

## NHS England and NHS Improvement Board meetings held in common

**Paper Title:** The future of UEC services

**Agenda item:** 5 (Public session)

**Report by:** Pauline Philip, National Director for Emergency and Elective Care  
Professor Stephen Powis, National Medical Director

**Paper type:** For discussion

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### Organisation Objective:

NHS Mandate from Government	<input type="checkbox"/>	Statutory item	<input type="checkbox"/>
NHS Long Term Plan	<input checked="" type="checkbox"/>	Governance	<input type="checkbox"/>
NHS People Plan	<input type="checkbox"/>		

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### Action required:

The Boards are asked to consider the approach to transforming UEC services.

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### Executive summary:

This paper sets out the how urgent and emergency care provision will be developed, drawing on our learning from Covid-19 and building on our existing programme. Throughout, our ambition is to improve the offer for patients, delivering improved outcomes and a better experience of care, whether that is by phone or online from NHS 111, at home from a paramedic, in a GP practice or pharmacy or when necessary in emergency department. Through changing the way that the urgent and emergency care system is both perceived and accessed by the patient, we will improve services and reduce the risk to patients by minimising unnecessary healthcare contacts.

This strategy focuses on five key pillars:

1. Building capacity
2. Improving remote access to urgent care services
3. Affecting public behaviours
4. Managing hospital occupancy
5. Measuring what matters

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### The Context

1. The Urgent and Emergency Care Review set out a vision of:
  - a) providing highly responsive urgent care services close to home, and
  - b) for those with more serious or life-threatening emergency care needs, centres with the very best expertise and facilities to maximise the chances of survival and a good recovery.



2. This has been supported by the adoption of technology including the introduction of NHS 111 Online; the development of NHS 111 as the key point of access to urgent care; the introduction of a consistent model of primary and community based urgent treatment centres; maximising the ability of the ambulance service to treat patients at scene and reduce avoidable conveyance to emergency departments; and developing a networked approach to urgent and emergency care so that no decision need be taken in isolation.
3. NHS 111 has been of increasing importance as an access route to Integrated Urgent Care, including locally led Clinical Assessment Services, rapid access to clinical advice for care homes and the ability to book appointments in urgent treatment centres or link to a consultation with a community pharmacist regarding minor illness or urgent medication.

### **Covid-19 – Shifting the urgent and emergency care paradigm**

4. The Covid-19 pandemic of 2020 has had a profound effect upon the delivery of NHS services and the behaviour of the general public in the way they access healthcare. We have seen rapid service change so that patients who are Covid positive receive the treatment they need, while at the same time protecting non-Covid patients.
5. There is an urgent clinical and operational imperative that Emergency Department crowding does not return to pre-Covid levels. The NHS 111 online and telephony services, using NHS Pathways, already provide a well-developed and understood remote triage function that can effectively stream patients to the most appropriate care setting for their needs.
6. This paper sets out the interventions that are required now to both help prepare the NHS for winter and to enable the next phase of the transformation of England's urgent and emergency care services, in the context of the ongoing Covid-19 pandemic. The key pillars of this transformation are:
  - i. Building capacity
  - ii. Improving remote access to urgent care services
  - iii. Public health care seeking behaviours
  - iv. Managing hospital occupancy
  - v. Measuring what matters

### **Investment in urgent and emergency care capacity**

7. A significant number of our emergency departments would benefit from additional capacity to ensure the smooth flow of patients and their ability to adhere to infection control requirements through the peaks of winter. While avoiding A&E attendances by providing alternative services will help, it is not enough on its own, and departments need to be the right size and configuration.
8. The Government has recently announced additional capital funding for the NHS, with £450m of this to respond to Covid pressures, improve flow, increase cubicle capacity or enable more same day emergency care.

## Transforming access to UEC services – a ‘111 First’ model

9. NHS 111 First includes a number of different interventions which, taken together, will augment existing NHS 111/IUC services through increasing their capacity, productivity and utility. Patients will still be able to choose to attend ED without having gone through 111 First. However, 111 First will improve the offer to patients and is proving popular in trials through:
  - Investment in clinical capacity within local Clinical Assessment Services.
  - Investment in NHS 111 call handling capacity.
  - Improved profiling of all local services on the national Directory of Service.
  - Establishing NHS 111 to ED referral processes.
  - Development of processes and IT enablers to appropriately stream low acuity unheralded patients to alternative non-ED settings.
  - Local patient communications and engagement.
10. At a national level there are also several initiatives that will be delivered for the benefit of all IUC systems. These include:
  - Ongoing development of NHS Pathways.
  - Development of other technologies.
  - Potential development of the recently established national COVID Clinical Assessment Service (CCAS).
  - National coordination of patient and public communications.
11. The central premise of NHS 111 First is that the offer to patients must be an improvement on the status quo, enhancing patient experience and quality of care.
12. ‘Early mover’ systems – one in each region – will be the first to trial some of these innovations. An early, formal evaluation of the impact on services within the early mover geographies has been commissioned for September. The ambition of then that all systems will have implemented a minimum specification of the model by the first December 2020.

## 999 – Optimising performance and reducing wider service pressures

13. We have worked with ambulance services and commissioners to appropriately increase the proportion of 999 calls that can be managed without dispatch of a vehicle, and additionally increased the proportion of calls that can be dealt with by a paramedic without conveyance of the patient to hospital. In addition to reducing avoidable attendances at emergency departments with benefits for patient flow and reduced nosocomial transmission risk, this work supports a more effective operational model for ambulance services and delivers an improved service for patients through treatment closer to home.

## A New ‘Social Norm’

14. We are now developing a campaign to encourage people to use 111 First, before they walk into an ED. This pairs developments in the NHS 111 service, such as booking into an ED time slot, which will be available across the country from December, with a national, regional and local communication push

through public and stakeholder messaging. This will feature national advertising, which we hope to go live in December.

15. The NHS 111 First campaign is part of the NHS England and Improvement NHS Winter Pressures public information campaign which is delivered each year to support the NHS in managing pressures on urgent and emergency care services throughout the challenging winter period. This year COVID-19 could significantly worsen winter pressures and the ability of the NHS to safely manage demand.

### Managing hospital occupancy

16. Ensuring the right capacity is available is reliant on: a) the impact on effective capacity of applying Covid-related infection control processes; b) extra hospital beds at the level the Government chooses to fund; c) in-hospital processes that safely reduce the length of time that patients stay in an acute hospital; and d) out-of-hospital processes to provide community and social care services.

### Discharge and community response

17. For those patients with ongoing requirements, community capacity is fundamental.
18. The Long Term Plan set out plans for urgent community response services and reablement; these remain integral parts of preventing hospital admission direct from ED. Urgent community response services are an integrated service provided by a multi-skilled team providing urgent community response within two hours to deteriorating patients to support their recovery and prevent hospital admission where possible.

### UEC Clinical Review of Standards – measuring performance in a transformed system

19. The NHS National Medical Director was asked by Government to review access standards to ensure that they measure what matters most to patients and are clinically relevant. The Covid-19 pandemic has reinforced the need for standards that also provide improved information, increase options, reduce crowding and help match patients to the most appropriate clinical setting. Reports during Covid-19 have confirmed that the preliminary findings of the Clinically-led Review of NHS Access Standards are now even more germane, for reasons that the Royal College of Emergency Medicine have also highlighted.
20. As a result of the insights trusts have gained from empirical testing, engagement undertaken with clinical leaders, patient groups and local leaders, and the experiences of the Covid-19 pandemic, the review is looking at a broader bundle of measures for urgent and emergency care in England. Expectations relating to thresholds for each metric will require further analysis and modelling as we aspire to create a better performing system than that which existed prior to the Covid-19 pandemic. Each metric must support

the changes made in the UEC transformation, and be aligned to the need to maintain social distancing in healthcare settings.

21. Experience during testing has shown that quality improvements are driven through the use of a wider set of metrics used together and not as individual performance measures. We know that changing behaviours is complex. **The roll out of new standards would need to be part of the wider transformation of urgent and emergency services described above.** This will require sufficient resource, with national oversight, regional support and assurance, and local leadership. The additional pressures of Covid-19 create a need for an immediate paradigm shift and systems will be asked to adopt new measures rapidly, learn from this process and implement improvements in a dynamic learning cycle over autumn.
22. Final recommendations will be set out in a report from the NHSE/I National Medical Director soon, reflecting the lessons learned in testing, the required transformation to UEC services, and the ongoing Covid-19 Pandemic.

## Conclusion

23. Through delivery of the goals of the strategy set out above, and the underpinning operational and transformational plans, we will work with national, regional and local partners to change the ways that patients access urgent and emergency health care services, resulting in **both an improved experience for patients and reduced risk of nosocomial transmission.**
24. The NHS will enable **greater efficiency and clinical effectiveness** through treating patients at the **most appropriate care setting** for them, making use of telephone and online resources as an extra option when appropriate to treat people at home without attending a face to face service.
25. the local NHS will support patients to **leave hospital as soon as they are able** and no later, with **clinically and socially appropriate support packages** in place. They will **measure what is important, and use this to drive tangible improvements in care.**