Briefing
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NHS CONFEDERATION
Urgent and Emergency Care Forum

A workforce fit for the future

Working together to improve the delivery of urgent and emergency care

Who should read this briefing?

- Chief executives, board members, senior clinicians, directors and managers involved in workforce planning for urgent and emergency care.
- Staff of national bodies involved in workforce design, planning and training.

What this briefing is for

- This briefing brings together the learning from two workshops held by the NHS Confederation's Hospitals and Urgent and Emergency Care Forums and hosted by PwC, which explored how to develop a more flexible, integrated workforce to deliver urgent and emergency care.
- It offers recommendations to national bodies involved in workforce design, planning, education and training on how to accelerate and better align their initiatives.
- It gives an overview of existing programmes designed to deliver workforce changes at system level and practical examples of their implementation, which health and care leaders can learn from.

Key points

- Health and social care demand has radically changed and the NHS needs a workforce ready to meet patient and public needs in the 21st century.
- Urgent and emergency care would particularly benefit from workforce transformation, ensuring the right type of care at the most appropriate time and place.
- Staff roles, training and deployment will need to change to enable more care to be delivered by teams outside of hospital.
- Seven-day services should not be seen as an added extra, but as a fundamental part of the NHS offer, and staff need to be supported in this transition.
- Leadership at all levels is key to setting the example for the workforce as a whole, and helping to shift culture in the NHS.

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Introduction

Health and social care needs have changed substantially over the past two decades, mainly due to rising levels of chronic diseases and complex conditions and the growing need for long-term care. Socio-economic factors and inequalities in access to healthcare have also increased this burden.[1]

Services have not sufficiently adapted to this change and are not always responsive to the needs of the population they serve. Too much emphasis is still on treating rather than preventing illness, often with overlaps or lack of integration in the provision, and commissioning, of services. This makes it difficult to manage the demand for urgent and emergency care and raises serious sustainability concerns.

To provide the new types of healthcare required, which are wrapped around people's needs and take into account the increase in the demand, there must be corresponding changes in the design, training, planning and deployment of the health and care workforce.[2]

NHS England's review of urgent and emergency care, led by Professor Keith Willett, recognises the importance of addressing workforce issues if we are to improve access to and outcomes from unscheduled care.

In February and March this year, the NHS Confederation's Hospitals and Urgent and Emergency Care Forums held two workshops, hosted by PwC, exploring system changes that would bring a more flexible, integrated workforce delivering urgent and emergency care 24 hours a day, seven days a week.

This briefing brings together the perspectives shared during those workshops. It is intended as a reference document for our members, providing an overview of existing programmes designed to deliver workforce changes at system level and practical examples of their implementation. It also offers some useful recommendations to national bodies involved in workforce design, planning and training on how to accelerate and better align their initiatives.

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A workforce that is flexible, across functions and settings

A key element of transforming the way people access and receive unscheduled care includes providing more services outside of hospital, by a flexible workforce with appropriate training. We need multi-disciplinary teams (MDTs) that can provide the right type of care – specialist services, general assessment, treatment, rehabilitation services or personal care – in locations where it is required, including where patients reside. This requires flexibility in the roles that staff can perform, and with it a different approach to workforce recruitment, training and skills development.

It will also require a change in the ways staff are deployed – with changes in workforce planning, training and development at national and local level. For instance, there is developing consensus that if doctors had more generalist skills, rather than entering specialist pathways early in their training, a more holistic approach to patient care would be possible.[3] This could also facilitate more effective referrals after the first healthcare needs assessments, particularly in emergency settings. Redesigning patient pathways, such as redeploying specialist nurses from hospital to community settings, may help patients get access to the right type of care at the most appropriate time and place.

To enable these changes in workforce deployment there has to be significant change to training. **Health Education England (HEE) should continue to develop, and strengthen, models of training that equip staff with transferable competencies, and which provide appropriate levels of senior support and supervision**.* The distribution of funds across, and general coordination between, health and social care education and training is uneven. HEE, Skills for Care, NHS Employers and professional representative groups should ensure that there is recognition of the need for health and social care training to be more closely connected, to facilitate a joint approach.

Health and other public services should also be coordinated when extremely vulnerable populations need urgent or emergency care. The Mental Health Crisis Care Concordat is an example of joint commitment to address urgent and emergency mental healthcare.[4] **Local partnerships should be established between the NHS, local authorities, and criminal justice system to ensure individuals have access to the most appropriate support before, during and after a mental health crisis point, and prevent future crises**. This includes local shared training policies and approaches – for example, between the police, mental health and ambulance services providers.[5]

Health and care providers should make more strategic use of existing job redesign tools to match workforce skills with current demand. The job evaluation system offered by the Agenda for Change is not always effectively used, with consequent problems for mixed teams. If appropriately implemented, the system enables local policies on organisational change and maintains consistency in banding across the different health sectors and organisations. It should not be reduced to a simple tool to change staff banding.

Commissioners and providers should also consider new models for workforce planning and deployment that better respond to local needs. For example, senior assessment teams available at the front door of emergency departments can enable early decision-making and rapid escalation where necessary. An example is the enhanced Rapid Assessment and Treatment (RAT+) model, where mixed teams including a consultant and an advanced assessment practitioner assess the patient at the beginning and during other crucial points of their treatment. Such models also capitalise on the development of innovative roles for qualified healthcare practitioners – for instance, medical nurse practitioners can cover

* Acting on the recommendations of Sir John Temple's *Time for training* and Professor John Collins' *Foundation for excellence*, HEE established the *Better Care Better Training programme*. It ensures improved training, and thus enhanced safety and higher quality care for patients, through nine workstreams looking at both trainers and trainees, funding issues, and workforce planning, among others. Phase 1 closed in March 2014 and the programme is now in its second phase of shared learning at national level. For more information, see www.hee.nhs.uk

lower acuity cases and thus enable more senior healthcare professionals to focus on more complex decision-making – and increase the consultant contact time with trainees, and therefore benefit training and skills development.*

Other models include liaison services, where teams responding to specific patient needs are assessing the patient when such needs present. This is particularly efficient to address mental health, alongside physical conditions. In hospital and community settings alike, liaison psychiatry has proven effective for managing specialist mental health needs, dementia or other cognitive impairment conditions, which can also aggravate during emergency admissions.[6]

When planning and delivering more integrated workforce models, it is essential to support staff to achieve greater autonomy in their decision-making and new ways of working. Lower banded staff should be empowered to deliver care within multi-professional teams, with more supportive frameworks for frontline staff and increased risk management skills development among managers. It is also crucial that local whole-system planning – involving health and social care providers and commissioners – draws on, and feeds into, innovative workforce approaches. The role of commissioners is key in ensuring that resources are re-allocated as necessary in order to support changes to workforce development and deployment.

Case study 1: South Warwickshire NHS Foundation Trust

After its acquisition of local community health services in 2011, South Warwickshire NHS Foundation Trust developed a community emergency response team, moving from a 'bed-based' model of care to a 'mixed model' of community care. This included investment in community capacity; in-reach to hospital wards from community and social care teams; community input to emergency departments; a 'pull through' model for hospital discharge (Discharge to Assess); and implementing seven-day services.

This mixed approach proved beneficial in reducing pressures on emergency departments, and contributed to the overall management of the demand for urgent and emergency care. In particular, the Discharge to Assess model involves joint health and social care commissioning to support three distinct discharge pathways, depending on patient needs at the time of discharge. This allows for a shared understanding of, and jointly addressing, the risk to be managed. Early evaluations of the model showed positive impact in terms of reduced costs, improved patient flow and quality outcomes.

The trust has adopted workforce models that respond to specific local population needs, such as five-day elderly care consultant cover for emergency admissions, given a population with large numbers of frail and elderly persons. The interface between primary and secondary care is addressed through new roles, such as using medical nurse practitioners, and 'see and treat' models are complemented by access to generalist doctors for those patients that are triaged and do not need specialist care. The use of an electronic common assessment tool also supports frontline staff in different sites to jointly manage demand and reduce duplication between teams and agencies.

* In 2012, King's College Hospital NHS Foundation Trust piloted a Rapid Assessment and Treatment (RAT) in its emergency department, and in 2013 further enhanced the model to a RAT+, involving a multi-disciplinary team delivering RAT, rather than a sole clinician, and a higher level of consultant contact on the patient journey. Early findings show clear evidence of reduced 'time to treatment' for all patients and 'time to referral' for patients referred to inpatient teams.

New roles and responsibilities

Key to efficient urgent and emergency care is providing highly responsive urgent care services outside of hospital[7], through a more flexible and appropriately trained workforce. This includes making better use of available clinical roles within MDTs and enhancing functions and responsibilities of advanced clinical practitioners, physician associates, pharmacists and paramedics. HEE has defined core minimum competencies for such roles and is lobbying for expanded responsibilities. With physician associates, for example, a faculty is being created, in collaboration with the Royal College of Physicians, which intends to lobby for statutory registration and prescribing powers. Such extension of responsibilities should be accelerated and reflected in training and workforce deployment.

Basic nursing training, for instance, currently does not include certain skills that could equip nurses for more supportive roles in urgent and emergency care, such as cannulation and prescribing.

To ensure integrated and responsive services in community settings, it is crucial that there are effective ways of working between primary, community, acute and mental healthcare providers, ambulance services, and social care organisations.

The Emergency Medicine Workforce Implementation Group (EMWIG)* is considering useful recommendations for a change of scope and role of primary healthcare workforce, to better support urgent and emergency care. Co-located GP facilities

Case study 2: Kent Community Health NHS Trust

Kent Community Health is working with the acute and other sectors, commissioners and local authorities to provide joined-up community health and social care services. A common system of risk stratification has been adopted by the partner organisations to identify high-risk patients who will be managed through MDTs.

Integrated neighbourhood teams are mobile and flexible, and are supporting GPs on prevention, self-care, integrated support for long-term conditions, rapid response, assistive technology, better use of health and social care beds. A single assessment process ensures coordination of care around patient pathway, with health and social care coordinators appointed in some localities.

Workforce models are proactive, with GP leadership for the MDTs and a single care plan and management. Enhanced rapid response enables interventions within two hours, with teams operational 24 hours a day, seven days a week. Geriatricians are also part of the team in west Kent, to enable appropriate management of frail elderly and multiple conditions in the community.

The trust is providing more places on community nursing courses, developing a system-wide skills passport and offers a postgraduate certificate in community healthcare. There is a wider role for lower bands or nursing staff including first line assessments and risk assessments. There is emphasis on recruitment with support to gain experience. Retention is also key.

This flexible and agile approach, focusing on frontline integration, improves outcomes and contributes to reducing A&E attendances and non-elective admissions. Kent Community Health and other organisations may move to further integration in the medium term, with joint roles and appointments, joint accountabilities, joint training and pooled resources.

* Chaired by HEE and the College of Emergency Medicine, the EMWIG comprises experts in emergency care and medical education and training. The group looks at implementing the recommendations of the Emergency Medicine Taskforce interim report (2012), incentivising and improving emergency medicine training.

in emergency departments, or GPs working within acute MDTs, would bring primary healthcare expertise into emergency departments, facilitate discharges, and enable GPs to develop emergency care skills as a special interest. Community pharmacists could also play a key role in reducing urgent and emergency care pressures on emergency departments, and their possible role with emergency department staffing is also being considered.

Ambulance services and their clinicians have a critical role in transforming how urgent and emergency care is delivered. 'See and treat' services – where advanced paramedics are able to provide appropriate care and support at the scene of a call, or refer on to appropriate health and/or social care professionals – are already an option across ambulance services in England.[8] Further development of this, and expanding the knowledge, skills and functions of paramedics in general, will undoubtedly accelerate the shift towards more care being delivered in the community setting.

HEE has been developing programmes to enhance healthcare practitioner roles, including specialist and advanced paramedics. It is currently considering recommendations for a national framework for paramedic education, as outlined in the Paramedic Evidence-based Education project, conducted by Bucks University and commissioned by the HEE's Allied Health Professional Advisory Board.[9] It is crucial that such frameworks include robust mechanisms for decision-making support, so that ambulance clinicians can treat more people at home or manage them in the community, rather than refer them to hospital. This will be helped by enabling paramedics to independently prescribe, if they have the requisite training or experience.

For appropriate decision-making, an up-to-date directory of services needs to be available, enabling efficient referrals, with certainty that another professional will take over where appropriate. Specific roles that support decision-making across sectors need to be strengthened – for example, hospital ambulance liaison officers can manage effective and smooth handovers at emergency departments.

Better integration of ambulance services with primary and community healthcare would also improve expediency, safety and patient satisfaction in the delivery of urgent and emergency care.[10] In particular, paramedics' skills could be strengthened, enabling them to screen communities for people at risk of admission, provide health promotion advice and/or refer them to the most appropriate services. If national agreement is reached on paramedics' scope of practices, they would become a new resource to primary care, managing patients sooner in the pathway.

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Case study 3: Yorkshire Ambulance Service NHS Trust

Serving a population of more than 5 million people, Yorkshire Ambulance Service (YAS) responds to over 750,000 emergency and urgent calls, and undertakes approximately 1 million patient transport journeys per year. Its activities are shaped by the region's health profile, including a high prevalence of long-term conditions and lifestyle-related diseases.

The trust has a strong focus on developing better ways of collaborating with other health and social care providers, and commissioners, in the region to develop new patient pathways for urgent and emergency care. The aim is to deliver safe, timely care at a patient's home or incident scene, while continuing to deliver effective multi-agency pathways for patients with major trauma, cardiac arrest or stroke.

Teams of advanced/specialist paramedics and emergency care practitioners support new service models in different areas across the trust, including rural, inner city and areas with diverse ethnic populations or specific healthcare needs. The trust is also exploring how the use of technology, such as telehealth, can better support paramedics in the delivery of urgent and emergency care.

Ambulance clinicians are also provided with guidance on accessing alternatives to emergency department admissions, clarifying pathway options and developing confidence that such options are safe and appropriate for the patient. This supports appropriate referral, rather than inappropriate conveyance to hospital.

YAS has also developed a public health strategy, because of the impact that prevention has in reducing the demand for urgent and emergency care, and which focuses on reducing alcohol misuse and smoking and promoting healthy nutrition. The strategy included developing health information for patients and the public, and staff training modules that enable paramedics to support patients and their carers in making healthy lifestyle choices or accessing appropriate services for support.

Providing 24/7 access to urgent and emergency care

Different ways of working are required to address the weekly and daily variation in the quality of care provided to patients. We know that lower levels of staff at night and on weekends are associated with increased hospital mortality[11], and this is part of what is driving the move towards seven-day services.

Not all services in a certain geographic area need to be provided 24/7. Planning should look at patient pathways and identifying where there are gaps, as well as areas where the demand is likely to rise.

But in urgent and emergency care, it is widely acknowledged that providing services seven days a week will have a positive impact on patients' outcomes.[12] There is also general clinical support and public demand to make the wider urgent and emergency care system accessible 24 hours a day, seven days a week, and where senior decision-making is provided as early as possible.

To enable this, training and skills development will need to be adapted, in particular to provide adequate training and development to staff who are deployed 'out of hours'. Clinical handovers are particularly crucial, and trainees need to be supported in these transitions. An example of good practice is Mid Cheshire Hospitals NHS FT, a small acute trust which introduced a standardised process for handover, including out of hours, supported by an electronic tool to schedule and record the completion of clinical tasks, patient lists and ward and admission details. An initial evaluation showed increased staff training and satisfaction, and an improvement in 'out of hours' performance.

It is also important to align access to seven-day services across primary, secondary and community health, and social care. The latter is particularly important to ensure a smooth patient flow across the system, through timely and safe discharges from hospital. This should be supported by innovative workforce planning, and possibly new models of employment. Seven-day services will also require consistent availability of staff, with associated recruitment costs for certain organisations.[13] This needs to be acknowledged and addressed.

Current financial levers and incentives need to be redistributed within the system. In particular, contractual arrangements do not always support the provision of services seven days a week. If patients need to have access to consistently high-quality care throughout the week, then services provided 'out of hours' need to be made more affordable. Contracts also need to link remuneration with the number of hours worked, and the time when the work is carried out.

From an operational perspective, there is not – and there should not be – a 'one-size-fits-all' model. Clinical teams that are delivering services seven days a week in different areas across the country have identified and implemented solutions that work locally and offer practical mechanisms to overcome barriers. Simple, flexible rota systems, with clear requirements for staffing levels and skill mix within trusts, have proven effective in some areas. Other trusts have decided to work together and implement rotational posts at consultant level. Such collaborative models are likely to increase in the future, after several national processes looking at how NHS organisations could work more collaboratively to transform the way health services are delivered – such as NHS England's review of urgent and emergency care and the Dalton Review that looks at different organisational models for NHS providers.

Different ways of working will mean a considerable cultural change, both organisationally and individually. NHS Confederation members' experience shows that such change is more easily embedded in an organisation if it is presented transparently to staff as an opportunity to improve services. Staff ownership is also crucial in order to respect any staff concerns and work to find individual solutions to these.

Supporting leadership

Staff engagement and supported decision-making at all levels is crucial for new, more integrated ways of working to be implemented in urgent and emergency care specifically, but also at system-wide level. It is essential to create the right culture across the system and in individual organisations, which in turn will enable supportive and distributive leadership.[14]

A strong correlation exists between levels of staff engagement and hospital mortality rates. Similarly, there is a strong link between medical workforce engagement, improved organisational performance and better patient outcomes.[15] Relatively straightforward changes – such as effective appraisals, clear job design and a well-structured team environment – can enable NHS organisations to better support leadership and engagement for workforce improvement.

In particular, NHS boards should value patient and staff engagement and pay attention to staff health and wellbeing, such as by actively responding to NHS staff surveys. NHS England and the Leadership Academy have a key role to play in modelling and supporting the development of leadership and engagement for improvement, through programmes that bring together leaders from different professions and organisations within and outside the healthcare sector.

Across the whole system, the pace-setting style of leadership needs to be complemented by other approaches, such as models to co-develop care with patients. Staff should be supported to engage with patients and make effective use of their feedback. There are already examples of changing relationships between patients and their healthcare staff and specific programmes to promote increased levels of self-care and co-management of chronic conditions. For instance, the Expert Patients Programme provides guidance to self-manage chronic conditions through trained volunteers who themselves have long-term conditions.

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Confederation viewpoint

The transition to a more integrated workforce that responds to current population health needs and prevents, or better manages, urgent and emergency care, requires a whole-system approach. Politicians, national bodies, NHS organisations, local authorities, third sector providers and local communities must come together and support new ways of delivering health and care, as set out in the 2015 Challenge Declaration signed by the NHS Confederation and its partners.[16]

We need to recognise the crucial role of ambulance clinicians in shaping the future delivery of urgent and emergency care services. Their role as providers of care in the community is recognised by the new clinical models for ambulance services, proposed by NHS England and which we welcome. Strengthened paramedic skills and leadership capabilities should also be reflected in a national framework for paramedic education, as recommended by the Paramedic Evidence-based Education project.

Workforce strategies and planning at local level should be guided by the different national processes for service transformation, including NHS England's review of urgent and emergency care; the Dalton Review, looking at different organisational models for NHS providers; and the integrated care agenda. However, they should also be allowed the flexibility to implement solutions based on local needs. Urgent care networks, proposed by NHS England's review, will be paramount to facilitate such joint approaches at local level, and could support joint workforce planning and deployment. However, the function and purpose of such networks need to be clearly set and shared at a local level, and their relationship with health and wellbeing boards further clarified.

For more information on the issues covered in this briefing, please contact **viviana.olivetto@nhsconfed.org**

To find out more about the 2015 Challenge, see **www.nhsconfed.org/2015**

"Politicians, national bodies, NHS organisations, local authorities, third sector providers and local communities must come together and support new ways of delivering health and care, as set out in the 2015 Challenge Declaration signed by the NHS Confederation and its partners."

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Urgent and Emergency Care Forum

The NHS Confederation's Urgent and Emergency Care Forum makes sense of NHS England's future models for urgent and emergency care; influences the population health and prevention agenda; informs and shapes the design of outcome-based funding models; and supports members on workforce and leadership development.

For more information about our work, please visit **www.nhsconfed.org/urgentcare**
or email **viviana.olivetto@nhsconfed.org**

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NHS Confederation
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Email enquiries@nhsconfed.org
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