Re: Engagement on the Urgent and Emergency Care Review

I. I write with regard to NHS England’s request for feedback on the evidence base and emerging principles of the Urgent and Emergency Care Review.

II. The Royal College of General Practitioners (RCGP) is the largest membership organisation in the United Kingdom solely for GPs. Founded in 1952, it has over 46,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. We are an independent professional body with enormous expertise in patient-centred generalist clinical care. Through our General Practice Foundation, established by the RCGP in 2009, we maintain close links with other professionals working in General Practice, such as practice managers, nurses and physician assistants.

III. We gratefully acknowledge the contributions of the RCGP Centre for Commissioning and RCGP Council members in formulating this response.

1. Overview

1.1. The RCGP welcomes the opportunity to comment on the evidence base and emerging principles of the Urgent and Emergency Care Review. We have opted to submit a written
response, rather than taking part in the online survey, as we have a number of detailed comments that we would like the Review to consider.

1.2. While we feel that there is much to support in the emerging principles document, we have some serious concerns about both the quality of the evidence base and the feasibility of a number of the implementation solutions (please see sections 2 & 3 below).

1.3. We believe that the Review’s emerging principles document does not adequately reflect evidence that the existing general practice workforce has insufficient capacity to meet current and expected patient needs. As acknowledged in the Review’s evidence base, there has been a significant increase in workload pressure on GPs over the past decade; for the average patient, the number of consultations per year rose from 3.9 in 1995 to 5.5 in 2008, with the biggest increases taking place amongst the over 70s. These problems have been exacerbated by underinvestment in general practice in recent years, with just 9% of the NHS budget in England being spent on general practice in 2010/11 (compared to 47% spent on A&E and acute care, 19% on other secondary care such as maternity and mental health, and 10% on community care). Unless more resources are invested in primary care and action is taken to increase the GP workforce there will simply not be sufficient capacity to deliver a number of the implementation solutions proposed by the Review.

1.4. Despite our concerns about the evidence base, we strongly support one of its key messages – that overall fragmentation of the system generates confusion among patients about how and where to access care, and so often leads to over-use of the most expensive services.

1.5. We believe that the key to providing high quality, efficient urgent and emergency care is integration. It makes good clinical, financial and practical sense for GPs, secondary and specialist colleagues, local authorities and the third sector to work together in designing, providing and maintaining services that ensure patients receive the highest quality care possible. Much of this can be achieved through good commissioning, as outlined in the

1 Centre for Workforce Intelligence, GP in-depth review: Preliminary findings, http://www.cfwi.org.uk/publications/gp-in-depth-review-preliminary-findings


RCGP's 2011 Guidance for Commissioning Integrated Urgent and Emergency Care. We have included some more detailed observations about what we see as key elements of a ‘whole system’ approach below (section 4).

1.6. We are keen to be involved in further work relating to the Review and look forward to ongoing dialogue with NHS England on this subject.

2. The evidence base

Overview:

2.1. We are concerned that the report makes a number of assumptions that are based on a selective or incomplete analysis of the evidence available. We have outlined some of our specific concerns below (paragraphs 2.2-16). Overall, we feel that the report does not adequately reflect the uncertainties of some of the evidence that it presents, and in some sections fails to acknowledge fully where evidence is lacking or contradictory. We were disappointed to find that some of the report’s key messages do not appear to be underpinned by the best available evidence, and to see studies being cited that may be lacking in balance or based on data of unknown quality. This is a significant weakness, not least as no mention is made in the evidence base of a system for assessing or grading the quality of the data it presents.

Specific concerns:

2.2. We are concerned that the report’s analysis of the increase in attendances at A&E departments (p.18) is somewhat misleading and does not adequately acknowledge uncertainties or differing interpretations of the existing data. The House of Commons Health Committee recently concluded that “there is a lack of clear evidence about trends in the level and nature of demand for urgent and emergency care” - it is important to recognise these uncertainties. Moreover, we feel that the evidence base does not clearly acknowledge that much of the top line rise in A&E activity in 2003/4 was due to a change in the data series to collect previously unrecorded attendances at walk-in centres (WiCs) and minor injuries

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units (MIUs)\(^6\). According to our analysis, attendances at major A&E units (type 1) in 2003-04 totalled 12,665,482\(^7\), while in 2011-12 there were 14,013,922 attendances at major A&E departments\(^8\). This equates to a 10.7% increase over the 8 year period, or on average 1.3% per year. We would observe that over the same period England’s population grew by around 6%, or 0.8% on average per year\(^9\). This would suggest that between 2003-04 and 2011-12 attendances at major A&E units increased at only 0.5% per year above the rate of population change.

2.3. **We would query the England population data** included in figure 3, page 20, which appears to be around 60 million and to have remained more or less flat over the last 8 years. According to the 2011 census, the population of England in 2011 was just over 53 million – an increase of 7.2 per cent on the estimate of 49.5 million people in 2001\(^10\). It is also important to note that this top-line population data makes no allowances for changes in the composition of the population, and so does not reflect the potential impact of an ageing demographic with more complex health needs.

We feel that it would be useful to note the King's Fund’s observation that over the past 30 months the overall increase in unplanned care attendances (across A&E units of all types) observed since 2001 has started to level off. Analysis of weekly attendances between November 2010 and April 2013 shows that the trend increase over the period November 2010 – April 2013 was around 3.5 per cent – about 1.3 per cent per year\(^11\). Similarly the

\(^{6}\) The Kings Fund (2013), Are accident and emergency attendances increasing?, [http://www.kingsfund.org.uk/blog/2013/04/are-accident-and-emergency-attendances-increasing](http://www.kingsfund.org.uk/blog/2013/04/are-accident-and-emergency-attendances-increasing)


\(^{11}\) The Kings Fund (2013), Are accident and emergency attendances increasing?, [http://www.kingsfund.org.uk/blog/2013/04/are-accident-and-emergency-attendances-increasing](http://www.kingsfund.org.uk/blog/2013/04/are-accident-and-emergency-attendances-increasing)
number of type 1 A&E attendances over this period has remained almost stable. See figure 1 below for both trends.

Figure 1: Weekly A&E attendances in England


2.4. We are concerned that the use of data on patient experience of general practice is selective. The most comprehensive data on patient experience of general practice comes from the national GP Patient Survey, which was based on 971,232 responses in 2012/13. This showed that 86.7% of patients rated their overall experience with their GP surgery as good in 2012/13; this should at the very least be mentioned alongside the 74% figure that the report cites from the British Social Attitudes survey, which is based on a much smaller pool of respondents. Similarly, we feel that undue prominence is given on p.22 to a survey of 1,328 patients from 15 practices, a small study that does not appear to have been published or peer reviewed. Overall, we feel that the evidence base document does not present a balanced or comprehensive analysis of the evidence available on the subject of patient experience of general practice, and as a result does not make an adequate attempt to describe the complexities underlying patient satisfaction with general practice.
2.5. We are also concerned that the report makes **wholly inappropriate direct comparisons of satisfaction data drawn from different surveys**. It is extremely misleading to compare 98% satisfaction with ‘999’ services, with 74% for GP services (p.26) without including any contextual information about the different surveys and their methodologies. We also note that the report cites data from the CQC national NHS patient survey for A&E departments (p.27), rather than the less favourable results for A&E from the British Social Attitudes survey (which is used when describing patient experience of general practice).

2.6. Similarly, **the figures on access to primary care (p.37) do not give an entirely balanced account**. We would note that the GP Patient Survey shows that 50% of people making a face to face appointment were able to see or speak to someone on the same day or the next day and 93% of patients said that the appointment they were offered was convenient.

2.7. We feel that **the report’s assumption that patient dissatisfaction with general practice is associated with increased A&E attendances is not evidence based** (p.23-24). The report states quite rightly that there is insufficient evidence to demonstrate a causal link between these factors, yet it is highlighted as a ‘Key message’ (p.24 ‘Data shows that some patients who have a good experience of their GP are less likely to use A&E departments’). Moreover, this summary message fails to take into account the variables mentioned briefly on page 24 and, most significantly, does not recognise that it is likely that the apparent relationship between A&E attendances and patient satisfaction with access to general practice (figure 4) is largely due to the fact that both are related to deprivation.

2.8. The Review should be aware of a study published this year (June 2013) that examines the relationship between access to primary care and emergency department visits in England. The study reports a number of useful findings, including that the percentage of a general practice’s registered population that was able to see their GP within two weekdays - a measure of access to GP services - was associated with a lower rate of self-referred discharged emergency department visits per registered patient. The study also found, however, that deprivation has a significantly stronger association with emergency department visits: **populations in the most deprived quintile had a 41.7% (P>0.001) greater rate of visits, relative to practices with registered populations in the least deprived quintile**. By contrast, the study predicts a 10.2% (P>0.001) lower rate of

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emergency department visits for those practices in the first quintile for access to appointments within two weekdays (for 91.12 – 100% of the practice’s registered population), relative to those in the quintile providing the least access (25 – 71.88%). Meanwhile, practices located in rural areas (with a practice population of less than 10,000) had a 15% (P>0.001) lower rate of emergency department visits than those in urban areas, suggesting that people in inner city areas are more likely to visit emergency departments.

2.9. We know that deprived areas of England broadly tend to have fewer GPs per head\textsuperscript{13}, yet these areas often serve patients with higher levels of physical and mental illness (commencing at a younger age than in more affluent areas), more multimorbidities and greater problems with self-care. Consequent to this mismatch of need and resource, consultations in general practices serving very deprived areas are characterised by: multimorbidity and social complexity; shortage of time; less patient enablement, especially of patients with mental health problems; and, practitioner stress. In order to improve both quality and access in these areas it is vital not only that action is taken to increase the GP workforce overall, but that a substantial share of this workforce increase should go towards improving support for under-doctored areas.

2.10. While we agree with the principle on pages 29-30 that improving access and encouraging the use of self care for minor ailments could help free capacity in primary care and reduce unnecessary use of urgent and emergency services, we feel that further evidence is needed to support this principle. Similarly, the evidence base cited for the potential for self-management for long-term conditions to reduce use of urgent and emergency services is not comprehensive. It is important that the existing evidence is not over-simplified and that the effectiveness of any new initiatives is adequately evaluated in pilot programmes.

2.11. \textbf{We see no evidence cited in the report to support the key message that ‘Variable management of long-term conditions in primary care may have contributed to a rise in the number of emergency admissions to hospital’} (p. 32). The evidence that is cited suggests associations but there is no evidence of causation. In fact evidence shows that there has been significant improvement in many long term diseases managed by primary care and that variability is being reduced across the country\textsuperscript{14}.

\textsuperscript{13} Ibid.

2.12. We would also dispute the statement on page 61 that research suggests that the continuing increase of very short-term admissions to A&E of children with common infections may be due to a systematic failure of both primary care and hospital care (by emergency departments and paediatricians) in the assessment of children with acute children [sic] that could be managed in the community, which can be attributed to the change in the GP contract and providing out-of-hours care and the introduction of the four-hour standards in A&E departments. The report does not present evidence of causation and there are several other factors which may be important that are not cited.

2.13. On page 32 the report states that approximately 18% of GP consultations per year concern minor ailments alone, which could largely have been dealt with through self-care with support from community pharmacy services. This is a potentially important point, but the figure appears to have been drawn from a trade association, with no details of a peer review process, and it is therefore impossible to know if it is reliable.

2.14. Similarly, the evidence cited to support the key message that use of telephone consultations is linked to reduced use of A&E departments (p.36) appears to be based on a study that has not been peer reviewed and is published on the site of an organisation that promotes telephone assessment models. It is important to acknowledge that the evidence for telephone triage reducing the demand for face-to-face appointments with a GP is mixed. A study examining the effects of demand for same-day appointments before and after the introduction of GP-run telephone triage found a reduction of 39%, with most calls taking less than five minutes, and good patient satisfaction. In another study, patients asking for same-day appointments were randomised to telephone triage or face-to-face appointments (patients specifically asking to speak to the doctor by telephone for advice, those deemed very urgent cases and those with no contact telephone number were excluded). While this found that use of telephone consultations for same-day appointments was associated with time saving (shorter consultations), the short-term saving was offset by higher return-consultation rates. Similar findings have been reported in other studies.


2.15. We would welcome further review of evidence on the efficacy of co-located urgent care centres, particularly given the emphasis on the use of urgent care centres in the emerging principles document (p. 6 & 9).

2.16. Lastly, we would like to see included in the report an evaluation of available evidence on the use of GPs in A&E departments.

3. Emerging principles

Overview:

3.1. In the main, we agree with the emerging principles (p.3) and most of the system design objectives (p.4-5), despite the flaws in the evidence base outlined above. However, we have some concerns about a number of the possible implementation solutions, which we feel raise expectations that cannot be delivered without a major increase in the capacity of the GP workforce. We also feel that it is difficult to comment fully on several of the implementation solutions as it is unclear what is meant or how these would be delivered.

3.2. We would welcome clarification of the process that the Review plans to follow to evaluate the advantages and disadvantages of the different implementation solutions proposed.

3.3. We feel that greater emphasis should be placed on a patient-centred, ‘whole system’ approach to care – to this end it would be helpful if the Review could outline a narrative of possible patient journeys through urgent and emergency care.

3.4. We note that no mention is made in the emerging principles document of the role that payment systems play in influencing behaviour. We would suggest that further thought is given to ways in which effective, integrated urgent and emergency care could be incentivised across primary and secondary care, with a view to feeding into Monitor/NHS England’s current review of the NHS payment system.

Specific concerns:

3.5. System design objective (4): “If my need is urgent, provide me with guaranteed same day access to a primary care team that is integrated with my GP practice and my hospital specialist team”, including “Same day, every-day telephone, web or email contact to a primary care team integrated with patient’s own GP practice” and “A same-day, every-day appointment system for urgent care facilities” (p. 6). It is not clear how this would work - for example, where would this primary care team be based and who would it be staffed by?
Without a shift of more resources into primary care it is difficult to foresee how this could be delivered by the existing primary care workforce. We would also welcome clarification as to who would be responsible for deciding whether a patient’s need is ‘urgent’. We would emphasise that, while it is important that patients with an urgent need are seen quickly, there is a risk that supply induced demand will be created by offering instant, ‘walk-in’ access without an effective risk management system (to screen out patients with self-limiting illnesses, for example).

3.6. “Urgent Care Centres staffed with a multi-disciplinary team with support of at least one GP or other registered medical practitioner” (p. 6 & 9). We agree that there are merits to using GPs to provide diagnostic and generalist support in an urgent care setting – particularly when dealing with the elderly and those with multi-morbidity. As mentioned above (paragraph 2.16), some A&E departments have employed GPs to provide this support and we would like to see an evaluation of this initiative in the evidence base. However, it is important also to acknowledge that the existing GP workforce has insufficient capacity to meet current patient needs – if the Review proposes that GPs should be taken from the existing workforce pool to staff Urgent Care Centres this will only exacerbate the capacity crisis faced by general practice.

3.7. “Identify and commission joint primary and specialist care of complex patient groups in the community (e.g. diabetics)” (p. 7). While we would welcome a move towards greater integration of primary and secondary care, there is a danger that, if limited to a disease specific focus, this approach would create new silos, fail to deliver integrated care for those with multi-morbidities and potentially duplicate services.

3.8. “Mobilisation of the appropriate level of decision making for the call/enquiry, and where appropriate, decision maker is sent to the home rather than taking the patient to the decision maker” (p. 7). It is difficult to comment fully without better understanding what circumstances would be considered ‘appropriate’ for home visits. While we broadly support this aim, we are concerned that increasing home visits is unrealistic given the existing workload and workforce pressures facing GPs.

3.9. “Decision support from a patient’s own GP practice and hospital specialist nurse/team, seven days a week” (p. 8 & 11) and “7 day continuity of care from a patient’s GP practice” (p. 8). While we welcome reference to the importance of continuity of care, we are concerned that this would not be sustainable and could only be delivered through major increases in the existing GP workforce, backed by a shift of more resources into primary care. Again, it is difficult to comment fully without understanding how this would work and what is meant by 7 day continuity of care. It is important to recognise that there are different type of continuity –
for example, relationship continuity (which may involve a relationship with more than one clinician), and management or organisational continuity, which concerns good communication between healthcare team members or between providers. There is also a need to define how continuity would operate in the context of out-of-hours care services.

3.10. “111 service fosters communication and co-ordination between different elements of the urgent care community, whilst developing an effective and expanding directory of services in every locality” (p. 8). While we welcome this aim, it is important to acknowledge that there have been serious implementation problems in some parts of the country and, as a result, many patients do not currently have confidence in the 111 service. It is therefore vital that procurement of NHS 111 services is driven by a concern for quality, rather than on the basis of lowest possible cost, and that provider quality is monitored over the duration of the contract. Meanwhile, it will be important to build confidence in and awareness of NHS 111 across the country.

3.11. “111 service to have greater medical input - senior clinical input in telephone triage and advice” (p. 8). It is essential that NHS 111 services are staffed by a sufficient number of well trained call handlers, working within the context of a well designed clinical assessment system that supports evidence-based decision making. To this end, we feel that it is important to ensure that those handling calls have appropriate access to clinical advice, such as a senior clinician or experienced practitioner trained in diagnosis, and we are concerned that in some areas of the country the ratio of clinical to non clinical staff in NHS 111 may have been driven too low by cost considerations (please see also our comments on commissioning for quality above). However, careful consideration must also be given to how a significant increase in medical input would be resourced, particularly given existing workforce pressures on both GPs and A&E doctors.

3.12. “GP telephone consultations both in and out-of-hours” (p. 8). We would welcome further details about how this would work – for example, does this imply access to the patient’s GP practice, or to a GP out-of-hours (OOH) service that has been commissioned separately? We feel that the former (access to the patient’s GP practice) would not be sustainable given the workload and workforce pressures currently faced by GPs. Instead we


need to focus on supporting GP OOH services to continue to improve the care they provide to patients, and to ensure they are integrated effectively with the local health system, both in and out of hours. In order to achieve these aims it is vital that GP OOH services are commissioned with quality rather than price as the main driver and that a level playing field is maintained for smaller organisations (such as GP cooperatives or federations) to bid against large providers. We are concerned that, as it stands, there is a risk of loss leader bids by large scale providers, which in the long term could be anti-competitive and push smaller organisations out of the market.

4. A ‘whole system’ approach

4.1. We believe that in order to successfully meet the challenges of delivering urgent and emergency care in the 21st century NHS we must redesign services based on a ‘whole system’ approach, more effectively integrating care across different parts of the system, and between in and out of hours care. Key elements of this will be:

4.2. **Shifting investment towards primary care:** As noted above, a disproportionately small amount of the NHS budget is spent on general practice, and if current trends continue this will further drop by nearly £200m in the next three years\(^\text{20}\). In particular we need to focus this investment on increasing the GP workforce, which in turn would enable GPs to spend more time with patients – such as those living with multiple morbidities – who require complex care. The standard 10 minute consultation is not long enough to deliver ‘anticipatory’ care which will help avoid unnecessary hospital admissions.

4.3. **Embedding a multi-disciplinary ‘care planning’ approach within primary care**, with GPs working alongside other health professionals to support patients with long term conditions to self manage their care. We must move away from reactively treating individual episodes of illness – often in secondary care settings – to better anticipating patients’ needs by planning and managing long term care in the community. Key to this approach is patient empowerment through the promotion of shared decision making and self care, putting patients in control. Major trauma and hyper-acute services should continue to be focused at dedicated centres with sufficient infrastructure, whilst ‘urgent’ (as opposed to ‘emergency’) healthcare needs to be developed locally, underpinned by models of primary care working with community services.

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4.4. **Improving the interface between primary, secondary care and social care:** Part of the solution to address current difficulties around emergency care will be to strengthen the interface between primary care, social care and A&E. There are challenges around discharge planning, shared access to patient records and ensuring A&E departments are aware of services available in the community. This is especially important for vulnerable patients such as the frail elderly, for whom the greater continuity of care and integration of services that general practice can offer are particularly important.

4.5. **Greater integration with ambulance services:** We should work towards greater integration of ambulance services within the system as a whole, including with general practice services both in and out of hours. Ambulance services should continue to develop alternative care pathways, offering treatment and transfer to a range of clinical services without the need to take patients to A&E. Local CCGs could also benefit from more data intelligence from the ambulance service, for example in the identification of particular nursing homes and/or post code areas with high call out rates.

4.6. **Building confidence and awareness of NHS 111:** As outlined above, part of the problem facing the current urgent and emergency care system is that patients are faced with a fragmented range of options. In principle, NHS 111 has the potential to provide patients with a single, clear access point as an alternative to calling 999. However, due to the problems with its implementation so far in some parts of the country patients do not currently have confidence in the system.

Finally, it is important to remember that, whilst the focus of the Review is on urgent, emergency and out of hours care, the vast majority of patient contacts with the health service occur in-hours, between 8am and 8pm. Regardless of the outcome of this review, it is vital to ensure that safe, effective, accessible and timely in-hours care continues to be delivered across primary care and the wider NHS.

The RCGP thanks all of those involved in the Review for their work to date and looks forward to further dialogue with NHS England on this subject.

Please do not hesitate to contact me if you have any questions about our response.

Yours faithfully,

Professor Amanda Howe MA Med MD FRCGP

Honorary Secretary of Council