AUEC0005

Written evidence submitted by NHS Confederation

NHS Confederation submission to the House of Commons Public Accounts Committee inquiry on Urgent and Emergency Care

About us

The NHS Confederation is the membership organisation that brings together, supports and speaks for the whole healthcare system in England, Wales and Northern Ireland. The members we represent employ 1.5 million staff, care for more than 1 million patients a day and control £150 billion of public expenditure. We promote collaboration and partnership working as the key to improving population health, delivering high quality-care, and reducing health inequalities.

We are submitting evidence to this inquiry using the knowledge and understanding we have gleaned from Urgent and Emergency Care (UEC) service leaders in our Acute Network, but also from across our other networks and our work on the streamlined access vision from the Fuller Stocktake as we feel it is important to highlight the interdependencies between parts of the system that impact access to UEC and that this should be given consideration as part of the committee's inquiry.

Our Acute Network provides a national voice for acute trusts, ambulance services and integrated secondary care providers. Our Mental Health Network represents mental health providers and commissioners. Our Primary Care Network is the only network bringing together primary care providers with the rest of the healthcare system. Our Community Network (hosted jointly with NHS Providers) supports trusts and not-for-profit organisations involved in providing care to the population in the community. Lastly, our Integrated Care Systems (ICS) Network is the only independent national network which supports ICS leaders to exchange ideas, share experiences and challenges, and influence the national agenda. We are delighted to have all 42 ICSs in membership.

Summary

Urgent and emergency care (UEC) services have experienced huge pressure in recent years from rising demand for care. There are multiple dependencies between UEC and different parts of the health system which mean it is impossible to scrutinize the provision and performance of UEC services without looking at how those services interact with other parts of the NHS and wider public services. Problems with capacity in one part of the health and social care system are reflected across different services. As we have increasingly seen in recent months, delays in transferring patients from hospital to social care services when they are medically fit to leave reduces available bed capacity, which results in slower admissions from emergency departments and then to longer ambulance handovers.

As such, this is an inter-linked system and solutions to address these challenges must be system-wide – they must look to address demand for UEC through primary, community and

other public services and improving flow of patients out of UEC to other services – or they will at best bring limited benefit.

NHS and wider public service leaders working across the health and care system want to see the following actions introduced in the run-up to winter 2023/24 in order to prevent a repeat or exacerbation of winter 2022/23, and to ensure UEC and the wider system can more sustainably manage patient need in the future:

Short-term

1. As recommended in the Hewitt Review, government must provide upfront winter funding to Integrated Care Systems (ICSs) and roll it into general allocations to better plan for increased pressure during winter. These allocations must give ICS leaders maximum possible flexibility so local leaders can make decisions in relation to the needs of the community and to ensure best value for money for the taxpayer.
2. Government must fully fund the pay uplift agreed with Agenda for Change unions, including staff employed by organisations from primary care providers, local authorities, charities, social enterprises and community interest companies (who may or may not be on Agenda for Change terms and conditions), and independent healthcare providers involved in delivering NHS care. In addition, health who are still in dispute and government must work to find a way forward.
3. As recommended by the Hewitt Review, conduct a cross-government NHS capital review to address the £10.2 billion maintenance backlog and ensure adequate investment in IT equipment, estates, and infrastructure to enhance patient safety and productivity. Following this, implement a 10-year capital plan that allows ICSs to tailor services to local needs and enables providers to access capital across systems, considering mental health, specialized, and ambulance providers.
4. Government must invest in intermediate and social care, particularly domiciliary care, to address discharge delays and reduce lengths of stay. This should include a commitment to Primary Care Networks (PCNs) beyond 2024, protecting preventative services as well as Enhanced Health in Care homes.
5. Ensure Integrated Care Boards (ICBs) implement the Fuller Stocktake vision regarding streamlined access for systems and ‘same day’ urgent care teams within primary care.

Longer-term

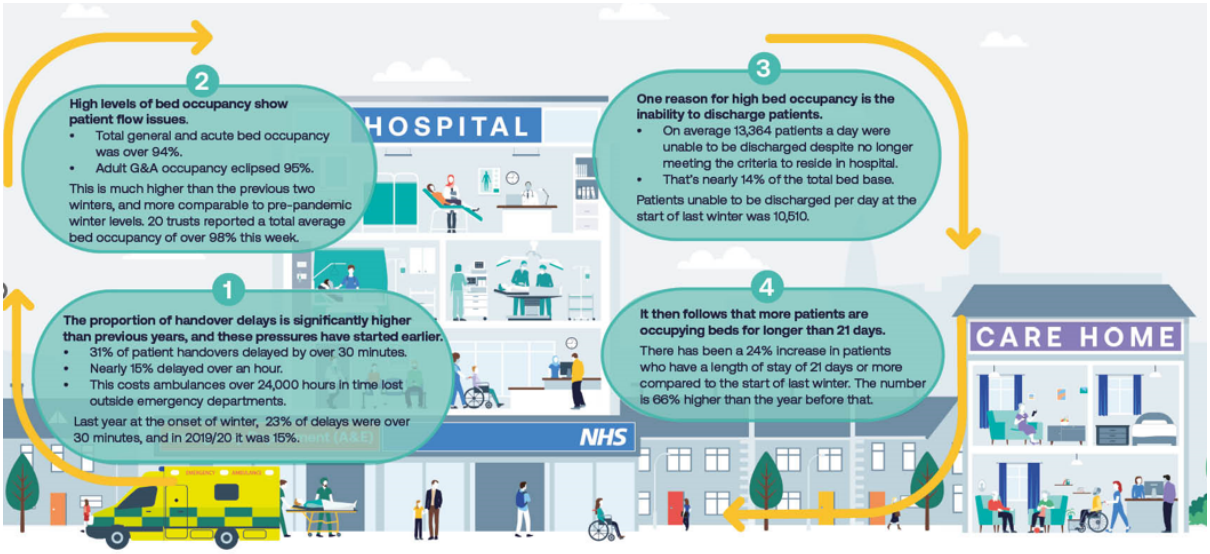
6. Systems need to be empowered to shift investment towards primary, community and early intervention mental health care to keep people – particularly, but not limited to, the elderly - as well as possible at home. Early intervention in mental health is needed for people of all ages, to reduce demand for acute and crisis mental health services and UEC services. Systems do still need to invest in acute and crisis mental services, improving patient experiences in ED, and alternatives to ED with a view to patients having timely access to the care they need.
7. ICS should continue to consider how to support and scale up successful initiatives such as the Care Coordination Hub and consultant-led services that help manage older patients at home and avoid unnecessary hospital admissions.
8. Government must publish the NHS long-term workforce plan without delay, and this must be fully funded and implemented.

Access and flow

1. UEC services have faced overwhelming pressure in recent years, pre-dating but exacerbated by the Covid-19 pandemic, and continuing post-pandemic with winter pressures. Many voices across the NHS and the wider health sector have identified winter 2022/23 as being the worst ever for the NHS since its inception.

2. For patient flow to work efficiently within a hospital and to optimise patient safety, bed occupancy should be no greater than 85 per cent. It is currently running at an average of 90 per cent and often reaches 10 per cent and has remained at about 9 per cent for mental health beds for around a year.[1]

3. Access to UEC is an issue that highlights the interdependencies between the different sectors of the health and care system. Issues in one part of the system create increased pressure in others and result in patients presenting in a less appropriate part of the health service or waiting for a long time to receive treatment. The infographic below shows this in more detail.



4. Although political focus has largely been on elective services, pressure on acute services, including same day capacity in primary care, and industrial action indirectly impacts the government priority of reducing elective waiting lists with staff getting re-directed to UEC. The mechanism of this cause and effect is associated with high levels of staff stress and burnout, staffing ratios become stretched, and staff being redeployed to unfamiliar areas and teams. Ultimately, this leads to a rise in staff

[1] https://www.england.nhs.uk/statistics/statistical-work-areas/combined-performance-summary/?utm_campaign=1365585_NHS%20Confederation%20responds%20to%20monthly%20performance%20figures%20%28May%202023%29&utm_medium=email&utm_source=NHS%20Confederation&dm_t=0,0,0,0,0

sickness, worsening staff retention, and the increased likelihood of patient safety incidents.

Role of primary and community care

5. While pressure in urgent and emergency care is often perceived primarily as a problem for acute providers, it also impacts primary and community providers. Primary care provides same day appointments in GP surgeries as well as, in many cases, running urgent treatment centres (UTCs), whilst both primary and community care are likely to have responsibilities for patient care post-discharge.

6. Both primary and community care providers are working collaboratively with system partners to increase the capacity for out of hospital care, which would allow patients to be cared for in the community rather than remaining in - or even entering - hospital. This includes enhanced discharge pathways, virtual wards and integrated neighbourhood urgent care teams, the latter of which was recognised in the 'Next Steps for Integrating Primary Care: Fuller Stocktake Report'.[2]

7. For example, PCNs in Gateshead have introduced a GP presence in A+E to stream patients to the most appropriate care provider. This service has seen large numbers of patients who require GP access attending A+E citing long waiting times in primary care. This has led to work to increase primary care capacity, including greater pharmacy involvement, to ensure that capacity issues in primary care do not spill over into the urgent and emergency services.

8. Bradford Care Alliance CIC has established a Child Health Hub which works with paediatric staff from secondary care within a primary care setting to ensure children who need same day, but non-emergency care, do not present in A+E. This service saw a huge amount of traffic during the Strep A peak in Winter 2022, but the urgent and emergency care service was insulated from this rise in demand as a result.

9. The role of general practice is vital as part of this, through both PCNs and, at a greater scale, through PCN Alliances or GP Federations, which enable better integration with secondary care and community care, thus creating more resilience within the health and social care system. Although, this approach was absent from the Delivery Plan for Recovering Urgent and Emergency Care[3], it holds potential to alleviate pressures on both primary care and the UEC sector.

10. The Foundry Model of Care, developed by the Foundry Healthcare Lewes Primary Care Network, is a key example of primary care transformation reducing demand on urgent and emergency services. The programme is based on a population health management approach to deliver a needs-led model of Primary Care. This involved segmenting their patient population to identify those where continuity of care should be prioritised and supported by a multi-disciplinary and integrated team. By adopting the Foundry's model, estimated savings can be seen in the reduction of 12,480 non-elective bed days, 751 fewer A&E visits, 170 fewer ambulance conveyances and 720 fewer locum GP sessions over a three-year period.[4]

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[2] https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/
[3] https://www.england.nhs.uk/publication/delivery-plan-for-recovering-urgent-and-emergency-care-services/
[4] https://kssahsn.net/improvement/an-evidence-based-roadmap-for-transforming-primary-care/

11. Primary care continues to deliver in the face of rising demand, demonstrated by the Covid-19 vaccine roll-out and provision of 12 per cent more appointments in general practice compared to pre-pandemic, despite a decline in the number of GPs. It is critical government invest in primary and community care – which has not been given the same level of political focus and priority as tackling the elective backlog – to ensure the maximum number of people can be cared for and kept as well as possible at home, which is the most appropriate setting for many people.

12. This means committing to PCNs beyond 2024, and fully funding the pay uplift for all staff, not just those on Agenda for Change terms and conditions, to prevent a two-tier pay system for those delivering essential services for communities[5].

13. Shifting investment toward prevention and early intervention would also support UEC. As seen from the innovations highlighted above, keeping people well in the community and at home is a vital part of delivering a UEC system that is fit for purpose. Investing in out of hospital solutions and in community and primary care supports people to stay well for longer, as well as enabling them to be treated for physical and mental health conditions within the community and at home.

14. Primary care, social care and the community sector are all very well placed to deliver effective and targeted prevention plans. PCNs and GP federations are already working to reduce local demand by tackling health inequalities, focussing on the Core20Plus5 group[6] which are most likely to suffer ill health and require treatment.

15. The Delivery Plan for the Recovery of Primary Care Access[7] has been welcomed for rightly prioritising patient access, but there are concerns that the reallocation of funding away from prevention services will negatively impact access in the medium to long-term.

16. Similarly, investment in primary care would have positive consequences for UEC. Primary care is often the front door of the NHS. Community pharmacy and general practice are delivering more patient contacts and appointments than ever before.

17. Support for primary care to increase capacity through improved estates, retention, recruitment and effective triage will reduce the number of patients who choose to present at ED rather than wait for an appointment. Good work has already been done increasing the number of primary care staff though investment in the PCN Additional Roles Reimbursement Scheme, but much more is required.

18. Lastly, despite the UEC recovery plan acknowledging many of the right areas of focus, it is unfortunately fairly short term. The NHS Confederation calls for a longer-term UEC plan that will resolve some of the difficulties once and for all.

Mental health services

19. There was a large increase in demand for mental health services during the pandemic, and due to a lack of early intervention services, people are often reaching crisis point before they access services. Mental Health Network members told us

[5] https://www.nhsconfed.org/publications/letter-secretary-state-health-and-social-care
[6] https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/core20plus5-cyp/
[7] https://www.england.nhs.uk/publication/delivery-plan-for-recovering-access-to-primary-care/

that the patients they are seeing are more acutely unwell, often with complex needs and so are staying in hospital for longer and there is still a large number of patients being placed out of area due to pressures on beds.

20. As per the NHS Long Term Plan[8], mental health transformation work is integrating primary and voluntary sector care and mental health services, for example in Sheffield[9], to help people to get support in the right part of the system. In Sheffield, there has been nearly a 90 per cent increase in mental health access rate for minority ethnic groups presenting to secondary care, from 11.6 per cent to 22 per cent.

21. However, the current degree of need for services means many patients with severe mental health symptoms are presenting at different parts of the system that are not necessarily best equipped to provide care.

22. Mental health services are often closely linked with UEC and the pressure on acute mental health services is unprecedented. Demand for mental health support increased during the pandemic and the current backlog is estimated to be 1.2 million people[10]. Increasing access to mental health crisis services via NHS 111 or other helplines is a positive step but other measures are required, particularly in the area of child and adolescent mental health where acute services are especially overwhelmed. Improving access to alternatives to ED, such as crisis cafes and sanctuaries is important, as EDs are often not a conducive setting for people experiencing a mental crisis, however some will need to access ED to meet their clinical needs.

23. People with acute mental health needs are more likely to have a poor experience of UEC services. One in 5 people with mental health needs accessing ED are waiting more than 12 hours[11] - double the rate of people with physical health needs.

24. In Hampshire, Southampton and Isle of Wight, they produced a single point of access to mental health crisis support using mental health nurses working in NHS 111[12]. This allowed 88 per cent of all calls to be supported with home management/self-care, compared to 11 per cent before the service, and reduced 999 mental health contacts by 26 per cent.

Delivery Plan for Recovering Urgent and Emergency Care Services

25. In the Autumn Statement 2022 the government identified two key targets to assess UEC performance: year-on-year improvements in ED waiting times; and a reduction in average category 2 ambulance response times to 30 minutes over 2023/24. Albeit, achieving the latter would still mean patients waiting almost twice as long as they should under the most recent national targets.[13]

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[8] https://www.longtermplan.nhs.uk/
[9] https://www.nhsconfed.org/case-studies/sheffield-primary-care-mental-health-transformation
[10] https://www.nhsconfed.org/news/high-levels-need-mental-health-care-shows-critical-government-seize-opportunity-ten-year-plan
[11] https://rcem.ac.uk/patients-in-mental-health-crisis-twice-as-likely-to-spend-12-hours-or-more-in-emergency-departments-than-other-patients/
[12] https://www.nhsconfed.org/case-studies/nhs-111-mental-health-triage-service
[13] https://www.gov.uk/government/topical-events/autumn-statement-2022

26. The Delivery Plan for Recovering Access to Primary Care lays out plans for improvements to access in primary care, including same day assessment for clinically urgent appointments and aligns with the Fuller Stocktake. [14] The NHS Confederation is supporting systems to engage with both plans for a cohesive approach to urgent, emergency and same day access across the system, including through our Access Design Group.[15]

27. The emphasis the UEC Recovery Plan puts on local flexibility and cross-system collaboration is welcome.

28. High bed occupancy and the delayed discharge from hospital of medically fit patients are the main drivers of suboptimal patient flow. The most important deliverable therefore will be an improvement in patient flow for which the proxy measures of ED waiting times and ambulance response times will be utilised.

29. The detail of the underpinning implementation plan is yet to be made available, but it is essential this plan is adequately and promptly funded through ICBs overall allocations to mitigate the impact of the forthcoming 2023/24 winter pressures. The government has previously identified funding to the tune of £1 billion for an increase in UEC capacity, £150m for mental health UEC and £1.6 billion for social care discharge funding (the Better Care Fund),[16] whilst the majority of PCN incentivised funding has been redeployed towards patient access within two weeks and away from prevention services, further investment in both prevention services and access to appointments is required.

30. This would account for the increase in patient demand since the funding was agreed in 2019 as primary care now delivers more appointments, with increased acuity, than pre-pandemic despite fewer GPs.[17]

31. NHS leaders have previously said that money for addressing winter pressures was received too late to be used as efficiently and effectively as possible.[18] Going forward, it is critical services know what they will be allocated in good time (and ideally over the summer) so they can make best use of taxpayer money.

32. For instance, the Winter Access Fund was announced in late October 2022, well after most systems had completed their winter planning. The fund was accompanied by a winter planning letter and winter resilience plans - collectively 121 pages of guidance on how the funding should be spent and how ICBs should report on allocation of funds so NHSE can performance manage this.[19] The funds available did not match with pre-existing, locally developed plans. Earmarking funds specifically for spending on additional beds prevented systems from achieving better value by using it on measures which would have kept people out of hospital.

33. The Adult Social Care Discharge Fund was made available to ICBs by DHSC at short on notice on 21 November 2022 with ICBs required to submit plans by 16 December

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[14] https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/

[15] https://www.nhsconfed.org/primary-care/shaping-future-primary-care

[16] https://www.gov.uk/government/speeches/oral-statement-on-new-discharge-funding-and-nhs-winter-pressures

[17] https://www.nhsconfed.org/news/we-need-primary-care-recovery-plan-matter-urgency

[18] https://www.nhsconfed.org/publications/discharge-funding-address-unprecedented-nhs-pressures

[19] https://www.england.nhs.uk/publication/going-further-on-our-winter-resilience-plans/

2022.[20] Funding was dependent on being spent against 11 criteria, assessed by six metrics, with repeated fortnightly reporting on spending through a template submission. This funding is worth about 0.3 per cent of the total NHS budget – proportionally the specificity of the criteria and volume of reporting significantly constrains ICSs flexibility and adds bureaucratic pressure.

34. A better approach would be to consolidate the funding available to systems in their overall allocations, with reporting based on the overall outcomes relating to ICSs' four core purposes and an overarching accountability framework, as recommended in the recommendations of the Hewitt Review, this funding must be allocated giving local leaders maximum possible flexibility, allowing them to use it to best meet the needs of local communities and ensure best value for taxpayer money.

35. NHS leaders are encouraged by the recognition of the need to build capacity across a range of services in the UEC Recovery Plan, rather than focusing solely on reducing demand. Increasing the number of ambulances including mental health ambulances, expanding same day emergency care to reduce the number of patients requiring an overnight hospital stay, increasing capacity in virtual wards run by trusts and Primary Care Networks (PCNs) and creating 5,000 new beds are all steps in the right direction.

36. However, additional capacity needs to be staffed appropriately. To improve recruitment and retention of skilled staff, the Agenda for Change uplift agreed between Secretary of State and the health unions for 2023/24 should also be funded for staff in primary care.

37. Reducing discharge delays from hospitals by increasing intermediate and social care, especially domiciliary care, following decades of underfunding, is critical to addressing discharge issues from acute hospitals. Shifting assessments for long term care from hospitals to the community will help decrease lengths of stay, but the benefit of the proposed 'care transfer hubs[21]' and increased numbers of discharge lounges remains to be seen as they risk introducing another step in an already lengthy process. This lack of investment outside of hospitals is the root cause of the current pressures on flow and resultant discharge delays, including pay for social care workers which, unless addressed, will continue to damage recruitment and retention.

38. Patients with the longest lengths of stay place the greatest demand on hospital services are often frail, elderly patients often with complex co-morbidities. Enhanced frailty outreach services, such as the national Enhanced Health in Care Homes PCN service, can help avoid hospital admission in this demographic.[22]

39. Innovative work such as that through the Care Co-ordination Hub in Bath & NE Somerset, Swindon and Wiltshire (BSW) ICS, has been shown to be highly effective[23] . This multidisciplinary team has run as a pilot since November 2022, ensuring ambulance crews can contact the Hub about any patient who is non-time critical and

[20] https://www.gov.uk/government/publications/adult-social-care-discharge-fund
[21] https://www.gov.uk/government/publications/hospital-discharge-service-action-cards/hospital-discharge-service-requirements-action-cards-for-staff
[22] https://www.england.nhs.uk/community-health-services/ehch/
[23] https://bsw.icb.nhs.uk/for-clinicians/anticipatory-care/coordinated-care/

over 70 years of age and who is being considered for conveyance to an Emergency Department. Since the pilot began one in four patients has been conveyed to ED, compared to one in three before. The Care Coordination Hub have taken calls off the ambulance call list, talking to the patient and carers and averting an ambulance call out. These 'hear and treat' outcomes have increased from 27 per cent to 41 per cent through the pilot. As well as creating less demand on UEC, this pilot is stopping elderly patients from being taken to ED when it is not the best place for them to be. Ensuring these services continue to be funded is crucial, including committing to continuing with PCNs beyond 2024 when the current GP contract ends.

40. South Warwickshire NHS Foundation Trust (SWFT) has worked with West Midlands Ambulance Service to better support older patients to be managed at home.[24] The trust provides a consultant led service that supports ambulance crews to ensure older patients are directed to the right speciality first time and increases the chance of them being able to be sent home on the same day or treated at home through a virtual ward. As a result of this nearly half of all conveyances have been avoided.

41. Meanwhile, Barts Health NHS Trust is working with partners across London to reduce unnecessary hospital admissions through facilitating alternative care pathways.[25] Their Remote Emergency Access Coordination Hub (REACH) has helped over 17,500 patients, with 65 per cent of them treated virtually or in the community.

42. ICSs need sufficient agency and funding in their allocations to drive this type of innovative good practice well in advance of the coming winter.

43. As recommended in the recent Hewitt Review[26], Integrated Care Systems need their additional winter funding upfront, and it should be rolled into general allocations. This way systems will be able to plan better for winter, which is always a time of increased pressure. In fact, the Review recommends the elimination of these small and inflexible 'penny packets' wherever possible.

Capital

44. Capital investment is how the system buys new IT equipment for diagnostics, new estates to expand and integrate care, and upgrades older estates. It has been shown to increase productivity, keep patients safer and regenerate communities. The cost to eradicate the NHS maintenance backlog currently stands at around £10.2bn[27], leaving staff working and patients being treated under leaky roofs and crumbling buildings being held up by props. This is an issue across NHS services, and not all parts of the service are equally addressed by the government's New Hospital Programme, such as mental health and primary care.

45. We support the recommendation from the Hewitt Review for a cross-government NHS capital review with implementation of resultant findings by 2024. A move to a 10-year capital plan would provide greater certainty for services and freedom over larger sums of money so that ICSs can do what they were introduced to do, tailor their services to local need. It should also look at the sign off process for capital

[24] https://www.nhsconfed.org/case-studies/reducing-conveyances-older-patients-south-warwickshire
[25] https://www.nhsconfed.org/case-studies/reducing-unnecessary-attendance-accident-and-emergency-department
[26] https://www.gov.uk/government/publications/the-hewitt-review-an-independent-review-of-integrated-care-systems
[27] https://www.nhsconfed.org/articles/crumbling-buildings-and-creaking-systems-nhs-capital-investment

funding, which can cause delay and spiralling project costs, and how to enable providers working across systems (particularly mental health, specialised and ambulance providers) to access capital to support population need rather than just in their headquartered ICS.

46. Whilst the government response to the Hewitt Review accepted the recommendations on capital in principle, NHS leaders believe adopting and implementing them is critical.

47. Some of this funding for capital may be allocated to improving technology which has a number of benefits including being better for the environment, improving patient experience and reducing administrative burden, but can also be used for virtual wards in some cases, alleviating pressure on wards and allowing patients to be cared for in the comfort of their own home.[28]

Workforce

48. The NHS is threatened by significant staff shortages with experienced and skilled employees leaving in unprecedented numbers because of stress, burnout, ill-health or opportunities to take early retirement or work abroad. Growing the workforce is vital but needs to occur in tandem with enhanced retention to be effective. Increasing the clinical triage capacity of NHS 111 and urgent call centres and numbers of Emergency Medical Technicians (EMT's) to support paramedics is helpful, but UEC recovery calls for a fully funded workforce plan. The NHS workforce plan is eagerly anticipated. Also, given the interdependencies between UEC and primary care, it is vital that primary care is funded to accommodate the Agenda for Change uplift for its staff that are on the Agenda for Change pay scale, which we have written to the Secretary of State about[29].

49. We are still awaiting publication of a fully funded workforce plan - something that NHS leaders have long been calling for, and that has repeatedly been delayed. As touched on previously, we will not be able to address the issues faced by UEC, and other areas of the health and social care system to make the service more sustainable in the future without a plan that addresses recruitment and retention, and with funding that is fully accounted for.

Social care

50. It is important to note the other health and social care services that have a knock-on impact on UEC, and vice-versa, and this need attention. The crisis facing social care is well known - underinvestment and understaffing most notably. Insufficient access to social care often leads to patients landing up in hospital, or requiring an ambulance, as well as patients remaining in hospital longer due to no appropriate place for them to be discharged to- this is the case for mental health patients too. Therefore, this is one of the root causes of UEC demand, but addressing the issues around social care capacity could offer solutions to issues across the system, including in UEC.

June 2023

[28] https://www.nhsconfed.org/publications/realising-potential-virtual-wards
[29] https://www.nhsconfed.org/publications/letter-secretary-state-health-and-social-care