Our urgent and emergency care improvement proposals

A joint statement on reform from: the Patients Association, Royal College of Emergency Medicine, Royal College of General Practitioners, College of Paramedics, National Association of Primary Care, Association of Ambulance Chief Executives

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Every winter the NHS struggles to keep up with the growing needs of our patients and the past few weeks have been no exception. We are seeing poor standards of care normalised and accepted as inevitable as part of the expected annual 'winter crisis.'

We have all seen and heard heart-wrenching and yet depressingly familiar stories from patients and our staff. Our clinicians have been pulling out all the stops and doing a superb job caring for patients care around the clock despite the pressures. They are exhausted and demoralised by the conditions they have to work in on a daily basis.

The NHS, as is always the case, has got the winter it prepared for. It is vital that we not only prepare for NHS winter pressures with short term measures implemented in the run up to the season, but also with mid and long term actions planned well in advance.

This is why, as major organisations representing patients, staff and NHS providers who work in urgent and emergency care, we have joined forces as an expert reference group focussed on working constructively with the government and the NHS in England on solutions.

Our ambition is that next winter, and every subsequent winter, is not as difficult as this one for either patients or staff. And if we are going to be properly prepared for next winter, the planning needs to begin now.

As a starter for ten, we have identified four primary causes of the problem, or "diagnoses" to use Lord Darzi's terminology, and then suggested our solutions:

1) **Primary care does not have the capacity to meet its patient demand.**

2) **We are not pro-actively looking after patients who are currently the most frequent users of urgent and emergency care to stop them getting so unwell.**

3) **The urgent and emergency 'system' in the NHS remains fragmented and disjointed, making it hard to navigate patients to the right place to get their care.**

4) **Emergency departments (EDs) have become hugely congested because of lack of flow into and out of hospital beds.**

Our proposals to address these issues are:

1) **Increasing primary care capacity by:**

    a. In 2025/26 ensuring the uplift in funding promised by the government does translate into the ability of practices to employ more GPs. In subsequent years increase the share of NHS funding for general practice to match the increased workload involved in the planned shift of care from hospitals to the community.

    b. Freeing up GP time, so they have more time to spend with the patients who most need continuity by cutting bureaucratic red tape, supporting practices to improve triage systems to help navigate patients to the right part of primary care and the wider NHS. This could also contribute to freeing up capacity in 111.

    c. Introducing a national alert system to flag unsafe levels of workload and allow GP practices to access additional support. Every Integrated Care System (ICS) should be required to establish alert systems for general practice, similar to the 'operational pressures escalation levels framework' in hospitals.

    d. Beginning the implementation of integrated neighbourhood working by aligning community services to each primary care network so we can better use existing resources across the primary and community care sector to focus on prevention and keeping people well in their communities.

    e. Making the best use of the paramedic workforce to support primary care with home visiting and face to face services.

2) **Improving care for the patient groups who are currently using urgent and emergency care the most by:**

    a. Resource is needed to enable every older person in a high risk group to have a full health 'MOT' every year, including consideration of loneliness and isolation risks, a known driver of ill-health. These should be conducted by integrated neighbourhood health teams with multi-disciplinary team input particularly from primary, community and mental health colleagues. The resulting care plans should be readily accessible to all healthcare professionals with whom they come into contact.

    b. All people in residential and nursing homes should have the NHS delivered to them. This should be led by GP and community teams with the expectation that care is provided to them in their place of residence and the first point of contact for most urgent care episodes is those teams and not 999.

    c. All patients known to be on a palliative care pathway should have a care plan, accessible to clinicians across the emergency care pathway that is explicit about where the patient would like to die so that we can honour their last wishes.

    d. Identifying the highest users of urgent and emergency care in each ICS footprint, in order to agree a care plan for these individuals and to reduce their use of ED.

e. Providing more support to patients in deprived communities by reviewing all funding streams (including primary care) to channel more spending to areas of greatest need.

f. Identifying patients who are at high risk of emergency admissions (supported by AI) with a particular focus on adults with chronic breathing and cardiac conditions to create bespoke care plans (including using wearable devices) with pro-active monitoring to minimise the spikes in demand we see every winter.

g. Consider making the flu vaccination available, subject to JCVI approval, to a much broader group than currently defined, and then making sure we maximise both the uptake and speed of vaccination.

3) Joining the urgent and emergency system back together

a. Creating a single 24/7 service for each ED catchment area that is focused on caring for people in their normal place of residence that brings together the current urgent community response teams, virtual ward teams and ED teams into a single multi-disciplinary team.

b. Supporting the development of the principle of senior clinical decision making in community as well as the ED environment.

c. Making it an expectation that community-based clinicians and hospital staff routinely discuss their patients to ensure they get the right care, blurring the boundaries between hospital and community / primary care.

d. Integrating urgent mental health services into ambulance, ED and 111 delivery and training many more clinicians with mental health skills for managing patients in mental health crisis.

e. Allowing the ambulance service the time to do a fuller clinical assessment for all patients who call 999 who do not obviously need conveying to an ED.

f. Having a patient's medical record that is accessible by all providers who can read and update it and that patients can see themselves.

g. Re-wiring the NHS financial flows to incentivise the system to work together and to reward providers who deliver the interventions in this paper.

h. Creating a workforce strategy for the urgent and emergency care system looking at capacity needed for in and out of hours GP services, community nursing, mental health and paramedics, aligning training and careers together.

i. Create an improvement culture in urgent and emergency care by routinely evaluating, learning and adapting initiatives.

4) Improving the flow through emergency departments

We have to improve flow in hospitals by beginning to resolve the bottlenecks that delayed discharges create, primarily because of insufficient bed capacity and lack of social care funding. Rather than rehearse the arguments that have been made in recent weeks, we endorse all the feedback being voiced by many, that the solutions for social care cannot wait until 2028 and we must begin to increase social care capacity before next winter. Implementing many of the recommendations from the Cavendish review from 2022 would be a good place to start.

We also need to maximise opportunities to prevent deconditioning of our frail or elderly patients when they are inpatients through improved therapy and dietetic support.

Our organisations believe that these actions are all doable and fully achievable within the next few years if we work together, with a step change improvement next winter.

We hope that the government will consider using these proposals as the foundation of the UEC Improvement Plan trailed by the Secretary of State.

We strongly believe there is a way to eliminate both corridor and car park care and eliminate hospital handover delays.

Patients will be much more satisfied with the NHS because they get the care they need provided the day they need it.

Our staff will be more motivated and their jobs more rewarding because more time will be spent providing high quality care and less time fighting the system they work in.

the patients association

The Royal College of Emergency Medicine

NAPC | National Association of Primary Care

Leading neighbourhood care development

RCGP Royal College of General Practitioners

ASSOCIATION OF AMBULANCE CHIEF EXECUTIVES

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