

# **Urgent & Emergency Care**

## **Review**

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## Executive Summary

There is some uncertainty about the overall structure, shape and scope of the urgent care infrastructure development arrangements across Yorkshire and Humber, with some differences in approach.

The review was also designed to compare and contrast how the approach to UEC differs across the region and set this all into the context of past trends (focused on A&E attendance), past and possible future policy context.

We set out to explore a number of areas including infrastructure for UEC, governance, strategy, past achievements, investments and evaluations and stakeholder's views on the future direction.

The end point was intended to be a report principally intended for use by the AHSN Standing Conference and to inform the views of providers and commissioners in Y&H.

### Results

**Population-** the population is projected to grow by c5-9% out to 2030. Some areas projected to grow more rapidly than others. Population set to grow most rapidly in elderly, and to fall in some working age bands.

**Activity-** A&E data is set out at trust level. This broadly tells us the same story as national data we are familiar with. A&E attendance per 1000 in the hospital catchment population varies across Y&H (this metric obviously takes into account population growth). Excluding obvious outliers (HDFT/York) between 10/11 to 14/15 attendances/1000 change ranged from 2.6% fall to 10% growth.

**Capacity/ Bed Base-** there is a long term secular reduction in hospital bed base – seen nationally and locally, though locally the picture is mixed. Some trusts are shrinking more rapidly than others. Broadly speaking at national level, occupancy has increased as bed base has decreased. Occupancy is more difficult to discern locally – maybe a function of use of Q1 data. The availability of beds per capita varies across trusts from 1.5 per 1000 to 3.7 per 1000. To date there is limited to no regional data available on community bed capacity. The NAIC may be able to answer some of these questions.

**Workforce-** The hospital medical workforce would appear to be growing faster than the General Practice workforce. This may be at odds with a policy of moving care closer to home, and at odds with the need for greater emphasis on generalist skills. Seemingly less attention is given to numbers, capacity and capability of other elements of the current and potential urgent care workforce – notably pharmacists, urgent care practitioners and caring roles.

**Spend-** For all CCGs (inc Bassetlaw) in 13/14, of the £6.583bn spend on health care (NHSE Programme Budget), 23% of the total (or £1.57bn) is categorised as unscheduled.

Of the £1.57bn: £181m in A&E, £188m in urgent transport, £99m in other urgent care, £1.1bn in unscheduled admission.

### What Stakeholders are telling us Through Interviews

#### Strategic issues

- Dialogue and strategic relationships are important, but often overlooked in our efforts to transform services.
- For some, getting all stakeholders into the same room, talking the same language and moving towards a common understanding of the problem was a significant success.
- There are blurry boundaries between planned and unplanned care, different perspectives on what matters most & what is easiest to change, and the roles and responsibilities of SRGs and UCBs varies from place to place.
- There remains a tension between a micro approach (addressing specific and particular service problems at the frontline) and a macro approach (where urgent care fits into a broader picture of system).

- Relationship building is an important achievement in itself – from the shop floor perspective through to the boardroom. It is difficult to measure the value of this (and thus justify the cost of time).
- Short term funding, a scattergun approach to schemes and lack of robust evaluation remains problematic but reality. This was specifically with respect to the approach to “winter money”. Some saw the role of SRG being simply to distribute this fund. The rapid cycling of this form of funding also often led to knee jerk responses, incomplete implementation and bedding in of schemes and sometimes little to no evaluation and opportunity to learn.
- Small, often short term investments may detract attention away from larger scale service.
- The time to embed and mainstream new innovations shouldn’t be underestimated
- There may be some benefit from coming back to the evidence we may have overlooked before – specific schemes, pathways and innovations
- The “scope” of urgent care may vary from place to place.
- Many want to increase the emphasis and resource commitment given to “prevention”, and a more sophisticated approach.
- Culture - some of the main challenges will be around cultural differences between different parts of the system. These manifest in different ways and offer many opportunities.
- The role of the citizen and the patient is an area where there may be an under focus.
- Supply side versus demand side – most of the focus is on supply side, at the expense of better understanding of the demand side.

### **Transforming the System and Rationalisation**

Different stakeholders will have different views and perspectives on “the problem” and the scope.

### **Transforming Versus Tinkering is a Long Standing Challenge**

- Macro level change and major transformation is seen as difficult, time consuming, resource intensive and risky; often with an uncertain return on the investment. For these reasons it is easy to understand why incremental changes to services within a system are more attractive, and easier to achieve.
- Tinkering is often the default option. A focus on incremental was change seen as is all that’s feasible, practical and the path of least resistance in the short term.
- Rationalisation and configuration of services – two competing problems require resolution – the well-argued “Keogh case” to centralise versus what’s best provided locally.
- Many acknowledge that local service rationalisation will need to be faced. This will be difficult – politically, clinically and managerially.

### **Systems vs. Services - People Naturally Think About their Service, Rather than the System as a Whole**

- Most stakeholders, but not all, expressed a concern that there was a tendency for all to adopt the understanding of “the problem” that best suited / fitted with the view of their organisation or professional perspective.
- The growing number of Vanguards and other nationally high profile initiatives may make system leadership more complex.
- The net effect of this was expressed as there being not a single common understanding of the problem, but many different understandings.
- “Systems for populations” looks to be the future model. “System governance” is therefore the most pressing challenge.
- Therefore who turns up matters? Focus on the WHOLE system, not just A&E. Who turns up to SRG matters to what gets decided. This is especially difficult in a scenario with an unprecedented focus on A&E waits. Many expressed that there was need to increase the input from non hospital stakeholders to SRG processes.
- Downstream knock on consequences of service changes in one part of a system are a major concern. The ripple effects are uncertain and unpredictable.

### **Services Within the System**

#### **Hospitals Don’t Create Demand, Patient Need Creates Demand.**

- Hospital stakeholders often challenge the notion that money is “wasted” in hospitals – they don’t “suck in business” – it may be that “the lights are always on”. Marginal tariff has meant that urgent care is not at all profitable.

- Tariffs and payment mechanisms for both hospitals and community providers are not fit for purpose.
- The broader acute model is being considered in many places.

### **Community Service Issues**

- The economics of community care, and the economics of hospitals - Enabling care closer to home may not come cheap, and may not be a net save.
- Some suggested that the “community offer” around urgent needs isn’t quite right.

### **Telephone Based Services**

- Telephone based services have a future, but may benefit from rationalisation and or standardisation. A simplified route in is wanted by all.
- Some suggestions were made about a simplified 999/111, maybe moving to a merged system as the single access points into urgent care.

### **New types of service, new types of clinician**

- There are many opportunities for skill mix and substitution. No single solution is a panacea.
- Many commented on positive developments around increasing urgent access to mental health professionals
- The role of the voluntary sector was seen as important, under developed but useful.

### **Flow**

- Many acknowledge flow to be the key issue.
- Many examples were cited about investment in re-ablement teams, integrated discharge teams, rapid response teams, taking system engineering approaches to manage flow through a hospital bed base.
- There are multiple solutions to the “flow” issue. These merit individual response.
- Don’t just consider flow only in hospitals.

### **Workforce**

- Capacity, capability, cross fertilisation, new forms of workforce are all issues of concern.
- The extent to which workforce planning is picked up in local approaches to UEC planning is uncertain. It may be missing in many local approaches. Obviously there are issues that are best addressed on a very large footprint and through working with HEE; there are also issues around developing new forms of workforce to address the challenges in novel ways.
- There are challenges in developing new forms of workforce – these probably aren’t unsolvable.
- The knock on impact of workforce changes requires consideration.

### **Supply and Demand Side**

- Supply side versus demand side – most of the focus is on supply side, at the expense of better understanding of the demand side.
- Adding more supply risks more complexity and supply induced demand – both of these may create new problems and not solve existing ones.

### **Optimal Scale – Planning and Delivery**

- This is unfinished business.
- Views about the most appropriate planning footprint varied, most often depending on the perspective of the interviewee and the nature of the problem.
- Different elements of planning were differentially suited to different footprints, both for planning and for care delivery aspects.
- Where there are economies of scale, concentration of scarce expertise, and a need for common & consistent standards, bigger footprint is usually preferable.
- Where there is a need to change culture at the frontline – local is clearly better.

### **Data and Information, Technology and Connected Care**

- The expected issues were highlighted. These include lack of community data, lack of real time data, system level vs. service level, ability to link datasets together and at the frontline –

a shared clinical record across a big footprint – there are some direct safety and quality implications of not being able to do this.

### **Recommendation 1    Footprint and Tasks - It Makes Sense to Do Once.**

Consideration should be given to what tasks and functions may be most efficiently undertaken across the whole of Y&H. This may be because there is a requirement of scarce skills, because of a benefit of a singular consistent approach in every economy or because there are economies of scale in doing a job once at a large scale.

Examples include:

- Common service specification.
- Common approach to capacity planning.
- Supporting all agencies with a common approach to IT, IG and data / record sharing. The Greater Manchester Data Well example may help.
- Developing a consistent approach for the response to specific groups of patients (e.g. frail elders, minor ailment schemes, urgent care practitioner, and new workforce models).
- Common and consistent approach to high volume pathways.
- Standardisation of clinical protocols and quality standards.
- Development of a common approach and standards for surveillance and escalation.

### **Recommendation 2    Evidence and Evaluation – Use, Ignorance and Misuse**

The AHSN may have a role in developing a common approach to the use of evidence for change, from macro system level through to implementation of schemes. There is also a role in terms of supporting the system with evaluation – either in the design of or/ and in the execution of evaluation. Evaluation needs to be focused on both formative and outcome questions – the why something “works” or doesn’t work is equally important to the outcome – especially in the early stages of an innovation.

### **Recommendation 3    Flow**

Further consideration should be given to what can be learned from other industries where there are absolute capacity constraints and variable (often difficult to predict) demand. Such examples might include transport (maybe especially train industry), or electricity.

Many efforts to map flow have considered the hospital component of the system. Given that between 80-95% of urgent care is delivered in the community – particularly general practice, there will be additional benefit of considering flow across the whole health and care system, admittedly this may be made more complex by poor quality (or unavailable) data.

### **Recommendation 4    Workforce**

The AHSN should explore the potential for where it can support the scaling up a range of postgraduate training for different types of workforce, skill mix development, models of clinical governance for multi-disciplinary multi agency workforce development.

### **Recommendation 5    Data**

There may be benefit of developing a single set of need, activity, quality, and outcome measures for the whole system across a large geography. If used consistently across Y&H – may enable a better collective understanding of variation. This would need provider level data to be shared across all areas. For A&E these probably exist as it is known there is a wealth of data that is recorded but not often used.

There would be benefit from consistently using simple statistical techniques such as SPC run charts to monitor key metrics. This would enable a more measured response to variation over time. This has been done already in some areas.

### **Recommendation 6    The Role of the Citizen and the Patient**

There may be benefit in the AHSN in leading some work across health and local government on the approaches to shifting the locus back towards the citizen, how this might be achieved and what it might mean in practice.

There may be a number of elements to this, including;

- Shifting from supply led model to a demand led model - public agencies typically know a lot about people's responses to service interventions, but far less about the assets, resources and networks of communities outside of this.
- Shifting the emphasis from organisations and services to place and population, and networks of care. The focus of discussion is never about the place or the service; it is about the population and the network.
- Shifting the emphasis from patients to collaborators. Can the system encourage much greater collective responsibility for health outcomes (adapted from Adebowale [HSJ 2015](#)).

#### **Recommendation 7    Systems for Populations**

There may be benefit from the AHSN leading some work on what "system governance" looks like in practice.

#### **Recommendation 8    Further Analysis**

There are many further analytic questions that this report has begun to scratch into the surface of. Caution should be exercised however, that any future analysis is linked to a clear decision that is needed. Furthermore further analysis may not resolve some of the broader strategic questions of culture, service and system design/ architecture.

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## 1 Background to This Review

There is some uncertainty about the overall structure, shape and scope of the urgent care infrastructure development arrangements across Yorkshire and Humber (Y&H), with some differences in approach.

As part of a broader piece of work around urgent care, the AHSN are seeing to *map the UEC infrastructure across Y&H*. Every health economy will have an Urgent Care Board (or similar); often with a range of underpinning arrangements. The exact nature and make up of this infrastructure will vary from place to place; as will the programme areas chosen as a priority.

There is a Y&H AHSN sponsored Standing Conference that has Chief Executive and Accountable Officer support. It has been established to use a 'Systems Thinking' approach to analyse Urgent & Emergency Care systems and procedures within geographical locations across Yorkshire and Humber. In addition there has been some initial work done on data linkage to enable a complete overview of the totality of the urgent care system in terms of patient flow. Finally the Standing Conference is tasked to support organisations to develop a model of improvement which will make an impact on the whole system.

## 2 Aims of This Review

This review was intended to explore a number of areas including infrastructure for UEC, governance, strategy, past achievements, investments and evaluations and stakeholders views on the future direction.

The review was also designed to compare and contrast how the approach to UEC differs across the region and set this all into the context of past trends (focused on A&E attendance), past and possible future policy context.

The end point was intended to be a report principally intended for use by the AHSN Standing Conference.

Bradford MDC Public Health Department were asked to conduct a review of the urgent and emergency care infrastructure across Yorkshire and Humber, to identify common themes and identify future areas of work for the AHSN Standing Conference.

### **What this document is not**

Invariably this report will not answer all questions of all stakeholders, particularly at local level. Nor does this report provide "the answer".

It is an amalgamation of what the policy framework is telling us, what a range of available data is telling us, what a wide range of stakeholders directly involved are telling us.

This report is NOT an evidence review of "what works" in transforming, or making specific service changes or investments in, urgent and emergency care. There are a number of significant sources of evidence around specific interventions, pathway design and broader system transformation.

These are not summarised here.

### **Some of the significant contemporary sources of evidence on "what works" include:**

- Purdy 2010 & 11 – evidence base around specific interventions to reduce non elective admission.
- Keogh 2013 – broad set of evidence around design principles for UEC.
- Imoson 2013 – NIHR review around evidence underpinning system transformation; specific sections on UEC and Acute.
- ScHARR 2013 - Pre hospital UEC.
- ScHARR 2014 - Whole System Solutions for UEC.

- Wilson 2015 – NIHR review. System transformation, non-elective care in elderly.
- NHS E 2015 – update of Keogh review of 2013

Furthermore this document doesn't attempt to provide a comprehensive analysis of evidence of demand and activity. The analysis of demand is fairly superficial, and uses readily available national sources of data. Finally this report doesn't attempt to provide detailed overview of arrangements at health economy level for each UCB/ SRG. Based on the interviews with a selected group of informants this report summarises some themes.

### **3 Methods**

#### **a) Document Review**

We undertook a high-level review of the literature, which included a library scan of articles that included key words in relation to system resilience/ urgent and emergency care. This was not a comprehensive thematic literature review. In addition a rapid review was undertaken of available Urgent Care Strategies. The aim of this was to contextualise the journey to date, how the national policy has developed, what the local response to this has been.

#### **b) Data**

A simple analysis of readily available data was undertaken. This used readily and routinely available data from a number of sources, principally with a view to illustrating some aspects of urgent and emergency care. There was limited new bespoke analysis.

#### **c) Interviews with Selected Key Informants**

Using a contact list supplied by the AHSN, a random selection of stakeholders was invited to be interviewed. Efforts were made to ensure there was an even split of clinician/ manager, provider/ commissioner and across the whole of the geography. This was to ensure a wide spread of views was incorporated.

It hasn't been possible to interview stakeholders from every SRG, inevitably this brings some bias. There was a great deal of commonality and consistency raised in the issues identified by stakeholders. The schedule of questions for these interviews is set out in the appendix. Given that this was not formal research, some allowance was given for the interviews to be led by the interviewee.

## 4 Results

### 4.1 – What the Policy is Telling Us

### 4.2 – What the Data is Telling Us

### 4.3 – What Stakeholders Told Us as Part of Interviews

## 4.1 What the Policy is Telling Us

It is not beyond the scope of this review to give a detailed history of the national policy on urgent and emergency care, nor would this be particularly helpful. Some aspects of this are appended, as is relevant to Urgent and Emergency Care.

There are a number of important policy drivers over the last 10 years that are directly pertinent to the development of UEC services. Obviously there is a far wider policy context that is not covered here.

#### **Reforming Emergency Care. First Steps to a New Approach. Department of Health 2001.**

- Focus was on A&E waiting times.
- Solutions were focused on; increasing clinical capacity, ED Consultant numbers, investment in planned care capacity (particularly independent sector) so as to enable faster throughput and additional funding for social care and intermediate care to speed discharge.

#### **Health Select Committee 2004.**

- Wider access and consistency of emergency services, as well as new professional roles and ways of working.
- Retain focus on 4 hour wait; though be mindful of perverse consequences.
- Be mindful of additional capacity in walk in centres – potential for supply induced demand and confusion.
- Emergency care networks should be established. Review local patterns of care.
- Address gaps in knowledge about costs and benefits of new forms of urgent care.
- More efficient use of or investment in diagnostic services, more effective bed management and timely access to specialist opinion - include widening staff responsibility for initial interpretation of x-rays, and using up-to-date equipment in diagnostic services.
- Address patient confusion by the variety of different emergency care providers.

#### **Health Select Committee 2013.**

- Wide ranging review covering the whole of the urgent care spectrum. This Growth in attendances at emergency departments has been limited, admissions have grown substantially placing more pressure on hospitals and restricting the ability of emergency departments to manage the flow of patients.
- The problems that have manifested themselves within emergency care cannot be attributed to any one factor or failure within the system.
- A broader failure resulting from fragmented provision of emergency and urgent care and a structure that is confusing to patients.
- A&E departments remain the default option for many patients.
- The report specifically considered some of the more recent changes to the overall management of the urgent care system.

#### **CEM 2013. The drive for quality.**

Focused on EDs. The report makes a number of recommendations.

1. **Commissioning:** strong network solutions.
2. **Configuration:** Urgent Care Centre development must be part of a wider networked solution.
3. **Workload:** Targeted funding strategies and appropriate co-located primary care services.
4. **Medical Staffing in the ED. Nursing staff and skillmix:**

5. **Clinical quality indicators of care:** the Clinical Quality Indicators be applied together, as a suite. **Robust and active clinical governance systems to support safety and continuous quality improvement.**
6. **Observation medicine and ambulatory emergency care:** Clinical Decision Units and ambulatory emergency care are an important component of Emergency Department function. This activity needs to be properly resourced
7. **Tariffs and informatics systems:** urgently address and correct the tariff structures for clinical activity in the Emergency Department. Currently not fit for purpose. **Urgent attention to the utility and integration of their Emergency Department information systems.**
8. **Create tools that will more accurately measure patient experience** in the Emergency Department.

#### **RCP, CEM, RCPH, RCS Acute and Emergency Care: Prescribing the Remedy 2013.**

Recommendations focused on:

- Access and alternatives
- Skill mix / case mix
- Integration and communities
- Seven-day service
- Funding / fair reward
- Information technology

#### **Keogh 1, 2013.**

The review set out a simple vision of a system that ended in a Major Emergency Centre and worked back to self care. The review set out a number of options for meeting needs closer to home (the subtext of which is that it is in a less expensive but equally safe setting to a more “intensive” setting)

The features of the vision that were specifically highlighted were:

- Self-care.
- Comprehensive and standardised care planning.
- Continue to support a 111 type system. Widening the DOS available to 111 handlers to increase the range of services a person could be routed to, and the ability to directly book an appointment.
- Increase accessibility to same day, every day access to primary care and community services.
- Harness the skills, experience and accessibility of community pharmacists.
- Develop 999 ambulances so they become mobile urgent treatment services, not just urgent transport services.
- Support the co-location of community-based urgent care services in coordinated Urgent Care Centres.
- Introduce two levels of hospital based emergency centre - “Emergency Centres” and “Major Emergency Centres”.
- Implement the findings of the NHS Services, Seven Days a Week Forum.
- Continue to develop Emergency Care Networks.

#### **NHS E 2015. Transforming Urgent and Emergency Care Services in England. Safer, Faster, Better: Good Practice in Delivering Urgent and Emergency Care. A Guide for Local Health and Social Care Communities<sup>1</sup>.**

Document designed to help frontline providers and commissioners deliver safer, faster and better urgent and emergency care to patients of all ages, collaborating in UECNs to deliver best practice.

It sets out design principles drawn from good practice, which have been tried, tested and delivered successfully by the NHS in local areas across England. The guide was not intended to be taken as a list of instructions or new mandatory requirements. Implementation should be prioritised taking into account financial implications and local context.

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<sup>1</sup> Transforming urgent and emergency care services in England. Safer, faster, better: good practice in delivering urgent and emergency care. A guide for local health and social care communities. <http://www.england.nhs.uk/wp-content/uploads/2015/06/trans-uec.pdf>

The primary audiences for this document are providers and commissioners of urgent and emergency health and social care services to all patient groups.

There is a considerable evidence and experience base for 'what works well' in urgent and emergency care systems, and the damage caused by poor patient flow. A summary was published by the Review in 2013 and is available at: <http://tinyurl.com/UECRph1EvBase>.

## 4.2 What the Data is Telling Us

This analysis used publicly available data, there is no data used that isn't publicly available.

### a) Population Projections.

ONS have published population projections for a number of different levels of geography. The below tables give ONS population projections at Area Team level, split by age bands. These are based on CCG level projections (resident, not registered) aggregated to Area Team, out to 2030.

**Tables 1-3** below give the 2015 population (this is based on a projection from the 2010 census) by 5 year age bands and the expected percentage growth out to 2030.

CCG level data is appended in an Excel file.

There are a number of assumptions and caveats that should be taken into account when interpreting this. For brevity, the caveats are not listed here.

**Table 1- West Yorkshire Population Projections**

Area Name	Age Group	2015 Resident Population	Projected % Change 2015 to 2030
West Yorkshire	0 to 4	157.1	-1
	5 to 9	149.8	4
	10 to 14	133.2	17
	15 to 19	145.9	11
	20 to 24	178.4	3
	25 to 29	160.8	-3
	30 to 34	158.6	2
	35 to 39	145.2	13
	40 to 44	153.1	2
	45 to 49	161.2	-6
	50 to 54	154.7	-11
	55 to 59	136.3	5
	60 to 64	119.1	24
	65 to 69	121.2	13
	70 to 74	87.3	31
	75 to 79	71.9	29
	80 to 84	52.0	60
	85 to 89	31.4	49
	90 and over	17.8	94
	All ages	2335.0	9

As an illustrative example, the CCG population of West Yorkshire is c 2.35m. The Office of National Statistics have projected this will grow to 2.47m out to 2025, 6% over the next 10 years, obviously with continued growth beyond this. This projected growth will not be equitable across all age bands. For example ONS are projecting relatively low growth across the next 10 years in younger ages (low single figure % wise); the working age population is relatively static. The 65 and older population is expected to grow rapidly, in some age bands by more than 30% over the next 10 years.

The relatively static working age population is an issue in that this group currently provide a significant amount of informal unpaid care for elders. The growth in older people is obviously important as this is where morbidity, and increasingly multi-morbidity is concentrated - with obvious implications for the need for health care.

**Table 2- North Yorkshire and Humber Population Projections**

Area Name	Age Group	2015 Resident Population	Projected % Change 2015 to 2030
North Yorkshire and Humber	0 to 4	93.0	-6
	5 to 9	94.7	-2
	10 to 14	86.9	11
	15 to 19	98.4	4
	20 to 24	107.3	-4
	25 to 29	103.6	-12
	30 to 34	96.2	0
	35 to 39	90.6	15
	40 to 44	105.8	-1
	45 to 49	120.1	-16
	50 to 54	125.2	-25
	55 to 59	110.4	-2
	60 to 64	101.5	19
	65 to 69	109.8	10
	70 to 74	81.1	25
	75 to 79	65.8	29
	80 to 84	48.0	66
	85 to 89	29.2	59
	90 and over	16.7	210
	All ages	1684.8	5

Expected population growth of 5% out to 2030. Fastest growth in elderly populations. Expected fall all in some younger age bands.

**Table 3- South Yorkshire Population Projections**

Area Name	Age Group	2015 Resident Population	Projected % Change 2015 to 2030
South Yorkshire	0 to 4	90.1	1
	5 to 9	88.5	14
	10 to 14	79.2	6
	15 to 19	90.8	-3
	20 to 24	114.9	-8
	25 to 29	100.1	3
	30 to 34	93.9	21
	35 to 39	85.0	4
	40 to 44	94.8	-13
	45 to 49	105.9	-19
	50 to 54	10.3	0
	55 to 59	91.3	24
	60 to 64	79.7	13
	65 to 69	82.1	23
	70 to 74	63.7	24
	75 to 79	50.9	54
	80 to 84	36.6	57
	85 to 89	21.8	100
	90 and over	12.1	
	All ages	1484.1	6

Expected population growth of 6% out to 2030. Fastest growth in elderly populations. Expected fall all in some younger age bands.

**b) Activity****A&E attendance**

Given that most would agree that A&E attendance is the key focal point of the UEC system we conducted a simple analysis of attendances at hospital level. We tried to address questions of absolute numbers in attendance and growth. The most readily available source of data on attendance was the NHSE Sit Reps<sup>2</sup>; this shows attendances per quarter split by the type of attendance (category 1, 2, 3). It is taken from the Unify 2 data collection, on the NHSE website. We aggregated the quarterly reports to provide four annual counts of attendances by hospital. Of note, some hospitals don't have a Type 2 or Type 3 capability, thus all attendances are categorised as type 1. We are not aware of any source of national data that characterises attendance by patient type (as opposed to unit type).

**Attendances by provider over the last four years**

The tables below show attendance by provider for the last four years of available data. Trust level data is in an appended Excel spreadsheet.

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<sup>2</sup> <http://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/statistical-work-areasae-waiting-times-and-activityweekly-ae-sitreps-2015-16/>

**Table 4- Attendance at West Yorkshire Trusts**

West Y					Airedale FT					LTHF					CHFT				
Number of attendances					Number of attendances					Number of attendances					Number of attendances				
Year	Type 1	Type 2	Type 3	Total attendances	Year	Type 1	Type 2	Type 3	Total attendances	Year	Type 1	Type 2	Type 3	Total attendances	Year	Type 1	Type 2	Type 3	Total attendances
2011/12	132,984	0	0	132,984	2011/12	45,714	0	0	45,714	2011/12	111,857	0	0	111,857	2011/12	117,846	0	0	117,846
2012/13	120,770	0	0	120,770	2012/13	41,328	0	0	41,328	2012/13	116,349	0	0	116,349	2012/13	117,279	0	0	117,279
2013/14	129,490	0	0	129,490	2013/14	48,670	0	0	48,670	2013/14	117,504	0	0	117,504	2013/14	121,260	0	0	121,260
2014/15	132,825	0	0	132,825	2014/15	51,963	0	0	51,963	2014/15	124,707	0	0	124,707	2014/15	120,064	0	0	120,064
Average annual attendance	124,000	0	0	124,000	Average annual attendance	46,919	0	0	46,919	Average annual attendance	117,604	0	0	117,604	Average annual attendance	119,112	0	0	119,112
4 year change	59,911	0	0	59,911	4 year change	6,249	0	0	6,249	4 year change	12,850	0	0	12,850	4 year change	2,218	0	0	2,218
growth 11/12 to 14/15	82.2%	0.0%	0.0%	82.2%	growth 11/12 to 14/15	13.7%	0.0%	0.0%	13.7%	growth 11/12 to 14/15	11.5%	0.0%	0.0%	11.5%	growth 11/12 to 14/15	1.9%	0.0%	0.0%	1.9%
Rate per 1,000 population					Rate per 1,000 population					Rate per 1,000 population					Rate per 1,000 population				
Year	Type 1	Type 2	Type 3	Total attendances	Year	Type 1	Type 2	Type 3	Total attendances	Year	Type 1	Type 2	Type 3	Total attendances	Year	Type 1	Type 2	Type 3	Total attendances
2011/12	352.8	0.0	0.0	352.8	2011/12	306.2	0.0	0.0	306.2	2011/12	303.7	0.0	0.0	303.7	2011/12	229.7	0.0	0.0	229.7
2012/13	316.4	0.0	0.0	316.4	2012/13	266.7	0.0	0.0	266.7	2012/13	313.1	0.0	0.0	313.1	2012/13	226.6	0.0	0.0	226.6
2013/14	339.8	0.0	0.0	339.8	2013/14	267.8	0.0	0.0	267.8	2013/14	313.9	0.0	0.0	313.9	2013/14	232.6	0.0	0.0	232.6
Rate change over 4 yrs	4.3%	0.0%	0.0%	4.3%	Rate change	15.1%	0.0%	0.0%	15.1%	Rate change	27.2%	0.0%	0.0%	27.2%	Rate change	-1.0%	0.0%	0.0%	-1.0%

**Table 5- Attendance at North Yorkshire and Humber Trusts**

York FT					HDFT					NLAG					HEY FT				
Number of attendances					Number of attendances					Number of attendances					Number of attendances				
Year	Type 1	Type 2	Type 3	Total attendances	Year	Type 1	Type 2	Type 3	Total attendances	Year	Type 1	Type 2	Type 3	Total attendances	Year	Type 1	Type 2	Type 3	Total attendances
2011/12	72,914	0	0	72,914	2011/12	43,980	0	0	43,980	2011/12	111,857	0	0	111,857	2011/12	117,846	0	0	117,846
2012/13	120,770	0	0	120,770	2012/13	44,459	0	0	44,459	2012/13	116,349	0	0	116,349	2012/13	117,279	0	0	117,279
2013/14	129,490	0	0	129,490	2013/14	44,967	0	0	44,967	2013/14	117,504	0	0	117,504	2013/14	121,260	0	0	121,260
2014/15	132,825	0	0	132,825	2014/15	45,834	0	0	45,834	2014/15	124,707	0	0	124,707	2014/15	120,064	0	0	120,064
Average annual attendance	114,000	0	0	114,000	Average annual attendance	44,810	0	0	44,810	Average annual attendance	117,604	0	0	117,604	Average annual attendance	119,112	0	0	119,112
4 year change	59,911	0	0	59,911	4 year change	1,854	0	0	1,854	4 year change	12,850	0	0	12,850	4 year change	2,218	0	0	2,218
growth 11/12 to 14/15	82.2%	0.0%	0.0%	82.2%	growth 11/12 to 14/15	4.2%	0.0%	0.0%	4.2%	growth 11/12 to 14/15	11.5%	0.0%	0.0%	11.5%	growth 11/12 to 14/15	1.9%	0.0%	0.0%	1.9%
Rate per 1,000 population					Rate per 1,000 population					Rate per 1,000 population					Rate per 1,000 population				
Year	Type 1	Type 2	Type 3	Total attendances	Year	Type 1	Type 2	Type 3	Total attendances	Year	Type 1	Type 2	Type 3	Total attendances	Year	Type 1	Type 2	Type 3	Total attendances
2011/12	216.8	0.0	0.0	216.8	2011/12	266.2	0.0	0.0	266.2	2011/12	303.7	0.0	0.0	303.7	2011/12	229.7	0.0	0.0	229.7
2012/13	356.0	0.0	0.0	356.0	2012/13	266.7	0.0	0.0	266.7	2012/13	313.1	0.0	0.0	313.1	2012/13	226.6	0.0	0.0	226.6
2013/14	379.0	0.0	0.0	379.0	2013/14	267.8	0.0	0.0	267.8	2013/14	313.9	0.0	0.0	313.9	2013/14	232.6	0.0	0.0	232.6
2014/15	386.1	0.0	0.0	386.1	2014/15	271.1	0.0	0.0	271.1	2014/15	330.8	0.0	0.0	330.8	2014/15	228.7	0.0	0.0	228.7
Rate change over 4 yrs	169.2	0.0	0.0	169.2	Rate change	4.9	0.0	0.0	4.9	Rate change	27.2%	0.0%	0.0%	27.2%	Rate change	-1.0%	0.0%	0.0%	-1.0%



**Table 6- Attendance at South Yorkshire Trusts**

SCH					Barnsley FT					Rotherham FT					STH									
Number of attendances					Number of attendances					Number of attendances					Number of attendances									
Year	Type 1 Depart	Type 2 Depart	Type 3 Depart	Total attendances	Year	Type 1 Depart	Type 2 Depart	Type 3 Depart	Total attendances	Year	Type 1 Depart	Type 2 Depart	Type 3 Depart	Total attendances	Year	Type 1 Depart	Type 2 Depart	Type 3 Depart	Total attendances					
2011/12	50,868	0	0	50,868	2011/12	77,741	0	0	77,741	2011/12	75,386	0	0	75,386	2011/12	111,731	13,228	17,236	142,195					
2012/13	53,056	0	0	53,056	2012/13	79,498	0	0	79,498	2012/13	74,990	0	0	74,990	2012/13	114,141	12,385	16,329	142,855					
2013/14	50,904	0	0	50,904	2013/14	79,199	0	0	79,199	2013/14	74,172	0	0	74,172	2013/14	114,398	14,018	17,332	145,748					
2014/15	53,659	0	0	53,659	2014/15	78,843	0	0	78,843	2014/15	76,649	0	0	76,649	2014/15	117,572	14,072	18,433	150,077					
Average annual attendance	52,122	0	0	52,122	Average annual attendance	78,820	0	0	78,820	Average annual attendance	75,299	0	0	75,299	Average annual attendance	114,461	13,426	17,333	145,219					
4 year change	2,791	0	0	2,791	4 year change	1,102	0	0	1,102	4 year change	1,263	0	0	1,263	4 year change	5,841	844	1,197	7,882					
growth 11/12 to 14/15	5.5%	0.0%	0.0%	5.0%	growth 11/12	1.4%	0.0%	0.0%	1.0%	growth 11/12	1.7%	0.0%	0.0%	2.0%	growth 11/12	5.2%	6.4%	6.9%	6.0%					
				1.05					1.01					1.02					1.06					
Rate per 1,000 population					Rate per 1,000 population					Rate per 1,000 population					Rate per 1,000 population									
Year	Type 1 Depart	Type 2 Depart	Type 3 Depart	Total attendances	Year	Type 1 Depart	Type 2 Depart	Type 3 Depart	Total attendances	Year	Type 1 Depart	Type 2 Depart	Type 3 Depart	Total attendances	Year	Type 1 Depart	Type 2 Depart	Type 3 Depart	Total attendances					
2011/12	457.2	0.0	0.0	457.2	2011/12	373.6	0.0	0.0	373.6	2011/12	326.3	0.0	0.0	326.3	2011/12	212.0	25.1	32.7	269.8					
2012/13	472.7	0.0	0.0	472.7	2012/13	378.7	0.0	0.0	378.7	2012/13	321.7	0.0	0.0	321.7	2012/13	214.7	23.3	30.7	268.7					
2013/14	450.3	0.0	0.0	450.3	2013/14	374.6	0.0	0.0	374.6	2013/14	315.9	0.0	0.0	315.9	2013/14	213.6	26.2	32.4	272.2					
2014/15	471.4	0.0	0.0	471.4	2014/15	370.3	0.0	0.0	370.3	2014/15	324.2	0.0	0.0	324.2	2014/15	218.0	26.1	34.2	278.3					
Rate change over 4 years	14.1	0.0	0.0	14.1	Rate change	-3.3	0.0	0.0	-3.3	Rate change	-2.1	0.0	0.0	-2.1	Rate change	6.0	1.0	1.5	8.5					
sheffield city GP HC					Care UK Rotherham diagnostic					Total														
Number of attendances					Number of attendances					Number of attendances														
Year	Type 1 Depart	Type 2 Depart	Type 3 Depart	Total attendances	Year	Type 1 Depart	Type 2 Depart	Type 3 Depart	Total attendances	Year	Type 1 Depart	Type 2 Depart	Type 3 Depart	Total attendances										
2011/12	0	0	66694	66694	2011/12	0	0	47432	47432	2011/12	0	0	0	0										
2012/13	0	0	70269	70269	2012/13	0	0	52936	52936	2012/13	0	0	0	0										
2013/14	0	0	67841	67841	2013/14	0	0	49397	49397	2013/14	0	0	0	0										
2014/15	0	0	65774	65774	2014/15	0	0	48003	48003	2014/15	0	0	0	0										
Average annual attendance	0	0	67649.5	67649.5	Average annual attendance	0	0	49442	49442															
4 year change	0	0	-920	-920	4 year change	0	0	571	571															
growth 11/12 to 14/15	0.0%	0.0%	-1.4%	-1.4%	growth 11/12	0.0%	0.0%	1.2%	1.2%															
Rate per 1,000 population					Rate per 1,000 population																			
Year	Type 1 Depart	Type 2 Depart	Type 3 Depart	Total attendances	Year	Type 1 Depart	Type 2 Depart	Type 3 Depart	Total attendances															
2011/12					2011/12																			
2012/13					2012/13																			
2013/14					2013/14																			
2014/15					2014/15																			
Rate change over 4 years	no catchment population available				Rate change	no catchment population available																		

## A&E Attendance per 1000 Population at Hospital Level

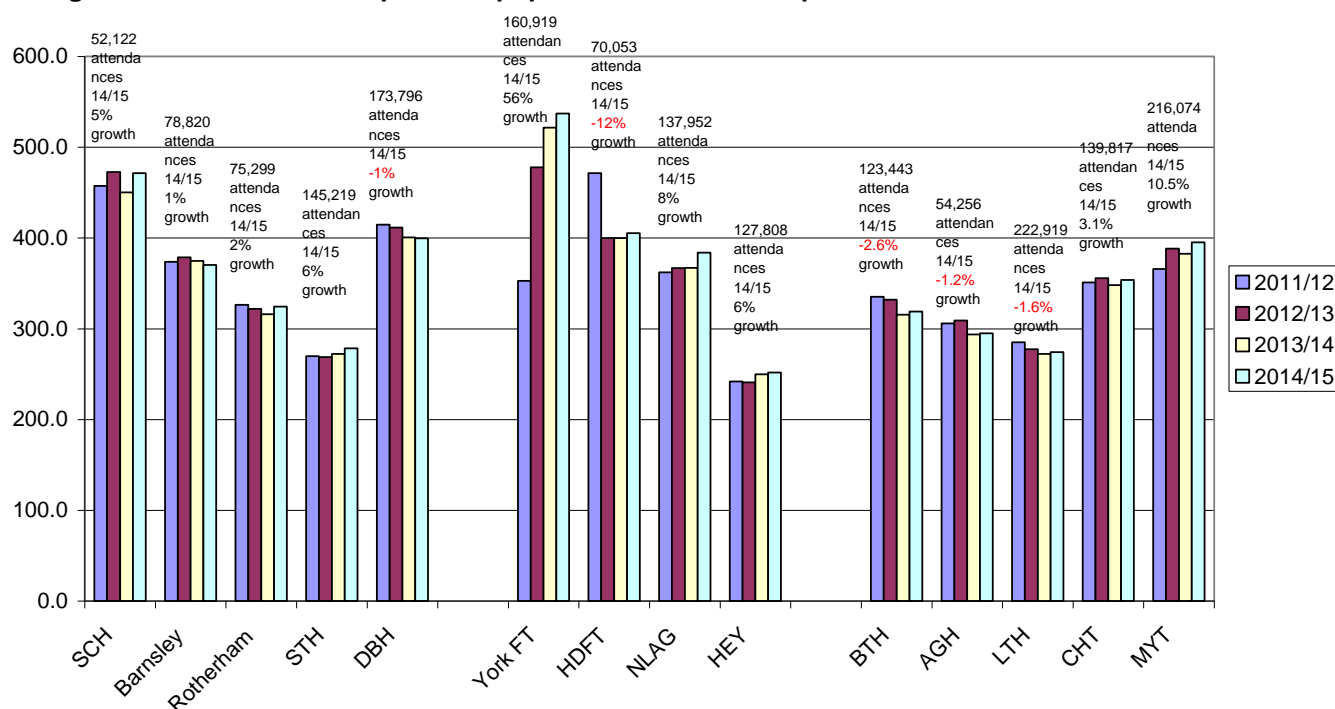
There is no way to attribute this Unify 2 data to CCG level. Thus to calculate attendance per capita we used hospital catchment populations. These were calculated based on a 2011 analysis, using a method established by East Midlands Public Health Observatory. The catchment populations were updated using an assumption of 0.7% growth per year.

The catchment populations used for each hospital are appended. It was not possible to derive catchment populations for standalone minor injury units.

The figure below shows attendances per 1000 population for each hospital in Y&H, for all categories of attendance for hospital A&E depts. The growth between 11/12 and 14/15 is shown and the number of attendances in 14/15 with absolute % growth over the period also highlighted.

There will be local contextual issues associated with service configurations.

**Figure 1- A&E Attendance per 1000 population for each Hospital in Y&H.**

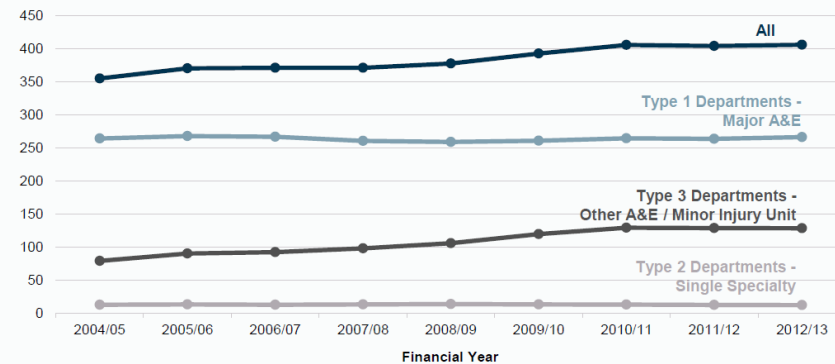


## Attendance by department type

A&E

Overall attendances have risen faster than the growth in population. This is largely driven by type 3 department attendances which have risen at 11 times the rate of population. Though the type 3 growth rate has decreased recently.

Attendances per one thousand population, 2004/05 to 2012/13



Data Sources: NHS England [A&E Activity \(WSitAE\)](#), Office for National Statistics [Population Estimates](#), mid year population estimates for 2012 are used for financial year 2012/13, 2011 for 2011/12 etc.

- There were 22 million A&E attendances in 2012/13 compared to an estimated 340 million GP consultations. Overall major (type 1) department attendances have risen slightly above the rate of population increase between 2004/05 and 2012/13.
- Minor (type 3) department attendances have risen at 11 times the rate of population increase over this period.
- Most major (type 1) department attendances are for people aged under 40, but the proportion of older attendees has risen.
- The pattern of attendance by hour of day has remained consistent.
- Due to the way the data are collected there are problems with coverage and content in some areas, notably reason for attending.
- While overall attendance figures are published from 2004/05, analysis of the detail making up these numbers is only possible from 2008/09.

### Attendance Numbers and Rates have a Bearing on Occupancy.

Previous analysis by QualityWatch<sup>4</sup> has concluded that the average occupancy of England's A&E units increased by around 8 per cent between 2010/11 and 2012/13.

This report also concluded that in the main the growth in attendance is in line with population growth, but that small increases in attendance to fixed capacity units, combined with slower flow through the system (for a multitude of reasons) has contributed a great deal to overcrowding, and thus the well documented problems with 4hr waits.

### However Overcrowding per se doesn't Explain all of the 4h Wait Problems – Around One Quarter of Breaches Occurs when the Department is Less Crowded than Would be Expected.

Explanatory factors given for the number of people waiting more than 4 hours included an increased number of older people being seen, and weather factors however there is no single explanatory factor.

The analysis did not find evidence that cases being seen in A&E were becoming more complex. The proportion of people with one or more long-term conditions attending A&E did not change notably between 2010/11 and 2012/13, and other expressions of case-mix also showed no particular change over time.

<sup>3</sup> Focus on A&E, HSCIC. December 2013

<sup>4</sup> Focus on: A&E attendances. Why are patients waiting longer? July 2014

This means that it is unlikely that these factors contributed to the decline in performance against the four-hour target. Finally there was no evidence that patient satisfaction with access to their GP is associated with achievement of the four-hour target, but it is related to rates of attendance.

More recently, a House of Commons briefing note<sup>5</sup> identified that in recent months, attendance at Accident & Emergency departments has been lower than 2014 but higher than previous years. Nevertheless, the number of emergency admissions via A&E continues to rise.

Waiting times performance on the four-hour measure recovered in recent months after a difficult winter, with June 2015's performance not substantially different from that of June 2014. Nevertheless, the target that 95% of patients should spend less than four hours in A&E has not been met since August 2014.

O'Keefe<sup>6</sup> had highlighted in a rapid literature review what we do (and don't) know about why UEC demand has increased. Factors cited include increasing number of elderly, loneliness & family support, changes in psychiatric care and primary care, impact of health promotion campaigns, convenience of the "one stop shop", risk aversion and deprivation. The paper also identified patient factors associated with reasons for accessing emergency care; and some papers on the impact of media campaigns to change urgent care use.

### **Activity - Admissions**

The Kings Fund has neatly illustrated recent trends in different types of hospital activity<sup>7</sup>. Not all activity is growing at the same rate. Non elective admissions grew by 2% between 2009/10 to 2013/14, elective admissions by 9%, first outpatient attendances by 14%, A&E attendances by 3% and follow up OP attendances by 10% during those same time periods. Planned care is growing markedly faster than unplanned care. Population growth varies from place to place and between age groups, overall the growth over recent years is c c0.7% per year. Similar, more up to date, data was recently published by the House of Commons Library<sup>8</sup>.

Comparing the twelve months ending June 2015 with the equivalent period in 2014 non-elective admissions to hospital for general & acute (G&A) specialities have increased in number by 1.0%. Elective G&A admissions have increased by 2.7%. Meanwhile, there were 2.6% more GP referrals and 3.3% more first outpatient attendances at hospitals for G&A specialities.

The charts below (from the HOC report) shows, activity has risen faster than population growth. Between 2009 and 2014 GP referrals rose 11% faster than population growth, elective G&A admissions 11% faster, non-elective G&A admissions 5% faster, and first outpatient attendances 9% faster.

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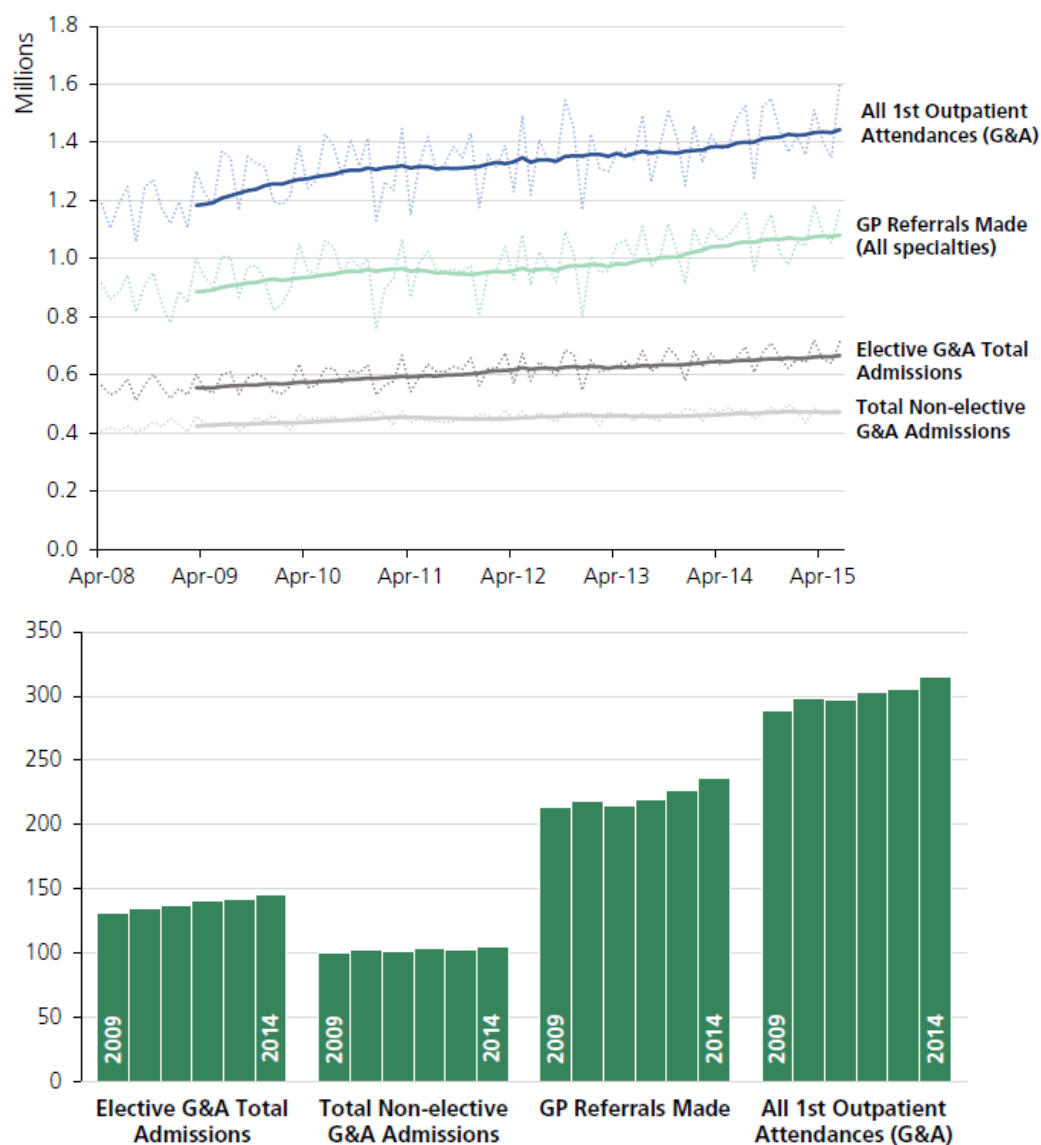
<sup>5</sup> NHS Indicators: England, August 2015

<http://researchbriefings.parliament.uk/ResearchBriefing/Summary/CBP-7281>

<sup>6</sup> What do we know about why EUC demand has increased? Colin O'Keefe. March 2014. University of Sheffield

<sup>7</sup> KF NHS in a nutshell

<sup>8</sup> NHS Indicators: England, August 2015. <http://researchbriefings.parliament.uk/ResearchBriefing/Summary/CBP-7281>

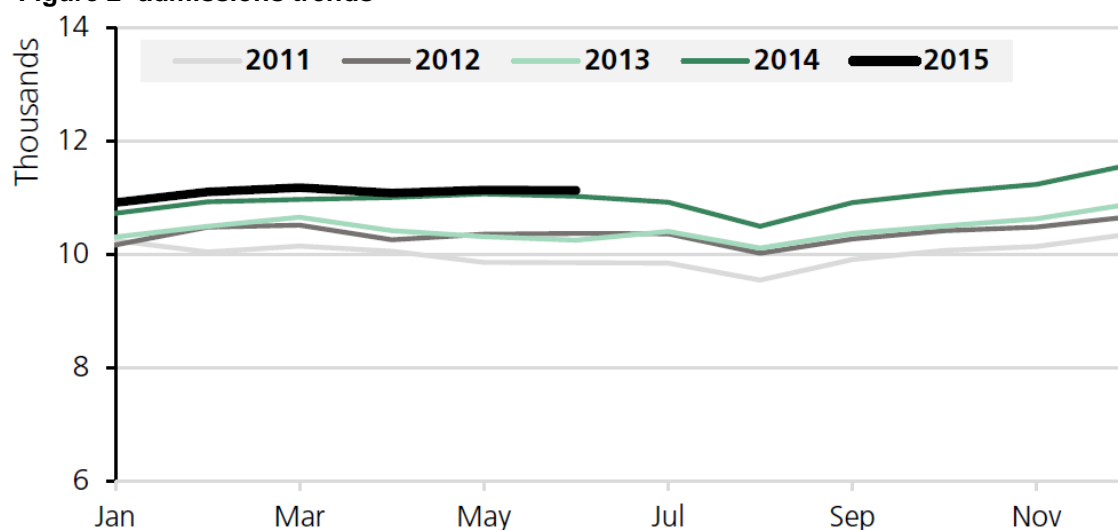


**In the Quarter Ending June 2015, the Number of Emergency Admissions to Hospital via A&E was 0.7% Higher than the same Quarter in 2014, with an Average of 70 Extra Admissions Each Day (England).** Admissions in April-June 2014 were 6.8% higher in number than the same quarter in 2013 – a level of increase which has not been repeated in 2015.

Emergency admissions to hospital have risen more quickly than population increases. In 2011/12 there were 69 emergency admissions per 1,000 population – in 2014/15 this had risen to 74 per 1,000, meaning that admissions have risen 7.4% above raw population increases.

**Figure 2** illustrates trends in admissions, showing the average daily number of admissions to hospital via A&E each month. Note that the small increase in admissions between 2014 and 2015 is in contrast to the trend in A&E attendances (shown above), which have fallen.

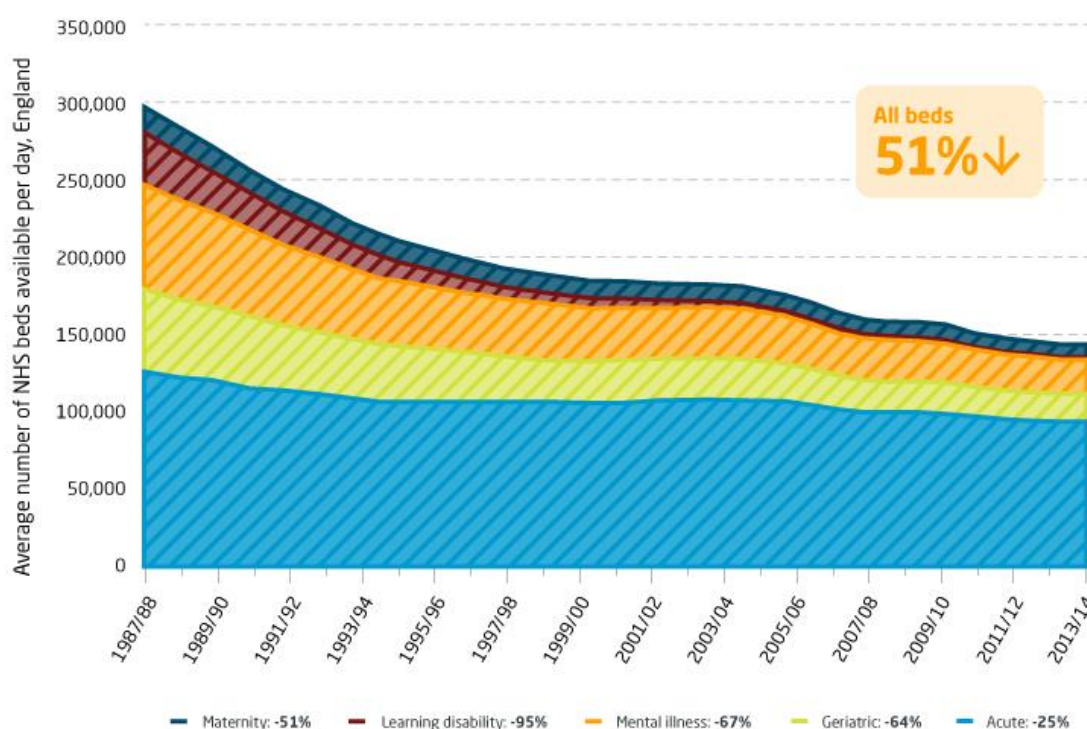
**Figure 2- admissions trends**



In response to the initial draft of this report, one person noted a seeming 2 year pattern in daily admissions in the above figure – i.e. 2012 and 2013 track each other closely, as do 2013 & 2014. There is no ready explanation for this.

### c) Capacity in Hospitals

Perceptions of pressure and actual pressure on the urgent care system is inevitably going to increase as the NHS continues with a long term 50% reduction in the number of beds, the reduction is most marked in mental health and LD beds. This is most neatly illustrated by the Kings Fund<sup>9</sup>.



During 2014/15 there were on average 135,616 beds available in wards open 24 hours a day in NHS hospitals in England. That is around half the beds available in 1989/90 and 6,855 fewer than in 2010/11.

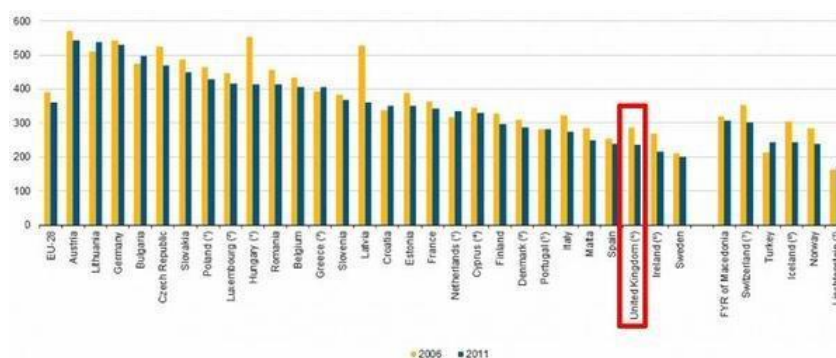
<sup>9</sup> [NHS England \(2015\)](#); The King's Fund estimate for 2011/12 to 2013/14. The number of hospital beds. 25 March 2015

The decline since 2010/11 has been particularly pronounced in learning disability specialities (-31%).

This long term decline is a result of deliberate policy to shift care closer to home and advances in technology.

### Hospital Beds Per Capita in England is Low Comparatively

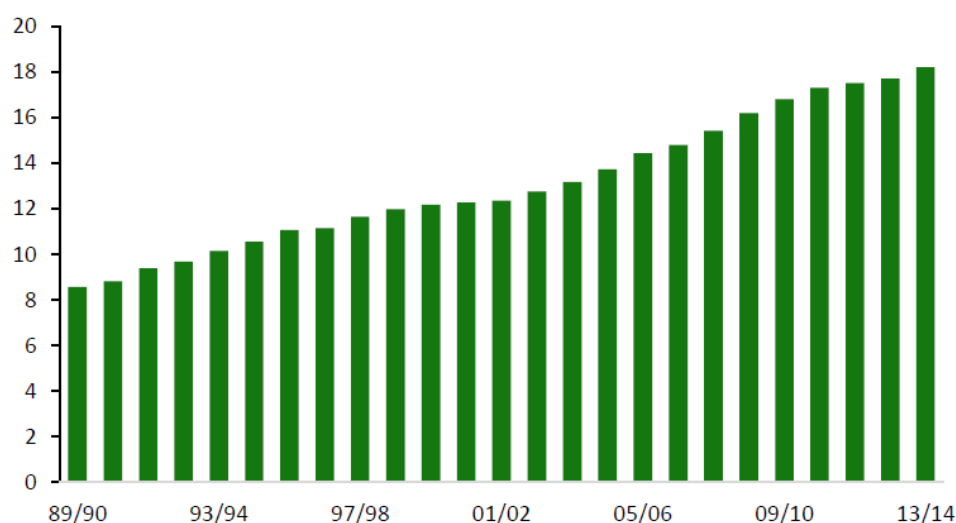
Looking across Europe the number of hospital beds per million population and the length of stay in England is low<sup>10</sup>.



### Hospitals are Becoming Busier.

There were 18.2 million finished consultant episodes (FCEs) in 2013/14, 2.5% more than in 2012/13<sup>11</sup>.

**FCEs (millions) England, 1989/90 - 2013/14**



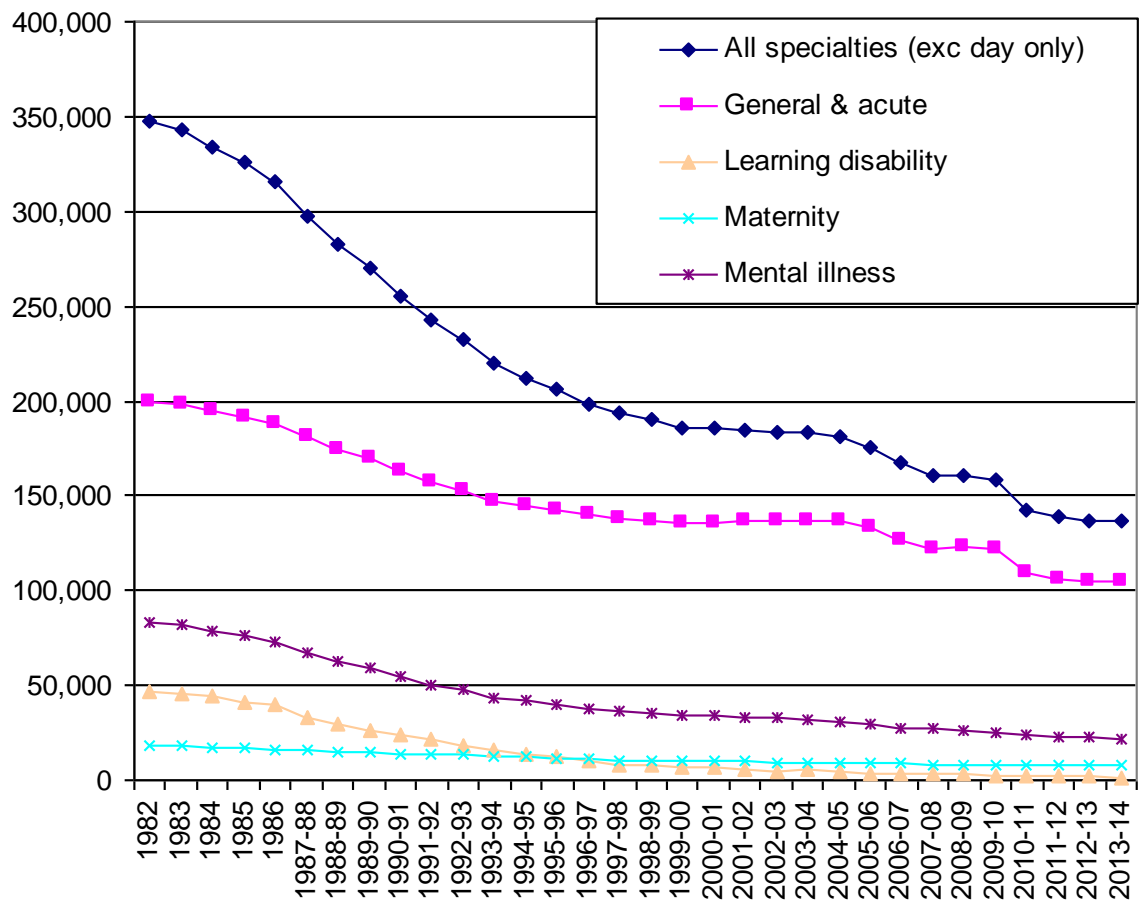
More recently that has been an increase in the intensity of bed use, as measured by occupancy - occupancy rates for acute beds have increased from 87.7 per cent in 2010/11 to 89.5 per cent in 2014/15. The NAO have suggested that occupancy rates above 85% will be associated with regular bed shortages.

The long term trend in bed availability is illustrated in the chart below, taken from KH03 returns. This is England data.

<sup>10</sup> OECD comparison

<sup>11</sup> HOC Library - SN/SG/2641

## Beds available, England





# **Bed Base - All beds Open Overnight, General and Acute Beds Open Overnight in Y&H Hospitals. Q1 10/11 to Q1 14/15**

Each of the charts below give some indication on the number of beds open overnight for each Y&H trust over a five year period. This data is taken from the KH03 return. Underpinning data completeness and quality is not known, and may vary from trust to trust.

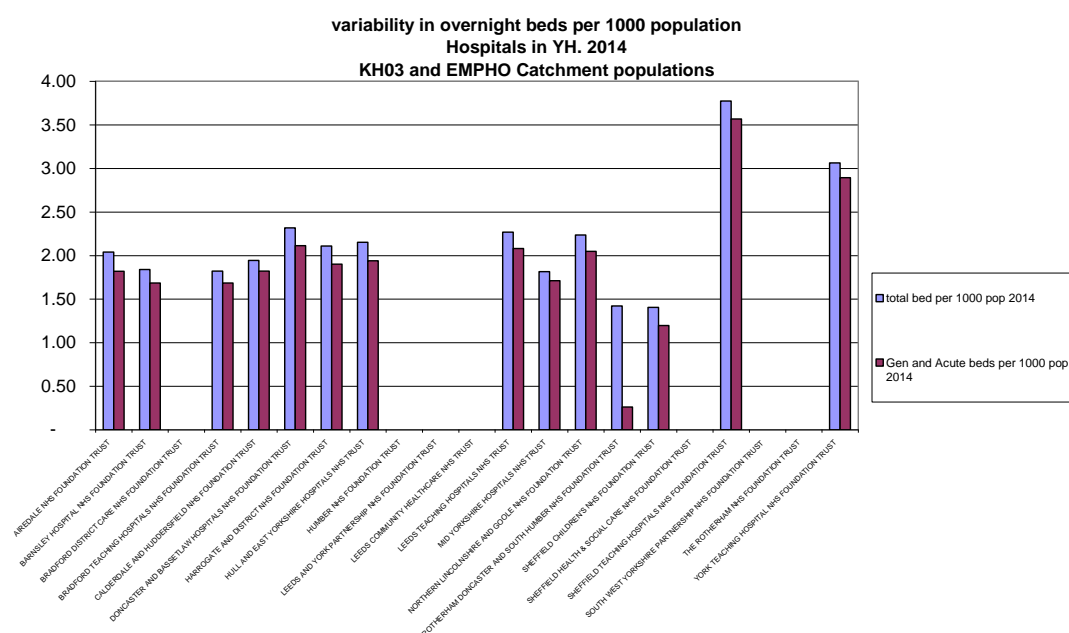
Data is shown for Q1 for each of the five years, for all beds and general & acute beds.

Hospital catchment populations are also in the tables; these were calculated using a method published by E Midlands Public Health Observatory.

Provider Level Data																										
Summary for All overnight beds + Gen& Acute																										
KH03		2010/11					2011/12					2012/13					2013/14					2014/15				
Org Code	Org Name	Catchment	Available Q1 10/11	Available Q1 10/11	% Occupied Q1 10/11	% Occupied Q1 10/11	Catchment	Available Q1 11/12	Available Q1 11/12	% Occupied Q1 11/12	% Occupied Q1 11/12	Catchment	Available Q1 12/13	Available Q1 12/13	% Occupied Q1 12/13	% Occupied Q1 12/13	Catchment	Available Q1 13/14	Available Q1 13/14	% Occupied Q1 13/14	% Occupied Q1 13/14	Catchment	Available Q1 14/15	Available Q1 14/15	% Occupied Q1 14/15	% Occupied Q1 14/15
		Total	General & Acute	Total 10/11	General & Acute 10/11	Total	General & Acute	Total 11/12	General & Acute 11/12	Total	General & Acute	Total 12/13	General & Acute 12/13	Total	General & Acute	Total 13/14	General & Acute 13/14	Total	General & Acute	Total 14/15	General & Acute 14/15	Total	General & Acute	Total 14/15	General & Acute 14/15	
		2010 pop					2011pop					2012 pop					2013 pop					2014 pop				
RCF	AIREDALE NHS FOUNDATION TRUST	176737	383	346	83.8%	84.6%	178248	346	309	96.6%	98.2%	179821	395	353	87.6%	89.8%	181130	422	382	79.7%	83.7%	182390	372	332	88.5%	94.8%
RFF	BARNSELY HOSPITAL NHS FOUNDATION TRUST	206320	494	437	87.6%	90.9%	208083	535	481	86.3%	88.5%	209920	525	471	84.6%	86.6%	211448	484	434	85.9%	88.1%	212919	392	359	92.5%	94.6%
RAE	BRADFORD TEACHING HOSPITALS NHS FOUNDATION	398944	743	689	77.7%	78.9%	402364	737	683	80.0%	81.5%	405905	745	690	76.5%	78.4%	408860	742	695	72.9%	74.1%	411704	750	694	69.8%	71.7%
RWY	CALDERDALE AND HUDDERSFIELD NHS FOUNDATION	389247	800	748	84.1%	85.5%	392573	770	759	86.7%	86.7%	396038	797	786	89.3%	89.3%	398921	786	739	86.1%	87.7%	401696	781	732	87.0%	89.1%
RP5	DONCASTER AND BASSETLAW HOSPITALS NHS FOU	415659	1,056	971	84.0%	87.1%	419212	1,071	986	79.0%	81.5%	422912	983	896	86.0%	89.8%	425990	974	887	83.7%	87.7%	428953	994	907	85.6%	89.8%
RCD	HARROGATE AND DISTRICT NHS FOUNDATION TRUS	163826	324	291	85.9%	90.8%	165226	331	296	84.1%	89.1%	166685	336	301	87.5%	93.1%	167898	335	301	86.6%	90.0%	169066	356	321	81.0%	85.6%
RWA	HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST	508693	1,298	1,206	86.1%	91.7%	513041	1,206	1,124	89.2%	94.9%	517569	1,104	1,021	92.1%	98.8%	521337	1,128	1,020	86.1%	94.7%	524963	1,130	1,018	90.5%	99.0%
RR8	LEEDS TEACHING HOSPITALS NHS TRUST	788000	2,176	2,039	87.5%	90.2%	794735	2,141	1,973	83.6%	87.4%	801750	1,933	1,777	82.6%	85.7%	807586	1,884	1,728	84.2%	87.4%	813203	1,845	1,692	86.4%	90.6%
RXF	MID YORKSHIRE HOSPITALS NHS TRUST	552768	1,126	1,076	85.6%	86.7%	557492	1,133	1,073	82.7%	84.0%	562413	1,082	1,022	87.0%	88.6%	566506	1,067	1,007	83.7%	85.3%	570447	1,036	976	88.9%	90.3%
RJL	NORTHERN LINCOLNSHIRE AND GOOLE HOSPITALS N	365252	842	771	78.7%	84.2%	368373	872	801	73.8%	78.9%	371625	862	776	72.4%	79.2%	374330	887	786	80.3%	84.4%	376934	843	772	83.3%	86.6%
RXE	ROTHERHAM, DONCASTER AND SOUTH HUMBER NHS	229091	244	-	86.6%	#DIV/0!	231049	327	54	83.5%	46.2%	233088	370	79	84.9%	99.3%	234785	352	71	81.4%	67.6%	236418	336	62	72.7%	78.7%
RCU	SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST	110312	147	131	76.6%	77.7%	111255	165	137	76.8%	76.7%	112237	156	135	74.6%	76.0%	113054	156	134	73.0%	72.6%	113840	160	136	74.2%	70.9%
RHQ	SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION	522526	-	-	-	-	526992	2,108	1,976	78.9%	81.5%	531644	1,927	1,836	86.9%	88.3%	535513	2,053	1,940	79.8%	82.1%	539238	2,034	1,923	79.3%	81.1%
RFR	THE ROTHERHAM NHS FOUNDATION TRUST	229091	-	-	-	-	231049	567	530	93.3%	92.8%	233088.4	594	569	81.8%	81.0%	234785	633	617	94.5%	94.4%	236418.1	534	509	87.7%	89.2%
RCB	YORK TEACHING HOSPITAL NHS FOUNDATION TRUS	333392	700	657	88.0%	90.4%	336242	741	695	91.4%	94.5%	339210	1,147	1,086	90.4%	92.8%	341679	1,054	997	89.2%	91.2%	344055	1,054	996	92.0%	93.9%
RCC	SCARBOROUGH AND NORTH EAST YORKSHIRE HEALTH CARE NHS FOUNDATION	233392	351	337	88.6%	89.7%	236242	367	353	83.5%	84.7%	239821	395	381	86.3%	87.5%	241130	422	408	85.0%	86.2%	242390	372	358	92.2%	93.5%

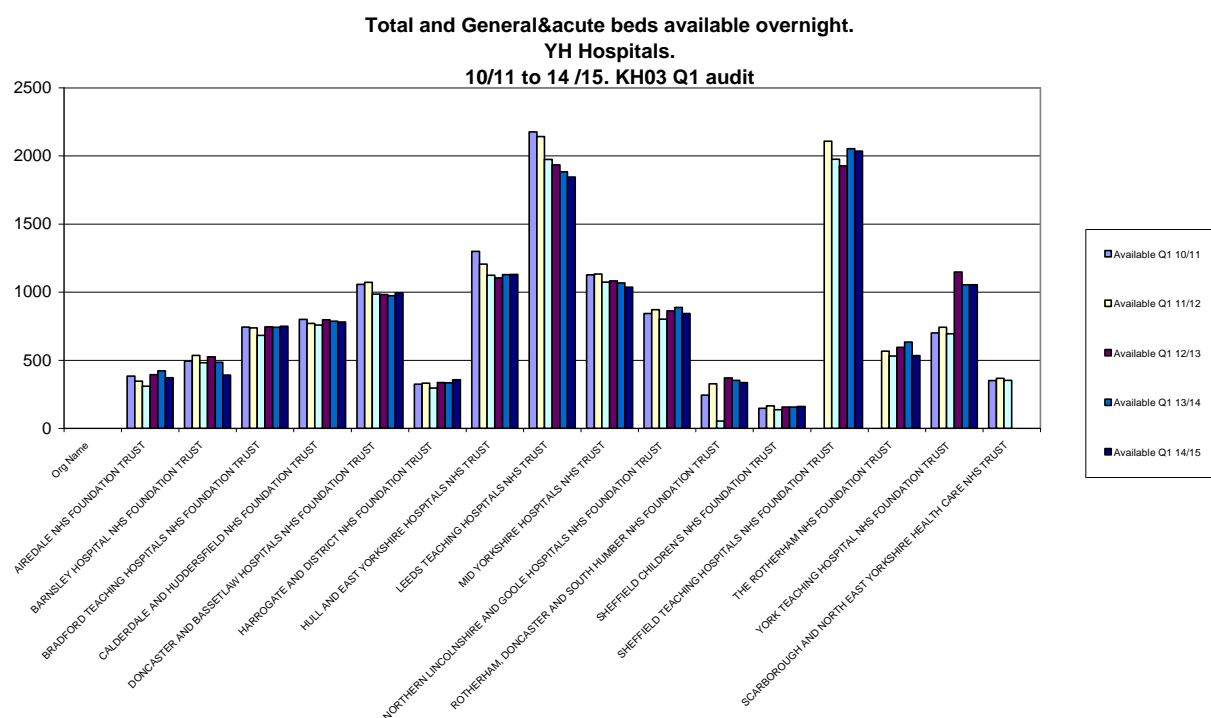
N.B. Data on occupancy should also be interpreted with data on the total number of beds.

## Overnight Bed Availability Per Capita Varies Across Y&H, there are some Notable Outliers.

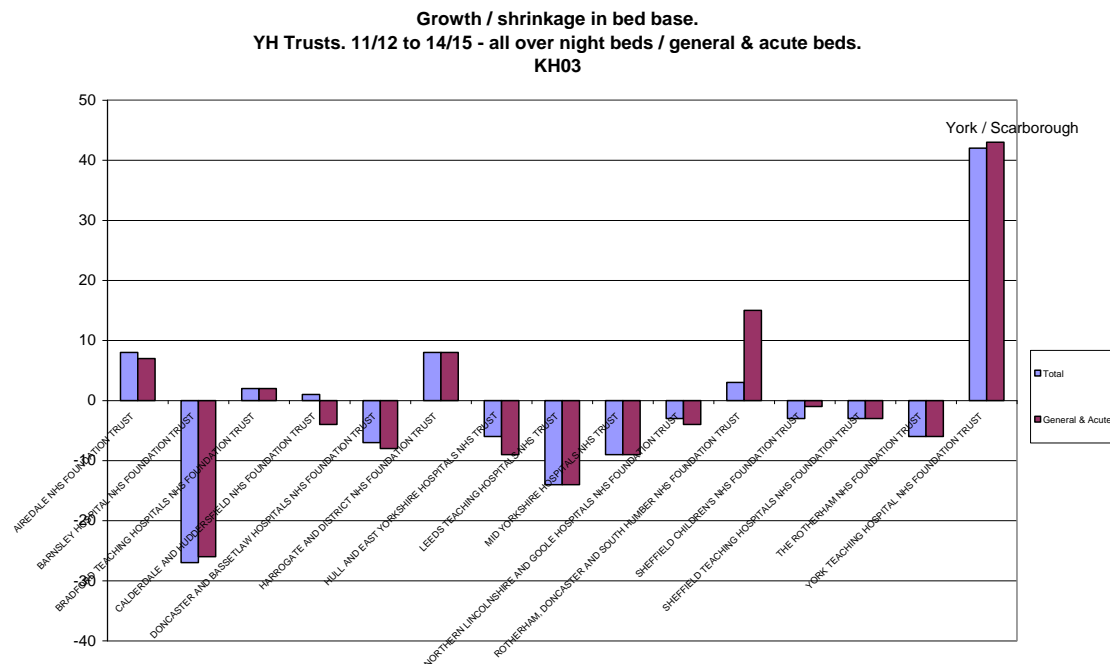


It is not readily possible to obtain data on the catchment populations of mental health trusts.

## The Bed Base is Falling Across the Region.



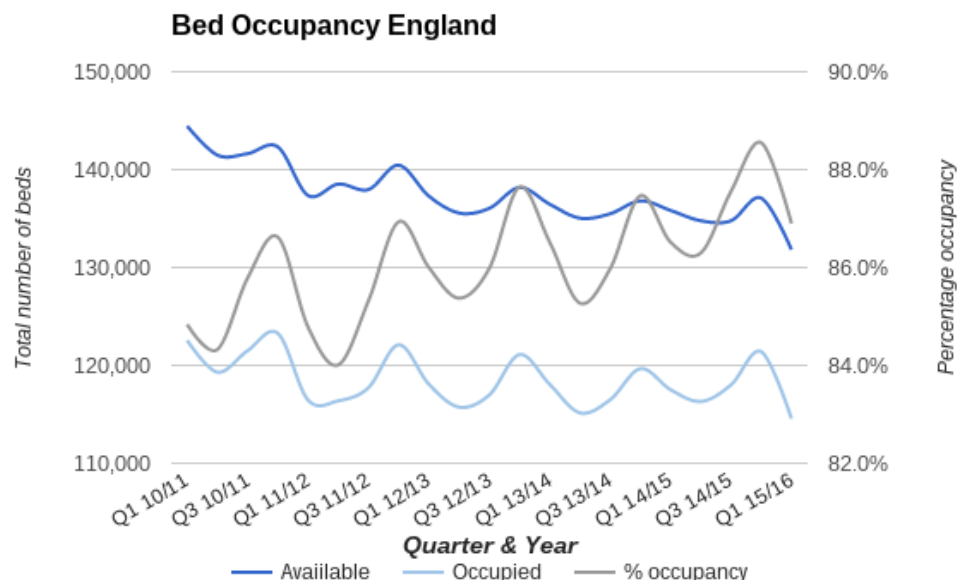
### Growth and Shrinkage in Y&H trusts.



Bed base is not falling uniformly across all trusts.

### Occupancy Nationally is Rising; Locally it is Static or Rising.

Occupancy is considered by many to be significant issue for maintaining patient flow. The national picture for bed availability gives a picture of occupancy climbing with bed closure.



### Y&H Data on Hospital Capacity

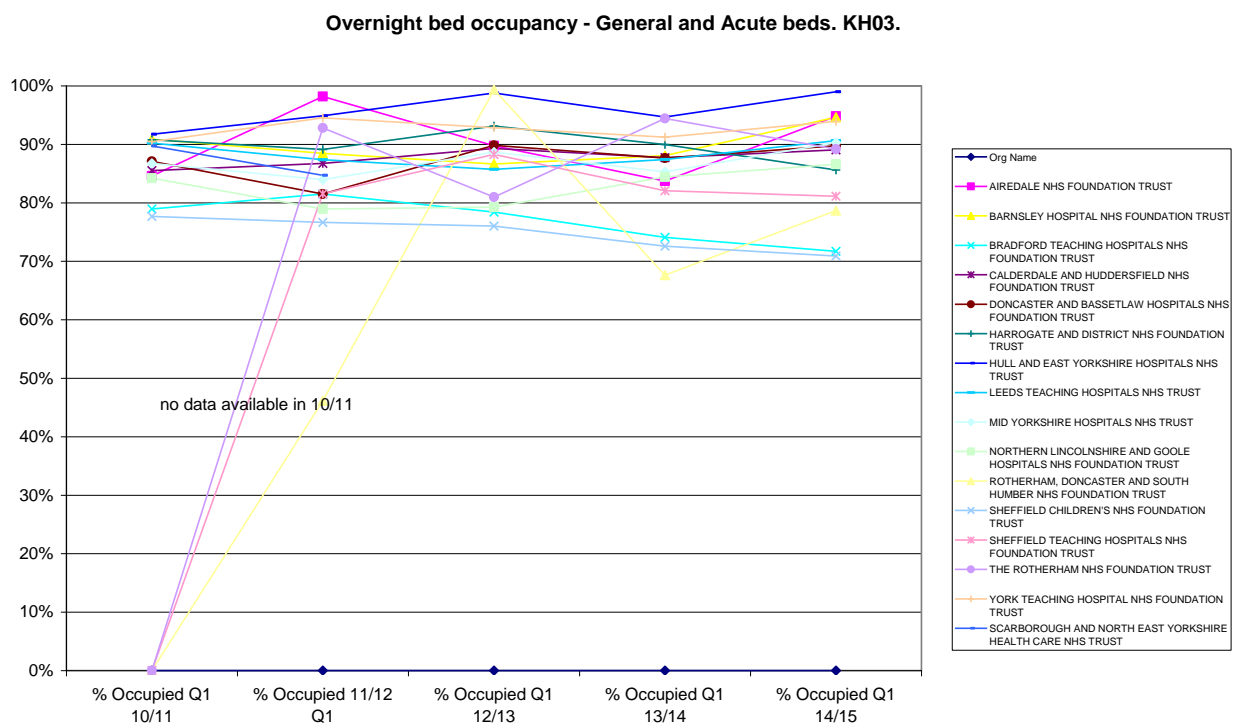
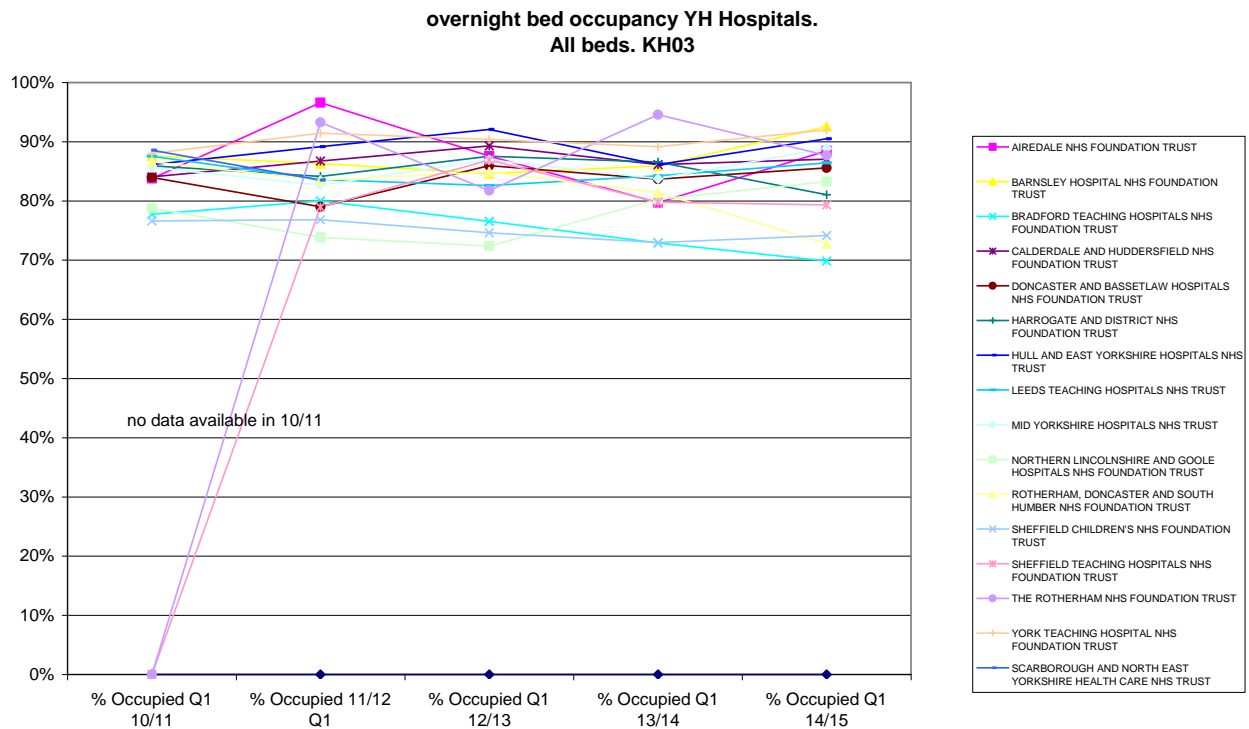
For hospital beds, there are routinely available data on bed numbers and availability. The KH03<sup>12</sup> is a quarterly collection from all NHS organisations that operate beds, open overnight or day only. It collects the total number of available bed days and the total number of occupied bed days by consultant main specialty. Prior to 2010-11 the KH03 was an annual return collecting beds by ward classification.

<sup>12</sup> <http://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/bed-data-overnight/>

Some initial analysis was undertaken on hospital capacity, specifically focused on beds open overnight (as opposed to day only beds) and using the KH03 Quarter 1 return, combined with hospital catchment populations.

This is illustrated in the below charts. N.B. This is Q1 data, other quarters may enlighten this issue further.

### Locally Occupancy Seems Static in Most Trusts



### Length of Stay Varies across the Region.

It is known from other work that enabling the discharge of long stay patients is considered a priority to aiding bed capacity and flow. There may be some merit in considering monitoring trends in mean length of stay.

### Length of Stay for Emergency Admissions for 2012/13 across NHS Comparators

Mean length of stay - Emergency inpatient admissions

2012/13

Source: NHS Comparators

Type	Code	Organisation	Average LOI
Provider	RXG	South West Yorkshire Partnership NHS Foundation Trust	34.7
Provider	5NV	North Yorkshire and York PCT	17.6
Provider	RV9	Humber NHS Foundation Trust	12.7
Provider	RXE	Rotherham, Doncaster and South Humber NHS Foundation Trust	10.6
Provider	RHQ	Sheffield Teaching Hospitals NHS Foundation Trust	6.4
Provider	RCC	Scarborough and North East Yorkshire Health Care NHS Trust	6.2
Provider	RCF	Airedale NHS Foundation Trust	5.6
Provider	RCB	York Teaching Hospital NHS Foundation Trust	5.5
Provider	RR8	Leeds Teaching Hospitals NHS Trust	5.4
Provider	RCD	Harrogate and District NHS Foundation Trust	5.3
Provider	RJL	Northern Lincolnshire and Goole Hospitals NHS Foundation Trust	5.3
Provider	RFR	The Rotherham NHS Foundation Trust	5.2
Provider	RWA	Hull and East Yorkshire Hospitals NHS Trust	4.7
Provider	RFF	Barnsley Hospital NHS Foundation Trust	4.6
Provider	RP5	Doncaster and Bassetlaw Hospitals NHS Foundation Trust	4.5
Provider	RAE	Bradford Teaching Hospitals NHS Foundation Trust	4.5
Provider	RXF	Mid Yorkshire Hospitals NHS Trust	4.3
Provider	RCU	Sheffield Children's NHS Foundation Trust	1.5
National		National	4.8
SHA	Q32	Yorkshire and the Humber SHA	5

There is a wealth of guidance on managing length of stay, from a hospital perspective. Most recently the Nuffield Trust has published a review<sup>13</sup> of the evidence here. The key points were:

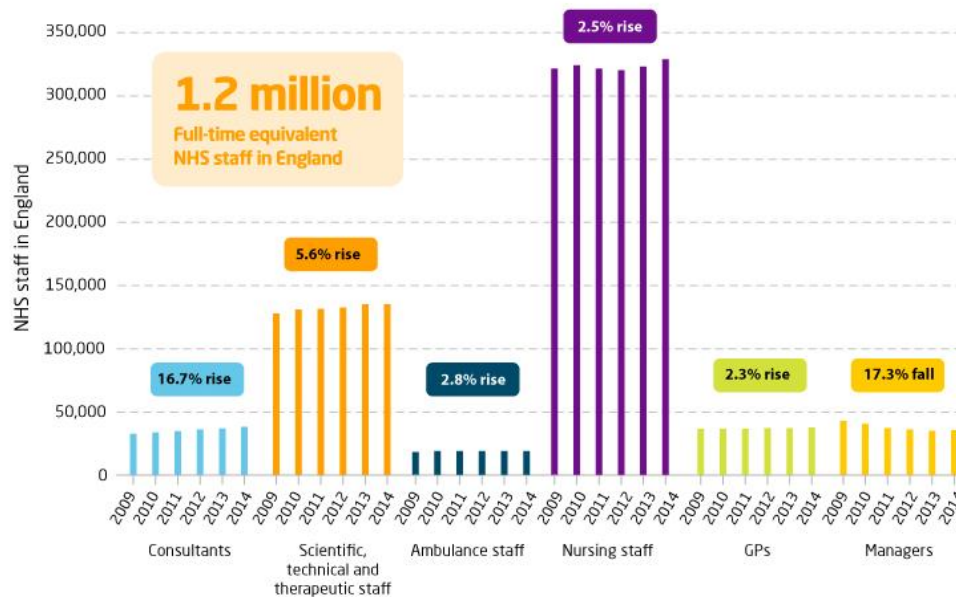
- Focus on flow
- Get the basics right
- 'Bundle' approaches together
- Maintain a rapid pace for decision-making and patient progress
- Ensure active support for discharge seven days a week
- Large-scale top-down change is often not required

### d) Workforce is often Cited as a Core Challenge across all the Policy Problems in the NHS. Specialist Workforce is Growing Faster than Generalist.

Many have highlighted the major disconnects between strategic goals and workforce trends. Though a point that is applicable to the whole of the NHS workforce, the increase in consultant body has considerably outstripped the rise in GP and other aspects of the NHS workforce over the last 6 years<sup>14</sup>.

<sup>13</sup> Improving length of stay: what can hospitals do? Nuffield Trust. *Research report*. Ruth Lewis and Nigel Edwards September 2015

<sup>14</sup> <http://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/nhs-staffing-numbers>



Obviously this is at odds with a policy ambition of moving care closer to home and might call into question whether the balance between generalist and specialist is correct. The important caveat to this is the large data gaps in the availability of information on workforce<sup>15</sup>.

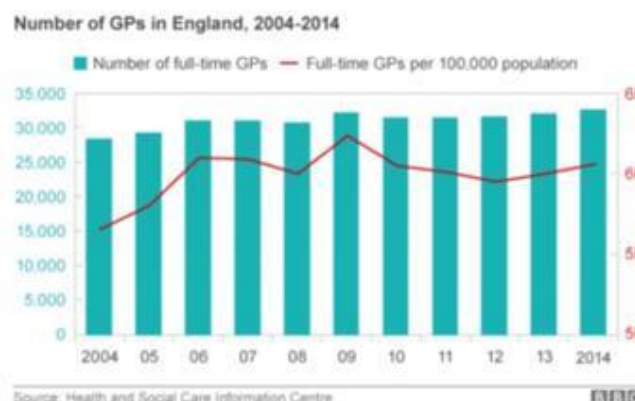
### Pharmacists and Paramedics

The pharmacist and paramedic workforce have historically been seen as a Cinderella aspect of the urgent care system. There is chronic shortage of paramedics (which may become more acute as we develop new models like the Urgent Care Practitioner) conversely some have suggested there is a surplus of pharmacists, but are not optimally utilised with regard to urgent care (and many other aspects).

Both are trained and skilled and carry great potential to help address problems. Data on workforce numbers is scarce.

### General Practice

Recent HSCIC data (national) on general practice workforce between 2004 and 2014 highlights that the UK population has risen by c2m since 2010 whilst GP numbers are relatively flat – thus GPs per 100,000 population have fallen from 62.4 to 60.0. Subsequent commentary had suggested that statistics on GP numbers do not take account of the increase in the non-clinical work of GPs.



During this time period, though data is only available from sample surveys, it is known that the average GP consultation rate in the population has increased by c40%.

<sup>15</sup> <http://www.kingsfund.org.uk/publications/workforce-planning-nhs>

## Other Elements of the Workforce Needed for Urgent Care

The CWFI recently published a report<sup>16</sup> highlighting initial results of the initiative to provide horizon scanning that will support the long-term strategic vision for the health, social care and public health workforce in England. The key findings were:

- A projection that the demand for health and care workforce time could grow more than twice as fast (+1.3 per cent as an annual average growth rate) as the rate of overall population growth (+0.6 percent as an annual average growth rate) to 2035.
- That over 80 per cent of additional demand is associated with long-term conditions, related to an ageing population and increased prevalence.
- The highest growth in demand will be for lower 'levels' of skill – such as those associated with unpaid care, support carers and NHS bands 1-4. These will outstrip demand for higher skill roles.

The report underscores the importance of a broad look at future workforce, not just “traditional” medical and nursing roles. There is relatively little available data on a large chunk of the care workforce.

## e) Spend on Urgent Care

NHSE Programme Budget dataset<sup>17</sup> has been used to give a sense of the proportion of the total NHS spend that could be characterised as “urgent care”. Only one years data has been used for this (2013/14) as this is the only data that was available to compare all CCGs (previously data was at PCT level and in a slightly different format). There are a number of well documented caveats of programme budget data, these are not highlighted here. However it is about the only routinely available metric of spend that allows ready comparison at commissioner level.

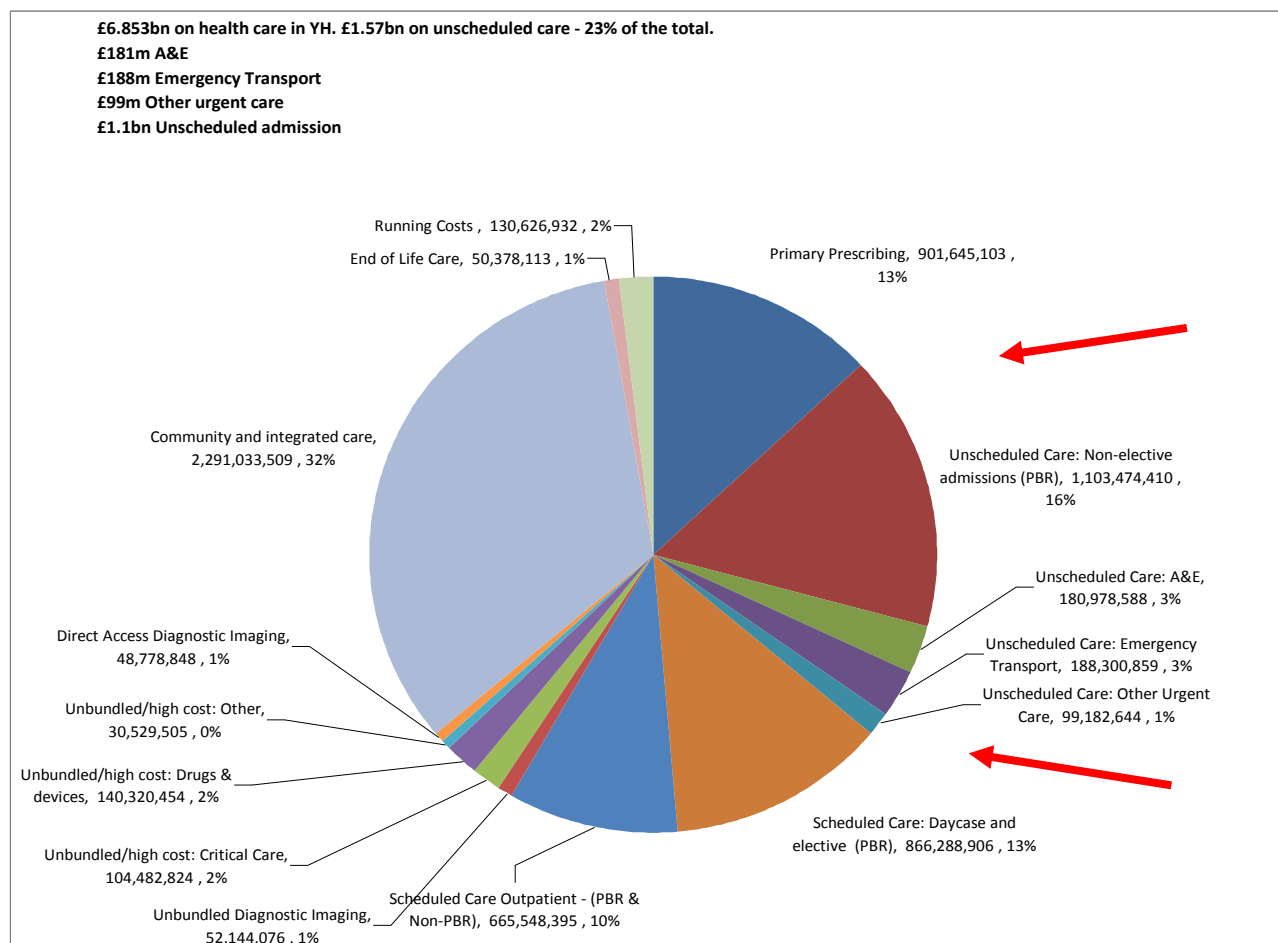
The table below gives the sum that CCGs record as being spent on different types of UEC, by CCG. This is based on activity data and uses well established algorithms. To date only one year of data is available at CCG level.

		Unscheduled Care: Non-elective admissions (PBR)	Unscheduled Care: A&E	Unscheduled Care: Emergency Transport	Unscheduled Care: Other Urgent Care	Total
	AWC	33,680,470	4,254,100	5,058,270	3,986,530	187,328,120
	Bradford City	14,449,025	3,924,006	3,388,802	1,870,557	115,667,594
	Bradford Districts	57,419,094	10,079,592	11,039,866	541,166	400,547,100
	Calderdale	47,129,000	7,487,000	7,725,000	2,051,000	261,962,000
	Greater Hudds	43,060,000	7,468,000	8,396,000	1,938,000	275,015,000
	Leeds North	31,700,000	6,724,000	6,361,000	2,009,000	234,285,000
	Leeds S&E	52,916,000	9,139,000	10,844,000	2,999,000	340,065,000
	Leeds West	57,155,000	11,880,000	9,861,000	3,286,000	385,926,000
	N Kirklees	32,019,610	6,983,654	6,293,441	1,998,398	222,412,349
	Wakefield	82,889,526	12,954,418	15,148,793	4,949,219	460,935,408
West York	TOTAL	452,417,725	80,893,778	84,116,172	25,628,870	2,884,143,574
	Barnsley	54,264,000	9,354,000	7,105,000	738,000	342,630,000
	Bassetlaw	22,215,000	3,526,000	3,854,000	858,000	141,245,000
	Doncaster	68,733,000	12,951,000	8,922,000	3,601,000	413,609,000
	Rotherham	51,986,311	8,758,422	6,849,763	4,197,570	327,547,353
	Sheffield	116,521,000	19,189,000	17,538,000	6,610,000	696,829,000
South York	TOTAL	313,719,311	54,178,422	44,268,763	29,731,570	1,921,869,353
	Eriding	63,587,000	5,771,000	12,201,000	11,984,000	354,934,000
	Hambleton Richmondshire and Whitby	27,087,000	3,255,000	5,474,000	4,134,000	170,796,000
	Harrogate	27,926,993	4,688,771	5,651,020	4,471,406	174,831,931
	Hull	63,645,694	9,706,587	9,999,667	9,843,456	367,007,868
	N Lincs	34,165,555	6,188,000	5,008,000	5,449,000	204,406,382
	NE Lincs	37,205,000	4,892,000	4,986,000	4,868,000	262,033,000
	Vale of York	60,281,065	7,887,513	11,920,237	5,865,185	365,842,989
	Scarborough and Rydale	23,439,067	3,527,525	4,676,000	3,207,157	147,857,069
N and E York	TOTAL	337,337,375	45,906,397	59,915,924	49,822,205	2,047,709,240
YH (inc Bassetlaw)		1,103,474,410	180,978,588	188,300,859	99,182,644	6,853,713,166

<sup>16</sup> Future demand for skills: Initial results. Centre for Workforce Intelligence. 2015 <http://www.cwfi.org.uk/news/new-progress-update-presents-initial-horizon-2035-messages-for-first-time>

<sup>17</sup> Historically DH, and now NHS England have published a number of tools to support the definition of the programme budget. <http://www.england.nhs.uk/resources/resources-for-ccgs/prog-budgeting/> here is data – current an historical – on spend in each of 23 categories for every population in England. This includes: Definitions of programmes and categories of care <http://www.england.nhs.uk/wp-content/uploads/2014/02/pb-cat-defins.pdf> detailed guidance for finance professionals in preparing a budget <http://www.england.nhs.uk/wp-content/uploads/2014/02/prog-budg-guid-08-13.pdf> most helpfully a mapping document linking specific lines of activity to programme categories <http://www.england.nhs.uk/wp-content/uploads/2014/02/pb-mapp-defin-08-13.xlsx>

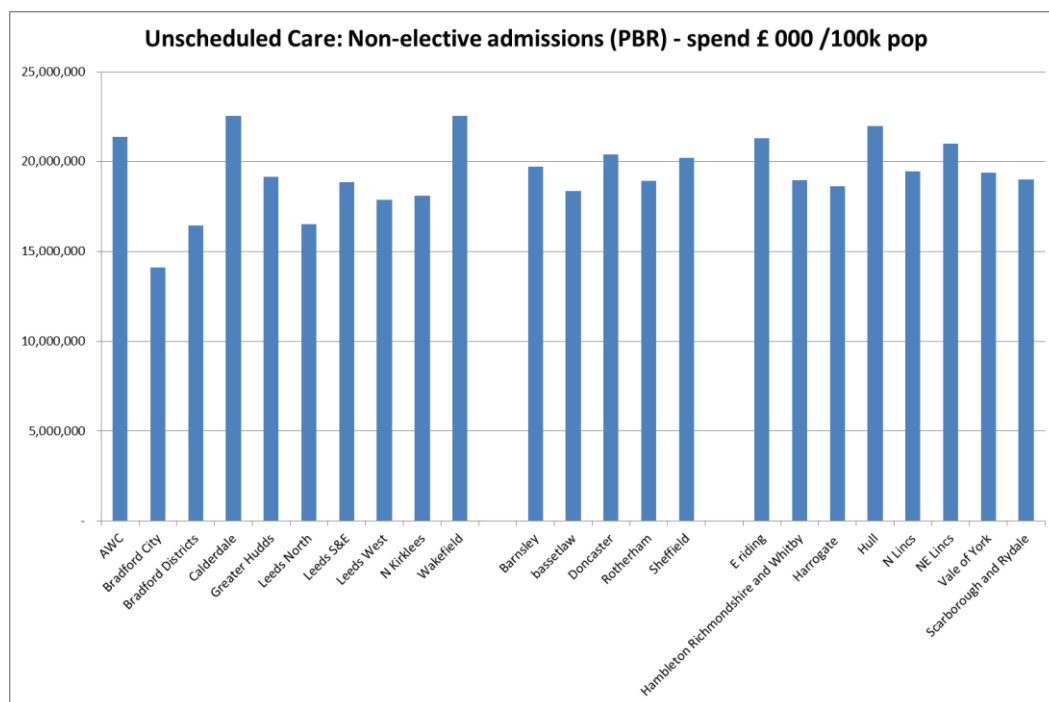
The chart below highlights the totality of spend on health care, as recorded in the programme budget dataset, for all Y&H CCGs (inc. Bassetlaw) for 2013/14. Of the £6.583bn spend on health care, 23% of the total (or £1.57bn) is categorised as unscheduled. Of the £1.57bn: £181m in A&E, £188m in urgent transport, £99m in other urgent care, £1.1bn in unscheduled admission. This is a relatively small slice of the total which some suggest might be the hardest bit to change given the nature of demand and the perverse incentives.

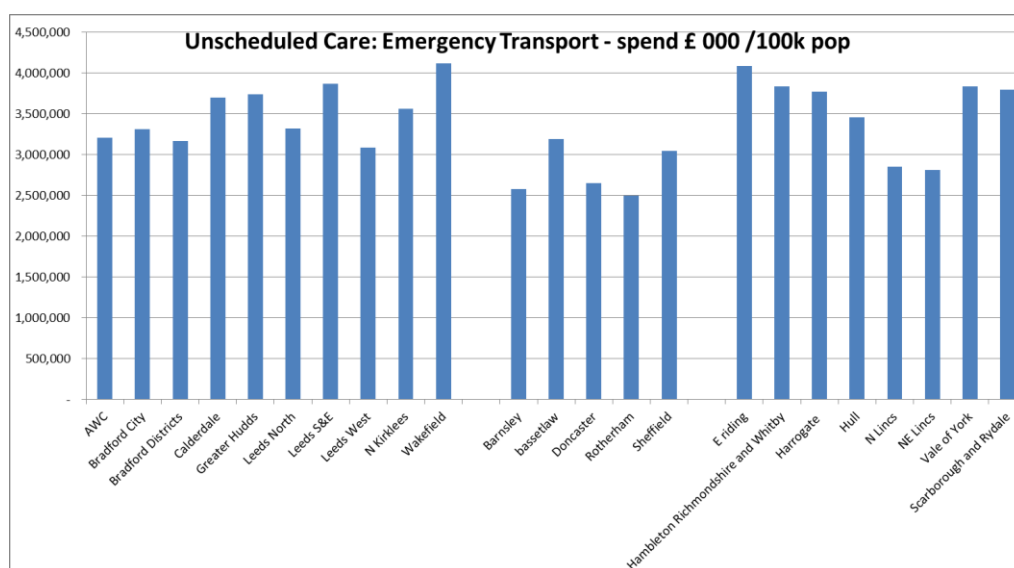
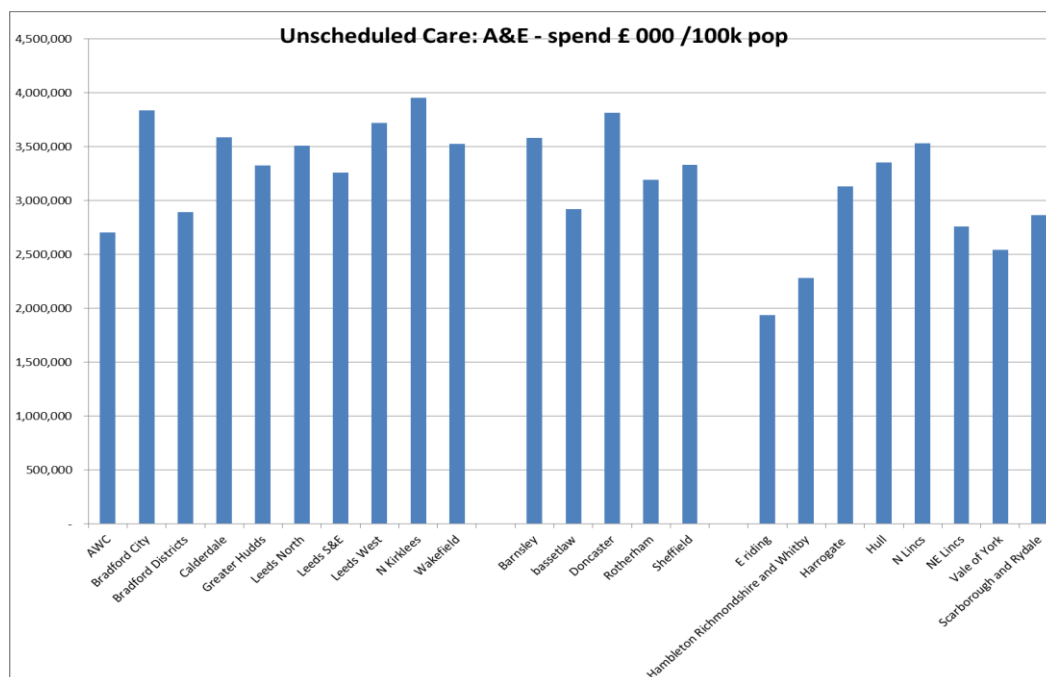


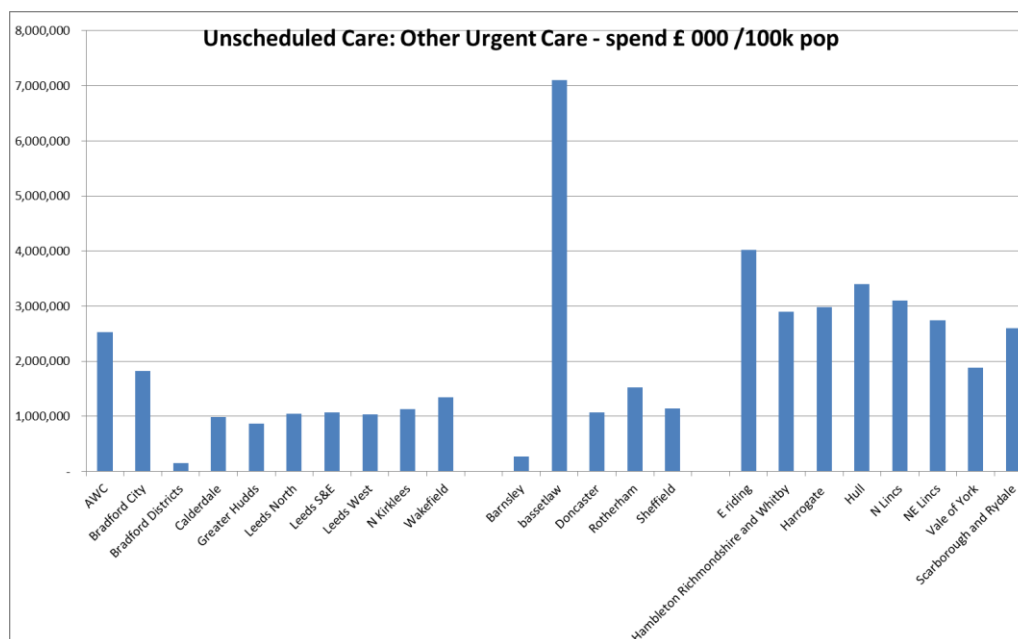
Urgent  
Care =



**Spend on Unscheduled Care per 100k Population at CCG Level.**  
(data is available in appendix files).







There are a number of additional analytical questions that may be considered. The data considered here used almost exclusively publicly available data.

#### f) Further Analysis on Health Care Use

Further analysis might explore more in-depth descriptions of main reasons for use of various forms of urgent and emergency care by diagnosis, geography and or age group. Such further analysis might be insightful in terms of determining whether that are large cohorts of patients that might be managed safely in alternative ways to the current.

#### Interdependencies

The data as it is informs us about demand/ capacity/ beds but does not pick up on the 'person'/ 'pathway'/ 'interdependencies' between different specialties. This has been done in some areas, for example some PHE/ NHSE work around the interdependencies around a number of areas e.g. CHD/ epilepsy/ vascular.

#### The "Right" Hospital Bed Capacity

The "right" bed capacity for any given population is not known. Some initial modelling work has been undertaken in one health economy (Bradford and Airedale footprint) on the long term need for acute and community beds. This is based on a number of assumptions about past intensity of bed use, past trends in admission and current bed stock, combined with expected future population growth. This highlighted and quantified a need to invest in step up bed capacity and act cautiously with regard to hospital bed base given future demographic and epidemiological trends.

#### The Right Capacity Requirement in Urgent Care Centres

Similarly there might be some mileage in conducting modelling around the likely requirements for capacity in ED or Urgent Care Centres. This has been undertaken in some health economies already, so methodology is available.

### **The Long Stayers**

During the course of this review, a number of stakeholders have consistently suggested that some focused attention on >28 day stays – from both an analytic/ quantification, a service response and a quality/ safety perspective would be warranted.

### **Primary care, ambulance, 111, community care**

There are many, often unanswered, questions about demand and capacity in many other parts of the system. Even when the data is available it seems that it is not often put together to tell a whole story.

### **Further Analysis.**

There are many further analytic questions that this report has begun to scratch into the surface of. Caution should be exercised however, that any future analysis is linked to a clear decision that is needed. Furthermore further analysis may not resolve some of the broader strategic questions of culture, service and system design/ architecture.

## 4.3 What Stakeholders are Telling Us?

The themes to emerge from stakeholder interviews are highlighted in this section and have been broadly grouped together. It is worth highlighting that this project was not a “formal” piece of qualitative research.

### **a) Strategic Issues**

#### **Dialogue and Strategic Relationships are Important, but Often Overlooked in our Efforts to Transform Services.**

For some, getting all stakeholders into the same room, talking the same language and moving towards a common understanding of the problem was a significant success of the UCB / SRG arrangements. Many argued that would not have happened without a push from external.

Whilst relationships were not yet perfect, a place to discuss the complex issues is valued. Dialogue was felt to have improved.

It seems the remains a tension between a micro approach (addressing specific and particular service problems at the frontline) and a macro approach (where urgent care fits into a broader picture of system transformation across multiple providers and many different agendas). The way in which this is managed seems to vary from place to place.

Similarly, many are contending with the ongoing tension between day to day operational issues (often fire fighting crises that crop up) and long term strategic planning.

#### **Relationship Building is an Important Achievement in Itself**

The need to have time and space to understand the perspectives and worldviews of different parts of the system was articulated by many. This might have been from a shop floor perspective – GPs spending time in ED, ED clinicians spending time in General Practice, or other permutations, or might have been at a strategic level.

At shop floor level, the time and commitment this takes shouldn't be underestimated. The return on investment of that time is also difficult to measure, but those who articulated it were universally of the view it was a valuable activity.

Dialogue between key stakeholders at strategic level was felt by many to have improved considerably. Again this is a difficult to measure gain, but many suggested that the UCB, SRGs had moved the debate on from a very hospital centric model, to a system centric model – obviously a positive development. Many suggested that simply getting people into the same room was an achievement in itself.

A few identified an important issue of clinicians not being given enough time to attend key meetings; as they carry critical intelligence that may not be capturable with “data” this needs to be addressed, even acknowledging the opportunity cost of that time.

Bringing groups of professionals together in a joint conference to explore potential for closer working has been considered in some areas – for example district nurses and practice nurses. Co-location in a single hub also achieves the same goal in a more micro level.

#### **There are Blurry Boundaries between Planned and Unplanned Care. Different Perspectives on what Matters Most & What is Easiest to Change, and the Roles and Responsibilities of SRGs and UCBs varies from place to place.**

The ramping up of focus on “urgent and emergency care” is not new – as is seen above the level of policy attention has been from 2001 forward, arguably with increased emphasis in recent years. Most recognise that the boundary between planned / unplanned was always an artificial one, and hence the development of systems resilience groups to take on additional responsibilities over and above initial expectation of “urgent care”. The boundary between planned and unplanned does make the problem a little more manageable, and also relates to how patients use services, and planners plan.

The question of whether making significant change to “urgent care” from either a demand side or a supply side was the easiest “target” was questioned by some, with suggestions that there may be readier gains from emphasis on planned care activity.

Many highlighted the notion that practically arrangements were largely provider dominated – often by resolving day to day problems and issues, often ED dominated - where the political pressure was perceived to be. That an A&E centric approach is taken to urgent care was highlighted both in policy terms and in response to policy.

Picking up on themes set out above, the focus on reaction led approach and the cyclical nature of “winter pressures” and “winter monies” led some to highlight the notion that in some areas the urgent care planning arrangements were simple seen as distribution of winter funding – or a non recurrent investment committee; at the expense of enabling and developing a broader more strategic vision. Obviously this may be an issue that resolved itself as winter pressures funding is put into baselines. The exact nature of the day to day responsibilities of Urgent Care Boards, Urgent Care Working Group, System Resilience Groups seems to vary from place to place: this is perhaps inevitable. In many areas, the SRG and UCB papers are common across all organisations and thus a common story is used for all bodies, but ultimately financial assurance rests with individual CCG and trust boards, who retain legal duty to their own governance and regulatory mechanisms.

The multi-faceted nature of the problem, the many organisations involved and the need for multiple assurances to multiple organisations might slow progress. The extent to which the agenda is truly shared is unknown; as stated above many admitted that people come to multi agency groups with their own organisational agendas and pressures. Where there are cross boundary issues and or where an agency spans many different geographies, this adds further complexity. Some questioned whether the path of least resistance may be to retract planning into a smaller boundary as it is perceived as easier to “get stuff done”.

**Focus on the Whole System, Not Just A&E. Who Turns Up to SRG Matters to What Gets Decided? This is especially Difficult in a Scenario with an Unprecedented Focus on A&E Waits.**

Whilst often priorities are worked out by consensus, the consensus can be influenced by who is in the room, how strong a voice those stakeholders have and what body of opinion they carry. Many commented on the need to improve ways of getting General Practice opinion and views more organised.

Though far from universal, many commented on the SRG/ UCB arrangements being trust and 4 hour wait dominated.

As one of the larger providers on any patch and a key pressure point this is understandable. Also understandable would be a view that all stakeholders would have a default position of arguing for more resource being injected into “their” part of the system.

Some examples were given of where organisations have come to address a FT issue (4hr/ flow), recognising that some investments need to be out of trust.

Knowledge and experience of day to day general practice was felt to be missing in some areas.

**Short Term Funding, a Scattergun Approach to Schemes and a Lack of Robust Evaluation Remains Problematic**

The approach to “winter money” was a source of frustration by some. Inevitably it is year to year and short term in nature, often with relatively short term timeframes from funds being available to a requirement to agree and sign off schemes.

Many stakeholders identified that a significant number of schemes are developed and agreed in any given year. For example one health economy identified 27 schemes, another 38 schemes implemented across their footprints. Specific schemes may be variable to locality; depending on what is already present, local views and what the perceived pressures are.

The rapid cycling of this form of funding also often led to knee jerk responses, incomplete implementation and bedding in of schemes and sometimes little to no evaluation and opportunity to learn how any particular scheme works (or doesn't) in the context of a whole system.

Furthermore many expressed that multiple, small, often short term investments may detract management and clinical attention away from larger scale service, system change or culture change. The approach is probably a statement of reality and a function of (evidence speaking) we are collectively not sure which horses to back, and may be reluctant to commit monies to "transformation" as it is hard to grapple with, define and measure.

The incomplete evaluation of many investments was seen as a significant problem by some, who argued that evaluation should be a core requirement of all investments.

All organisations are becoming more risk adverse financially, and assumptions about whether specific services or investments will be continued once "mainstreamed" into core contracts are challengeable.

### **Evidence and Evaluation – Use, Ignorance and Misuse**

Many suggested we don't spend enough time looking to what has been achieved in other areas, or looking at what the published evidence is telling us and learning from that.

There are few natural opportunities to share successful schemes and initiatives. Similarly, there is much to learn from less successful schemes, often these lessons are not shared widely. There may be lessons from other parts of the world that we are not taking in, or lessons on the adoption and evaluation of innovation that we are not harnessing.

### **The Time to Embed and Mainstream New Innovations Shouldn't be Underestimated**

Even when there are excellent and well evaluated schemes, it takes a long time for people to realise there is a new service there, especially if the new service or innovation "breaks the mould". This was cited by many as one of the key difficulties in getting new services to be well used, as we all take the path of least resistance.

### **There may be some Benefit from Coming Back to the Evidence We may have Overlooked Before – Specific Schemes, Pathways and Innovations**

Some suggested that there may be a great deal of specific benefit in reconsidering some of the high impact changes suggested in earlier evidence reviews (Willets, Keogh Phase 1) that may have been overlooked in an effort to find quick wins.

A focus on falls was consistently noted as one area where there may be considerable benefit from a more focused consideration; it is estimated that 20-30% of ambulance calls are due to falls and there is a great deal of under implementation of effective falls prevention interventions (where the clinical evidence is robust).

In similar area was the extent to which there is consistency of approach across all health economies re pathways – for example whether the pathway for DVT is the same in Bradford as it is in Barnsley, or whether there are high volume pathways that have been poorly, or not, implemented (the NICE guideline on feverish child) was mentioned in this context.

The AHSN may have a role in developing a common approach to the use of evidence for change, from macro system level through to implementation of schemes. There is also a role in terms of supporting the system with evaluation – either in the design of or/ and in the execution of evaluation. Evaluation needs to be focused on both formative and outcome questions – the why something "works" or doesn't work is equally important to the outcome – especially in the early stages of an innovation.

### **The "Scope" of Urgent Care may Vary from Place to Place**

The scope definition of "urgent care" is variable across the Y&H patch. For example, whether ambulatory care is in the concept of urgent care or not in. The extent to which minor ailments is "in" may vary from place to place, similarly long term conditions, normally the core role of general

practice. “If we manage respiratory conditions better there will be less demand”; this is often not included in “urgent care”.

However set against this is the real danger that everything becomes “urgent care”.

### **Many want to Increase the Emphasis and Resource Commitment Given to “Prevention”, and a More Sophisticated Approach**

Many were clear of the need to invest in upstream prevention with greater investment of resources and funds in a preventive approach as opposed to care management now. Obviously this implies a leap of faith in that many preventive interventions don’t have an immediate return on the investment.

### **Population Level Approaches to Slowing Frailty**

One stakeholder highlighted the work being undertaken in other systems around healthy ageing and population health care – systematic population wide effort to improve coverage of self care and health improvement to improve health at a population level. This was essentially an approach to invest in population level initiatives to slow or delay the development of frailty. This was seen as a necessity rather than a luxury, in order to provide some hope of dealing with the anticipated growth of elderly patients with multiple morbidities.

### **Culture**

Some of the main challenges will be around cultural differences between different parts of the system. These manifest in different ways and offer many opportunities. The cultural differences in the way different specialties practice medicine has been well described by others. Reconsideration of the cultural difference between the way in which clinical practice in General Practice is perceived to work, where there is limited availability of a range of different imaging and diagnostic technology – thus “risk management and the eyeball” method are common, contrasting this with the culture of practice in ED, where there is less population segmentation (thus a more homogenous approach to all) and more availability of diagnostics (thus a tendency to use them). Arguably this leads to higher levels of investigation, and delay and heightened cost.

Considering the risks and benefits of both approaches in a range of settings may be beneficial. One example cited was around exploring the potential for early discharge of patients from ED before all test results were back with follow up call to patients. This was seen as a de-crowding intervention, and may be suitable for a large volume of ED walk in patients. It would be a clinical culture step for A&E medicine.

Similarly the fundamental cultural differences between commissioner / provider, health and social care require a great deal of thought.

There is an increasing emphasis in most health care systems on the role and place of both self-care and shared decision making. The latter is arguably most appropriate to planned care. The extent to which increased implementation and coverage of self-care interventions will yield short term financially measurable benefits is debatable.

In parallel, some stakeholders highlighted that many local authorities are actively reconsidering the balance between state funded services, local policy and the role of the individual. It is broadly expected that the relationship between state and individual will be reset over the next 10 years.

There may be benefit in the AHSN in leading some work across health and local government on the approaches to shifting the locus back towards the citizen, how this might be achieved and what it might mean in practice.

There may be a number of elements to this, including:

- Shifting from supply led model to a demand led model - public agencies typically know a lot about people’s responses to service interventions, but far less about the assets, resources and networks of communities outside of this.
- Shifting the emphasis from organisations and services to place and population, and networks of care. The focus of discussion is never about the place or the service; it is about the population and the network.
- Shifting the emphasis from patients to collaborators. Can the system encourage much greater collective responsibility for health outcomes (adapted from Adebawale [HSJ 2015](#)).



Even when “system leaders” are fully on board, these cultural issues are deeply rooted in the way that all those working in any one part of the system thinks. This may be further exacerbated by perverse clinical, quality or financial incentives. So the extent to which a Chief Exec carries the opinion of all their organisations remains to be seen. “The exec level might see the need for change, but making it happen down the ranks of the organisation...will always be difficult”.

## **b) Transforming the System and Rationalisation**

### **The Vision**

In five years, the FYFV will have run its full course, the system will have transformed and we will be in a more sustainable place to manage the greater burden of disease from long term conditions. The population will be using self care at scale and willing to use a wider range of skill mixed services where historically a doctor would have been the default. We will have redesigned primary care access and 50% of GPs time will become available through different roles providing care that would have historically been GP care.

### **Different Stakeholders will have Different Views and Perspectives on “The Problem” and the Scope.**

“Our understanding of any problem is shaped by where we sit in a system, the geography we serve and the expectations of the board or/ and the regulator to whom our organisation is responsible”.

Some stakeholders, particularly where they cover a large geography, clearly will have many different perspectives on “the problem” into which they must fit their answer. Also, there are different expectations from Whitehall and local politicians about what priority should be afforded to specific themes, for example whether a focus should be on the number of EDs, quality and outcomes of ED/ out of hours/ other, community care, hospital reconfiguration, ambulance services, urgent social care response. All of these themes are legitimate targets for service improvement, different stakeholders will think differently about priorities.

### **Transforming Versus Tinkering is a Long Standing Challenge**

Macro level change and major transformation is seen as difficult, time consuming, resource intensive and risky; often with an uncertain return on the investment.

The system is complex; arguably we don't have a full understanding of it. To make systems changes across whole system extremely challenging; the up front resources aren't there to implement large change

For these reasons it is easy to understand why incremental changes to services within a system are more attractive, and easier to achieve. This is often manifested as the use of non recurrent funds to make small changes in surge/ escalation plans. The downside of this was seen as this distract us all from making system changes as we react to the day to day challenges

### **Tinkering is Often the Default Option**

Whilst many acknowledge that a whole system redesign is needed, a focus on incremental was change seen as is all that's feasible, practical and the path of least resistance in the short term. However, a systematic system wide long term plan containing many small changes that is relentlessly implemented can amount to a significant change in itself.

### **Rationalisation and Configuration of Services - Two Competing Problems Require Resolution**

Firstly there is the well-argued “Keogh case” – centralise care and improve outcomes. There is a good evidence base around this, and faced only with the evidence on outcomes it is a straightforward option. The critique of Keogh is that it is too A&E/ hospital centric; at the expense of a focus on a response to patient's needs & way they use existing services.

However, competing with this is the conflicting dilemma of resolving what type of activity is “safe” to provide locally where people prefer local.

With regard to Specialist Emergency Centre (SECC) type services, a simple application of the Keogh formula ends with a small number of (mostly tertiary) providers and the simple question is one of where we should site/ how many trauma centres. Invariably the world is more complex and there are

space and physical capacity issues with centralisation on this scale so hub and spoke arrangements are the compromise, and maybe a more sustainable solution.

Few argued with the Keogh view as being probably optimal for Urgent and Emergency care. However it was acknowledged that all current planning assumptions are based on demand profile as it is now, and this tests our belief in whether those planning assumptions are correct.

There are examples of cross CCG/ cross trust collaboration to agree configuration of services on a big footprint – e.g. the West Yorkshire Urgent Care Vanguard, and the Working Together Programme in South Yorkshire.

There is acknowledgement that whilst Keogh might make recommendations for concentration, for example where to site a SECC, in one site physical capacity constraints might preclude this, thus a networked hub and spoke type model is more practical. In this way a regional model becomes one not about buildings but about services for a population across multiple organisations.

Some further facilitation may be beneficial here, whilst chief executive level may be fully on board, the extent to which the exec team carry the support of the full staff may not be as complete as needed. Furthermore there is the issue of accountability. Organisations are accountable to their board, in turn to the regulator. Organisations are not accountable to “the system”. This is a national issue; it may be addressed through the vanguard programme.

A recent Health Technology Assessment by Imoson<sup>18</sup> et al provided a comprehensive set of evidence around many aspects of urgent and emergency care, making a number of recommendations for policy makers and those responsible for implementation.

#### **A&E Rationalisation may be Necessary, but will be Difficult.**

Some stakeholders identified that there would be likely rationalisation of A&E across the region, implying a possibility of closures or at least a more sensible configuration.

All recognise this needs to be carefully considered in the context of the whole system, including General Practice, pharmacy, ambulance and paramedic services and a range of other services. In this way there might be a reconfiguring of which providers offer what emergency and urgent care at both provider and specialty level.

Some seemed enthusiastic about investments to increase the capacity around extended hours in primary care, some less so suggesting it was not an investment that would yield net savings at health economy level. No stakeholder cited any local evaluation, though some has been undertaken. The recently published evaluation of Greater Manchester CHLARC on this matter will be helpful in answering the question of net savings.

Some acknowledge there will be greater centralisation of acute care – possibly focused on the trauma model, and there are difficult decisions about how pathways work, who provides them, and from what location. The process for making such decisions has operational, clinical and political parameters.

Imoson found that centralising services can pool expertise and facilities but can also increase travel time of severely ill, a Sheffield review (and Imoson) found such a strategy was not necessarily cheaper.

This isn't to say that some centralisation is needed, and this has been shown to be beneficial in trauma care<sup>19</sup>, but there are many other factors other than purely “the evidence” base that have a bearing on centralisation.

#### **The Political Ramifications of Major Change are Uncertain**

The extent to which it is long term viable to maintain the current configuration of hospital and community services is unknown. However, significant change may have major ramifications in terms

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<sup>18</sup> <http://www.journalslibrary.nihr.ac.uk/hsdr/volume-3/issue-9>

<sup>19</sup> <https://www.tam.ac.uk/Content.aspx?c=3477>

the broader viability of trusts, or political aspects that may preclude even the earlier stages of implementing the Keogh recommendations. A more directive approach from Whitehall may be needed to avoid local arguments about relatively small changes to configuration or resource envelopes.

### **c) Systems vs. Services - People Naturally think about their Service, Rather than the System as a Whole.**

The notion of complex systems was a recurring theme across the interviews. All acknowledge that UEC is complex and relies on the interactions of many actors. However there is an understandable natural tendency to primarily consider “the bit that I can see, understand and most important to me”.

Most stakeholders, but not all, expressed a concern that there was a tendency for all to adopt the understanding of “the problem” that best suited/ fitted with the view of their organisation or professional perspective; this is understandable, but problematic from a whole system perspective. People come to the table with an organisational view of the system – “how will these changes impact me and my organisation”, as opposed to a cohesive system strategy perspective.

Commissioners also come to the table with a whole system perspective, but obviously this is from a commissioner view as opposed to system management view. Providers tend to come to the table from the perspective of that provider, not “providers” as a whole. Historically this was a role undertaken by the SHA who approached from a broadly utilitarian perspective; there isn’t an equivalent in the current system.

The growing number of Vanguards and other nationally high profile initiatives may make system leadership more complex. The net effect of this was expressed as there being not a single common understanding of the problem, but many different understandings.

“Everyone has their own view of what problem is. Hospitals view the world from hospital perspective, GP see the world from a GP perspective, and commissioners see the world from a commissioner perspective. Few carry the ability or the mandate to see the world from a helicopter view.”

Some provider stakeholders suggested that local 5yr forward views were CCG centric (a function of who was required to write them) and maybe don’t reflect the realities of provider as well as they might. Providers may be penalised (financially and in other ways) for failure of “their” part of a chain; obviously this exacerbates single organisational level thinking.

### **“Systems for Populations” Looks to be the Future Model**

Through this review, a number of important developments have been agreed – including West and South Yorkshire acute trust vanguard bids and the West Yorkshire urgent care vanguard bid. Two of these three bids have been successful; it is clearly the direction of travel to focus on systems and populations, with a focus on sharing estate, expertise and capacity across multiple sites and populations. It is likely that clinical and financial governance across many sites and organisations will be the key rate limiting step. Currently, the single institutional approach to governance is hard wired into the system; where the trust chief executive is held to account (by the board and the regulator) for the actions of the trust rather than the system as a whole.

**There may be benefit from the AHSN leading some work on what “system governance” looks like in practice.**

Commissioners have an overview over the whole system so the obvious commissioner role in this will be about establishing the extent to which active steer is needed and how much emphasis commissioners would need to give to “system governance”.

The commissioner role here becomes one of shaping the dialogue and the overall system (as opposed to one of micro managing many separate contracts) – obviously this is a different role for commissioners.

The presence of multiple commissioners and a changing regulatory environment may make this more complex. The extent to which commissioners are actively exploring these issues with regulatory bodies is unknown.

### **Service Change versus System Change**

Service change would appear to be the default approach, there seems a lesser focus on system change, and an even less focus on behaviour and culture change – either clinician, corporate or patient behaviour change.

An under recognised component of new models of care is the need for substantial OD work on staff behaviour, how they interact across different organisations and the culture across organisations. There is a tendency for system change to be led by “what’s in it for our bit of the system” rather than “what’s in it for the whole system”.

### **The Downstream Knock on Consequences of Service Changes in One Part of a System.**

Furthermore, whilst many may understand there is a broad system they may not have deep insight into all aspects of that system. Some argued that the knock on consequences of a change in one part of a system to another are poorly understood. The ripple effects are uncertain and unpredictable.

“Everyone now realises that all of the entry points / pathways and exits are all interdependent, but excellence in one area can be devastating to another part of the same system. We don’t know whether it’s possible to have such a sophisticated model of the system that can understand how whole system works.....we don’t even know the methods yet.”

Some acknowledged the disparities between different parts of the system – and the level of funding to some sectors was not matched to the policy expectation. The impact of local government funding cuts may exacerbate this, but again the impact is difficult to precisely quantify.

### **System Complexity**

“The factors involved in UEC are more than most individuals can get their head round, nobody understands the whole”.

Taking a complex system theory approach to “solving the urgent care problem” may be intuitively attractive, but would present profound challenges to the way our organisations and systems currently operate.

### **d) Services within the System**

“Maybe we don’t need to change the services, as they often work quite well, it’s how it all hangs together that is more problematic, do we need to change the architecture in which services operate”.

A number of themes emerged here relevant to specific services (or sets of services) within the broader system.

### **Hospital Issues**

#### **Hospitals don’t Create Demand, Patient need Creates Demand.**

One explanatory factor for why demand often defaults to the hospital is that it is the place where the lights are always on; and that patients want to go to A&E regardless of what else is there; people choose A&E.

#### **Hospital Stakeholders often Challenge the Nation that Money is “Wasted” in Hospitals**

A significant chunk of the budget is spent in hospital care. Some suggested that acute providers are often wrongly demonised for “sucking in business”; and set out a perception that seems to hold sway that a significant amount of cash is “wasted” in acute systems.

Hospital responses to this perception would point out the errors; the long term implications of (particularly) the marginal tariff has stripped “spare” cash out of hospitals (as evidenced by provider deficits), and most hospitals are highly efficient.

### **Tariffs and Payment Mechanisms for both Hospitals and Community Providers are not fit for Purpose**

The 2013 HSC report concluded that “the marginal tariff has failed to encourage the delivery of care outside of emergency departments and penalises them for being open and available to all patients 24 hours a day, 7 days a week”.

Existing tariffs can provide perverse incentives and do not reflect the need for providers of different services to work together to make sure patients get the best treatment.

Most recognise the imperative that tariffs are designed to reward all NHS providers for putting patients on the correct pathway at the first time of asking; however they come in to contact with the health service.

Monitor<sup>20</sup> have already noted the net effect of the implementation of the 2009 marginal tariff (and penalties for 30d readmissions) has been to remove money from the hospital urgent care portfolio. If demand side factors are not taken into account and a provider doesn't change its cost base, simply changing the tariff will likely (from a providers perspective at least) make matters considerably more intractable to change.

NHS England and Monitor recognise that a new approach to reimbursing urgent and emergency care ('UEC') services could make this vision more achievable.

It seems likely that any new payment mechanism will include a substantial proportion of fixed core funding (reflecting the 'always-on' nature of the services and to serve to concentrate providers' and commissioners' attention on planning capacity across the system). It may be that a proportion of funding is volume-based (enabling the management of unpredictable fluctuations). It seems certain there will be provider-specific and system-wide quality metrics.

However it is clear that changes to payment mechanisms and tariffs by itself is no panacea. It seems likely that changes to tariffs will be relatively subtle and some questioned whether minor changes would be a powerful incentive to shift how a system operates.

### **The Broader Acute Model is being Considered in Many Places**

Most see some rationalisation of the broader model of acute care, the precise footprint and nature of this is unclear. The process for determining this is not clear. Many have written extensively on the specialist/ generalist balance in hospitals.

For example the 2012 Hospitals on the Edge<sup>21</sup> report from RCP noted the large number of specialties in many English hospitals (64) vs. a much smaller number in (example) Norway (20) with a greater emphasis on generalist care. In a similar space, the more recent Future Hospital Commission<sup>22</sup> set out a future vision for hospital care, especially focused on urgent care.

### **Community Service Issues**

#### **The Economics of Community Care, and the Economics of Hospitals - Enabling Care Closer to Home may not come Cheap, and may not be a Net Save.**

From patients perspective all were clearly supportive of the shift from hospital based model to a community based model. Where there is a need for hospital based care it might be a local community bedded facility for a shorter period; arguably there may be a greater emphasis on chairs, and less on beds.

Many commented on the overriding policy objective of care closer to home and in the cheapest setting. Whilst this is obviously desirable from a range of viewpoints, some challenged the underpinning wisdom of whether in fact "care closer to home" is cheaper than care in hospital, or better.

Some suggested the evidence for this was not clear cut, and if considering the problem and proposed solution from a whole system perspective we may need to get into the underpinning economic case for care closer to home and the impact of shift of care setting to hospital marginal finances. This wasn't just a hospital view point; some questioned the extent to which the underpinning economics of community care had been factored in.

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<sup>20</sup> Monitor. Reimbursement of urgent and emergency care: discussion document on options for reform. Sept 2014

<sup>21</sup> <https://www.rcplondon.ac.uk/sites/default/files/documents/hospitals-on-the-edge-report.pdf>

<sup>22</sup> <https://www.rcplondon.ac.uk/projects/future-hospital-commission>

There was acknowledgement that there will need to be a substantial investment in imaging and diagnostic capacity in non-hospital settings in order to truly shift a large volume of care closer to home. However some questioned the economics of this, particularly when that capacity is already present.

Until such an investment is made, the hospital will continue to have a significant diagnostic role in supporting care closer to home.

### **There is a Residual Tension between Standardising the Offer across a Big Footprint and Localising/ Tailoring**

If moving care closer to home, priority should be afforded to addressing a number of perceived deficiencies of community services with respect to urgent care. These include:

- Variability in what is offered between areas, within a health economy and between economies.
- Ability to respond urgently – real and perceived. Two stakeholders suggested that most community services are 2-3 years away from having the capacity to respond to urgent care need, so as to enable other services to deliver emergency care.
- Addressing the service model, for example a lack of interlink between paramedic services in community settings to deliver urgent care in conjunction with community staff, and so reduce pressure on the need for emergency services.

### **Some Suggested that the “Community Offer” around Urgent Needs isn’t Quite Right.**

This manifested itself as a perception of there being no real sense of “urgent” in the community care response. There is emergency and routine, but limited response to urgent and with little to no real defined urgent response. This is obviously exacerbated by fragmentation between various providers of community care.

### **Care Homes**

Care homes were felt by many to be a significant area of concern. The care homes workforce was felt to be varied and of variable quality, and often with limited connections to other parts of the health and social care system. Lines of intervention include support to enable care homes to look after their own patients a little better, improving the ability of care homes to be better risk managers, with care home clinical leadership in care homes, active medication reviews. However there are many other varied approaches to improving care home interventions with respect to unscheduled care use.

Many are concerned about sustainability however, some suggesting that the CQC is not helping matters. Concerns were expressed about care homes closing at scale, and that the financial stability/ business model of care homes is not stable. This will have uncertain impact on unscheduled care use.

### **General Practice**

Stakeholders emphasised that between 80-90% of urgent care is delivered in the community – particularly general practice, thus understanding flow across a whole system is important. Even relatively slight changes in demand at individual practice – might not be noticeable at the level of that practice but aggregated across many practices that slight change can have a significant impact on the focal point of A&E.

### **Out of Hours General Practice**

Some suggested the need to rationalise the offer out of hours – does it have to be as confusing as it currently is. It was suggested there is benefit from a stripped down offer with a change in the profile of standard GP opening.

The extent to which “weekend GP opening” would be a net save for a health economy was questioned; the early evidence is not encouraging in this respect.

### **Telephone Based Services have a Future, but may Benefit from Rationalisation and or Standardisation. A Simplified Route in is Wanted by All**

There would certainly be support for enhancing the offer through telephone based services. Examples of this that were cited include

- Clinical and patient evidence clearly identifies problems about the complexity of routes into the urgent care system.
- Some suggestions were made about a simplified 999/111, maybe moving to a merged system as the single access points into urgent care. Obviously this would need to be supported by a clinical hub, and supported by that hub having access to clinical records and care plans. Such a thing might be easier to effect at local level (vs. regional), but there are economies of scale for operating at regional level.
- Can VSC services be on the DOS for call handlers? The menu of options varies across the areas, so hard to be standardised about it.
- Linking the DOS to digital care navigation tools. The crucial elements are obviously a DOS that is live, kept up to date and agile to enable signposting to local services; with access to local clinical teams to enable hear and treat / see and treat with links to local services. Such functionality would be felt to lead to major system efficiencies.
- Identification of frequent callers to 999 / 111 and linking to local services to enable proactive alternative responses.

### **New Types of Service, New Types of Clinician**

There are many Opportunities for Skill Mix and Substitution. No Single Solution is a Panacea. Following full evaluation, capitalise fully on opportunities presented through schemes like Urgent Care Practitioners and Pharmacy based minor ailments schemes. Consistency of offer, standardisation of offer and being fully embedded at local level is crucial to such things. For schemes that are directly patient accessed, it may take a long time to change patient culture and habits.

### **Many Commented on Positive Developments around Increasing Urgent Access to Mental Health Professionals**

This included 24/7 liaison psychiatry input to ED, development of a single point of access for all mental health care, including urgent care, integration of mental health nurses in the emergency operation centre at YAS.

Soft intelligence consistently suggested that such schemes have far outperformed expectations and increases the ability to efficiently meet needs as those clinicians both know the systems and processes in mental health care, and have direct clinical skills.

Such initiatives were considered to have brought more parity to urgent mental health care need. The development of the Crisis Concordat, and the high level of political spotlight on this has enabled this development to happen quickly.

### **The Role of the Voluntary Sector was seen as Important, Under Developed but Useful**

Some examples were cited of third sector organisations having the ability to get people out of ED more quickly than the standard PTS model, and ensuring that a person's home was warm when they arrived. The Age UK Leeds' Hospital to Home service is being evaluated by the Nuffield Trust.

### **e) Many Acknowledge Flow to be the Key Issue**

There is evidence on activity which clearly identifies that flow through the system is a considerably more important factor in recent years than the numbers of patients attending.

This was also reflected in evidence from stakeholders about how this was being addressed in service terms. Many examples were cited about investment in re-ablement teams, integrated discharge teams, rapid response teams, taking system engineering approaches to manage flow through a hospital bed base.

The extent to which there is overlap between different iterations of services to improve hospital flow, and the extent to which there may be benefit of greater cross system learning and common evaluation was not tested.

Many argued that systems approaches to flow was something that is easier to achieve in a smaller hospital than a larger one.

Improving flow is, by itself, not universally acknowledged as a good thing. From a broader perspective, increased flow equates to more patients receiving spells of care, and thus from a CCG perspective more spend. Thus managing demand in to a system, as well as improving flow is important.

#### **Even Within the Current Configuration there may be Scope to Improving Flow**

One hospital stakeholder identified potential for hot / cold planning on one site (as opposed to where a trust has two sites). The starting point for this was consideration of where on site it is best to deliver urgent care (mainly equipment siting) and design elective and emergency care in completely separate parts of the hospital. Around this there is split of hot and cold staff rostering, with a streamlining of the workforce to deliver most efficiently. Thus one end of the hospital will be “hot” and one “cold” with staff rostering designed around this – when on a “hot” shift no elective work at all would be undertaken. This was felt to efficiently resolve the conflict between unplanned and planned care, and reduce the frequency of planned being rescheduled to make room for urgent, thus reduce problems further downstream.

Many identified that flow would be improved by maximising early senior review of cases as far as possible, this is also clear from published evidence.

There were conflicting views on the extent to which problems in social care led to inability to discharge, though it is clearly a problem in some places. Some suggested that the “official data” and the on the ground intelligence were very mismatched.

#### **Don't Just Consider Flow Only in Hospitals**

Given the importance of community care and General Practice to the issue of flow, some CCGs have begun to consider this with work around capturing current activity in general practice and ensuring there is sufficient capacity to manage demand, have the right configuration of phone based advice, urgent practice based appointments and the ability to home visit. It is acknowledged there are significant constraints to this with regard to data availability and quality.

Further consideration should be given to what can be learned from other industries where there are absolute capacity constraints and variable (often difficult to predict) demand. Such examples might include transport (maybe especially train industry), or electricity.

Many efforts to map flow have considered the hospital component of the system. Given that between 80-95% of urgent care is delivered in the community – particularly general practice, there will be additional benefit of considering flow across the whole health and care system, admittedly this may be made more complex by poor quality (or unavailable) data.

From a practical management perspective the Emergency Care Intensive support team recommend an approach to hospital flow in four work streams:

- 1) short stay (mild to mod illness. 1-2d stay);
- 2) patients with specific needs (true specialty needs);
- 3) not clear what's wrong (need an experienced generalist);
- 4) complex (mostly frail older multiple morbidities that impacts on acute illness, and a need to address the acute illness quickly so it doesn't exacerbate other illnesses and thus lengthen stay).

#### **f) Workforce – Capacity, Capability, Cross Fertilisation, and New Forms of Workforce.**

The extent to which workforce planning is picked up in local approaches to UEC planning is uncertain. It may be missing in many local approaches. Obviously there are issues that are best addressed on a very large footprint and through working with HEE; there are also issues around developing new forms of workforce to address the challenges in novel ways.

The medical workforce has altered significantly over last few years. On account of a number of factors, the junior doctor base has shrunk, the consultant base has increased, but some views were expressed that more junior doctor posts had been removed than had been replaced with consultants. There is limited data readily available on the general practice workforce, the Kings Fund publication had made clear that the GP workforce is growing far more slowly than the hospital doctor workforce.



Throughout this the nature of urgent and emergency care service (and arguably demand) has not changed, in many respects the service still functions today as it did 30 years ago.

Some stakeholders described how the SRG arrangements had led them to think differently about both workforce capacity (for example investments in ED consultant capacity, and extended working and 7 day working and training).

There was significant support for the model of GP in ED. Many had made such an investment, and cited good results in terms of patients presenting getting their needs met without an ED attendance. It is unknown whether there is much formal evaluation of this, particularly in the context of the whole system, or how the economics work. A positive spin off from bringing GPs into ED was the ability for General Practitioners as clinicians to input into the A&E staffing model – and the cross fertilisation of ideas.

### **Challenges in Developing New Forms of Workforce**

Perhaps a challenge with respect to workforce is that stakeholders are inculcated into thinking within the current system; whereas the challenge is to think in terms of new models (that often don't yet exist), new forms of workforce, a workforce defined around population needs rather than service delivery needs. Also many acknowledged a need to define a workforce around competencies rather than traditional job titles. Developing new competencies in existing workforce is difficult but necessary – for example prescribing pharmacists, diagnosing urgent care practitioners, or UCP with admitting rights.

There is a fundamental issue about the return on investment of significant changes/ developments to the urgent care workforce. It is difficult to see a tangible ROI, and measure it in cashable terms. If the ROI isn't there, obviously this will detract from the inclination of organisations to transform their workforce, either for the good of that organisation or the health & social care economy more broadly.

The important roles of pharmacists and urgent care practitioners was emphasised by some. Bringing new clinicians into the urgent care response was seen as important and the most obvious example was pharmacists.

18% of GP consultations are for minor ailments that could be managed by the patient with pharmacy support (Keogh). Community pharmacy has great (arguably under utilised) potential to address some of the commonly occurring problems in most health systems. It has shown to be a cost cost-effective way to manage patients presenting with minor ailments<sup>23</sup>, to improve flu vaccine uptake in the public<sup>24</sup> and social care workers<sup>25</sup> and manage access to emergency medicines<sup>26</sup>. In West Yorkshire there are a number of evaluated schemes that have been in place, these are well regarded by local stakeholders.

99% of people live within 20 min drive of a pharmacy and 96% within easy reach by walking or public transport<sup>27</sup>. Where it has been measured, there is a higher density of pharmacy in the most deprived areas<sup>28</sup>; local analysis tends to confirm this. Thus the availability and flexibility of community pharmacies (in Bradford 31 pharmacies are open for 100 hours) gives some ability to counteract the well described inverse care law in General Practice.

Similarly bringing pharmacists into practices is also acknowledged to have had some impact, for example the potential for reducing falls that are related to poly pharmacy and prescribing errors.

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<sup>23</sup> Pharmacy First, Bradford. 8 month evaluation. <http://www.cpsy.org/doc/795.pdf>

<sup>24</sup> West Yorkshire Flu Evaluation 2014-2015. <http://www.cpsy.org/pharmacy-contracts-services/research-evaluation/evaluations.shtml#wyflu#wyflu>

<sup>25</sup> Wakefield Front-line Social Care Worker Flu Vaccination Service Evaluation. <http://www.cpsy.org/pharmacy-contracts-services/research-evaluation/evaluations.shtml#wfle#wfle>

<sup>26</sup> Pharmacy Urgent Repeat Medication Service Evaluation 2014-2015. <http://www.cpsy.org/doc/961.pdf>

<sup>27</sup> Keogh Phase 1 Report, Appendix 1: Evidence.

<sup>28</sup> BMJ Open.

Urgent Care Practitioners were seen by many as an important and cost effective investment, and an important part of future urgent care response. There was, however, a trade off between an approach to implementation on a regional scale (economies of scale, consistency of offer and access into service) and a local level (integration into local teams and systems, development of local relationships). Both are important, and something to be supported. The development of workforce competencies and how these roles fit into local and regional systems is an important, and still to be answered, question. There are also a number of questions of evaluation.

One hospital stakeholder described how the training programme for Advanced Clinical Practitioners had been fundamentally changed so as the trainees spent more time with all the different organisations involved in urgent care, rather than just ED, or General Practice. This leads to a more rounded view of a system and an ability to see, understand and work with all aspects of the urgent care system. Obviously it is a medium to long term investment focused on developing a multi diplomacy workforce who are generalist enough across the whole of the urgent care.

### **Scaling Up New Models of Workforce that have been Developed Locally and Tested Locally Remains a Challenge**

There may be opportunity to think of the role of community pharmacy well beyond the current roles such as Pharmacy First/ minor ailment schemes, and to actively build into urgent care centre and out of hours equations; there may be up skilling and CPD implications of this – these can be addressed through links to local academic centres of excellence.

Health Education Y&H have also indicated some commitment to this area if there is an expressed need to respond to local strategies and commissioning plans - i.e. responding to direction from both providers and commissioners. The AHSN may have a role in supporting service models and determining numbers. To address this at scale there would need to be a degree of certainty about the endpoints and a clear commitment to a direction of travel.

### **The Knock on Impact of Workforce Changes Requires Consideration**

For example, where there is already a shortage of paramedics, recruitment to Urgent Care Practitioner roles is most likely to come from the paramedic pool, thus further depleting capacity. This may not solve a problem.

The AHSN should explore the potential for where it can support the scaling up a range of postgraduate training for different types of workforce, skill mix development, models of clinical governance for multi-disciplinary multi-agency workforce development.

### **g) Supply Side Versus Demand Side**

Most of the focus is on supply side, at the expense of better understanding of the demand side. There are many examples where increases in capacity in the supply side have created arguably more problems than have been solved. Supply sensitive care is a well known and well described phenomenon in elective care; there is less literature in non elective and urgent care.

Walk in centres were consistently cited as an example of supply induced demand in urgent care. Some felt that where walk in centres existed, they had led to increased demand in totality but no concurrent drop off in A&E attendance. There is also a set of published research evidence highlighting the nature of supply led demand in urgent care walk in centres.

In addition to supply induced demand issues, increasing the diversity of supply carries the risk of further exacerbating confusion for patients in terms of where they should go under a range of circumstances.

There seemed, comparatively speaking, relatively little focus on understanding demand and how to change public perceptions. This might be a function of there being significantly less evidence, or might be a function of the “historic” approach to health service problems being one of services rather than patient behaviour. Bradford and Sheffield had undertaken some demand side analysis on why people attend walk in centres and A&E.

It is easy to understand how the system has become as complex as it has, essentially we have bolted new components into an existing system, and in addition there was a view in policy terms that

giving more choice we would divert people away from A&E. The parallel view is that we increased capacity but also created confusion.

Behavioural change in populations of patients, who, individually speaking may rarely access UEC, is acknowledged to be harder to change. Some A&E stakeholders highlighted that a reasonable proportion of patients attend A&E saying “what’s 111”.

Patients will always go to the place that they perceive will serve them most completely and quickly. Some suggested that there is a need to definitively shift away from a patient blame culture (the patient turned up at the wrong place) towards a view that – it’s never the patient’s fault that they “turned up at the wrong place”; they turned up at the place that made most sense to them.

Various media attempts to change this have been patchy, short term and not at the right scale, intensity or duration. This may be something to consider on a large footprint.

#### **h) Defining the Optimal Scale – There are Both Planning and Delivery Aspects to This.**

The views expressed about the most appropriate planning footprint varied, most often depending on the perspective of the interviewee and the nature of the problem. In general those with a regional role were clear that the region was the optimal footprint and those with a local health economy perspective usually that was seen as the optimal footprint.

When questioned in more detail, different elements of planning were differentially suited to different footprints, both for planning and for care delivery aspects.

Most were in agreement that for most delivery, the trust footprint was optimal; this enables the local system to ensure the right pathways are in place, flows between hospital, community services, social care, intermediate care and General Practice were optimised.

It was acknowledged that this may create problems for stakeholders whose organisational boundaries straddle a number of acute trusts. Furthermore, where complex urgent care delivery is concerned this was best organised around existing tertiary centres.

Some who had a local health economy view expressed that there are more dis-benefits than benefits of a bigger (sub region or region) footprint. The corollary is that some with regional perspectives suggested a view that 15 different front end arrangements for urgent care are neither efficient nor sensible, and there may be great scope to rationalise. It is obviously acknowledged that all would want to design a system they best feel suited local needs.

Other planning functions – for example data, IT, workforce development – a regional or sub regional focus was universally considered optimal. A number commented that whilst delivery should be local there would be great mileage in ensuring there is standardisation of the offer – the clinical pathways and processes should be reasonably consistent and a helpful regional response would be to help address this, perhaps commencing with some high volume pathways. This would improve the equity of the offer.

Obviously those with a regional view, whether planning or delivery, invariably cited a bigger geography as optimal.

Whether the optimal planning footprint was “sub regions” – WY, SY etc or the whole of Y&H was not resolved within the group of people interviewed. Some suggested that sub regions have an identity that is known to the public and fits (largely) with the way that local government and tertiary care operates, also the three sub regions were very different in their history and makeup. Others suggested that Y&H was the optimal footprint given the past planning boundaries and the need for economies of scale. There was certainly no clarity on who is best to “hold the ring” at a supra CCG level, and what geography this should cover.

If there was any consensus, it would be that for service delivery functions (including the planning arrangements around this) sub region works best and for enabling functions (workforce, IT etc) a Y&H approach might be optimal (if for no other reason that ensuring equity and economies of scale).

**Suggested Considerations for Determining Footprint Included:**

- The precise problem to be solved.
- The trade off between need for local engagement and development of trust and relationships between local partners versus regional consistency and equity.
- The trade off with economies of scale of undertaking some functions at bigger scale versus the dis-benefits of loss of local nuances.
- The benefits of standardisation across a big geography.
- The risks of duplication of effort.
- Flow outside the geography concerned, some suggested that for West Yorkshire, as little as 10% of the patient flow is outside WY.

York Health Economics Consortia have done some work about the service lines that constitute “urgent care services”; there would be merit in this work being widely shared once complete.

All acknowledge that this issue of optimal scale remains difficult, unresolved and to date in the too hard box. The issue is beginning to be addressed, most obviously through the West Yorkshire Urgent Care network and tentatively through the Working Together Programme.

**Tasks It Makes Sense to do Once**

Consideration should be given to what tasks and functions may be most efficiently undertaken across the whole of Y&H. This may be because there is a requirement of scarce skills, because of a benefit of a singular consistent approach in every economy or because there are economies of scale in doing a job once at a large scale.

Examples include:

**Specification**

Tasks that it makes sense to do once or/ and at some scale. Development of a common specification for Urgent Care Centres, Specialist Emergency Care Centre (possibly NHSE role), 111, pharmacy based service models. Pathways, what conditions, exit points, exclusions, co dependant services. This is a task that is likely to be repeated many different times.

**Common Approach to Capacity Planning**

What is the likely future capacity needed for hospital bed base, community beds, and urgent care centres?

**IT, IG and Data**

Issues of common approach to underpinning hardware. Support to local efforts re IG and consent. Development of common set of linked data for both clinical care and population level analytics – the Greater Manchester DataWell approach being led by GM AHSN. Development of a real hub of expertise.

**Consistency of Response to Specific Groups**

There may be merit in developing a consistency of approach to some high impact population groups. For example:

- Frailty - systems may wish to review how services for people living with frailty in community settings are developed and commissioned. There are issues of identification, proactive care, comprehensive geriatric assessment, shared care plans, end of life planning and advance directives where appropriate.
- Minor illness – developing a consistent approach to minor self-limiting illness with involvement of 111, pharmacist and general practice.

**Commonality and Consistent Approach to High Volume Pathways**

Why does DVT pathway in Bradford look different to Barnsley? Which is best? Are there pathways that aren't implemented - feverish child, breathlessness were mentioned by some.

**Standardisation of Clinical Protocols and Quality Standards**

- Door to doctor time.
- Core principles and standards of General Practice urgent care response.
- Core principles and standards of “community service” urgent care response.

- Internal professional standards – in each organisation – clinical, process and system, then across the organisations.
- Common standards for ambulatory emergency care.
- Standardised protocols for handover at provider level - performance management of handovers; standards for repatriation if people are treated away from their “home” system.

### **Surveillance and Escalation**

During the interviews, few identified a proactive escalation system that worked beyond individual organisations. There may be benefit in considering the specification for a system wide escalation plan that uses readily available data, and has the ability to provide early warning triggers. This may require real time data.

### **There is a Tension between Micro and Macro Level Planning and Delivery**

Overarching principles, workforce development, and configuration of tertiary care are obviously best agreed on a large footprint, but the need to have ability to flex to suit local needs and circumstances needs to be in place locally.

At smaller levels of geography there will be more opportunity to influence the views of clinicians, to change cultures through co-location and close joint working. Changing culture at team level rather than at organisational level was considered by some easier - create a new culture that individuals can buy into, in turn this may influence bigger organisational cultures. Some stakeholders working in small geographies identified the issue of developing a new ecosystem to change the micro parts, which was easier to effect than big organisational changes, and seen as a way to keep the workforce engaged with things they can see and can grapple with.

## **i) Data and Information, Technology and Connected Care**

### **Clinical Care Level**

Shared clinical information across multiple providers. Ability for all providers to be able to see into a shared care record.

Shared care plan that included information on a patients goals and aspirations. Access to care record across all organisations providing care will have important safety and quality benefits; for example when a patient has multiple contacts and is asked for different information by different services, its only when the data is put together that important diagnoses may be seen. Some stakeholders identified examples of potentially avoidable harm in this area, for example in sepsis care.

### **System Level Data Versus Service Level Data or Organisational Data**

Development of a single, real time dashboard that is used consistently across a large geography; This would enable a system wide understanding of what is happening, real time capacity and demand intelligence, what is changing. It would also allow some measure of evaluation at high level.

The underpinning IT infrastructure in many trusts is set up in such a way that it should be able to readily facilitate this, though it is acknowledged that multiple GP IT systems and YAS/ 111 each having their own unique systems makes real time dashboards complex.

Enabling this may require a strategic investment in IT infrastructure across a large geography. There are elements to this that are “question led” (what are the analytic questions I need to answer) and IT architecture led (in 20 years time what do we want to have achieved in system terms).

Data linkage would enable a better understanding of what creates micro level variability across time, and allow better ability to react and respond more efficiently; for example modelling the impact of GP closures, or other service changes.

### **Community Care, Social Care and General Practice Data is Largely Missing**

The balance between what can readily be counted (A&E activity) versus what might be far more important (community care), but much harder to count and codify, was noted by many.

Data on primary, community and social care was perceived to be largely absent by many, in real time or retrospectively. It is an issue that can be solved, for example some CCGs are beginning to work with their membership to collect General Practice data, either as a snapshot (Huddersfield) or on an ongoing basis (Bassetlaw).

The establishment of surveillance systems in primary care, and possibly pharmacy, were suggested as important activities that will enable demand prediction in real time, and analysis to develop new insights.

For example if practices note increases in attendances for certain complaints this might trigger a notification to other providers. This might be based on real time data or soft intelligence.

### **The Importance of Real Time Data**

Many stakeholders identified the lack of real time data as a rate limiting step in understanding flow, and impeding the ability to evaluate the impact of changes.

In theory, achieving real time data is relatively easy to achieve for some parts of the system, but by no means all. Linking it together remains problematic with problems with data flow and data acquisition, especially a balcony view of what is happening in primary care – many suggested this is a key issue to resolve.

### **There are Many Examples of the Smart Use of Data to Enlighten Operational Capacity Planning and Service Monitoring**

For example Leeds have undertaken a number of significant pieces of analysis with available data to plan capacity at operational level and predict spikes in demand based on associations of one set of data with another (e.g. children's acute care a good precursor for adult, short term capacity planning intermediate care, using SPC techniques to monitor A&E attendances over a long period.)

### **Quantitative Data Alone Might Not Give Full Insight**

The issue of data isn't just a quantitative issue; one stakeholder described some work undertaken in asking people in A&E what their journey had been prior to attending. This followed an observation about peak attendances in A&E in early afternoon, on asking a significant proportion of this early afternoon A&E cohort had called their GP in the early morning but not been able to get an appointment. The qualitative data adds insight to what the numbers tell us.

### **Solving the Data Issue will Require Heavyweight Support, Long Term Commitment and some Resourcing**

This is obviously a national problem. Local solutions might include a requirement to sign up to data acquisition and analysis in any local service enhancements that are made.

### **Addressing the Cultural Barriers of some Parts of the Health and Social Care Workforce to use of IT might be a Live Issue**

The example cited was the use of IT in direct clinical care, IT in direct clinical care and in terms of population risk management has been in place for a quarter of a century in general practice but is seen as new and novel in some other parts of the system. Obviously there are both hardware and software issues to attend to in addition to cultural issues.

There may be benefit of developing a single set of need, activity, quality, and outcome measures for the whole system across a large geography. If used consistently across Y&H – may enable a better collective understanding of variation. This would need provider level data to be shared across all areas. For A&E these probably exist as it is known there is a wealth of data that is recorded but not often used<sup>29</sup>:

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<sup>29</sup> Improving the speed and appropriateness of treatment in emergency departments using evidence-based methods such as senior doctor triage. March 15, Prof Suzanne Mason University of Sheffield, YH Improvement Academy

**Single Set of Metrics to Include:**

- Attendance.
- Unplanned attendances.
- Left without being seen.
- Time admitted patients spend in the department.
- Time non-admitted patients spend in the department.
- Time from arrival to initial assessment.
- Time from assessment to treatment.

Similar may need to be developed for all parts of the care system, for example General Practice, ambulance, 111, community care. Common and consistent standards would need to be applied.

There would be benefits from consistently using simple statistical techniques such as SPC run charts to monitor key metrics. This would enable a more measured response to variation over time. This has been done already in some areas.

## 5 Recommendations

This has been a broad ranging review of a wide range of issues associated with urgent and emergency care. As the report was principally designed to address questions set by the AHSN, the recommendations are principally pitched to that arena.

### **Recommendation 1    Footprint and Tasks it Makes Sense to do Once**

Consideration should be given to what tasks and functions may be most efficiently undertaken across the whole of Y&H. This may be because there is a requirement of scarce skills, because of a benefit of a singular consistent approach in every economy or because there are economies of scale in doing a job once at a large scale.

Examples include:

- Common service specification
- Common approach to capacity planning
- Supporting all agencies with a common approach to IT, IG and data / record sharing. The Greater Manchester DataWell example may help
- Developing a consistent approach for the response to specific groups of patients (e.g. frail elders, minor ailment schemes, urgent care practitioner, new workforce models).
- Common and consistent approach to high volume pathways
- Standardisation of clinical protocols and quality standards
- Development of a common approach and standards for surveillance and escalation.

### **Recommendation 2    Evidence and Evaluation – Use, Ignorance, and Misuse**

The AHSN may have a role in developing a common approach to the use of evidence for change, from macro system level through to implementation of schemes. There is also a role in terms of supporting the system with evaluation – either in the design of or / and in the execution of evaluation. Evaluation needs to be focused on both formative and outcome questions – the why something “works” or doesn’t work is equally important to the outcome – especially in the early stages of an innovation.

### **Recommendation 3    Flow**

Further consideration should be given to what can be learned from other industries where there are absolute capacity constraints and variable (often difficult to predict) demand. Such examples might include transport (maybe especially train industry), or electricity.

Many efforts to map flow have considered the hospital component of the system. Given that between 80-95% of urgent care is delivered in the community – particularly general practice, there will be additional benefit of considering flow across the whole health and care system, admittedly this may be made more complex by poor quality (or unavailable) data.

### **Recommendation 4    Workforce**

The AHSN should explore the potential for where it can support the scaling up a range of postgraduate training for different types of workforce, skill mix development, models of clinical governance for multi-disciplinary multi-agency workforce development.

### **Recommendation 5    Data**

There may be benefit of developing a single set of need, activity, quality, and outcome measures for the whole system across a large geography. If used consistently across Y&H – may enable a better collective understanding of variation. This would need provider level data to be shared across all areas. For A&E these probably exist as it is known there is a wealth of data that is recorded but not often used.

There would be benefit from consistently using simple statistical techniques such as SPC run charts to monitor key metrics. This would enable a more measured response to variation over time. This has been done already in some areas.



**Recommendation 6    The Role of the Citizen and the Patient**

There may be a benefit for the AHSN to lead some work across health and local governments on the approaches to shifting the locus back towards the citizen, how this might be achieved and what it might mean in practice.

There may be a number of elements to this, including:

- Shifting from supply led model to a demand led model - public agencies typically know a lot about people's responses to service interventions, but far less about the assets, resources and networks of communities outside of this.
- Shifting the emphasis from organisations and services to place and population, and networks of care. The focus of discussion is never about the place or the service; it is about the population and the network.
- Shifting the emphasis from patients to collaborators. Can the system encourage much greater collective responsibility for health outcomes (adapted from Adebowale [HSJ 2015](#)).

**Recommendation 7    Systems for Populations**

There may be benefit from the AHSN leading some work on what "system governance" looks like in practice.

**Recommendation 8    Further Analysis**

There are many further analytic questions that this report has begun to scratch into the surface of. Caution should be exercised however, that any future analysis is linked to a clear decision that is needed. Furthermore further analysis may not resolve some of the broader strategic questions of culture, service and system design/ architecture.