS organisations and staff are continuing to work very hard to ensure that performance against key standards (such as the percentage of A&E patients discharged, admitted or transferred within 4 hours) are maintained, but it is clear that the service is at the limit of its capacity.

Every winter this pressure increases further and the signs are most visibly seen in our A&E departments, where last year's cold snap resulted in very considerable strain. The Government has announced a significant two year investment in A&E departments to help them with the further pressures that are anticipated during the forthcoming winter. This will be beneficial but it is not the sustainable long-term solution. It is also important to recognise that the pressures facing our urgent and emergency care services are not simply a phenomenon of winter. They are present all year round and require a systemic not just a seasonal response, although preparations have started earlier than ever before this year.

We know that if we do not provide an adequate or responsive service to those with less serious, but nevertheless urgent, care needs we risk allowing such problems to become worse. We also know that a failure to meet people's needs outside of hospital results in them seeking help from those services that are highly responsive - particularly A&E departments and 999 ambulances - but are intended to help those with the most serious, complex and life threatening needs. The reality is that the pressure our A&E departments and ambulance services are experiencing is absolutely not a sign of failing services, but

that these services have become victims of their own success. The unsustainable demands being placed upon them have been fuelled by their own responsiveness but also the difficultly patients experience in navigating and securing help for their urgent care needs elsewhere.

Be assured, it is not that the NHS has not modernised. Indeed, the hospital service has become very efficient. Over the last 15 years patients admitted to hospital as an emergency have increased by almost 50 per cent yet the NHS has managed to not only improve survival rates year on year, but also achieved a reduction in annual bed-days from 37 million to 32 million by almost halving the length of stay. But the options to improve hospital efficiency are ever more challenging and when it is estimated that one in five patients could be treated equally well or better out of hospital it becomes clear that we need to address the whole urgent and emergency care system. The Government's £3.8bn health and social care integration fund has the potential to make an important contribution to ensuring people are treated closer to home.

However, we must recognise that we cannot rely on spending increasing amounts of money on a system that needs to be improved, and which is already approaching its limits. We have to be more radical than this if we are to deliver lasting solutions.

Scope and purpose of the review

In response to these challenges, Professor Sir Bruce Keogh announced a comprehensive review of the NHS urgent and emergency care system in England. The overall objective of the review was to consider how to improve services for patients right across the spectrum of urgent and emergency care, and to identify potential solutions.

This Review is being conducted in two phases.

Phase 1 of the review aimed to understand the way in which the NHS responds to patients who have urgent and emergency care needs, with a view to developing an authoritative summary of the research evidence and a set of underpinning principles and objectives on which to base the design of a new system. This report, which marks the conclusion of phase 1, sets out:

- the case for change and the opportunities for improvement - **Chapter 2**
- our proposals for improving urgent and emergency care services in England - **Chapter 3**
- next steps towards implementing our proposals - **Chapter 4**

The findings and conclusions set out in this report have been informed by extensive engagement with patients, clinicians and commissioners across the NHS, including a formal period of engagement between June and August 2013 on our research evidence base and emerging principles and objectives for how an improved service should be designed. Our updated **evidence base (Appendix 1)**, revised **principles and objectives (Appendix 2**)

and a full **summary of engagement responses (Appendix 3)** all form an important part of this report.

Phase 2 of the review will focus on improving these proposals in the light of further public debate, and putting in place mechanisms for realising the ambition of the proposals set out in this report. This will include establishing groups to develop and test: the clinical standards, skills and workforce needs, financial impact and commissioning support that will be required to deliver the new system. An update on progress will be published in Spring 2014.

Chapter 2: The case for change, opportunities for improvement

We have tried to base this review, where possible, on hard research evidence to build a clear picture of how people currently access urgent and emergency care services, and to help us understand how effectively we use our NHS infrastructure.

We started by publishing a detailed summary of the available research, which has been updated in the light of comments and contributions received during our engagement exercise, and is published alongside this report. We are very grateful to all those who responded to our engagement exercise for assisting us in making this document more comprehensive and, we believe, authoritative.

This chapter draws heavily on that evidence, and sets out both the case for change and the opportunities that exist for making urgent and emergency care services more responsive, more efficient and clinically more effective.

Rising demand, rising expectations

Every year the NHS supports hundreds of millions of contacts from members of the public who need urgent or emergency care. The reasons vary. Some people simply need advice or treatment for relatively minor illnesses, others need help with pre-existing long term health problems which fluctuate or deteriorate. A smaller number need treatment for a serious illness or have a major event or injury which requires swift access to highly-skilled, specialist care to give them the best chance of survival and recovery.

Every year the NHS deals with:

- 438 million visits to a pharmacy in England for health related reasons;
- 340 million GP consultations;
- 24 million calls to NHS urgent and emergency care telephone services;
- 7 million emergency ambulance journeys;
- 21.7 million attendances at A&E departments, minor injury units and urgent care centres;
- 5.2 million emergency admissions to England's hospitals.

Importantly, demand for these services has been rising year on year:

- The average number of consultations in general practice per patient rose from 4.1 to 5.5 per year between 1999 and 2008 indicating greater demand and complexity in primary care.

- There were 6.8 million attendances at walk-in centres and minor injury units in 2012/13, and activity at these facilities has increased by around 12 per cent annually since data was first recorded a decade ago.
- Attendances at hospital A&E departments (officially referred to as Type 1 and Type 2 A&E) have increased by more than two million over the last decade to 16 million.
- The number of calls received by the ambulance service over the last decade has risen from 4.9 million to over 9 million.
- Emergency admissions to hospitals in England have increased year on year, rising 31 per cent between 2002/03 to 2012/13.

This growth in demand is set to continue as people live longer with increasingly complex, and often multiple, long-term conditions.

These facts have led to an overwhelming consensus that our current services are unsustainable.

There have also been societal and technological changes. Most notable is the way we run our lives. Social, financial, retail and travel transactions are conducted online. Information is a couple of clicks away on a mobile device. Younger generations live in a world of rapid knowledge transfer, a world of immediacy, a world of rising expectations. We must respond – not just to the increasing demand but also to societal and technological trends.

A confusing system

Previously we have tried to deal with increasing demand by developing new facilities. Although well-conceived and well-intentioned, these have created additional complexity and confusion, not just for patients but also for those working in the NHS.

Starting from scratch, nobody would design the current array of alternatives and their configuration. A short history of the last 30 years reveals that we have opened 'walk-in centres', 'minor injury units', 'urgent care centres' and a vast range of similarly named facilities that all offer slightly different services, at slightly different times, in different places. A telephone service, NHS Direct, was introduced in 1998, and last year was replaced by NHS 111. Even the simple task of ringing a GP practice to request an appointment can result in a frustrating assault course on a telephone keypad.

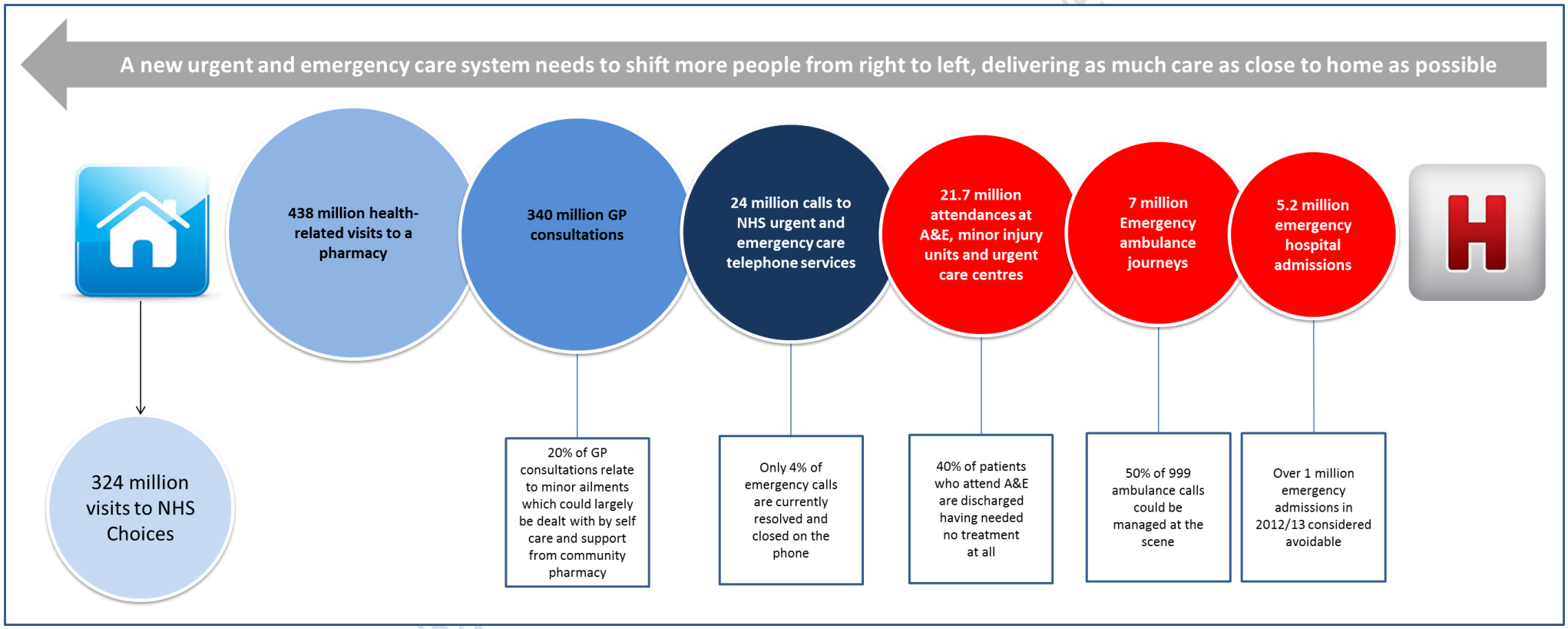
All the public want to know is that if an urgent care problem ever arises, they can access a service that will ensure they get the right care when they need it. They do not want to decide whether they should go to an MIU, a WIC or A&E, or whether they should ring their GP, 111 or 999. We shouldn't expect people to make informed, rational decisions at a crisis point in their lives: the system should be intuitive, and should help people to make the right decision. We have created a complicated system which in itself has contributed to increasing demand by sending people around various services, confused about who to call and where to go.

Opportunities for meeting people's urgent care needs closer to home

Most urgent care problems are not life-threatening. For these problems patients need help, advice and simple treatments delivered as close to home as possible. The vast majority of people already seek and receive treatment and care for their urgent and emergency care needs in the most appropriate setting. However, we know from our analysis that millions of people every year could receive advice and treatment closer to home. There is a huge opportunity to shift treatment and advice from acute hospital based services to home or close to home as highlighted by Figure 1 and the supporting text below:

- Last year, there were 5.2 million emergency admissions to hospital, yet we know that up to 1.2 million of these admissions could have been avoided. Hospitals can be harmful to some people. Frail and elderly people may be made worse by hospital admission, which takes them from a familiar home environment to a confusing and noisy place where they are also at risk of harm from infection and falls. Very often their medical need is small and they just need a bit more care to help them through. With improving technologies it is now possible to manage many problems in a patient's own home or local community that would have required hospital admission 10 years ago. Innovative schemes have shown how early assessment, with good communication between primary and community health services and hospital specialists, can improve outcomes by keeping people out of hospital. These should be developed and expanded.

Figure 1: Opportunities for meeting people's urgent and emergency needs closer to home



- Of the 9 million emergency "999" calls made last year, 7 million resulted in an emergency ambulance journey. Ambulance services are highly valued for the speed of their service and the skills of paramedics, but these skills are incompletely used when, in some cases, an ambulance simply drives a patient to hospital. By supporting and developing paramedics, and providing direct access to the expertise of general practitioners and specialists, around half of all 999 calls which require an ambulance to be dispatched could be managed at the scene, avoiding an unnecessary trip to hospital. However, there is a great deal of variation around the country in the number of paramedics available, access to GPs and the frequency with which patients are transported to hospital. This must be improved so that ambulances can become and are seen as a community-based mobile urgent treatment service, rather than solely a means of transportation.

- 40 per cent of patients who attend an A&E department are discharged requiring no treatment. Many of these individuals could have been helped just as well closer to home, for example at their own GP's surgery or a local GP run Urgent Care Centre, provided the services were accessible and convenient. The NHS should ensure that primary care services, close to home, are consistently available to help patients with urgent care needs. At the moment, patients contacting their GP's surgery with an urgent problem receive a very variable response, and may be directed elsewhere. This places extra pressure on other services such as A&E, and we know that when A&E departments get crowded safety becomes compromised. It is therefore essential that we find ways to improve access to primary care without significantly increasing the overall workload of these already busy services. This will mean reducing bureaucratic burdens on primary care. There is strong evidence that a significant proportion of the urgent work done by GPs can be handled over the phone. An efficient telephone service is more convenient for patients, allows more people to be helped and also frees up face-to-face appointment slots for those who need or prefer them. Patients also tell us they are less worried about seeing their own GP for one off advice and treatment.

- Community pharmacies are an under-used resource: many are now open 100 hours a week with a qualified pharmacist on hand to advise on minor illness, medication queries and other problems. We can capitalise on the untapped potential, and convenience, that greater utilisation of the skills and expertise of the pharmacy workforce can offer.

- We can also do much more with the telephone. NHS 111 has the potential to provide a fast and effective service that decides how serious a problem is, how it should be dealt with and how soon. This is important because without a single, clear point of advice it has been shown that people "bounce around" the system, being sent from one place to the next and being given conflicting information and advice. Telephone services such as NHS 111 can be made even more effective when there are doctors, nurses, mental health teams, dentists and other professionals on hand to advise

patients over the phone, and where necessary book the appointment or further care that a person needs. This type of approach has been shown to be effective in other countries, and would also work for the NHS. More modern forms of communication, for example via the internet, can also improve the speed and convenience of access to urgent healthcare.

- For the vast majority of patients, their nearest source of help will be at home; from family, friends and their own knowledge. Many individuals will use the telephone or internet to get advice. Research tells us that where patients are properly informed, empowered and supported they are quite capable of managing many problems themselves. This is particularly true when an individual has a long-term condition, such as diabetes or asthma. When they become experts in their own problems they know how to look after themselves and when to seek help, including directly from their hospital specialists. The NHS needs to promote and support self-care and provide readily accessible, reliable advice to help people take responsibility for their own health.

- Hospitals are a source of valuable expertise, but community healthcare staff and patients with long-term conditions who are under specialist care shouldn't always have to travel to a hospital to access this expertise. Improved communication between the hospital and community will allow GPs and patients to obtain specialist advice in a more timely way, or directly access a clinic or similar service when required. This approach has been shown to improve health outcomes and patient satisfaction, and should be more widely adopted. By removing the barriers between hospital and community it is possible to build a network of care in which information and expertise flows to where it is needed when it is needed, allowing urgent care to be provided closer to home.

A&E - same name, very different services

Although the section above clearly highlights the potential to meet the urgent care needs of millions of patients outside of hospital and closer to home, there will always be patients who require hospital based services for more serious problems.

The A&E "brand" is particularly trusted, but it is under serious threat from the relentless advance of medical science and steadily increasing demand. In the 1970s most A&Es and their hospitals could offer most people the best treatment of the day for most conditions. This is no longer the case.

Take heart attacks for example. In the 1970s heart attacks were treated with bed rest. The hospital mortality rate was about 25 per cent. Then coronary care units emerged so that similar patients were admitted to the same place and could be looked after by experts. The mortality fell to about 15 per cent. Then clot busting drugs came along. The mortality fell to 10 per cent. Then in the 1990s it became clear that the best treatment was to mechanically unblock the culprit coronary artery which was causing the heart attack. Evidence showed

that this reduced mortality to around 5 per cent, saved dying heart muscle, reduced the risk of a recurrent heart attack and prevented heart failure later. This was clearly the best treatment; but it required very expensive diagnostic equipment and cardiologists with special skills, and needed to be done quickly to be effective.

This combination meant that modern treatment of serious heart attacks was outside the realm of many hospitals. This treatment of heart attacks is now done by about half the hospitals in England, with about a third offering a comprehensive 24/7 service. We have good results by international standards because the diagnosis can be made in the ambulance and the right patients are taken to the right hospitals for the most advanced treatment. This means that for paramedics to get patients to the best and most appropriate services, they will sometimes drive past the nearest A&E to get the patient to the right place.

Similarly the treatment of those strokes which occur when the blood supply to part of the brain is blocked, has evolved. Effective treatment requires rapid transfer to a highly specialised unit with expensive diagnostic scanners and clinical expertise so that drugs can be given to minimise the extent of brain damage. Stroke services in London have been reorganised to offer this high level treatment, but this required redirecting patients with suspected strokes from 32 admitting hospitals to only 8. The end result is that London has the best stroke services of any capital city in the world, saving more lives and returning more patients back to independent living. The bald fact is that many hospitals should not be offering to treat acute strokes.

We have made good progress on treating heart attacks and strokes. Advancing science has directed the way we deliver services to achieve the best results, but this has also exposed the illusion and perpetuates the misconception that all A&Es are equally able to deal with anything that comes through their doors. We now find ourselves in a place where, unwittingly, patients have gained false assurance that all A&E's are equally effective. This is simply not the case. We also know that the likelihood of recovering from a particular illness or injury varies considerably between hospitals. Despite the best efforts of the staff who work there, many hospitals and their A&E departments do not have consistent consultant presence overnight or at weekends, and the support services available vary considerably. About 1 in 7 do not have on-site services such as critical care, acute medicine, acute surgery or trauma and orthopaedics.

So, A&E departments up and down the country offer very different types and levels of service and staffing, yet they all carry the same name. We need to ensure that there is absolute clarity and transparency about what services different facilities offer and direct or convey patients to the service that can best treat their problem. Most importantly, we need to ensure that anywhere that displays a red and white sign is a place that will provide access to the very best care to the most seriously ill and injured patients, 24 hours a day and 7 days a week. A place that can resuscitate, make a diagnosis, start treatment and ensure rapid transfer to the right place if it can't offer the very best care. This is what this review is about; building a responsive network of services across the system to better meet the needs of patients in the 21st century.

Chapter 3: Proposal for improving urgent and emergency care services in England

This chapter sets out our proposals for improving urgent and emergency care services in England. It has been informed by what we have learnt from building a research evidence base of facts and figures, and from our public engagement with clinicians, commissioners and patients.

Our vision is simple:

Firstly, for those people with urgent care needs we should provide a highly responsive service that delivers care as close to home as possible, minimising disruption and inconvenience for patients and their families.

Secondly, for those people with more serious or life threatening emergency care needs, we should ensure they are treated in centres with the very best expertise and facilities in order to maximise the chances of survival and a good recovery.

Figure 2 and the supporting commentary below sets out what we think needs to happen to deliver this vision.

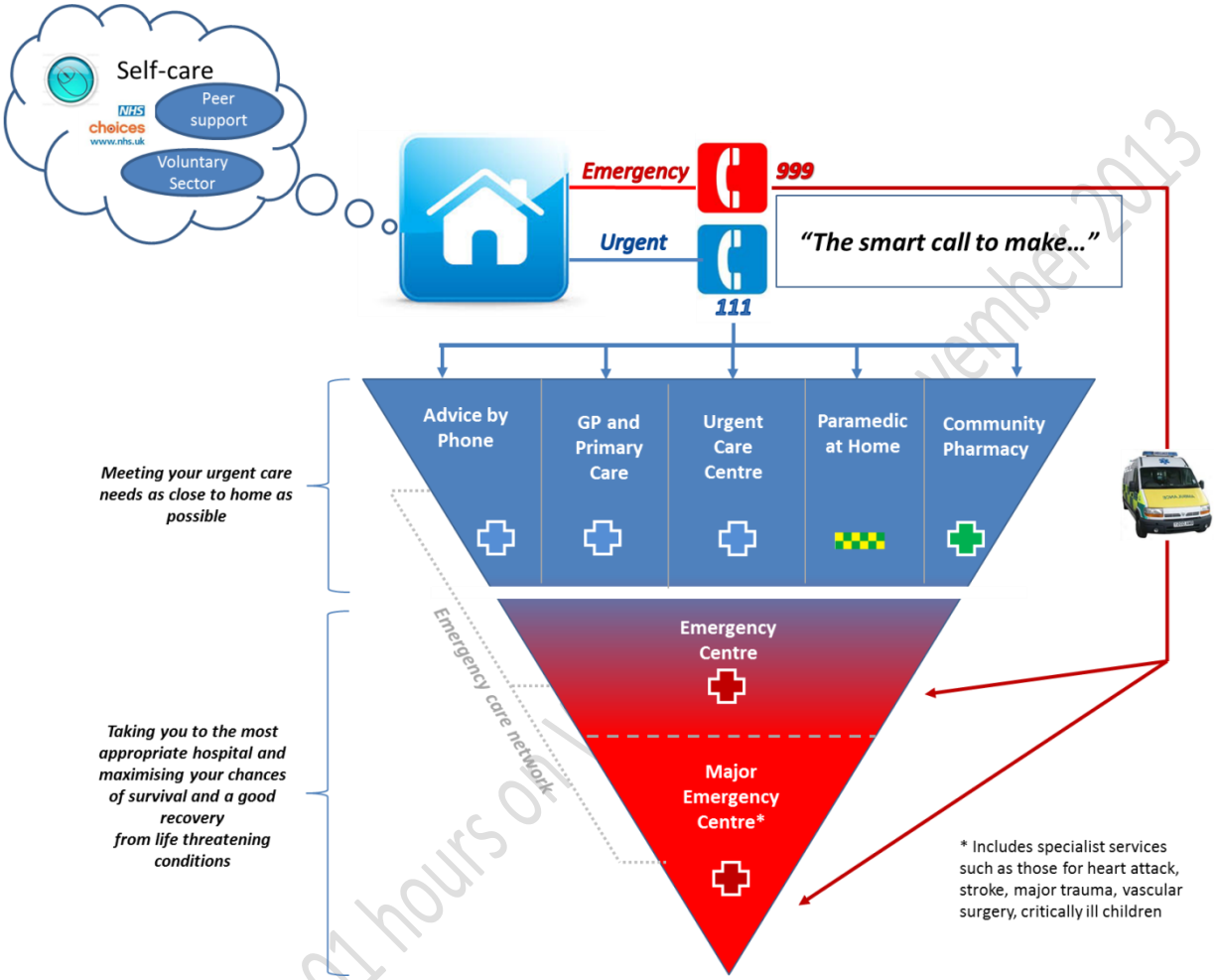
A. Supporting self-care.

Our starting point must be to equip as many people as we can with the skills, knowledge and support needed to self-care. This is by far the most responsive way of meeting people's urgent but non-life threatening care needs. Millions of people already do this, but millions more could be better supported to take control of their own health. To achieve this, we will need to:

- **Provide much better and more easily accessible information about self-treatment options so that people who prefer to can avoid the need to see a healthcare professional.** This will be developed with patient groups, NHS clinicians, charities, NHS Choices and other expert groups to maximise the opportunities offered by symptom-check technologies, health advice media, expert patients and peer support.

- **Accelerate the development of comprehensive and standardised care planning**, so that important information about a patient's condition, along with their values and future wishes, are known to all relevant healthcare professionals. This way, patients will be better supported to deal with their own condition before it deteriorates or additional help is required.

Figure 2: The proposed look and design of the new system.



B. Helping people with urgent care needs to get the right advice or treatment in the right place, first time.

Where people feel they need clinical advice or treatment for an urgent care need they must be rapidly supported in accessing the right advice or service first time and as close to home (or where they are) as possible. To achieve this, we will need to:

- **Significantly enhance NHS 111 so that it becomes the smart call to make, creating a 24-hour, personalised priority contact service. This enhanced service will:**

- **Have knowledge about you and your medical problems, so the staff advising you can help you make the best decisions.** Clinicians in the new NHS 111 service will have access to relevant aspects of your medical and care information, if you consent to this being available. This is particularly advantageous for people with long-term conditions or rare disorders, and those who are receiving end of life care.

- **Allow you to speak directly to a wider range of professionals (e.g. a nurse, doctor, paramedic, member of the mental health team, pharmacist or other healthcare professional)** if this is the most appropriate way to give you the help you need.

- If needed, **directly book you an appointment at whichever urgent or emergency care service can deal with your problem, as close to home as possible**. That could include a booked call back from a GP, a pharmacist review at a local chemist open for extended hours, an appointment at an urgent care centre, or a home visit by a community or psychiatric nurse.

- **Still provide you with an immediate emergency response if your problem is more serious, with direct links to the 999 ambulance service,** and the enhanced ability to book appointments at Emergency Centres.

C. Providing a highly responsive urgent care service outside of hospital so people no longer choose to queue in A&E.

To avoid people choosing to queue in A&E, or being taken to hospital unnecessarily to receive the treatment they need, the service outside hospital must be improved and enhanced. To achieve this, we will need to:

- Provide **faster and consistent same day, every day access to primary care and community services for people with urgent care needs.** This is likely to mean general practice, out-of-hours services, community health teams and the NHS 111 service working together, and differently, to ensure that patients with urgent care needs can receive prompt advice and care 24 hours a day, seven days a week. There are many innovative options to explore. The evidence for prompt telephone consultations is compelling, and can free up appointments to spend with those patients who would benefit from face to face care. GPs could lead integrated multi-disciplinary teams to manage whole pathways of care including the exacerbations of those patients with long term conditions, whilst improving assessment and treatment opportunities for the frail and elderly. We also need to ensure that GPs are better supported by hospital specialists so that they have access to a rapid, specialist clinical opinion, thus potentially avoiding the need to admit a patient in an emergency.

- **Harness the skills, experience and accessibility of community pharmacists** up and down the country. Pharmacists, with 4 years of training, have a wealth of knowledge and experience. They can advise on minor ailments, medication and prescription concerns and many have consultation rooms. We intend to ensure that these are utilised more effectively.

- **Develop 999 ambulances so they become mobile urgent treatment services, not just urgent transport services**. We know that paramedics can now deliver treatments that would only have been done by doctors 10 years ago, whilst with the support of improved community services they can safely manage many more people at scene. This gives us both more options to treat people at home, and to travel further to reach specialist care. There are opportunities for extending paramedic training to better assess, prescribe for and manage patients with exacerbations of chronic illnesses and work more closely with GPs and community teams.

- **Support the co-location of community-based urgent care services in coordinated Urgent Care Centres.** These will be locally specified to meet local need, but should consistently use the "Urgent Care Centre" name, to replace the multitude of confusing terms that are available at present. Urgent Care Centres may provide access to walk-in minor illness and minor injury services, and will be part of the wider community primary care service including out-of–hours GP services. Considering all local facilities in this way will mean that networks will need to examine the extent of duplication or gaps in service offered by all of these facilities currently. Urgent Care Centres may also be advantaged by co-location with hospital services, particularly in urban areas. Urgent Care Centres would not carry the emergency red sign, nor be considered the right place to go in a medical emergency, but would have protocols in place with the ambulance service if such events occurred.

D. Ensuring that people with more serious or life threatening emergency needs receive treatment in centres with the right facilities and expertise to maximise chances of survival and a good recovery.

Where people have more serious or life threatening emergency care needs then they must receive treatment at centres with the necessary facilities and expertise, 24/7, to maximise their chances of survival and a good recovery. To achieve this, we intend to:

- Introduce **two levels of hospital based emergency centre.** For the purposes of this report we have called these "Emergency Centres" and "Major Emergency Centres", but the final names will be determined in consultation with NHS staff and

patients to ensure maximum clarity. These two levels will only be introduced once access to urgent care services outside of hospital have been sufficiently improved and enhanced, and in time will replace the inconsistent levels of service currently provided by A&E departments:

- **Emergency Centres will be capable of assessing and initiating treatment for all patients**. We anticipate that Emergency Centres in remote and rural communities, distant from more specialist services, will expect almost all patients to be directed or taken to them for initial assessment. Suitable patients will be managed by the local hospital services on the same site as the Emergency Centre. Those needing specialist treatments after assessment will be transferred; indeed critical care transfers will be a core part of the new system. In more urban areas, where specialist services are much closer, the assessment and commencement of treatment will often be undertaken by paramedics, followed by direct transfer to the specialist centre best suited to the patient's needs. This will, in turn, reduce demand at urban Emergency Centres.

- **Major Emergency Centres will be larger units, capable of assessing and initiating treatment for all patients and providing a range of specialist services.** Major emergency centres will have consistent levels of senior staffing and access to specialist equipment and expertise. Transfer from a Major Emergency Centre will be rare, with the exception of patients returning to community settings closer to home when they are well on the road to recovery from major illness and injury.

- **Implement the findings of the NHS Services, Seven Days a Week Forum**, which will be published before the end of the year. This report will focus on improving urgent care services at the weekend and will include proposals to adopt of a set of clinical standards that should be delivered seven days a week. The presence of senior clinicians is important for ensuring the best decisions are taken, reassuring patients and families and making best use of NHS resources.

These proposals are **not** about cutting existing urgent and emergency care services. Indeed, we expect the overall number of Emergency Centres (including Major Emergency Centres) to be broadly the same as the current number of A&E departments. Our intention is to achieve a substantial shift of care out of hospitals and into community settings in order to create a comprehensive system of care across a network that will deliver good outcomes for all patients in a safe and effective way. As local communities achieve this, by re-designing their systems, some new services will be created and some old services will no longer be required. However, these decisions must be made in the context of local need and resources, and with the overall aim of improving the urgent and emergency care system.

E. Connecting the whole urgent and emergency care system together through networks.

To make the whole urgent and emergency care system operate as effectively and efficiently as possible, and become more than just the sum of its parts, a networked approach must be introduced in which patients, along with all relevant information, flow smoothly between the different components. To achieve this, we intend to:

- **Develop emergency care networks.** The recent introduction of major trauma networks has been a huge success story that has saved the lives of hundreds of patients. These principles will be extended to the whole emergency care system, ensuring a consistent approach to the delivery of services and formally linking the community and hospital components of the urgent and emergency care system. Major Emergency Centres will have a lead responsibility for the quality of care and operational performance of service across the network they support, including linked Emergency Centres. Furthermore, ensuring that there is senior clinical support available throughout this structure will improve outcomes and ensure the best use of resources.

- **Support the introduction of an efficient critical care transfer and retrieval system.** To ensure that patients with specialist needs reach the best possible care in a timely fashion we will support the introduction of formal transfer and retrieval systems in remote and rural areas. These will be modelled on the best existing services for critically ill and injured children and adults, and will be key to achieving the best possible outcomes for all patients.

- **Ensure that the networks extend to community services, with free flow of information and expertise between the hospital and community.** We will use the emergency care networks as a means to challenge and dissolve traditional boundaries between hospital and community based services, to facilitate a dialogue between primary and secondary care staff and to ensure the timely flow of information relevant to a patient's care. This will ensure that important clinical decisions are not made in isolation, but with the full support of the expertise and experience of the supporting network.

Chapter 4: Next Steps

The system-wide transformation of urgent and emergency care services, as described in the previous chapter, is a major undertaking. There will be many challenges along the way. Traditional barriers and vested interests will need to be broken down.

But the truth is that if we don't change the whole urgent and emergency care pathway, from start to finish, we will simply repeat the mistakes of the past: timid, limited or disjointed initiatives will be insufficient. All NHS staff and the public in England have an important part to play in implementing and supporting the changes that lie ahead.

With this in mind, we have already begun the work needed to deliver this change. We are working closely with our patients, partners and stakeholders in the NHS and local government, to make this happen. Throughout this review, we have committed ourselves to being open and transparent – developing and delivering this work in public on NHS Choices (www.nhs.uk). We will continue to do so and we will act on the feedback we receive.

We know people will want to see change as soon as possible, but we need to ensure that there are no risky, ill considered "big bangs", and that there is a managed transition to the future system. We anticipate that it will take 3-5 years to enact the major transformational change set out within this report. However, we expect to make significant progress over the next 6 months on the following areas:

- Working closely with local commissioners as they develop their 5 year strategic and 2 year operational plans;

- Identifying and initiating transformational demonstrator sites to trial new models of delivery for urgent and emergency care and 7 day services, supported by NHS Improving Quality;

- Developing new payment mechanisms for urgent and emergency care services, in partnership with Monitor;

- The completion of the new NHS 111 service specification so that the new service (which will go live during 2015/16) can meet the aspirations of this review; and

- Working through the NHS Commissioning Assembly to develop and co-produce with clinical commissioning groups the necessary commissioning guidance and specifications for new ways of delivering urgent and emergency care (with this process continuing over the remainder of 2014/15).

Some issues will take longer to resolve than others, and longer term streams of work are required to:

- Develop, cost and assess some of the clinical models described in this report, including those for primary care, Emergency Centres and the ambulance service;

- Carefully consider and develop the clinical standards, metrics and outcome measures which will enable us to monitor and measure the success of the new system;

- Develop models and tools to improve the monitoring and management of capacity within the system all year round;

- Amend contracts and make changes to their respective incentives to ensure that organisations can deliver the proposed changes; and

- Develop a programme with Health Education England to ensure that the correct workforce structure is in place to support the future changes.

We are particularly conscious that any new system must be responsive to the needs of the most vulnerable people in society who rely on the urgent and emergency care system: people at the extremes of age, people with troublesome long-term health problems, people from deprived communities and people suffering mental health crises. Unless we serve our most vulnerable and disadvantaged as well as our most affluent, we will be failing the values of our society and the values of the NHS.

Only by building the right system, and better supporting patients and the public to use it effectively, will we achieve improved outcomes for urgent and emergency care in the NHS and truly deliver high quality care for all, and ensure the same for future generations. We will report on progress in Spring 2014.

Appendices (published separately)

Appendix 1: **The Evidence Base from the Urgent and Emergency Care Review**

Appendix 2: **Revised principles and design objectives for a new system of urgent and emergency care**

Appendix 3: **Summary of Engagement Responses**