Creating a sustainable emergency care system in London

The quality of NHS urgent and emergency care services is always a priority for patients, who rightly expect access to prompt, safe care in an emergency. Between January and March 2013, the NHS in London failed to meet the four-hour operational standard for A&E with 6% of those attending A&E not being seen within that time. The NHS in London is responding to patient and staff concern at the dip in A&E performance, by focussing on ways to improve the responsiveness of services to those in crisis through improved waiting times at A&E, but also by improving how community services respond to ensure that patients are seen and treated quickly and safely.

The London picture

Nationally, there are approximately five million extra people using urgent and emergency services (22m compared with 17m in 2004). However this is only part of the challenge. In fact more recently the number of patients attending A&E in London has stabilised with only 0.2% more people attending A&E in 2012/13 compared to 2011/12, although admissions rose slightly faster (0.7% increase) Hospitals need to accommodate the rising admissions and potentially greater acuity of patient need by working more productively. Without this flow of patients through the hospital, the A&E department can become over crowded, compounding problems across the hospital. More often than not, improvements are needed across the whole hospital system in order to see better performance in A&E.

In London we know that other factors can add to the problem and that from hospital to hospital, different problems can occur, such as longer hospital stays leading to beds not being available to accommodate acutely ill people; paucity of services for people with complicated long term conditions; or areas with high rates of alcohol and drug use leading to higher presentations at A&E. Disjointed health and social care services can also lead to delays in the discharge of patients from hospital and therefore put extra pressure on A&E departments who can not move people from A&E to inpatient wards.

Estimates of the number of people currently in hospital who could be cared for in other settings, puts the figure at around 25%, significantly higher than the formal ‘delayed transfer of care’ statistics. The reasons for this are various; from delays in discharge occurring to questions over whether individuals needed to be admitted in the first

instance. Whatever the reason, this impacts adversely on the hospital when there are patients with acute needs that need to be admitted.

The national A&E standard is that 95% of patients are seen and treated in four hours. The last published information about the performance of hospitals across London shows that in the last quarter of 2012/13 (the winter quarter) the average performance was 94.6%. This figure has now improved and stood at 95.55% at the end of quarter 1 2013/14.

Nine of the 22 hospital trusts in London with an A&E accepting all types of emergency patients did not achieve the 95% operational standard in the last quarter of 12/13, where as only three of the 22 hospital trusts did not achieve the standard in the week ending 30th June. Many Trusts have performed consistently well during the last year such as Chelsea & Westminster, West Middlesex and Imperial Healthcare NHS Trust.

However, we are concerned that performance in some hospital trusts is below the standard and these need urgent work to improve their performance. As we approach the next winter it is crucial that A&E performance remains top of the improvement agenda for all NHS Trusts and that even the best performers do not become complacent.

NHS England's (London region) role

Our role is to oversee the commissioning arrangements of the whole system, and in partnership with the NHS TDA, Monitor and local health economies ensure that every Trust is supported in making sure that patients receive the best quality care. In London we are also working closely with local authority social services departments to improve the links between health and social care.

NHS England (London) is also a direct commissioner of over £5bn worth of services provided in London, including specialist services, health visiting and primary care which accounts for £1.7 billion. NHS England (London) has a key role as commissioner to see that improvements in primary care happen.

A&E Recovery & Improvement Plans

We have asked all Clinical Commissioning Groups to work with NHS Trusts, social care and others in their area, to develop Recovery and Improvement plans to strengthen performance in A&E departments and across urgent and emergency care that is delivered in the community, ensuring that high standards can be sustained all year round.

We are working with CCGs and Trusts to review these plans by identifying gaps in the application of urgent and emergency care best practice, from community through to

hospital and out again. If we think plans are insufficient we expect CCGs and Trusts to do further work to improve them.

We expect Recovery and Improvement plans to contain a comprehensive approach for dealing with pressures in A&E, including seasonal demands such as cold winters, clinical workforce capacity and unexpected events.

Many CCGs will choose to publish summaries of their plans on their websites.

London Clinical Quality Standards

In February 2013 the London Quality Standards were published. These built on the London quality standards for acute medicine and emergency general surgery which were published in September 2011 and commissioned from 2012. The London quality standards outline the clinical standards that are to be met within London's acute emergency and maternity services across all seven days of the week. These include early senior assessment in A&E, early specialist assessment in A&E if it is considered that a patient needs to move to a specialty ward, better access to diagnostics and reporting, consultants working in acute medical units (MAU) having no other duties when they are responsible for emergency patients and twice daily consultant review. Implementing these standards would significantly improve flow within the hospital and improve the care and experience for patients. This will mean services being delivered in different ways by hospitals.

The London Quality Standards were endorsed by the London Clinical Senate – a pan-London group that brings clinical leaders together to support commissioning and provision of high quality healthcare. The Clinical Senate considered the challenges in maintaining safe, high quality urgent and emergency care services at its meeting on 4th July 2013. The Senate debated clinical priorities and actions that if implemented would sustain improvements across the urgent and emergency care pathway.

London recognises that improvement in the A&E four hour standard is not just about what happens in hospital. Changes are also needed in the community.

Better access to GP services

Many people still can't access GP services when they want. A patient survey in 2010/11 showed that Londoners are significantly less satisfied with their ability to see a GP of choice, '48 hour' access and opening times.

There is a link between satisfaction with access to primary care and use of A&E.

Evidence has shown that the highest users of A&E are 20 to 39 year olds. They are also the largest group to leave A&E with no investigations and no significant treatments.

We need to understand what 'good access' means to people. Good access may well vary dependent upon whether a person is elderly, young, has a longer term condition, needs to attend at specific times etc. Several studies have shown that obtaining an appointment on a day of choice was considered most important by many patients, seeing a particular health professional was also a high priority for some patient groups along with speed of access.

For general practice, this presents a challenge in how to design and deliver a truly personalised service that best responds to individuals' attitudes and concerns about access

To address this we are working with GP practices and Clinical Commissioning Groups to increase the quality of service that patients receive from their GPs using the national primary care outcome measures. Practices are also experimenting with 'networks' and other initiatives to provide greater access and a greater range of expertise available to a wider population.

London is establishing a clinical and patient board to oversee the development of a set of access standards for general practice in 13/14 that will take into account a range of different access requirements including:

- Urgent/unscheduled care
- Seeing a named clinician
- Booking ahead
- Range of opening times
- Method of appointment
- Ease of contact
- Choice of practice
- Out of Hours Care

The clinical board will examine the evidence for widening access in response to patients needs. It will examine new technology changes, the potential for telephone, email, and web consultations so that it is as convenient for patients to access general practice as it currently is for them to see an A&E doctor.

Integrated care

Generally people are living for longer, and can often be living with several complex conditions that need constant care and attention. Likewise, children born with complex conditions are now living to adulthood, while those with learning disabilities and other groups have lifelong needs. All these people need continuous care and support and co-ordinated health and social care systems in their communities.

Following the Health and Social Act there has been a welcome increase on the national focus in integrated care that complements the sustained effort that has been put into developing integrated care in London.

In May a National Collaboration for Integrated Care and Support published “Integrated Care and Support: Our shared commitment”. The unifying message is “our shared vision is for integrated care and support to become the norm over the next five years.” The announcement also invited expressions of interest from areas interested in becoming integration pioneers. More than 100 applications were received nationally with significant interest in the pioneer programme across London (15 expressions of interest). The Comprehensive Spending Review for 2015/16 announced the creation of a pooled health and social care fund of £3.8bn – the Integration Transformation Fund. Local plans will determine how this money is spent and plans will need to be agreed by local clinicians and signed-off by local health and wellbeing boards.

Partners across health and social care in London have now come together to form a London Health and Care Integration Collaborative to support the development and delivery of integrated care across London with representation from NHS England (London region), London ADASS, London Office of CCGs, London Clinical Commissioning Council, Medical Directors, patient / user voice, London Health Board Chief Officers Group, London Councils and Department of Health.

The alignment of thinking, both nationally and locally, has acknowledged that the integrated care agenda needs to move at pace and scale, in order to have a significant impact on the experiences and outcomes for people who require a complex blend of care and support, particularly the frail elderly and those with one or more long-term conditions. Although the evidence base is still patchy, high level modelling suggests that providing high quality, person-centred care should result in a shift of care from high cost acute settings to lower cost community settings and hence to overall cost savings for local populations, even after allowing for additional investment in primary care, social care and community services.

London is committed to supporting the system to ensure that every local health and social care system in the capital is providing high quality person-centred co-ordinated care for people with complex needs - the top 20% (very high risk to moderate risk) of the population, particularly, the frail elderly and those with dementia, one or more long-term conditions and at the end of life. These populations have multiple and complex needs, meeting which requires 75% of current health and social care service spend. They require a complex blend of services and hence are a logical focus for better co-ordination of services that in turn should result in improvements in individual outcomes and experience and more effective use of resources.

At a national level

A longer term review led by NHS England’s Medical Director, Sir Bruce Keogh was announced in January 2013 and explores the current issues across England’s urgent and emergency care system. The review’s aim is to develop a new national framework for urgent and emergency care to build a safe, more efficient system, 24 hours a day, seven

days a week. The review has developed an evidence base for change, emerging principles on how a future system might be shaped, objectives which the new system would seek to achieve, and possible implementation options. These have been published for an eight week period of wider engagement which will close on 11th August 2013.

A vulnerable older people's plan is also being developed by the Department of Health.

The vision for 7 day services as outlined in *Everyone Counts: Planning for Patients 2013/14* describes an NHS in which routing services are available seven days a week. As a first stage the national programme has been initiated to focus on diagnostics and urgent and emergency care, looking at the consequences of non-availability of care and making proposals for improvements in the shortcomings.

The five day model of care no longer meets justifiable user expectations of an efficient, effective and responsive service. The review will largely focus on the pathway for patients admitted as an emergency to hospital but will also consider the availability of primary and community services and the impact non-availability of these services has on weekends admissions, length of stay and delayed transfers of care. Five work streams have been established, each reporting into the forum chaired by Sire Bruce Keogh:

1. Clinical standards
2. Levers
3. Workforce
4. Finance
5. Provider models