



Transforming Urgent & Emergency Care Together

Phase 1: Final Report

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Partnership involving East Kent Hospitals University NHS Foundation Trust, SECAmb, NHS Ashford CCG, NHS Canterbury & Coastal CCG, NHS South Kent Coast CCG and NHS Thanet CCG.

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Abbreviations

Academy of Medical Royal Colleges- AMRC
Acute Medical Unit – AMU
Advanced paediatric nurse practitioners - APNP
Ambulatory care sensitive – ACS
Ambulatory Emergency Care – AEC
American Inter professional Education Collaborative Expert Panel – IECEP
Child and Adolescent mental Health Service - CAMHS
Chronic obstructive Pulmonary Disease - COPD
Clinical Commissioning Groups – CCGs
Clinical Decision Support Service – CDSS
Community children’s nursing teams – CCNTs
College of Emergency Medicine –CEM
Deep Vein Thrombosis - DVT
Department of Health- DOH
Ear, Nose and Throat - ENT
East Kent Hospitals University NHS Foundation Trust – EKHUFT
Electronic medical records - EMRs
Emergency departments –EDs
Emergency Care Practitioners – ECPs
Foundation Trust Network – FTN
Health Education England – HEE
General Medical Council - GMC
General medical services contract – GMSC
General Practitioners – GPs
Kent Community Health NHS Trust – KCHT
Long term conditions – LTCs
National Audit Office - NAO
National Health Service – NHS
National Institute for Clinical Excellence - NICE
Out of Hours – OOH
Practitioners with specialist interests - PwSI
Pulmonary Embolism – PE
Quality, Innovation, Productivity, Prevention – QIPP
Royal College of Paediatrics and Child Health – RCPCH
Royal College of Physicians – RCP
Single Point of Access – SPA
Society for Acute Medicine – SAM
South-East Coast Ambulance Service - SECAmb

Executive Summary

Phase 1 Project Purpose and Aims

The purpose of this Health Education, Kent Surrey, Sussex (HEKSS) funded research project is to develop and deliver the future integrated Urgent and Emergency care workforce in East Kent through a collaborative provider led partnership initiative. The research questions guiding this collaborative work are:

- i) How do we solve the current workforce crisis in emergency departments creatively to promote sustainable transformational change?
- ii) What does the workforce of the future look like?

This report presents the findings of phase 1 which aimed:

- ▶ To identify current gaps and ‘pinch-points’ in urgent care pathways across one large trust (East Kent Hospitals), local ambulance services and community health care trust to identify the current and future competences required to provide a seamless and integrated service
 - Develop a gap analysis tool for urgent and emergency care to guide workforce development
 - Identify competences required for urgent care now and in the future
- ▶ To inform a workforce development plan (to be developed in Phase 2) that focuses on the development of the future workforce needed to deliver high quality integrated urgent and emergency care across the patient pathway by:
 - Contributing an options analysis for how these competences will be developed
 - Paving the way for the curriculum modifications and developments required within higher and further education to take place in Phase 2 and integration of new roles in phase 3.

Findings from an extensive literature review highlights the need for a whole systems approach to redesigning urgent and emergency care which will allow for the design and implementation of an ideal clinical model to maximise outcomes, including appropriate investment in primary, community and social care services and much better patient sign posting to these services (Foundation Trust Network, 2013). The current fragmented system depicts a lack of a clear system management and clinical governance across the emergency care system (both within individual hospitals and across the wider health community). The aim is to shift care closer to home when it is safe and appropriate to do so to reduce avoidable hospital admissions and facilitate early discharges.

Methodology and Methods

The project uses a systematic practice development approach combined with a stakeholder Fourth Generation Evaluation (Guba and Lincoln, 1989) to mirror the ways of working required to enable whole systems approaches to urgent and emergency care. This approach involves active participation

to develop a shared purpose and to identify ways of achieving this purpose at a number of levels. Processes also focus on developing ownership for what needs to be done to achieve the shared purpose.

Methods included:

- i. Stakeholder events were held across the region using 5 key questions and number of patient stories were also collected from service users in relation to their experience of urgent care.
- ii. A short electronic survey designed for the whole health economy.
- iii. A process mapping activity informed by the emergent themes from the stakeholder events and survey findings to provide in-depth perspectives of current issues and challenges; good practice and what works well; asking the miracle question in terms of what perfect integrated urgent and emergency care would look like, and also, future skills and competences required.

Findings

The outputs/outcomes from this phase have produced:

- i. A gap analysis tool to triangulate data from methods 1-3 to identify gaps and pinch points in the urgent and emergency workforce and the competences required for an integrated urgent and emergency whole systems approach.
- ii. Project data has been triangulated to identify the enabling factors, characteristics, inputs, outputs and workforce development needs required to enable a whole systems approach to urgent and emergency care to become real across the health economy where all interdependent partners would work together towards the same aim.
- iii. An integrated Career Competence Framework for Urgent and Emergency Care across the NHS Career Framework summarising the core competences required by any practitioner to deliver person centred safe and effective care in any context mapped against existing competence frameworks for all professions.

Options & Recommendations

There is no single workforce solution to address all the gaps and pinch points that will enable the achievement of a whole systems, integrated approach to urgent and emergency care. The options therefore identified tackle this aspiration at different levels and from different perspectives, all will have some impact in the short, medium or long term on workforce issues.

Option 1: Testing and refinement of the integrated career and competence framework for urgent and emergency care encompassing the contributions of all interdependent partners and staff groups as well as volunteers

Option 2: Establish Joint Appointments across integrated partners for systems leaders in a number of key areas at level 8 of the NHS career framework – consultant practitioner, for example; in areas such as: Key long term conditions; children’s services, mental health, older people with dementia; end of life care; supporting people with pain; people with learning disabilities; prevention and tissue viability; urgent integrated care, Integrated intravenous care. These posts require expertise, clinical credibility and clinical leadership (rather than management) in caring for people within client groups as well as expertise in all the functions needed for culture change to enable people to work together towards

achieving a shared vision, purpose and values; improve, learn and develop together; and also use consultancy approaches that enables expertise to be accessed by as many people as possible

Option 3: Develop a consistent and streamlined approach to co-locating General Practitioners (GPs) in the proximity of Minor Injury Units (MIUs), ambulatory care to provide in-reach, so that their impact is maximised (Medway model provides a good model for this)

Option 4: Develop advanced level practitioners and emergency practitioners across all key professions,(nursing, allied health practitioners, ambulance service paramedics) to strengthen different contexts 24/7 with experienced and expert practitioners (advanced practice level), also developing some joint appointments across primary and secondary care and establishing emergency practitioners that will continue to feed into the advanced practitioner level, particularly in areas such as ambulatory care, MIUs, community, residential homes and GP practices.

Option 5: Take forward programmes around Physicians Associates to develop the recruitment pool available from graduate scientists to address shortage of Drs, nurses and paramedics and provide additional support to residential homes, community and ambulatory care teams.

Option 6: Develop both support workers in health and social care focusing on Hospital at Home and social care in residential homes.

Option 7: Increase number of associate practitioners in areas such as ambulatory care.

Option 8: Develop administrative expertise around urgent and emergency care.

Recommendations

The following stakeholder recommendations are proposed:

Health Education England, Kent Surrey Sussex (HEKSS)

Refining and Testing the Framework

- ❖ Endorse the need for an integrated career and competence framework across urgent and emergency care to:
 - enable the contribution of all interdependent partners to be recognised;
 - support inter-professional learning and development; and
 - provide a developmental pathway that makes clear expectations the skills required for all roles or new roles linked to the NHS Career framework (and pay).
- ❖ Further test and refine the integrated career and competence framework with different stakeholder groups¹ in phase 2 of the project to spell out expectations at each level of the NHS Career Framework including opportunity to work with Higher Education Institutes (HEIs) running and students undertaking advanced and specialist practice programmes.

Supporting an Integrated Workforce Planning and Development Strategy

¹ FE Colleges, HEIs, HEKSS, Acute Trusts, Community Services, Ambulance Services, GPs, AHPs,, volunteers, care homes, fire, police

- ❖ Work with the four Clinical Commissioning Groups (CCGs) to develop a joint whole systems integrated workforce commissioning strategy to support development of an integrated seamless urgent and emergency care service
- ❖ Invest in development of Joint Appointments between Urgent and Emergency Care Key Services across primary and secondary care (with links to HEIs) in End of Life Care (EoLC), Long Term Conditions, Dementia, Frail Elderly, Children, Mental Health, People with Learning Disabilities, People with Chronic health conditions: i.e. Diabetes, Chronic Kidney Disease, Coronary Heart Disease; Chronic Respiratory Disease (section 6.2)
- ❖ Support the creation of joint appointments across primary and secondary care with development of associated consultancy approaches that enable expertise to be accessed by as many people as possible.
- ❖ Develop a regional Urgent and Emergency Care Fellowship Scheme to support development of Specialist, Advanced and Consultant Practitioner level roles.
- ❖ Support development, implementation and impact evaluation of an in service accredited A & E programme for band 5 and 6 practitioners to upskill the workforce with the knowledge, skills and competences to deliver safe and effective care in A & E.
- ❖ Develop strategies to retain the existing urgent and emergency care workforce through workplace learning, development and support for formal and informal career development opportunities.
- ❖ Invest in programmes of learning and innovation that support the development of whole systems leadership skills across the health economy.

Commissioners

- ❖ Develop an integrated workforce commissioning strategy across the four CCGs to remove barriers to whole systems seamless working e.g. financial barriers, information technology
- ❖ Implement a regional award scheme to support the celebration of innovations in workforce design
- ❖ Commission joint systems leaders posts across primary and secondary care with the full range of skills to be effective leaders to create the cultures that are required in the workplace to sustain safer and person centred services as well as places where everyone can flourish
- ❖ Prioritise recruitment and retention actions that will enable the current workforce to be retained and developed to their full potential as well as making attractive career progression models that will recruit new staff and motivate those in post to further development
- ❖ Prioritise Integrated information systems to enable ease of access to information and continuity in care across the system through patient record systems that support continuity of care cross the system
- ❖ Develop a comprehensive directory of local services for partners and users 24/7
- ❖ Consider integrating 111 with Local Referral Units so that local knowledge benefits local population
- ❖ Support a rotational placement scheme for GPs to work in Ambulatory Care and MIU Settings to promote whole system working, continuity of patient flow and support admission avoidance initiatives

- ❖ Identify the exact deficits across the health community and move staff to enable 7/7 working by mapping numbers of staff against demand and activity sharing workforce strand underpinning commitment to sharing

Integrated partners

- ❖ Create a rotational scheme around interdependent partners to increase understanding of the whole systems framework
- ❖ Develop a model of integrated clinical supervision to maintain standards and consistency
- ❖ Develop in-service workplace learning programmes and initiatives to build the competences of the workforce rapidly by focusing on growing the number of practitioners who are able to work at the advanced level in all disciplines, and also those working at NHS levels 5-6 to grow emergency practitioners
- ❖ Reduce barriers to autonomous decision-making including prescribing
- ❖ Develop strategies to simplify the management of risk across the system and avoid system duplication and over investigation through work on role clarity and role definition

Higher Education & Further Education

- ❖ Explore opportunities to develop an integrated portfolio of curricula for development of the Advanced Practice and Physicians Associate roles across KSS supported by a rotational placement scheme
- ❖ Maximise opportunities to support blended and workplace learning initiatives with a seamless model of accreditation linked to NHS Career Framework and role development
- ❖ Support a regional fellowship scheme and joint appointment roles
- ❖ Develop an accredited model for facilitating learning, development and inquiry in the workplace with FE Colleges
- ❖ Enabling rotation of learning and development opportunities to enable wider understanding of the whole systems and partnership working with other HEIs
- ❖ Develop collaborative initiatives with Further Education Colleges (FECs) to develop the role of support workers, and career development opportunities for volunteers and business administrators
- ❖ Offer a pool of expert mentors, supervisors and coaches to support development of learning in the workplace

1. Introduction

Over recent years the number of patients using hospital emergency services has risen at an alarming rate, placing the staff who work there under increasing pressure. Emergency departments (EDs) have become the default route for urgent and emergency care (NAO 2013). Urgent care leads to at least 100 million NHS calls or visits a year and represents about a third of the overall activity in the NHS, and more than half the cost (NHS Alliance 2011). As one of the largest acute Trusts in England, East Kent Hospitals University NHS Foundation Trust (EKHUFT) provides 40.2 percent of the urgent care in Kent and Medway and represents up to 95 percent urgent care activity in hospital (George 2012).

In Kent, the 2009/10 data indicates that the most patients were discharged with no follow up required (40.9% at Dartford and Gravesham NHS Trust; 57.1% at East Kent Hospitals University NHS Foundation Trust; and 32.7% at Maidstone and Tunbridge Wells NHS Trusts). These statistics suggest that many patients could have been treated at alternative facilities (George 2012). Despite much analysis there is no single trend or factor to explain the deterioration and performance continues to vary both across the country and within areas where similar factors apply (King's Fund 2013, NHS England ref.00062).

To address this ever increasing trend and make sure that the future workforce in urgent and emergency care in East Kent is able to give patients consistently high quality, safe and effective care, the England Centre for Practice Development at Canterbury Christ Church University, East Kent Hospitals University NHS Foundation Trust (EKHUFT) and the South-East Coast Ambulance Service (SECAMB) and Commissioners of Primary Care in East Kent have joined together to work on an innovative project.

Research Questions:

- I. How do we solve the current workforce crisis in emergency departments creatively to promote sustainable transformational change?
- II. What does the workforce of the future look like?

2. Purpose of the project and objectives

The overall objective for the three planned phases of the project is to develop and deliver the future urgent and Emergency care workforce in East Kent. The purpose of phase 1 was to develop and pilot a gap analysis tool which identifies a modelling strategy to look at how the workforce requirements may change as the service reconfigures and more care moves out of the Emergency Department into Community/Primary Care. This report focuses on findings from the first phase of the project.

2.1. Phase 1 project aims

- ▶ To identify current gaps and 'pinch-points' in urgent care pathways across one large trust (East Kent Hospitals), local ambulance services and community health care trust to identify the current and future competences required to provide a seamless and integrated service

- Develop a gap analysis tool for urgent and emergency care to guide workforce development
 - Identify competences required for urgent care now and in the future
- ▶ To inform a workforce development plan (to be developed in Phase 2) that focuses on the development of the future workforce needed to deliver high quality integrated urgent and emergency care across the patient pathway by:
- Contributing an options analysis for how these competences will be developed
 - Paving the way for the curriculum modifications and developments required within higher and further education to take place in Phase 2 and integration of new roles in phase 3.

2.2. Project assumptions

The project assumptions underpinning the projects direction and approaches are as follows:

- A radical approach is required to identifying the future needs of service users for seamless urgent and emergency care and these will be identified inductively from the expertise and experience of providers and service users to complement what is known about local population health care needs need and urgent and emergency care service use
- Engaging experts, across all stakeholder groups (service provider and service users) in project processes will model collaboration and develop some ownership for our future direction
- Our focus is on achieving integrated urgent and emergency health and social care

2.3. Project team

Project Director	Dr Kim Manley CBE – Kim is Associate Director Transformational Research & Practice Development, East Kent Hospitals University Foundation NHS Trust & Co-Director England Centre for Practice Development, her expertise is in developing effective workplace cultures, participative research approaches, clinical and systems-wide leadership, practice development and using the workplace as the main resource for learning, development and inquiry
Project Leader	Carolyn Jackson - Carrie is Director of the England Centre for Practice Development, her expertise lies in workforce research, innovation, development and design, advanced practice, workplace learning initiatives and programmes of leadership for all levels of workforce. She also possesses a coaching qualification and has experience of executive coaching in health and social care settings. Carrie has worked in a number of international settings.
Project Consultant	Juliet Apps – Juliet is a service improvement and innovation manager working within East Kent Hospitals University Foundation NHS Trust, with a background in operational hospital management. She has extensive expertise in service development innovation underpinned by systematic approaches and process mapping across a wide ranging of different context and pathways.

Research Fellow	Anne Martin - Ann Martin is a Research Fellow in the England Centre for Practice Development with a background in International health, children and families, HIV/AIDS, and community development. She is an experienced researcher and project manager with a particular interest in survey and evaluation techniques. She is currently supporting research studies in Community Workforce Development, Mental Health, Urgent and Emergency Care and developing education Impact Tools.
Research Assistants	<p>Ian Setchfield - Ian is a Critical Care Matron at East Kent Hospitals University Foundation NHS Trust, who has recently piloted the role of Consultant Nurse in Urgent Integrated Care. He has an extensive background within critical care, patient transfer and the management of the deteriorating patient. He has an interest in healthcare leadership, recently completing the first cohort of the NHS Leadership Mary Seacole Programme.</p> <p>Gemma Oliver - Gemma is the Vascular Access and Hospital at Home Matron at East Kent Hospitals University Foundation NHS Trust, who has also recently piloted the role of Consultant Nurse in Urgent Integrated Care. She has worked within both primary and secondary care settings as part of the community respiratory team and Critical Care Outreach respectively.</p>

3. Literature review

The purpose of this literature review is to identify current gaps and ‘pinch-points’ in urgent care pathways across hospitals, local ambulance services and community health care trust so as to identify

the knowledge, skills and competences required to provide a seamless and integrated service for current and future roles in the Trust. The literature review is framed around six key questions that guided the review. These include:

1. What is urgent care?
2. What are the redesign, innovation and policy issues around urgent care
3. What are the standards for urgent care
4. What are the competences for urgent care
5. What are the enablers and Inhibitors
6. What are the service user perspectives on urgent care

3.1. Literature search strategy

A snowballing method was used to find relevant published literature on the current workforce crisis in emergency departments and hints on what the workforce of the future should look like? This method was used to elicit the background to the current workforce crisis, past attempts to solve the crisis and the practicality of recommendations to inform the creative promotion of sustainable transformational change.

Three documents mainly guided the snowballing approach of searching for literature including:

1. Urgent and emergency care: a prescription for the future (July 2013)
2. Urgent and emergency care: a review for NHS South England (March 2013)
3. Guidance for commissioning integrated urgent and emergency care: a whole systems approach (August 2011)

The snowballing method led to excerpts of policy documents, case and service reviews and some academic articles. Further web searches of Google and Google scholar were supplemented with an electronic search of MEDLINE, CINHAL and PUBMED. Table 1 below shows the search terms and the number of items found for the period 2006- 2014.

Table 1 search terms and the number of items returned (2006 – 2014)

Search term	Related terms	Database	Number of items returned
Urgent care	<ul style="list-style-type: none"> • unscheduled • unplanned • emergency 	MEDLINE	570
		CINHAL	353
AND			
Emergency care	<ul style="list-style-type: none"> • critical 	PUBMED	152

Search term	Related terms	Database	Number of items returned
	<ul style="list-style-type: none"> • crisis • urgent 		
Redesign	<ul style="list-style-type: none"> • innovation • reshape • remodel 	MEDLINE	422
AND		CINHAL	134
Urgent care	<ul style="list-style-type: none"> • unscheduled • unplanned 	PUBMED	78
Patient perspectives	<ul style="list-style-type: none"> • Attitudes • Views • Opinions 	MEDLINE	9,130
AND		CINHAL	2,176
Urgent care	<ul style="list-style-type: none"> • unscheduled • unplanned • emergency 	PUBMED	463

All items were screened for relevance to the urgent care workforce in in the UK. Journal articles were not included in the review if their focus was on urgent care for paid services as the majority of such studies examined the use of Emergency Departments (EDs) and users' ability to afford paying health insurance. In this case the demand and supply of health services do not truly reflect the health service provision structure in the UK. Journal articles were also eliminated if studies were on ED's internal medical procedures (e.g. surgery, CT scans etc.) and if the articles centred on people presenting at EDs with specific diseases and their treatment (e.g. stroke, asthma). Long term conditions (LTCs) were looked at collectively in relation to the pressure imparted on EDs and the workforce competences required to proactively manage people with LTCs.

3.2. What is urgent care?

The Department of Health (DOH) reviewed and modified the definition for urgent care several times to provide clarity alongside healthcare service developments. Users, providers and commissioners of emergency and urgent care often use the terms 'urgent' 'emergency', 'unscheduled' or 'unplanned'

interchangeably. The terms are not inconsistent but their emphases vary and the terms are not precise about what is meant by urgent care (DoH 2006).

In the guide for telephone access to out-of-hours services, the DoH (2004) sought to clarify the terms generally used. **Unscheduled care** was defined as services that are available for the public to access without prior arrangement where there is an urgent actual or perceived need for intervention by a health or social care professional. **Emergency care** was referred to as the immediate response to time critical healthcare need and Urgent **care** as a response before the next in-hours or routine (primary care) service is available.

This was an unsuccessful attempt by the DoH to provide simplicity and inform service development. The fragmented terminologies inevitably confused the public. One of the recommendations from the Case of Penny Campbell clinical review in 2005 was to address the policy confusion over whether an out- of- hours service is for urgent care or unscheduled care (Care Quality Commission (CQC) 2010). The DOH England issued a definition for Urgent care:

Urgent care was then distinguished as *‘the range of responses that health and care services provide to people who require – or who perceive the need for – urgent advice, care, treatment or diagnosis. People using services and carers should expect 24/7 consistent and rigorous assessment of the urgency of their care need and an appropriate and prompt response to that need’ (DOH cited in RCGP clinical audit tool kit 2010).*

The term “urgent care” was designated as the umbrella term to include:

- unscheduled care
- unplanned care
- emergency care

The aim was to ensure a single recognisable identity and to promote a more integrated approach to commissioning and service provision (Royal College of Physicians (RCPG), CGP 2007, CQC 2010). From this definition, urgent care denotes any care that needs to be delivered urgently, whether this is within or outside standard hours. This can include specialist secondary care services, ED’s, urgent care centres, walk-in centres and minor injury units, the ambulance service, GP practices, community services, pharmacies, National Health Service (NHS) Direct/NHS 111, mental health crisis resolution teams and other health and social services (Martin 2008; George 2012).

The Academy of Medical Royal Colleges (AMRC) refer to Urgent Care as the assessment and management of common problems where the patient thinks there is moderate degree of urgency; and Emergency Care to be the assessment and management of illness and injury where the patient or the clinician thinks there is a need for immediate assessment and care of their problem (AMRC 2007). This definition for urgent care is based on the assumption that much of this care is delivered by General Practitioners (GPs) and their teams, although GP out-of-hours services and Emergency Departments deal with increasing numbers of patients with urgent care needs. The definition for emergency care connotes care provided mainly by out-of-hours services, Emergency Departments and hospitals.

In 2011 the DOH defined **Urgent and emergency care** as the range of healthcare services available to people who need medical advice, diagnosis and/or treatment quickly and unexpectedly. This is the current and standing definition for urgent and emergency care.

East Kent Clinical Commission Groups implement urgent care as an umbrella term in the assessment of the urgent care needs and the provision of the urgent care service for the population in the catchment area (George 2012). The poster [guide](#) to local health services emphasises GPs as the first point of contact. Yet patients' perceived reality of care relates to their subjective estimation of importance. Users of urgent care tend to contact more than one service in the process of obtaining definitive care for an urgent problem (Knowles et al 2012).

3.3. Who goes to emergency departments?

A significant proportion of patients treated in acute sector beds could be treated more effectively elsewhere but the causes of increased ED attendances remain controversial (Lakhani 2007, Foster 2012, King's Fund 2012; Trigg 2013). Older people and children form a significant proportion of the workload of the ED (20% of patients are over 65 years old and 22% of patients are under 16). A remarkable eight per cent of patients are over the age of 80 and this number will certainly rise unless sustainable, appropriate, alternative solutions are found (Hassan et al 2013). Paediatric emergency admissions in England have increased by 28% over the last five years (King's Fund 2013). This is ascribed to the shortage or perceived shortage of out-of-hours (OOH) GPs, poor quality paediatric primary care, telephone triage and doctors being more cautious.

Some parents attempt at-home treatment in the form of comfort measures or medication accessed over the counter but their need for reassurance leads them to ED use. Barriers to accessing professional services and the high numbers of professional referrals point to an urgent need for effective primary care services in the community (Truman et al., 2002). The NHII believe that variations in clinical practice (e.g. walk in centres not seeing children under a certain age) and variations in competence and confidence of pre-hospital staff are likely to contribute to high rates of admissions of children under the age of 2 years (NHII 2011). Six common conditions in children and young people present in urgent care and emergency care. These comprise of abdominal pain, asthma/wheezy child, bronchiolitis, feverish illness, gastroenteritis (diarrhoea and vomiting) and accidental head injury. Fever makes up the highest volume of admissions activity, accounting for 28 percent nationally, followed by asthma and wheeze which account for 23 per cent. Despite the high volume of paediatric admissions there is significant variation in the length of stays (NHII 2010).

The frail older people are increasingly likely to account for a significant proportion of health and social care service use (King's Fund, 2012). Despite the majority of urgent care being delivered in the primary care setting, an increasing number of older people are attending emergency departments with progressively complex needs requiring competences, skills and attitudes not present (Fernandes 2011). This is partly related to the demographic shift that has resulted in a rapid increase in the number

of older people, but may also be due to lower thresholds for accessing urgent care (Blunt 2010). Dedicated teams delivering comprehensive older people assessment can support this, but in themselves are not sufficient to realise whole system change (Cook et al., 2009). A systematic review by Conroy et al., (2006) evidenced that early geriatricians' assessment of frail elderly patients in EDs can improve outcomes but further development of such initiatives will depend on ensuring sufficient specialty capacity.

The main challenge for services is that acutely ill older people are very sensitive to delays in care. The longer they wait for a definitive consultation, opinion, investigation and treatment, the more likely they are to end up attending the hospital (Cook et al., 2009). Reports published by the National Confidential Enquiry into Patient Outcome and Death (2010), Parliamentary and Health Service Ombudsman (2011) and the Patients Association (2012) highlighted major deficiencies in the care of older people in acute settings, ranging from concerns about privacy and dignity to peri-operative care. If a diagnosis can be made within the four hour access standard, it is often impossible to arrange appropriate community and social care support to allow patients to be discharged home safely. If patients who require further inpatient care cannot be transferred out of an emergency department after their condition has been stabilised, both they and subsequent arrivals are disadvantaged (RCP et al 2013).

Admitting elderly patients to a crowded hospital often leads to inefficient management especially in wards that are not permanently staffed by a multi-disciplinary geriatric team (Roland and Boyle 2013, Vile 2013). Patients with multiple co-morbidities rapidly decompensate once admitted and become increasingly difficult to transfer back into the community. Edward (2013) suggests that the way nursing and residential care are incorporated into the system needs to change by building them around natural communities and involving a new relationship between the different providers. All this requires strong leadership across a system instead of individual components. A number of initiatives have had success through targeting nursing and residential homes, including providing support, care planning, medicines reviews, geriatrician ward rounds, and best practice end of life care plus a variety of other interventions (King's fund 2013).

Due to increased demand and limited capacity, patients are often not seen by the right speciality teams, hospital stays are prolonged, and the patient experience risks being unsatisfactory, or worse (King's Fund 2013). In a simulation for emergency care (Vile 2013) a mathematical modeller for the Cumberland Initiative established that, while increasing demands in the older people presenting at EDs is common to all Health Boards in the UK, the problem for the excessive number of beds taken up by older people is not the raw numbers of patients that turn up at EDs presenting with urgent care needs, but the way their needs are being addressed within the system. There is a critical need to reconfigure urgent care services to reduce the strain placed on EDs, bearing in mind that the elderly population is predicted to dramatically increase over the next decade. The number of elderly people with dementia is also predicted to rise steadily (Knapp et al., 2007). Systems need to be designed to ensure that empty capacity is maintained to enable fluctuations in demand to be safely managed (King's Fund, RCP 2013). Comprehensive training of staff managing care of older people in the emergency settings is paramount to safe and effective delivery of care. This should not be restricted to medical staff, but all health care agencies, social services and community teams involved in older

peoples' care. Wherever possible and appropriate, this training should be undertaken jointly (Cook et al., 2009). Workforce redesign cannot be approached as an isolated topic, but should be integrated with processes for redesigning care, identifying the best site of care, and utilising technologies that facilitate alternative ways of working (Imison et al 2013).

Effective response to changing healthcare needs can be achieved by putting people more in control of their health and wellbeing; overcoming fragmentation through the development of integrated care; and giving more attention to resources in the community that can support the transformation that is needed (Horne et al., 2013). There is a mismatch between the location of the current workforce and where care is needed. For example while the need for home and community care is growing the number of district nurses fell by 38% between 2001 and 2011 (RCN 2013). The care for children with severe neuro-disability, complex co-morbidities, mental health needs and those in need of palliative care could be improved by having proactive community children's nursing teams (CCNTs) who can predict and respond to emergency and urgent care needs (NHII 2010). A study by Kyle et al. (2012) highlighted poor communication and weak interpersonal relations between paediatricians and CCNT as key barriers to making early referrals to CCNT as an alternative to hospital care.

Multiple pathways for patients with long term conditions need to be integrated to create a connected web of care to co-ordinate all services and people that patients have a relationship with (Kodner et al 2000). This may involve community, primary, secondary and tertiary care; health and social care; the NHS and voluntary sector; informal care from the community, friends, family and neighbours; and, where appropriate, other public services such as employment, housing and education (Horne et al., 2013, King's Fund 2013).

3.3.1. Long term conditions

According to the disease registers, the most prevalent long term conditions in East Kent are: diabetes (5.9%), asthma (5.6%), chronic kidney disease (4.4%) and chronic heart disease 3.6% (George 2012). Blunt (2014) found that attendances at major EDs have only increased in line with what would be expected from population growth and that the proportion of people with one or more long-term conditions attending EDs did not change notably between 2010/11 and 2012/13. However there is evidence to demonstrate the correlation of multi-morbidity with high rates of emergency admission (Bottle et al 2006) and longer waits in EDs (Blunt 2014).

In their 2014/15 operational submission to 'Monitor' (2014) EKHUFT underlined fragmented LTC care across the local health economy as one of the challenges facing the urgent care long term conditions division. This has resulted in duplication, waste and unmanageable patient pathways henceforth poor patient experience and repeated crisis management. East Kent is experiencing insufficient capacity in community and primary care services resulting in increased numbers of Delayed Transfers of Care across the EKHUFT. There is a general lack of knowledge about how best to apply in practice, the various strategies and approaches to care co-ordination. Goodwin et al. 2010 recommend population management – an approach that seeks to reduce expensive and distressing emergency admissions, by promoting high-quality proactive care for patients.

LTCs clinics are mostly run by nurses and despite the majority being run by practice nurses with specialty, treatment room/ generalist nurses and nurse practitioners run quite a number of LTC clinics (Jenkins and King 2012; Fletcher et al 2012). There is a discrepancy between the level of training a nurse needs to run a clinic safely (longer courses and accredited modules with accompanying course work) and the preference of nurses to attend shorter and more local training courses. Time constraint and limited availability of local courses in East Kent are highlighted as barriers to up skill training for LTC and diabetic foot care (Jenkins and King 2012). Further education and training for practice nurses to develop competence, confidence and the required knowledge levels would improve the quality of life of the people living with these conditions (Fletcher et al.).

3.3.2. Ambulatory care sensitive (ACS)

Admissions are the most costly system of healthcare and because of this, concerted efforts have been made to decrease Ambulatory Care Sensitive (ACS) admissions to reduce costs and increase productivity (Purdy 2010, NHS Institute for Innovation 2011). ACS conditions are chronic conditions for which it is possible to prevent acute exacerbations and reduce the need for hospital admission through active management, such as vaccination; better self-management, disease management or case management; or lifestyle interventions (King's Fund 2013). Ambulatory Care offers a new way of providing high quality emergency, urgent and booked medical day care. It is designed to be delivered in a timely fashion and to make sure that patient get the best outcomes.

Ambulatory care is defined as clinical care for urgent conditions, which may include diagnosis, observation, treatment and rehabilitation that are not provided within the traditional hospital bed base or within traditional outpatient services; the healthcare setting may vary, but optimal clinical care will often require prompt access to diagnostic support for clinical assessments (DOH 2010). The ability to control rates of emergency admission, especially for those conditions where preventive management is possible in the community is a common marker for success of health systems. ACS admissions are used increasingly as markers of changes, and are now in the NHS Outcomes Framework (DOH 2010). However it is important to note that an absence of ACS admissions is not necessarily an indicator of better care being delivered elsewhere, just that it is not being delivered in a hospital context. Additional information from primary and community care should be utilised to assess whether or not low ACS admission rates is accompanied by better care outside of hospital (Cheema et al 2014). The bottleneck is that the data currently available does not allow community and Primary Care Trusts services between to be accurately compared (King's Fund 2013).

ACS admissions increased by 48 per cent over the last eleven years in England. Although ambulatory care sensitive admissions are relatively low in Kent, Surrey and Sussex, they follow the same trend of increase, which is partially attributed to population growth and a change in the demographic composition of population in England (Cheema et al., 2014). Particular concern is about the rapid growth of 'other and vaccine preventable' ambulatory care sensitive admission rates as well as the steady rise in acute ambulatory care sensitive conditions. The NHS Institute for Innovation (2011)

stipulate that by focusing on a limited range of high volume pathways, the NHS can make the maximum impact on improving the quality and value of care for NHS patients.

Nationally, ACS admissions make up one in every five emergency admissions to hospitals and half of these are accounted for by five of the [nineteen ACS conditions](#); urinary tract infections (UTI)/pyelonephritis, pneumonia, chronic obstructive pulmonary disorder (COPD), epilepsy and convulsions and ear, nose and throat (ENT) infections (Blunt 2013). Of the five main ACS conditions, COPD, UTI/pyelonephritis and pneumonia disproportionately affect older people whilst the epilepsy and convulsions and ENT infections unduly affect children and young people (Cheema et al 2014). Kent Surrey and Sussex (KSS) carry a comparable drift in the incidence of the ACS top three admissions in England. There are notable differences in the conditions with smaller volumes; for example ENT infections are reported to be the second highest amongst acute conditions nationally, but fourth highest behind UTI/ pyelonephritis, gastroenteritis and cellulitis in Kent Surrey and Sussex (KSS).

Across KSS pneumonia features the highest growth in admissions with a reasonably static average length of stay of between 11 and 12 days. The condition is more apparent in the over 65 age group, with males consistently showing higher volumes of pneumonia admissions than females in all age groups under 85 (Nuffield Trust 2013, Cheema et al 2014). UTI/ pyelonephritis is the most common ACS admission condition accounting for 17% of all ACS admissions, approximately 900 admissions per month, across the region. These figures exclude patients admitted primarily for other reasons who also have a UTI (Cheema et al 2014).

The 2011/12 Kent Urgent care Joint Needs Assessment report showed that East Kent has considerably higher admission rates for COPD than West Kent, compared to the other top ACS conditions. Overall, ACS admission rates were slightly higher in East Kent than West Kent over the last few years (Kent Urgent Care JSNA chapter 2011/12). EKHUFT currently offer 13 in total – Painless obstructive Jaundice, Low Risk GI Bleed, Asthma, Lower Respiratory Tract Infection without Chronic Obstructive Pulmonary Disease (COPD), Pleural Effusion, First Seizure, Community Acquired Pneumonia – all from the Directory of AEC for Adults which highlights 49 pathways.

Despite the rapid growth in ambulatory care, nursing programs still use the hospital for the majority of their clinical rotations. Instead of learning through performing the role, nurses need new knowledge and enhanced skills to meet their learning needs as they transition to the ambulatory care environment. An Ambulatory Module is part of the degree course in conjunction with Christchurch – the first in the country and is entering its second year. In ambulatory care registered nurses make rapid assessment of sicker patients in a time constrained environment and therefore need critical thinking skills and sound clinical judgement. Some skills and competences may be generally applicable in both settings but the complexity and broadness of their scope make practice in the outpatient setting largely different (Swan 2007).

Evidence from a systematic review by Purdy et al. 2012 demonstrated that education/self-management, exercise/rehabilitation and telemedicine in selected patient populations, and specialist

heart failure interventions can help reduce unplanned admissions. Nevertheless the majority of the remaining interventions included in the Purdy et al. systematic reviews were found not to help reduce unplanned admissions in a wide range of patients. UK health services perform badly compared with other countries in involving patients of all ages in supported self-care and shared decision-making (Health Foundation 2010); for example, older people are less likely to be educated and supported in self-management of diabetes than younger people with the same condition (Melzer et al. 2012). Localities should examine local performance with this in mind, to ensure that older people are not disadvantaged (Oliver et al. 2014).

While day case interventions have clear benefits for the patient, a minority (about 3 per cent) of cases develop complications that lead to an emergency admission. The increase in day-case activity has also led to an increase in emergency readmissions due to complications (NAO 2013). Ambulatory Emergency Care (AEC) requires prompt clinical assessment, undertaken by a competent clinical decision maker, and while the healthcare setting may vary, optimal clinical care will often require prompt access to diagnostic support. Effective AEC is part of a whole systems approach that is only achieved by reorganising the working patterns of emergency care, diagnostic services and alternative services (RCP et al., 2013).

3.3.3. End of life care

As our population ages, there is a considerable overlap between living with and dying from various conditions, and this is reflected in the concept of end-of-life care. This incorporates care for those who are nearing their final years, months and weeks of life – not just those who are in the final days of life (Oliver et al. 2014). Despite people's preferences of place of death, the acute hospital remains the most frequent place for the majority that die every year in East Kent (Gorge 2012). Hospitalisation often appears to carers and emergency response teams as the only option in social and medical crisis but acute staff do not have sufficient training and skills to provide end of life care for people with LTCs such as dementia and cancer (Sampson et al, 2009; Pettifer et. al, 2011). The use of emergency services may be prevented with adequate advanced planning to reduce the significant burden placed on the health economy (Gorge).

Ambulance crews frequently deal with patients at the end of life with little knowledge of what to do. They face complex competing challenges with little or no support in making decisions and default to the safe option of 'admit and resuscitate' (Pettifer et al. 2011). Good end of life education and on-going training is essential so that paramedics feel competent in end of life care. The competences underpinning values and knowledge encompass: communication, assessment and care planning; advanced care planning; symptom management; maintaining comfort and wellbeing and not to forget the occupation specific obligations (Skills for Care 2014).

3.4. Redesign, innovation and policy of urgent and emergency care

The urgent and emergency care (UEC) system has undergone several transformations attributed to not only numerous policy requirements to improve the quality of care provided for patients (*including improving responsiveness, simplifying patient journeys, ensuring that the patient is seen by the professional that is best able to meet their needs and reducing waiting times*) but also to a general medical services contract (GMS) introduced in 2004. The GMS provided new governance and incentive arrangements for general practice (Peckham, 2007). The 2004 GMS enabled general practitioners to opt out of their 24 hour responsibility for patients and required primary care organisations to re-think their strategies for urgent care service delivery (NHS Confederation, 2014a).

Berwick (2008) argues that change at times makes sense but many changes drain energy and confidence from the workforce, which learns not to take risks but to hold its breath and wait for the next change. The time has come for stability to be established on the basis of which paradoxically, productive change is easier and faster for the good, smart, committed people of the NHS (Dixon 2010).

The UEC transformations have caused mounting pressures on the workforce across all specialists (NHS England 2013). The growth of the range of urgent and emergency care services available to patients, increased the complexity of decision making for patients requiring urgent care. Uncertainty about which service to contact means patients may access services not best placed to meet their needs but because they have confidence in them and find them easy to access (NHS Alliance 2011, King's Fund 2013). Demystifying such a complex system for the public will be crucial in reducing the pressures placed on EDs. This will also ensure patients and service users are more quickly treated in the right place, which may often be in community based settings rather than hospitals (NHS Confederation 2014a).

3.4.1. Policy Strategies for Urgent Care

There have been many attempts to divert people from EDs by providing alternative primary care type services. Despite many initiatives to reduce demand over the last 10 years, none seem to have successfully created a sustained change and diversion of work away from EDs (Coleman et al., 2001, O'Cathain et al., 2007, Hassan et al., 2013). These schemes appear mainly to increase overall demand, particularly for minor injury and illness, and have also created a highly fragmented system which generates disorder among GPs and other referrers about how and where to access care.

Qualitative findings from a review conducted 15 years ago on developing emergency services in the community revealed that patient confusion about which service to attend when they had an urgent health problem is an old trend (Turner et al., 2012). While the last ten years have seen real achievements – with more resources and new forms of access to urgent care, the results have been a fragmented and complex system, leading to more confusing care journeys that are difficult for patients to navigate or understand. This situation is further complicated by the increasing plethora of organisations offering urgent care, and the wide range of professionals involved in providing that care (RCGP 2010, NHS Alliance 2011).

Walk in centres were introduced to augment primary care services and reduce the EDs workloads (Monitor 2014; Ansari et al 2008). Minor injuries units and walk-in centres opening times and diagnostic support vary on a daily basis, making it difficult for the ambulance service to actively use these facilities as an alternative to EDs (King's Fund 2013; George 2012). Unlike countries like US, Australia and Canada, walk in centres in the UK are mostly led by nurses rather than doctors. Although they offer quick and convenient access to primary care, especially when GP surgeries are closed or are not able to offer a quick appointment, walk in centres are criticised for delivering low-quality, fast throughput care with no continuity, leaving other health providers to deal with demanding, complex, and on-going problems (Salisbury et al 2003; Jones 2000). Primary Care Trusts closed many of the walk in centres in 2008/09 to replace them with GP led health centres. Clinical Commissioning Groups (CCGs) continue to modify walk in centres services and/ or close them due to increasing costs arising from service duplication (Monitor 2014). In East Kent the services offered by minor injuries units and walk in centres are inconsistent and ultimately more confusing for the public (George).

Until 5 years ago, change in urgent and emergency care has predominantly focused on timeliness driven by national targets rather than on improving quality and the patient experience (Fernandes 2011). The Francis report (2013) called for a fundamental change in culture in the NHS, whereby patients' care and safety are put first, with the patient being the priority in everything done. The White Paper, Equity and Excellence: liberating the NHS, represented one of the biggest shake ups of the health system since the NHS was established (Dixon and Ham 2010). This included a commitment to developing a coherent 24/7 hour urgent care service, incorporating GP out-of-hours services in England. Several changes were introduced in the hope of achieving universal, continuous access to high quality urgent and emergency care.

The NHS 111 was born out of the confusion among the general public about which of the myriad urgent care services they should contact when they have an unexpected, unplanned health care need- and what number to call, when (NHSCC 2012). In August 2010 the Secretary of State announced the three digit memorable number that was piloted in four areas in England in 2011 and 2012 and eventually rolled out nationally to replace the NHS Direct 0845 service NHS Direct Trust ([ES 31](#)). Given the enormous significance of NHS 111 for the operation of the emergency and urgent care system and resources, it is inexcusable that the objectives and benefits of the NHS 111 programme were never accurately identified, articulated or quantified for commissioners or potential providers of the NHS 111 and other affected NHS services (NHS Direct Trust ES 31).

There key differences between NHS 111 and the NHS Direct service are deemed to have increased pressure on the wider urgent and emergency care service. The NHS 111 does not aim to promote self-care as its first premise; uses significantly less qualified clinical input in assessments; uses clinical content that is new and immature to the urgent care setting; meets a narrower range of patient needs; and is a telephone-only service (NHS Direct NHS Trust ES 31).

The evaluation of the impact of NHS 111 on the use of the urgent and emergency care system indicated a significant reduction of calls to NHS Direct and no significant change in emergency

ambulance calls, emergency department attendances or urgent care contacts/attendances (Turnbull et al, 2012). In fact the service was predicted to increase overall demand in urgent care (Turnbull et al., Kings Fund 2013). There are major concerns about the non-medically trained call handlers assessing calls (Kaffash 2013, NHS Direct NHS Trust ES 31). The use of inexperienced staff for triage also ignores evidence from hospitals that senior members of staff are better than juniors at keeping patients out of hospital. It is less effective and more costly to use a junior/ inexperienced workforce in urgent and emergency care (White et al 2010). A study in Denmark (Moth et al., 2013) established that the costs of out-of-hours care would rise rather than fall if nurses were substituted for doctors in triaging out of hours calls.

The following case study from Bassetlaw Hospital in Nottinghamshire shows how consultant led care can improve patient/ service user outcomes and experience. This collaboration has been facilitated by a cultural shift among clinicians and managers with a focus on shared responsibility and leadership both at a system and organisational level (NHS Confederation 2014a)

Case Study 1

The Bassetlaw Seven- day Care Initiative

The Bassetlaw seven- day care initiative was a response to a 2011 external audit that highlighted higher weekend mortality rates in Bassetlaw Hospital and an avoidable 14 per cent of admissions. The drive to redesign the non-elective medical pathway at Bassetlaw Hospital was largely due to delays in assessments and treatment planning following admission. The innovative service is a hospital consultants led hands-on care delivery, seven days a week to acutely unwell patients. The 21-bed Assessment & Treatment Centre (ATC) at Bassetlaw Hospital receives patient admissions from EDs, GPs (in hours and out of hours), community services and ambulances. The ATC has access to diagnostics, and enhanced pharmacy and dedicated social care support. An acute physician present Monday to Friday and a general physician at the weekends are supported by the community rapid response service to discharge patient over seven days. The result is consistent, high-quality seven-day consultant-delivered care. The ATC also has a non-bedded ambulatory day care facility for patients with conditions that do not require them to be admitted in hospital e.g. vein thrombosis.

The skill mix and experience of staff supporting the ATC has improved due to a rotation system enabling them to gain a variety of skills as a part of a multi-disciplinary team. Improved staff morale, team working and training has contributed to an environment that offers on-going development. EDs are now supported with a clinically robust follow-on service.

3.4.2. Current Role of NHS 111

Call handlers act as translators between the technology and the caller as they conversely interpret the caller's description of the medical problem to fit the options in the Clinical Decision Support Service (CDSS). This implies flexibility to use common sense, which may potentially create variability in the way call handlers perform their role (Turnbull et al, 2012). There are no standard competences for call handlers or guidelines for using individual judgement while performing the role. In their study of skills of NHS non-clinical call-handlers, Turnbull et al 2012 established that service providers required call handlers to have a minimum of five GCSEs, effective communication skills, the ability to offer information and advice , active listening, skilled questioning and effective use of the CDSS. In July 2013 the SECamb, which runs Kent's NHS 111 service, was slated for targeting students for recruitment

(BBC News report 2013). The ten week training programme which the new recruits complete before answering calls is deemed inadequate and trainees do not feel fully prepared for the role (Mooney 2013; ITV report July 2013). In the Turnbull et al 2012 study call handlers expressed the value of team work especially in consulting each other on knowhow. Confidentiality breaches are therefore common as many staff unaware what decision to make often invite others to help (Anonymous 2013).

The NHS 111 is undergoing an overhaul to ensure the service definitively manages calls (Kaffash 2013). It is anticipated that the enhanced service will have knowledge about people's medical problems and allow them to speak directly to a nurse, doctor or other health care professional (NHS England 2014). Effective triaging and assessment relies on the availability of services that the patient can access but Primary Care Trusts are at different stages of developing an electronic directory of local services. It is imperative that call handlers have facts about relevant services that have the capacity to respond without gaps in service provision (NHS Alliance 2012).

Turnbull et al., 2012 found that 'trained users' of technology, need clinical expertise in addition to a broad range of skills. To enable effective use of the CDSS the right range of skills should be incorporated into the training for and management of, emergency and urgent care call-handling. Computer decision support systems are increasingly used to support diagnosis and treatment decisions by healthcare practitioners but technological interventions may require new resources to support their effective use, for example, requiring new roles, new organisational functions and considerable management time (Pope et al., 2013).

NHS Pathways originated as a result of concerns about clinical performance and costs of triage in out of hours services and NHS Direct. It was initially an NHS Direct project and was intended to become a second generation triage system for use by nurses. A group of clinicians introduced the NHS Pathways to deliver a single clinical assessment tool that provides effective triage over the telephone in any setting taking calls from the public. This can include 999, NHS Direct, GP OOH, NHS 111 and any other Single Point of Access (SPA) number in place. Although NHS Pathways remained an NHS Direct project, the focus shifted from one which used the clinical decision making skills of nurses to the development of more structured triage which explored how far the assessment by non-clinical, but specially trained, call handlers could be extended. The key role for nurses continued but at a higher and more supporting level. It was realised that the NHS Direct approach, with the focus on triage mainly done by nurses, might be too costly and not be sustainable in the out of hours and broader urgent care clinical situation (Turner et. al., 2008).

The Quality, Innovation, Productivity, Prevention (QIPP) initiative was introduced at national, regional and local levels to support clinical teams and NHS organisations to improve the quality of the care they deliver while making efficiency savings that can be reinvested in the service to deliver year on year quality improvements (RCGP 2010). The QIPP Urgent Care work stream aimed to maximise the number of instances when the right care is given by the right person at the right place and right time for patients (Fernandes 2011). The development of the QIPP is one of the many assumptions that led to increased demand and reduced capacity in hospital emergency departments. There was a reduction

in bed numbers and staff as hospitals tried to deliver cost improvement plans (NHS England ref. 00062).

The marginal rate policy was introduced in 2010/11 in response to concerns about the growth in the volume of patients being admitted to hospital as emergencies. The policy set a baseline for income from emergency admissions for each provider. The provider received 30% of the normal price for emergency admissions above the set baseline. It was anticipated that if the baseline was set appropriately, the number of patients triggering this marginal rate would not be large. From 2013/14, commissioners were required to invest the 70% retained funds in controlling demand for emergency care.

The Foundation Trust Network (FTN) declared the 30% marginal rate policy fundamentally flawed and argued the NHS England to replace it as quickly as possible on the basis that there was little or no evidence that the policy rate was facilitating more effective demand management (FTN emergency care and emergency services 2013). In their review of the marginal rate rule, Monitor and NHS England found inconsistencies in the implementation of the rule. They identified a lack of transparency about how some CCGs were spending the 70% of the funds retained and that some providers could not plan their emergency care costs effectively because CCGs possibly set activity levels for urgent and emergency care unrealistically low.

NHS England deemed the large majority of providers managing with the rule in place and updated the marginal rate rule to: give providers in some localities leeway of adjusting the baseline where necessary to account for significant changes in the pattern of emergency admissions faced; ensure that retained funds from the application of the marginal rate rule are invested transparently and effectively in appropriate demand management and improved discharge schemes. Monitor and NHS England are in the process of gathering and analysing further evidence to underpin reform of the funding for urgent and emergency care.

As part of the NHS England improvement plan for emergency care, Urgent Care Boards were created to provide oversight, evaluation, standardisation and communication to all parts of the system (Lipley 2013). The East Kent Urgent Care Board covers four CCGs by Ashford CCG, South Kent Coast CCG, Canterbury and Coastal CCG and Thanet CCG. According to the King's Fund review of urgent and emergency care (2013) Boards seem to be at different stages of development and vary in effectiveness.

In view of the UEC rapid developments, the Royal College of General Practitioners in partnership with The College of Emergency Medicine (CEM) developed and validated a universal [Urgent and Emergency Care Clinical Audit Toolkit](#) for healthcare service provider as a powerful mechanism for on-going quality improvement, identifying weaknesses or delivering clinical and cost effectiveness. The tool allows individuals to benchmark their performance against the criteria in relation to the organisation's mean score for any individual criterion. This is both to aid reflection and to enable an individual to monitor their progress (RCGP 2010). The urgent and emergency care toolkit further provides

techniques for communicating positive feedback to ensure that any proposed changes are implemented and correctly adhered to. Constructive feedback can improve motivation and correct mistakes providing there is reinforcement of what has been learnt and steps are taken to help learners or organisations reach their goals (Ende 1983).

3.4.3. Access to Urgent Care

Community care

In order for people to receive the support that they need in a community or home setting, the NHS needs a workforce trained with the right skills, in the right number with the right behaviours in primary and community care settings. This will help to better manage long term conditions by increasing shift to the community and power to the patient (HEE 2013). Current staff not only need to develop the skills to care for people with multi-morbidities that span mental and physical health, but they also need to develop the skills to act as a 'partner' and 'facilitator', rather than an 'authority' and this will require significant cultural change (Imison et al., 2013; Mind 2011).

The organisation of community services got back on track following Lord Darzi's NHS Next Stage Review (2008) which reported that community health services have a vital role to play in delivering care closer to people's homes, but they are not yet fit for purpose. Community services have suffered many years of neglect with specialists sitting in hospitals, GPs in surgeries and community health service staff always on the move, often detached from primary and secondary care (Imison 2009). So, the services provided vary widely in terms of performance and productivity and the necessary facilities and support, both managerial and technological are often lacking. There is a pressing need for more specialist skills in primary and community care and for more generalist skills in hospital care. Across the sector, there needs to be much closer collaboration between generalists and specialists, hospital and community and mental and physical health workers. The NHS and social care sector needs multi skilled staff to work across these boundaries (Imison et al., 2013).

Primary mental health presentations for example account for 5% of emergency departments' attendances and mental health problems occur in 30-40% of unscheduled medical and surgical admissions (Himelhoc 2004; Blunt 2010). Mental health problems are one of the most common forms of co-morbidity, particularly among people from the most deprived population groups (Barnett et al., 2012). On site liaison psychiatry services are needed in acute hospitals and crisis response mental health services are required to support community pathways (Fernandes 2011). An account on getting to 'grips with integrated 24/7 emergency and urgent care reported that individual urgent care providers in areas sampled (East Kent and North West) worked very well but this did not stop the erratic patient flow, taking the worst turn if mental health issues were put in the mix (NHS Alliance 2012). The lack of access to mental health crisis care contributes to situations that often involve contact with the police or child protection services, before a person seeks or receives support (DOH 2014). For some people, poor previous experience of services leads to a reluctance to have further engagement. The DOH published a Mental Health Crisis Care Concordat in which the NHS mandate for 2014-15 is to ensure that every community develops plans, based on the principles set out in this Concordat that means no one in crisis will be turned away. The Concordat signatories believe

responses to people in crisis should be the most community-based, closest to home, least restrictive option available, and should be the most appropriate to the particular needs of the individual.

Competent, convenient mental health assessment and psychosocial intervention are rarely delivered in the right place, at the right time and by the right person. Southern et al., (2007) suggest that integrating mental health services into urgent care in the community could be a solution to this problem. Realising the vision of an integrated system requires the NHS to invest in changing the culture as well as new practices and technologies. The dominant NHS workforce culture uncompromisingly focuses on clinical excellence and shows resistance to more equal working relationships between management, clinicians, patients, non-clinical practitioners and communities. The workforce culture is also led by an approach that focuses on individual body parts rather than the wider determinants of health (Horne et al 2013). The shift in culture will be more rewarding for both professionals and patients, and more financially sustainable.

GP Practices

Good primary care systems emphasise personalised, comprehensive and coordinated care (Stange, 2009). Although standards exist for monitoring OOH services, these are inconsistently applied and there is no clear mechanism for routine national reporting and discussion (RCGP 2007). Despite politically driven initiatives such as intended to make primary care/ GPs more accessible, general practice has become a Monday to Friday, daytime service with increasing emphasis on health promotion, disease prevention and chronic disease management. The changes to the GP contract in 2004 included a crucial shift in responsibility for out of hours care from individual GPs to PCTs. GPs are no longer necessarily the first contact when patients need or want to gain access to particularly unplanned care (Cox 2006, Lone 2012). Patients are choosing with their feet and opting for other routes to obtain health care. EDs, minor injuries units, walk-in centres, NHS Direct/ 111, palliative care teams and the NHS Ambulance Service increasingly provide the advice, attention and care formerly given by GPs and primary healthcare teams (Cox). Although GP practices are not contractually responsible for OOH work, they should champion and influence optimal care for their patients (Lakhani 2007).

The national workforce analysis highlighted a growth in the GP workforce in England but there is unequal access to GPs between areas of high and low deprivation. The workforce analysis further stresses that the GP workforce is under significant pressure in some areas, with insufficient capacity to meet needs (NHS England 2013, CFWI 2011). GPs are doing all they can but are being seriously crippled by a toxic mix of increasing workloads and ever-dwindling budgets, leaving patients waiting too long for an appointment and not receiving the time or attention they need and that GPs want to give them (Triggle 2014 BBC Health correspondent).

There is no evidence to suggest that patients who have accessed primary care out-of-hours through the ED gateway in their local hospital understand any better than they ever did that such Departments are ill-equipped to meet their needs. Thus they wait for many hours to be treated by staff whose training and experience is wholly different from that of a primary care physician (Department of Health

2000). A change in GP behaviours would go a long way in supporting, managing demand in primary care and providing joined up out of hour's services. There is lack of consistency for patients accessing GP services for urgent care. While many people find it difficult to get advice or an appointment with their GP when in need of urgent care, others applaud the urgent appointment system and ring back services available at their GP surgery and this varies greatly between GP practices (Patient and Client Council 2013).

Although GPs are no longer contractually responsible for OOH work, Practices must have systems in place for alerting urgent care providers to patients with complex care needs (Lakhani et al 2007). Nonetheless, the lack of detailed information about quality or GP workload leaves a significant gap in understanding the primary care system (King's Fund 2013). Any efforts that GPs make to reduce admissions will not be productive because there is no control over the other stakeholders who refer patients to the emergency department or admit patients to hospital (Lone 2012). Patterson et al., (2014) emphasised that if the primary care pipeline is to be maintained and expanded, it is important that workforce planners and policymakers are able to accurately assess the availability of primary care.

Britinell (2005) maintains that the principle providers of out-of-hours care are still GPs themselves working in cooperatives, pricing themselves highly especially over bank holidays. In a market economy, the NHS should not be sustaining payments of this magnitude when alternative providers such as nurse and paramedic emergency care practitioners exist and more can be trained. Extended prescribing rights for nurses and pharmacists will enable them to extend the ranges of their clinical practice (Avery et al., 2005).

Pharmacies

Although there appears to be adequate commercial high street pharmacy provision in towns and cities, and dispensing practices in rural areas, greater use of the skills of pharmacists to provide advice about minor ailments and actively promote self-care and anticipatory care in people with long-term conditions has not been fully exploited (Fernandes 2011). The clinical training that pharmacists get is sufficient for them to do much more like providing direct patient care than just dispensing medicines. Pharmacists increasingly provide services that help people stay well and use their medicines to best effect. However, the pace of change remains slow, and financial and structural incentives are not sufficiently aligned to support this initiative. Robotic dispensing and online prescribing, combined with the use of technicians to do much of the work of dispensing continues to threaten the future existence of community pharmacies (Smith 2013).

There is a window of opportunity for pharmacists to participate in urgent care and the care of vulnerable older people with LTC, who typically rely on multiple medications, yet sometimes the drugs are not taken as intended. High street presence and long opening hours mean that community pharmacies have the potential to play a crucial role in new models of out-of-hours primary and urgent care (Smith et al. 2013). For the system to respond accordingly, the NHS England should do more to support general practice federations and primary care networks, including pharmacy providers, community and voluntary sector services to work together at developing innovative ideas for

improving urgent care, based on their understanding of local resources and needs (NHS Confederation 2014a).

Ambulance Services

Increasingly, ambulance services are recognised as having a wider role, being pivotal to the performance of the entire urgent and emergency care system. Ambulance services have developed considerably from the days when their only response was to transport patients to hospitals. There is compelling evidence to demonstrate that paramedic practitioners can treat people effectively at home with high levels of patient satisfaction. Ambulance services now manage between 30% and 50% of all 999 calls without taking a person to a hospital, by providing advice (hear & treat), referring to an appropriate alternative service (see & refer), or by treating the person on scene (see & treat). As a result of the implementation of these local services, the role of NHS ambulance services, and the skills and competencies of their clinicians, has changed significantly (Cook et al., 2009; Mason et al., 2007; NHS Confederation 2014b). Like the College of Paramedics, the SECAMB paramedic career framework lists different levels of paramedic practice including: emergency care support worker, ambulance technician, paramedic, paramedic practitioners & critical care paramedics, advanced paramedic, consultant paramedic and clinical director of service. The different practitioner levels have associated levels of training and education (Newton 2009).

Ambulance clinicians, predominantly paramedics, face a number of challenges when responding to older people, especially those who live alone or are cognitively impaired. This combined with polypharmacy; complex co-morbidities and a frequent lack of patient information make the assessment of urgent rather than emergency conditions more difficult and the decision to manage the individual safely at home certainly more challenging. Lack of an integrated community-based approach in risk assessment and information sharing adds to this intricate task (Cook et al., 2009). The training and deployment of ambulance Emergency Care Practitioners (ECPs) is highly variable across the country. ECPs work to a medical model with the attitude, skills and knowledge base to deliver holistic care and treatment within the pre-hospital, primary and acute care settings with a broadly defined level of autonomy (Ainsworth-Smith 2012). It is essential that ECPs are trained to [national standards](#) (Skills for Health/ Department of Health 2007) which include an assessment of competence with appropriate monitoring (Khalani 2007, PEEP report 2013). Khalani suggests that ECPs should work within a proper clinical and educational governance structure under the guidance of a GP, as GPs have the experience of providing comprehensive urgent care

In their audit of the cost effectiveness of ambulance services to patients seeking urgent and emergency care, National Audit Office (2011) highlighted inconsistencies in performance measurement criteria, meaning performance cannot always be compared across the sector. It is more applicable for ambulance services to have a clear understanding of the extent to which ambulance crews are utilised. However there is no consensus among ambulance services on the best way to measure resource utilisation, or what 'good performance' looks like (NAO 2011). The lack of data on patient outcomes and comparative information that can be used to benchmark performance limits the ability to improve a highly regarded public service.

Call assessment is a key operational function for ambulance services. The requirement to assess, prioritise and provide an appropriate and timely response to emergency calls based on clinical need is the principal measure of ambulance service performance (Turner 2008). The evaluation of the safety and accuracy of NHS Pathways demonstrated shortfalls in the operational function, with the majority of complaints emanating from call handlers failings to apply the correct path, resulting in the wrong disposition (Turner 2008). This was resonated with concerns about the sufficiency of the level and depth of clinical knowledge provided in the training course falling below the level of knowledge required for NHS pathways.

In April 2011 clinical quality indicators replaced the four hour waiting standard in EDs and the category B, 19 minute response time target for ambulance services. This was aimed to provide a more balanced and comprehensive view of the quality of care. The Increased demand for emergency care services from category A, ambulance (immediately life-threatening) incidents was found to be a key driver behind periods of lower performance at EDs (Beyer et al., 2009). Findings from the King Fund research (2013) reported poor and high risk ambulance handovers mainly because staff regarded patients waiting in ambulances, or in corridors with ambulance crews in attendance, as being relatively 'safe' and not their direct responsibility. Ambulance handover was not taken as a priority and resulted in delays and clinical risk. Effective handover contributes to adequate management of patient and information flow across departmental and organisational boundaries. Handover can be rendered ineffective by errors in communication between the two parties and this can be detrimental to the patient (Iedema et. al, 2012). Documentation can be of variable accuracy and quality since there is a general tendency for people to write less in situations of high workload. Documents should be supplemented with a verbal handover as information may be communicated inadequately, be forgotten or shortened (Sujan and Spurgeon 2013). A pre- alert about a patient being conveyed to the ED enables adequate preparation and allocation of resources in the ED.

The concept of 'flow' is a prerequisite to efficient, safe and effective care of patients in emergency departments and AMUs. Delays in patient flow through the hospital are exacerbated by workforce, demand issues at the 'front door, and insufficient bed capacity within the hospital (RCP et al., 2013). One of the ways to tackle this is to have a combination of advanced practitioners and consultants making clear decisions at the front door and taking patient care beyond the traditional hospital walls by using beds in nursing and residential homes and in the patient's own home (Edwards 2013).

The most advanced practitioners are not often used in ways that make full use of their skills (NAO 2011). A closer engagement of this workforce with pre-hospital urgent care and prevention of hospital admission should benefit the wider community (PEEP report 2013, Vile 2013). To enable this situation to be realised, a more robust education and training system needs to be in place (PEEP report.) Health Education England needs to continue to support the development of more community based services through, for example, enhancing advanced practitioner, physician associates, pharmacists and paramedic roles (NHS Confederation 2014a&b).

The current education and training model in England is very locally determined, resulting in very different student experiences and different levels of learning outcomes achieved at the point of registration. Since 2006 September, SECAmb embraced the educationally-based preparation for paramedics to increase the quality of inputs to the paramedic training and education process. The preparation for paramedics moved from an occupational training based model to one that is now predominately established on a university-based educational curriculum and Higher Education Institutions partnership. The time taken to produce an individual paramedic lengthened and this led to a period a fall in the numbers of paramedics. SECAmb however were not concerned by the fall in numbers urging that paramedic numbers alone have little effect on how efficiently they are utilised to meet patient need but the intelligent use of the resource that involves focused tasking and more logical deployment practice (Newton 2009).

Ambulance services have the potential to meet a higher proportion of urgent and emergency care demand and prevent onward transportation to hospital. However ambulance services do not currently have sufficient clinically-trained staff to achieve this (NHS England 2013). In the NAO (2011) audit report, ambulance services were found to be funding a costly over time budget (nearly 80 million per year) to cope with the management of matching staff availability with demand. High sickness absence rates contribute to poor resource utilisation and reliance on overtime. Quaille (2013) suggests that the urgent need is to develop an ambulance services workforce with advanced clinical decision making skills.

The UK has more difficulties in managing the increased demand for emergency care within a reducing resource of inpatient beds and deployment of medical staff than other western healthcare systems (RCP 2012). Despite the high cost of hospitalisation, the NHS has been slow to develop comprehensive and, effective alternatives to admission. Although the demand for 24 hours, seven days per week urgent care continues to rise, the current drive to seven-day working in secondary care is not matched in the community (RCP 2012). The fragmented out-of-hours GP coverage is fragmented and is supplied by agencies more frequently since the introduction of the new contract in 2004. This frustrates efforts to avoid out-of-hours hospital admissions and prolongs the length of stay for inpatients unable to access pathways out of hospital seven days per week, disrupting the capacity to manage new admissions (Purdy 2010).

3.4.4. The urgent care workforce

The shortage of senior staff in emergency departments is an on-going crisis raised in different fora. For example audit reports (NAO 2013, Parliament Health Committee, the media (PULSE), and medical journals (BMJ: Gould 2013, Limb 2013, Roland 2013, Lacobucci 2013). This is said to threaten the future of sustainable high quality emergency care by highly skilled emergency medicine specialists (Schneider et al 2010). The UK Borders Agency levied a number of new restrictions on Tier 1 or eligible Tier 2 immigrants in 2012 which have further limited the supply of qualified emergency medicine doctors previously sourced from non-EU countries (HCL 2013). In 2006 the DOH introduced guidelines according to which, hospitals must prove they cannot recruit a junior doctor from the UK before they shortlist candidates from other countries (Snow and Jones 2011). Evidence clearly demonstrates that the UK has a chronic shortage of emergency medics and that less students are choosing to enter the

profession and the recruitment of both EU and non-EU doctors has been recently discussed as a method of raising clinical standards in the NHS (HCL 2013). The College of Emergency Medicine (CEM) is worried that staffing of Emergency Departments has lagged dramatically behind with neglect and limited investment over the past 10-20 years and suggests that an expansion in consultant numbers is needed as a matter of urgency (Centre for Workforce Intelligence (CFWI) 2011). The BMA however persist that this could displace graduates of UK medical schools creating medical unemployment (Adams 2012). HCL (2013) believe that the real emergency in the UK's emergency departments lies in the chronic shortage of trained medics which, unless urgently and nationally addressed, will reach crisis point in the future.

The suggestion that hospital based specialties could consider a reduction in future training numbers or plan a workforce with a different skills mix is neither ideal nor applicable to emergency medicine due to the shortage of consultants and the still to be realised impact of the introduction of Regional Trauma Networks (RTN) (CFWI 2012).

The inability of Trusts to recruit doctors to substantive posts in EDs has already led to an increase in the use of locums to deliver services, putting cumulative pressure on acute trust resources (HCL 2013; Broad 2010; RCS Policy Unit 2010). The current coping strategies are untenable and with average spends of over £500 000 per trust on locums to staff emergency departments, it is self-evident that the money exists to solve this crisis (Gould 2013). If no changes are made to the current system the NHS will be spending around £6billion on consultant salaries by 2020 CFWI (2012). This is a highly unsustainable prospect given that the NHS challenge of making long-term savings with a target of £20 billion of efficiency savings by 2014 has not been realised.

The widespread tactical reliance on emergency medicine locum doctors is further aggravated by the intense competition for these medics which encourages some unregulated commercial staffing agencies, which operate 'off-framework', to attempt to hold the NHS to ransom by supplying candidates to the highest bidder. This is happening against the national procurement frameworks and again is a symptom of Trusts operating pre-emptively and reacting to urgent situations. The result is a leakage from the framework, opening the system to unnecessary costs and risk as off-framework providers are not always as committed to value or compliance as those on-frameworks (HCL 2013).

Despite the best efforts of the staff who work there, many hospitals and their emergency departments do not have consistent consultant presence overnight or at weekends. The report on the evaluation of consultant input into acute medical admissions management revealed that mortality is greater for patients who are admitted at weekends and this appears unrelated to illness severity (RCP 2010). Consultant led intervention in acute care settings is beneficial where rapid diagnosis, with appropriate investigations and clinical response to the patient's condition is paramount (RCP 2007). However consultant provision outside of normal working hours is a real concern. The situation would evolve if more acute physicians are appointed to achieve a 12-hour, 7-day (12/7) consultant presence on the Acute Medical Unit (AMU) but this involves significant challenges. For example extending the hours of acute physician presence on the AMUs into weekends bears a risk of compromising weekday service provision (RCP October 2012).

The workforce crisis lingers, following five years of increasing difficulties in recruiting into acute and emergency medicine with gaps in training schemes, an increasing reliance on locums, and unfilled consultant posts. This also includes three successive years of only 50% fill rates for emergency medicine trainees, resulting in a 'lost cohort' of over 200 potential consultants. As a result, all UK emergency departments have a significant shortfall in senior trainees which affects service delivery and patient safety on a daily basis (CEM 2012). The impact falls on the effectiveness of the urgent and emergency care system, which depends on collaborative partnerships with other services and specialties that are crucial to improving care pathways and outcomes (NHS Confederation 2014a). Support services available also vary considerably, with 1 in 7 lacking at least one "essential" on-site service, such as critical care, acute medicine, acute surgery or trauma and orthopaedics (NHS England 2013). Gould (2013) emphasises the need for long term measures to deal with the shortage of consultants, trainees and experienced nurses in emergency departments. (Phase 2 of Sir Keogh's review is yet to report on potential solutions to these issues). Without a skilled workforce there is no NHS. The current and future healthcare workforce will be the means by which the ambitions of the NHS are realised (HEE July 2013).

The British Medical Association believe that physician associates could be "a valued part of the NHS," but that the scope of their work needs to be clear so that they can best provide an intermediate level of care and reduce workload pressures. 15 per cent of existing physician associates work in NHS emergency departments and the Department of Health keen to increase the numbers, working in emergency medicine (Porter 2014). The Royal College of Physicians (RCP) describes them as dependent practitioners who, work within their sphere of competence and therefore must be supervised by a doctor. Currently, physician associates are not nationally licensed but they can join the Managed Voluntary Register administered by the UK Association of Physician Associates (UKAPA) (Rimmer 2014).

Careers in the emergency and acute medicine need to be made more attractive possibly through reflecting the challenging nature of the job in the level of pay, and providing greater opportunities for professionals to move into other specialties later in their careers (or management / teaching leadership roles portrays careers in the emergency medicines as attractive career opportunities (Ham 2013). A national survey of emergency nurses revealed a highly stressed workforce that is heaving under the pressure of increasing patient numbers and staff shortages. A quarter of the 263 respondents surveyed reported their expectation to leave the speciality practice within two years (Trueland 2013). In their study of the workforce in emergency medicine, Patrick et al. (2007) found that the emergency nursing workforce is aging and career goals are changing. New graduates are filling more positions, and thus limited experience presents a challenge to providing quality patient care (Lintern 2012). Patrick et al call for innovative nurse staffing and retention programs to meet such ordeals in the future challenges of emergency patient care.

East Kent has a workforce plan that details commissioned education and CPD for both medical and non- medical staff; and the specific Further Education partners with respective budgets. The workforce plan demonstrates a high rate of current staff fill against baseline and forecasted demand but no prediction to reflect the impact of education and training on available staff numbers. This

could not be compared across other partners because access to their workforce plans could not be attained.

The continuing shift from the acute sector to care closer to home will drive further changes in the way that the workforce is educated and trained, as the skills necessary to work as part of a multi-disciplinary team in a hospital are different to those required by individuals working autonomously out in the community where the homes of patients may become their primary place of work. Workforce planners need to be alert to both identifying and responding to such changes in their approach to workforce planning and through the education and training system (*HEE Strategic Intent 2013*). Demand is likely to increase further given the rise in prevalence of long term conditions. The challenge for workforce planners is how to balance demand with supply.

The approach to workforce planning must be predicated on addressing and supporting the CPD of the existing workforce (both qualified and support workers) and cannot simply be focused on producing the professional workforce of the future (*HEE Strategic Intent (2013)*). The most qualified health professionals play an important role but it should not be that they head the hierarchy of professions. They are likely to be more effective and their contribution more valued by service users if they contribute as part of a team or are available to teams for consultancy rather than always 'in charge' or wholly 'responsible' for care (*Mind 2011*).

Strengthening the urgent and emergency care workforce is a key priority to delivering high quality integrated urgent care across the patient pathway. This requires integrated and coordinated approaches that focus on critical steps in the 'supply chain' of the healthcare workforce and that also recognise the role that different components in the health economy play. It involves addressing capacity, management and working conditions, as well as a solid understanding of issues that affect the production, deployment, absorption in the health system, performance and motivation of the healthcare workforce (*Global Health Workforce Alliance 2013*).

3.4.5 Redesigning urgent care

In the first phase of the review for transforming urgent and emergency care services in England, (*NHS England 2013*) Sir Bruce proposed a two tier emergency service, remodelling existing emergency departments to differentiate between smaller emergency centres and larger trauma centres. Conversely the *NHS Confederation (2014a)* cautions against modelling emergency care networks on the major trauma network, with responsibility for system delivery resting with emergency centres. Patients with life-threatening conditions requiring the care of specialist major emergency centres comprise the smallest proportion of the urgent and emergency care population. The major concern is about whether assigning responsibility for system delivery and performance to the provider responsible for the smallest sub-set of patients is acceptable to the wider system, and if such providers are best placed to manage the complexity of workforce and skill mix deployment across primary, community and acute services. Ensuring that adequate staffing capacity and capability is maintained can be a challenging and complicated process. Even where there appears to be enough staff, the skills of the workforce must be considered because a very dilute skill mix of registered to non-registered staff can compromise patient safety. Professor Sir Bruce Keogh's review of 14 hospitals with elevated

mortality rates unearthed depending on non-registered and temporary staff as one of the sources of poor patient outcomes (Keogh 2013).

With a two tier emergency services system, it is unclear how governments will deal with the local unpopularity of downgrading emergency departments and how patients will be triaged to the scaled down departments (Roland and Boyle 2013). The innovation is likely to be frustrated by the chronic short supply of clinicians in England. Fernandes (2011) emphasises that models that are to be developed on a huge scale should have an unquestionable source of the workforce with the expertise needed to deal with urgent care presentations and make the right decisions. To a greater degree, Trusts with geographically separate minor and major services may find it difficult to manage effective patient flow and ensure that staff with the right skill sets are in the right areas at peak times (King's Fund 2013). On the other hand the NHS Confederation (2014a) presume that the two tier system might solve the NHS recruitment and retention challenge if emergency care networks can exercise the necessary autonomy around coordination to ensure the right staff are deployed in the right part of the system. The Confederation however emphasises that it is crucial that both levels are configured to make them an attractive place to work, with links between the networks and deaneries.

A whole systems approach is the most recent prescription to the long term solutions to redesigning urgent and emergency care. This requires a fundamental re-design of the whole pathway, including appropriate investment in primary, community and social care services and much better patient sign posting to these services (FTN 2013). The fragmented system depicts a lack of a clear system management and clinical governance across the emergency care system (both within individual hospitals and across the wider health community). The NHS Institute for Innovation and Improvement (2011) stipulates that a whole systems approach allows for the design and implementation of an ideal clinical model that will maximise outcomes. The aim is to shift care closer to home when it is safe and appropriate to do so to reduce avoidable hospital admissions and facilitate early discharges.

Units run by different organisations with no shared urgent care governance and limited consultant input have implications for staff training and supervision, effective patient management and patient safety. Workforce alignment is a key component that will ultimately improve patient experience and the quality of care. Training and development although necessary, require integrated models of care to tackle the current problems facing urgent care. This will help build on the strengths of the professional groups and shield their weaknesses in much of the existing workforce (Fernandes 2011).

The redesign of UEC should match the complexity of factors but its success depends on the ability of people to understand, share and play the expected roles (Muntlin et al., 2010; Kyle et al 2013). Successful implementation starts with engagement of people, most especially clinicians (Lega 2007). Healthcare professionals at times feel that the power to effect the necessary changes is beyond their control. For example in acute care the NHS values 'getting the patient out of the system as quickly as possible, an approach that restricts opportunities for interaction and collaboration (Muntlin et al., 2010).

Advocates for strong leadership to drive the creative reshaping of the system acknowledge that it is challenging to change a system that was built on different assumptions. But the changes if adopted will transform professional identities and roles, as well as challenge what patients expect from professionals (Horne et al., 2013). The key to delivering effective UEC is to ensure that the whole system is designed to support self-care and community care at home there by reducing unnecessary hospital admissions and facilitating early discharges (NHII 2011).

Emergency care networks (ECN) bear the responsibility to challenge and dissolve traditional boundaries between hospital and community based services, to facilitate a dialogue between primary and secondary care staff and to ensure the timely flow of information relevant to a patient's care (NHS England 2013). Although there is considerable variation in the organisation of ECN, a common feature of all networks is the focus on a whole systems approach to emergency and urgent care delivery with the network providing the organisational means of introducing change and achieving appropriate policy initiatives (Knowles 2011). NHS reforms in England have created systems with new institutions and organisations whose roles and functions are still being defined. This presents an opportunity to instil the values of a seamless and integrated service (Horne et al., 2013).

For the urgent care system to work together there needs to be a clear understanding of how the system as a whole performs as well as individual parts (Fernandes 2011). Clinical commissioners need to have an overview of the commissioning processes as a "whole system" to develop strategies which ensure: a coherent 24/7 urgent care service with greater consistency, improved quality and safety and improved patient experience (Fernandes 2011). The model of commissioning urgent and emergency care ought to be reconsidered to empower providers with a stronger leadership and responsibility in determining delivery. The King's Fund review (2013) suggested that the model of commissioning emergency care needs to change from an adversarial approach of micro-managing performance to one where CCGs take an oversight and scrutiny role, supported by a system dashboard that highlights capacity and demand.

Supporting changes in EDs and ambulance services is necessary but not sufficient to create a system and workforce apt for the future. Community, primary, mental and social care services need to be developed too to play their part in mastering a whole system demand (NHS Confederation 2014). Commissioners and local health boards should not assume that one model will fit all. One particular configuration of services for urgent care may not be appropriate in all communities and settings. Commissioners of urgent care and local health boards ought to be flexible and creative at providing personalised and community-specific solutions (Mind 2011). There is a real opportunity for the whole network to think afresh about how to get the best possible urgent care system across a local community. Some things are different and distinctive based on the needs of the local population or specific geography, but many other features are common across all (NHS Alliance 2011).

Healthcare policy for long term conditions is driving a shift toward primary care, multi-disciplinary teams and greater involvement of patients in their own care (HEE 2013). On the other hand the current healthcare workforce is trained for single episodes of treatment in hospitals. Systems need to steer away from 'continuing professional development' and embrace 'collaborative practice development'–

working across professions and not just developing individual professions (Albury 2013 cited in Imison 2013).

The prevalence of diabetes for example will impact on other NHS services and professions. Statistics show that there was an increase in conditions such as retinopathy (118%), stroke (87%), kidney failure (56%), cardiac failure (43%), angina (33%) and amputations (26%) as a result of complications from diabetes, between 2006 and 2010 (State of the Nation 2012, Diabetes UK). Many of these complications are avoidable with good risk assessment and early diagnosis, patient support and good on-going services, but require that public health strategies are part of the workforce planning processes. This evidence demonstrates the importance of the whole health and social care system working together to develop plans that can meet current and future challenges.

3.4.6. Health Information Systems

Presenting the 'right' data to diagnose issues within the system remains a challenge in the majority of NHS south England units reviewed by the King's Fund. In some NHS services, paper records are still extensively used and the mechanism for their routine retrieval needs to be considered (RCGP 2010). The paper based method for recording clinical notes can lead to fatal patient outcomes (Kings Fund 2013). The investigation into events that led to Penny Campbell's death discovered that the failure of the out of hours doctors to recognise the seriousness of her condition was partly due to practical problems involved in getting hold of notes from her previous consultations. This was a major system failure and a direct factor that led to Penny Campbell's death (Panel Report 2007). Stange (2009) postulates that Electronic medical records (EMRs) not only act as a monitoring tool for long-term conditions but also facilitate communication among clinicians serving the same patient, as well as communication with the patient). The American Medical Informatics Association (2008) identified core competences for people working with EMR in five domains including: i) health information literacy and skills; ii) health informatics skills using EMR; iii) privacy and confidentiality of health information; iv) health information/data technical security; and v) basic computer literacy skills. These competencies can be used by healthcare employers and other relevant organisations as part of on-going orientation and training programs for staff that use the EMR and health information in their daily roles.

Capacity, demand and performance management is hampered by problems with the quality of data or how it is reported (King's Fund 2013). The lack of system wide information and data collecting/coding systems does not allow a patient's progress to be tracked through the system or followed up easily (NHII 2011, Kings Fund 2013). In Kent, ED attendance rates for 2009/2010 were not chartered accurately due to the variation in quality and practice of submission of non-elective data across different local provider trust organisations (Joint Strategic Needs Assessment 2012).

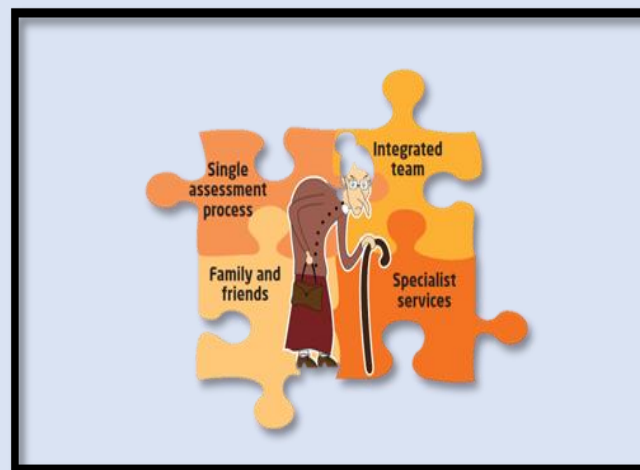
3.4.7. Innovations in Urgent Care

There is an obvious need to develop a less fragmented skilled workforce to support community care. However, it is not clear that this is happening at a sufficient scale or quickly enough (Kings Fund 2013). The current emphasis on the cost benefits of service integration has been overstated and the difficulties of maximising cost and quality benefits underestimated (Coupe 2013). Torbay continues to provide the best example of a successful set of community-based interventions that have reduced emergency admissions (Thistlethwaite 2011). Collaborative working makes the vision of providing seamless integrated care attainable instead of a major challenge (Assid 2011).

Case study 2

Integrating health and social care in Torbay

Integrating health and social care for older people in Torbay evolved from small-scale beginnings to system-wide change. The focus was on how health and social care for Mrs. Smith (a fictitious character) could be improved. Teams worked closely with general practices to provide care and to help Mrs. Smith live independently in the community. The appointment of health and social care coordinators was an important innovation in harnessing the contribution of all team members in improving care. Co-ordinators do not have formal professional training but know how to harness the contribution of team members to improve the care of Mrs Smith and people like her. The work of co-ordinators was underpinned by a commitment to sharing data, enabling co-ordinators to access information about users from the hospital, general practices and the care trust.



3.4.8. Integrating health and social care

Integrated care takes various forms. In some circumstances, integration may focus on primary and secondary care and in others it may involve health and social care. In many cases, integrated care involves providers collaborating, but it may also entail integration between commissioners, as when budgets are pooled (Ham and Curry 2011).

Achieving integrated care requires those involved with planning and providing services to impose the patient's perspective as the organising principle of service delivery' (Shaw et al., 2011). Kent Community Health NHS Trust (KCHT) is one of the largest providers of NHS care in patients' homes and the community in England. Components of integrated care include: a system of risk stratification to determine which high-risk patients the multidisciplinary team are going to work with; co-located, mobile and flexible teams; a single assessment process with assistive technology at the core; and health and social care co-ordinators appointed in some localities (Kings Fund 2013). Their aim is to

provide high quality, value for money community-based services to prevent people from becoming unwell, to avoid going into hospital or to leave hospital earlier and to provide support closer to home.

Integrating health and adult social care services is especially important for children and young people; people with LTC; and older people whose needs are rarely either just 'medical' or 'social' (Thistlethwaite 2011, NHII 2010). All children's health systems need to be integrated with education and social care. Social care involvement in urgent care is crucial to avoid hospital admissions and/ or readmissions. This will require a huge cultural change as the social care workforce do not regard themselves as an emergency service (NHS Alliance 2012). Following the shocking failures that occurred at Mid Staffordshire NHS Foundation Trust, the Francis Inquiry (2009) concluded that a transformation of systems, leadership and culture is needed throughout the NHS. Cultural changes at organisational level are also instrumental to reducing the unscheduled demand for urgent and emergency care services (RCP et al 2013). For example the Southern Health NHS Foundation Trust, a merger between Hampshire Partnership NHS Foundation Trust and Hampshire Community Health Care has continued to observe several achievements, especially in the substantial reduction in EDs admissions of frail elderly patients, emanating from redesigning the primary–secondary care interface (Southern Health NHS FT 2011/2012). Such programmes require partner organisations to incorporate new values and behavioural models, both at clinical staff and managerial level (RCP et al 2013). More work is required to understand how networked solutions and integrated pathways can best support delivery of high quality care.

There are other good examples of individuals and organisations working together to create joined-up, integrated care that is centred on patients' needs ([Goodwin et al 2011](#)). The Newquay Pathfinder project for example provides integrated care to patients with long-term medical conditions, bringing together the NHS, Adult Social Care, the voluntary sector (Age UK) and local volunteers to provide a range of services to people identified as being in need of support. Together the integrated care team works towards achieving agreed and shared outcomes for the individual based on the shared management plans.

The Newquay Pathfinder approach involved analysing national and international best practices to identify a range of morbidities most receptive to supporting behaviour changes and reducing clinical demand. This was used as the evidence for a series of local shared care management plans. It was imperative that organisations participating in the pathfinder understood their respective roles and responsibilities. The shared care management plans define potential interventions to support a person to become more independent. The Newquay Pathfinder project evaluation report (2014) demonstrated a 30% non-elective emergency hospital admission reduction and a 40% reduction in non-elective emergency hospital admissions for long-term conditions. These results show that by working with people to understand their aspirations it is possible to improve peoples' own feeling of wellbeing; improve practitioners' morale and the efficiency of the team and to reduce costs across the system. The Newquay Pathfinder project was awarded the Health Service Journal Award for 'Managing Long Term Conditions' in early December 2013.

KCHT is one of the largest NHS community health providers in England, with a workforce of 5,500 staff. KCHT provides wide-ranging NHS care for people, in their community, in a range of settings including people's own homes; nursing homes; health clinics; community hospitals; minor injury units; a walk-in centre and in mobile units. During the period of the KCHT integrated performance review (2012/13), activity levels were found to be below plan for a number of the larger Adult Services e.g. Community Nursing, Community Matrons and ICT, seemingly attributed to the late submission of data rather than true underperformance (Integrated Performance Report - 2012/2013).

The KCHT continues to experience a steady increase in staff sickness absence levels with the main reason being musculoskeletal followed by stress/depression (KCHT 2012/13) and yet the community hospital is significantly understaffed benchmarked against the Royal College of Nursing (RCN) recommendation (KCHT Quality Committee meeting minutes 07.02.12). The TUPE transfer of staff in the Child and Adolescent mental Health Service (CAMHS) service following the loss of this service and compulsory redundancies associated with the Wheelchair Service redesign resulted into an increase in the overall (planned and unplanned) turnover. The high reliance on agency staff is costly and does not cater for continuity of care. In 2012/13 the KCHT costs for temporary staff were £5,144k, representing 5.8% of the pay bill.

Case studies of projects aimed to improve the flow of patients in emergency department's show the explosion of small schemes has led to unhelpful complexity which uses up time and resources. Some of these schemes are said to be based on manipulating price differences between hospital and community settings that may not be a true reflection of the actual cost. They are often too small to make a major impact and their evaluation has been patchy, based on hunches rather than evidence (Edwards 2013). There is inconsistency in the audit, monitoring and evaluation of approaches and projects. Schemes are plasters on a complex system and may have a limited impact on flow through the whole system. A focus on a single problem rather than the whole patient journey may also not be very appropriate for some service use. Where community approaches have been more successful they have tended to be large scale and integrated with other services (King's Fund 2013).

While there seems to be consensus on what constitutes an effective intervention, there is much less evidence in the area of community services and the success of different approaches seems to be more context based (King's Fund 2013). Integrated care does not appear to evolve as a natural response to emerging care needs in any system of care whether this is planned or market-driven. Achieving the benefits of integrated care requires strong system leadership, professional commitment, and good management (Ham et al., 2011). In integrated systems patients do not see the joins between services and information is available at every stage rather than having to take patient details many times. Then, when it is the right thing to do, hand over responsibility of care to other services or professionals, ensuring that the barriers are removed (Fernandes 2011).

As the drive to shift specialised and non-specialised care out of hospital gathers momentum, there is a greater demand for a skilled and competent community workforce to facilitate this shift. Patients in the community are now requiring more complex care and complicated nursing and therapy interventions than before. Traditionally, staffing has been linked to the number of beds and has not

taken into account changes in dependency or acuity (South West Commissioning Support 2014). To make a real impact, focus needs to be on key groups: the frail elderly at home; terminally ill patients; people in nursing and residential homes; some specific groups with particular chronic conditions such as heart failure (Emeny 2013). Sibbald 2004 found that changing the skill mix of the workforce is often regarded as the primary solution to contemporary constraints, such as skills shortages and the need to reduce health care costs, and in response to opportunities to maximise the benefits to patients from new treatments and programmes.

Work by the NHS Institute for Innovation and Improvement evidenced that there are four main stakeholder groups that need to play an active role in the whole systems improvement.

- ✚ Commissioning leaders to own the vision, facilitate negotiations in pursuit of the ideal model of care and to ensure that following redesign money follows the ideal model of care.
- ✚ Executive sponsors who will help to secure support from the organisation, ensure alignment with organisational priorities and strategic direction and to help overcome barriers that require senior leadership intervention
- ✚ Clinical lead to help influence peers and test acceptability of changes
- ✚ User involvement to provide a patient/family perspective on the service and proposed changes.

Heyworth (2010) believes that strengthening general practice to provide improved access at all hours, combined with consultant led emergency care in EDs with a colocation of primary care services 24/7, tailored to local demand will ensure safety, quality and cost savings required by commissioners in a service that the public deserves. However, the Sir Keogh review into the future of UEC called for more strategic approaches to reduce the complexity of the system for patients, with leadership across the whole system rather than attempted individual fixes. It is envisaged that reshaping primary care and chronic disease management; supporting patients in their own homes and in care homes; and providing flexible and timely community services to allow rapid patients discharge from hospital will relieve the growing insurmountable pressure on EDs (NHS England 2013). In the analysis of how well England's Urgent care services are performing, Hurst (2008) concluded that further improvements could be achieved through greater integration of services, better sharing of patient information and streamlining information gathering.

3.5. Standards for urgent care

The health economies that make the most progress are generally those that set and enforce clear service standards and create opportunities for peer review and constructive clinical challenge around standards (King's Fund 2013). Quality standards consider the complete care pathway, across public health, health and social care. The primary purpose of quality standards is to describe high-priority areas for quality improvement, which are aspirational but achievable, in a defined care or service area (National Institute for Clinical Excellence (NICE)).

Ham (2013) supposes that standardisation does not occur through telling clinicians what to do or asking them to comply with externally imposed targets and standards, but results from their commitment to provide the best possible care within available resources. Ham concludes that this cannot happen without well-developed clinical leadership at all levels, and works better when doctors take responsibility for actively managing the care of patients at all stages. The King's Fund research report (2013) identified a lack of internal professional standards (IPS) and their uniform adoption. The failure to consistently apply IPS can be typically regarded as a symptom of wider cultural issues, such as a lack of clinical engagement and a lack of focus on improving service quality.

The West Midlands Quality Review Service (WMQRS 2010) developed general [urgent care quality standards](#) following the patient's journey from their first contact with urgent care services through to discharge or transfer to the care of an appropriate specialty-specific team. These were aimed to improve the quality of urgent care services including primary care, ambulance services, Emergency Departments, acute medical and surgical admissions, acute Trust-wide and commissioning. In 2012 the [quality standards for acute medical units](#) were revised and published jointly by WMQRS and the Society for Acute Medicine (SAM). The Acute Medical Unit Standards link with the WMQRS Quality Standards (Qs) for Urgent Care which cover the whole urgent care pathway and are based on and support implementation of national strategies and guidance, including [NICE guidance and Quality Standards](#).

The Qs for primary care apply to general practice OOH, NHS Direct, Walk-In Centres, Urgent Care Centres and Minor Injuries Units. Where services are co-located with an Emergency Department, Quality Standards may be achieved through collaboration with or use of facilities within, the Emergency Department – so long as there is access to these services for patients attending the primary care facility.

The Urgent Care Qs cover the care of adults and young people aged 16 to 18 years. The Urgent Care Qs include the care of people with mental health problems attending primary care and hospital-based urgent care services. There are no standards for GP unscheduled appointments but it is assumed that the primary care Qs could be applied to these services. Cook et al., 2009 compiled a [Silver Book](#) which establishes standards for safe and effective emergency care of older people and provides an important reference for those commissioning such services or studying the quality of the care delivered. The end of life care guidelines for adults in emergency departments were developed to standardise and improve quality of clinical practice and facilities in end of life care (CEM 2012).

The [guidance and competences for providing urgent and emergency care services](#) published by the RCGP et al 2009 are for doctors and pharmacists whose objective is to extend their competences and skills within a formally accredited 'practitioners with special interests' (PwSI) framework.

Quality Standards for hospital-based urgent care for children under 16 years of age are covered by the [Standards for the Care of Critically Ill and Critically Injured Children](#). The [standards for children and young people in emergency care settings](#) provide healthcare professionals, providers, service planners

and commissioners with clear requirements of care applicable to all urgent and emergency care settings across the UK. Measurable and auditable, these standards are designed to improve the experience and outcomes of children and young people in their journey through the urgent and emergency care system (RCPCH 2012).

There is also a myriad of standards and service changes proposed by professional bodies to ensure patient safety and better use of specialists and those in training including: The [Facing the Future](#) standards and modelling for children's services; [EM Consultants – Workforce Recommendations](#); [Paramedics Standards of Proficiency](#) and [Emergency Surgery: Standards for unscheduled care](#) for emergency surgery provision, to mention a few.

Guidelines and standards for providing high quality urgent and emergency care also specify workforce specialists and the required competences that should be available at the different levels of urgent care. Hospitals have set standards and internal procedures that are not always adhered to, for mostly genuine reasons. Quite often job plans need to be renegotiated, the system is constrained by the shortage of key staff and the challenge seems to be getting harder. These systems are very fragile and vulnerable to fluctuations in demand, changes in staffing or a hold-up in the discharge process (Kings Fund 2013).

For example, quality standards (WMQRS 2010) require all urgent care services to have a nominated lead to ensure that the quality standards are implemented. In their audit report of 126 hospitals surveyed across England, Wales and Northern Ireland, the RCP (2010) indicated that some of the hospitals did not have first line responsibility for patient care. Many patients were found to be only seen by a consultant in AMU once per day in the acute phase of their illness and in up to a half of hospitals assessed consultants were undertaking simultaneous duties, contradictory to the set AMUs quality standards. Many large units could not demonstrate adequate monitoring facilities or staffing to manage acutely unwell medical patients.

The standard requirement for EDs to have 'sufficient junior doctors (FY1&2 or CT1-3), nurse practitioners and other registered practitioners with appropriate competences available to maintain the flow of patients through the Department and achieve waiting time targets for the expected number of patients' is a ridicule of the current EDs workforce situation. The NHS workforce as a whole is under considerable pressure, with reports of both existing and predicted shortages in many professional groups (Imison et al., 2013, RCN 2013, HCL 2013). Current staffing levels in the AMU and EDs do not match service demands and patient needs, to reflect both the numbers of patients and the times at which they are most likely to attend. An assessment of the current working practices of consultants and other senior decision makers in the EDs showed that 62 per cent of consultants reported that their current job plans are unsustainable (Hassan, et al., 2013). While the majority of trainees enjoy their time in the EDs, the number wishing to pursue a career in speciality continues to decline due to poor working conditions, the adverse work-life balance, a target driven culture and the absence of 24 hour support for the EDs (RCP 2012, NHS Confederation 2014). The involvement of senior doctors 24 hours a day and consultant presence at times of peak activity seven days a week is required to ensure timely patient care and flow in an ED. Many EDs do not have the recommended

number of emergency medicine consultants or middle grade doctors to support such a rota (NHS England 2013 00163)

The intended outcome for clinical supervision is 'a safe patient experience and an opportunity for clinical staff to reflect on their practice, develop their competence, maintain and improve standards. Clinical Supervision also provides a restorative function for staff. However the supervision that consultants can offer to trainees is often inadequate due to the pressure of clinical work and a fragmented team structure. Nearly a quarter of RCP fellows and members rate their hospitals' ability to deliver stable teams for patient care and education as poor or very poor (RCP 2012). The KCHT integrated performance report established gaps in access to clinical supervision (Integrated Performance Report - 2012/2013). The review of Preceptorship in Adult Nursing (2011) suggested that some Preceptees were not well supported and some were apparently quite concerned about their practice and lack of support. Given that 60% of the nursing workforce is newly qualified, the transition from student to qualified nurse should be a major concern for the NHS and Nurse Managers (Whitehead et al., 2011). The KCHT redesigned their preceptorship programme focusing on the main risks to patient safety and to support the development of the newly qualified registrant's competence and confidence including their transition from student to a responsible practitioner.

There is an average of six per cent (ranging up to 16 per cent) vacancy rate in nursing posts and the nursing shortage is creating serious difficulties in recruiting to these vacancies. Evidence gathered by the RCN shows that 22 per cent of trusts have to recruit from abroad and a further nine per cent are actively considering the possibility of doing so to plug these gaps. With rising demand for health care services, workforce shortages will have serious implications for staffing levels and the ability for providers to deliver safe, good quality care for patients (RCN 2013).

Nurses can be used in EDs to provide greater clinical leadership and address issues faced by other areas of the urgent and emergency care workforce. This can result in better patient outcomes at less cost. However there are no standard qualifications, role preparation or competencies for Emergency Nurse Practitioners and therefore a lack of clarity and consistency in the roles they perform (NHS England 2013: NHS LHP 2013). Due to lack of adequate monitoring systems in place, there is concern that some nurses and ECPs may be exposed to situations beyond their competencies. The opportunity to expand nursing roles and the roles of all health disciplines in EDs needs to be accompanied with strategies to support the basic but essential clinical practice elements such as teamwork, handover and effective communication, which are not likely to change when work roles do (Duffield et al 2010).

Over the last decade acute medicine has evolved into a distinct specialty, and now has full specialty status for medical trainees (Myers and Lees 2013). Despite this development and expansion of AMUs across the UK nursing was regarded as a hybrid of emergency care and general medical nursing with no official acknowledgement of it as a specialty, for nurses working in acute medicine. The Society for Acute Medicine (SAM) sought to address this anomaly through an integrated career and competency framework in acute medicine. The framework aimed to maximise the value of experiential learning through setting out the standards expected at each level of experience (Jones and Lees, 2009).

In the King's Fund report (2013), it was proposed that non-medical roles could be developed alongside national standards ensuring that levels of training and quality are maintained to maximise the potential of professional skill mix. This should be done to support and not to replace professionals in the system (Lakhani 2007). Duffield et al 2010 highlight inefficiencies that may arise out of this strategy including work duplication, lack of role clarity and professional regulatory difficulties, especially in instances where a title such as 'nurse practitioner' is used to refer to staff performing different roles. Staff and patients may be confused about the skill set or knowledge level of those providing their care (Duffield et al., 2009; McKenna et al., 2009). There can be more confusion over tasks and duties because of the lack of regulation and legislation that may surround the establishment of new roles (Daly and Carnwell, 2003; Rutherford et al., 2005). Berrings et al. (2008) suggest that it is essential that learning and training are carefully structured to take into account the skill, complexity and required knowledge of the clinical task. Duffield et al. (2010) caution that cross-boundary work is difficult to regulate when carried out by those without membership to professional bodies.

Children and young people should be cared for in environments that are specifically designed for their needs, separate from adult care settings. Play is seen as a right for all children and young people and they need access to age appropriate play facilities and recreational activities wherever they are looked after (NHII 2010). In their audit of acute paediatric service standards in the UK, the Royal College of Paediatrics and Child Health (RCPCH 2013) discovered that standards were not being met as regularly at weekends and evenings as they were between the hours of 9am and 5pm. At times of peak activity, when the standard of service should be at its most robust, the most senior, skilled and experienced staff were not always present. The RCPCH cautions that standards cannot be met with the current workforce, and current number of inpatient units. There will need to be a reduction of approximately 50 paediatric inpatient units in order for the defined acute service standards to be achieved with the current and proposed consultant workforce in the UK (RCPCH 2013).

In 2007 the Health Care Commission reported that 5% of acute emergency departments in England had insufficient cover for serious paediatric emergencies in the daytime, and 16% out of hours. The follow-up review in March 2009 found that the availability of trained staff in management of pain and life-support for children was insufficient in a significant proportion of the unit's surveyed (Healthcare commission 2009). It is essential that paediatrics is a 24/7 specialty, and consequently service planners should organise rotas more carefully around the needs of the child. This will require careful job planning, but the principles outlined in RCPCH guidance on the role of the consultant paediatrician in providing acute care in the hospital are paramount (RCPCH 2013).

The WMQRS require that all trust have regular collection of data and monitoring of: (a) activity levels (b) response times and locally agreed key performance indicators, (c) referrals to other services, including local Emergency Department/s and (d) compliance with national standards on clinical documentation. As seen in earlier sections good service needs to be mirrored but the regular collection of data is a standard requirement that many trusts struggle with. It is therefore essential that units ensure that their service is safe and sustainable by implementing robust audit and data collection programmes to demonstrate the quantitative impact of adhering to standards upon outcomes (RCPCH 2013)

3.5.1 Competences for urgent care

All urgent and emergency care providers are argued to ensure that practitioners with specialist skills are suitably qualified with demonstrable competences, training and experience. These factors underpin the delivery of safe high quality care (Fernandes 2011; RCPCH 2013). The Nursing and Midwifery Council (2009) use the term competence to refer to the skills and ability to practise safely and effectively without the need for supervision.

Several authors (Brook and Crouch, 2004; Charters et al., 2005; Griffin and Melby, 2006), cited in Duffield et al. (2010) are in consensus that the core skills that a range of health professionals working in EDs require include: undertaking a rapid and comprehensive clinical assessment and history taking; assessment of deviations from 'normal'; the capacity to assess, treat, refer or discharge; timely and effective clinical decision-making; cross-disciplinary teamwork; managing the staff and environment; providing education and research and leadership.

There is no benchmark for measuring clinical competency. The reliability and validity of instruments are rarely addressed and most are not specific or sensitive enough. There are questions of subjectivity; whether competence is measured using instruments or by assessors making judgments, biased assessments are likely to arise (Merotoja and Leino-kilpi 2001). According to the NHS knowledge and skills framework there are levels of competence: for example a competent nurse is able to demonstrate the knowledge, skills and behaviour required to provide safe and effective care for a group of patients utilising local policy, standards, guidelines and protocols. The experienced nurse is able to demonstrate all the former plus the ability to include teaching, mentoring, and appropriate delegation skills. Senior nurse should demonstrate the knowledge, skills and behaviour required to co-ordinate comprehensive, safe and effective practice for all groups of patients utilising local and national policy, standards, guidelines and protocols (SAM 2013).

The environment in which nurses in acute medicine work is dynamic and challenging, thus these nurses must have the ability to operate in an organised, focused manner, prioritising patients calmly under conditions of extreme pressure (Lees et al, 2013, Lees, 2012). Appropriate assessment and care for patients presenting to the AMU can only be delivered by nursing staff able to demonstrate very well developed skills regarding patient assessment, re-assessment, patient observation, immediate treatment, coordination and implementing good clinical decision-making skills (Myers and Lees 2013). Training staff in quality improvement techniques ensures high quality care, which often costs less as it reduces waste and unwarranted variations in care (Ham 2013).

In the Robert Francis report (2010) complaints recorded in the inquiry about care were predominantly focused on the emergency departments and the emergency assessments units. The majority of accounts related to basic nursing care as opposed to clinical errors leading to injury or death. The care provided evidently fell below the accepted standard. Issues highlighted in the report involved uncaring staff with poor attitudes towards service users, lack of training in the procedures that the staff had to

perform (continence care compromising infection) , staff not sufficiently qualified to cope with proper risk assessment and deficiencies in record keeping.

The competences seen as most essential for health care workers in older people teams are communication skills - both with patients, their carer's and other health and social care professionals. Others include an understanding of the physiology of ageing, comorbidities and polypharmacy to underpin knowledge to ensure accurate assessment of the older person in an emergency episode (Dawood 2012). Skills for care (2014) developed [common core principles and competences for social care and health workers working with adults at the end of life care](#). The guide is aimed at specialist workers and their managers, and describes the underpinning competences, knowledge and values they should have. Haas et al. 2013 found that care coordination and management of transitions between ambulatory care providers and community settings is often overlooked, episodic, and accountability is lacking. Supported by the American Academy of Ambulatory Care Nursing (AAACN) the authors (Haas et al.) worked with expert stakeholders to produce [Registered Nurse competences for care coordination and transition management](#).

PwSI need to first demonstrate that they are competent generalists. Competent practitioners are able to show:

- Good communication skills across a range of models (e.g., telephone, face-to-face) with patients, carers and colleagues
- The ability to explain risk and benefits of different treatment options
- Skill in involving patients and carers in the management of their condition(s) (Fernandes et al RCGP)

The competences for a PwSI in UEC encompass:

- ✚ Clinical management of urgent and emergency conditions
- ✚ Therapeutic use of medicines in the clinical management of urgent and emergency conditions
- ✚ Palliative care in the urgent and emergency setting
- ✚ Provision of urgent care for the elderly
- ✚ Clinical management of children within urgent and emergency care services
- ✚ Provision of urgent and emergency mental health care
- ✚ Consultation skills for urgent and emergency care
- ✚ Management and leadership within urgent and emergency care services

A practitioner should only be employed to work as a PwSI in urgent and emergency care once their competence for that service has been assessed and confirmed against the set standards. However in real practice emergency physicians who are not qualified to undertake the whole range of ED duties are recruited as consultants to ease the pressure arising from the shortage of consultants and nurses. Junior trainees are asked to practice beyond their level of competence and without appropriate or adequate supervision (Francis 2010, Collin 2010). Under the 'European Working Time Directive', junior doctors are limited to a 48- hour working week. Regulations under this legislation include mandatory rest period such as 11 hours rest a day, a right to a day off each week (British Medical Association). By limiting junior doctors working hours, training opportunities and experience is limited. The RCP evokes

that the pressure junior doctors feel working beyond their experience, particularly at night and weekends, has increased their sickness and vacancy rates (RCP 2010). Sufficient support and engagement is needed with the trainees throughout the process, to enable them devote appropriate time to their training (NHS Confederation 2014a).

It is vital that consultants and trainees have the skills, knowledge and time they need to make clinically appropriate decisions and communicate with patients (NHS England 2013, RCP et al., 2013). In a survey of consultant nurses in emergency care, Charters et al. (2005) established that the majority of participants were under prepared for their role especially in the domains of transformational leadership, education and training, and practice and service development. All participants had worked for two years in the speciality but 24 per cent of consultant nurses surveyed had changed Trusts. The change was attributed to lack of role clarity and the poorly defined organisational frameworks within which the consultant nurse roles were established.

The DOH is keen to train more physician associates with the hope that they will relieve the workload pressures experienced in emergency departments (Rimmer 2014). Most qualified physician associates work in the NHS, in areas such as acute adult general medicine, general practice, accident and emergency, and surgery. In 2010, the Royal College of Surgeons and the CEM joined the RCP and the Royal College of General Practitioners to revise the original and produce the current [competence and curriculum framework for the Physician Assistant](#). Once an Assured Voluntary Register for Physician Assistants is established, it is hoped that those who are on the Register will be given prescribing rights as a standard part of their role rather than an extended role (The RCP et al. 2012).

Decisions about determining the clinical roles of staff in an ED must be based on a particular ED context and relate to specific patients' needs plus staff capabilities (Duffield et al 2010). Children and young people present with a different range of clinical problems and symptoms, which may not be familiar to professionals who work only with adults (NHII 2010, 2011). Paediatric skills of the emergency department staff must be enhanced. This applies particularly to distinguishing minor from more serious illness, life support skills, stabilisation and transfer skills, and child protection awareness (RCPCH 2012, NHII 2011). All clinical staff should have minimum competencies including effective communication skills, recognition of the sick or injured child, basic life support skills and the ability to initiate appropriate treatment in accordance with locally agreed protocols and (RCPCH 12).

The Open University generated [a competency list for students pursuing a foundation degree or diploma of higher education in Paramedic Sciences](#). It is advised that the demonstration of these competences should be considered in addition to local organisation competency requirements. Paediatric skills maintenance may be difficult for Emergency Care Practitioners because critically sick children are often transported to emergency departments by car. A small percentage of 999 calls are to children, and only a small proportion of these actually have a condition requiring urgent intervention. The ED lead consultant for paediatrics should be familiar with the local ambulance training and equipment for paediatrics, and give advice where possible to help ambulance personnel maintain confidence in their skills (RCPCH 2012).

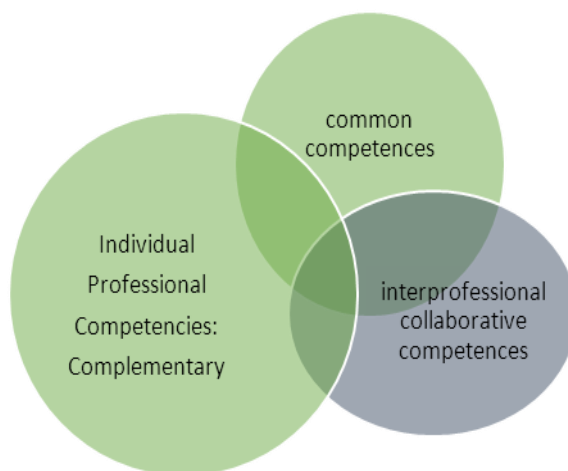
A number of different health professionals have contact with children and families needing urgent or emergency care, including GPs, nurse practitioners, radiologists, physician assistants, emergency care practitioners and pharmacists. Given the skill mix of professionals involved in the care of children with urgent care needs in different settings, whether face to face, by the telephone or through formal telephone triage and advice systems, multidisciplinary training and attainment of specified competencies should be envisaged in the future right across the care pathway (RCPCH 2012). It is the responsibility of individuals, the emergency care settings team, and the employing organisation to ensure any child or young person is reliably cared for by staff with the necessary competencies, at any time (NHII 2011).

There is a set of [common core skills and knowledge for the children's workforce](#) to enable multi-disciplinary teams and volunteers to work together more effectively in the interests of the child. These are bracketed in child and young person development; effective communication and engagement with children, young people and families; multi- agency and integrated working; safeguarding and promoting the welfare the child or young person and information sharing. In addition to these, the Royal College of Paediatrics and Child Health published, on behalf of other professional bodies including the RCGP, a list of expected [roles and competences](#) at six different levels of staff working with children in health care ranging from non- clinical staff to those with specialist roles.

For the future, it is extremely important that there is integrated workforce planning which recognises the multi-professional nature of pathways and networks for urgent and unscheduled care and that new working practices (for example the role of community children's nurses in supporting these pathways for children) are recognised and developed (RCPCH 2012). Interprofessional collaborative working is recognised and accepted as essential for effective health and social care delivery by governments across the world. Interprofessional, interactive learning promotes flexible, mutually supportive, patient centred and cost effective collaboration, not only in interprofessional teams, but also more widely within a policy-aware understanding of organisational relationships (Centre for the Advancement of Inter-professional Education (CAIPE) (2011).

An American Interprofessional Education Collaborative Expert Panel (IECEP) (2011) developed [core competences for interprofessional collaborative practice](#) to prepare all health professions students for working together with the common goal of building a safer and better patient-centred and community health care system. Cited in *IECEP (2011)*, Barr (1998) distinguishes between three types of professional competences as shown in figure 1 below:

Figure 1: Barr's (1998) three types of professional competencies



Cited in IECEP (2011)

Common competences are those expected of all health professionals. Although this can be a source of interprofessional tensions, the overlap may be an advantage in extending the reach of a health profession whose practitioners are inaccessible for various reasons. While post registration interprofessional education (IPE) changes practice, preregistration IPE can meet immediate objectives such as modifying common attitudes and perceptions and acquiring shared knowledge bases (Barr 2012). Individual competencies enhance the qualities of other professions in providing care while collaborative competencies are those that each profession needs to work together with others, such as other specialties within a profession, between professions, with patients and families, with non-professionals and volunteers, within and between organizations, within communities, and at a broader policy level IECEP (2011).

Collaborative competencies for health professionals provide a transformative direction for improving the health care system (Schmitt et al. 2011). The IECEP identified four interprofessional competency domains, each with a general defining statement and a set of specific behavioural sub-competencies that each learner should demonstrate by the end of preregistration or precertification education. The four interprofessional core competencies and corresponding general competency statements include³:

1. Values/ethics for interprofessional practice: Work with individuals of other professions to maintain a climate of mutual respect and shared values.
2. Roles/responsibilities: Use the knowledge of one's own role and of other professions' roles to appropriately assess and address the health care needs of the patients and populations served.
3. Interprofessional communication: Communicate with patients, families, communities, and other health professionals in a responsive and responsible manner that supports a team approach to the maintenance of health and the treatment of disease.

4. Teams and teamwork: Apply relationship-building values and the principles of team dynamics to perform effectively in different team roles to plan and deliver patient-centred care that is safe, timely, efficient, effective, and equitable (Schmitt et. al, 2011).

The urgent and emergency care system needs a workforce appropriately trained to identify risks and characteristics of abuse and understand the reporting, advice and communication systems in place locally with health partners and social services (NHII 2010, RCGP et al 2008). Emergency medicine, anaesthetic and paediatric trainees and consultants in these disciplines should be competent (i.e. have been trained and assessed) in advanced life support that is appropriate to their roles (RCPCH 2012).

Well-designed systems need constant senior attention and need to be adjusted and redesigned by people with an understanding of how these processes work (King's Fund 2013). A study by Smith et al., (2010) evidenced that there are some functions that GP commissioners are neither competent nor motivated to take on. While some of these functions would fall to the National Commissioning Board to perform, others are better undertaken at a local system level. Examples include joint commissioning with local authorities and other partners for services such as learning disabilities and mental health, and the reconfiguration of specialist services like stroke care and trauma services in order to achieve better outcomes.

High-quality commissioning requires extensive collaboration and the ability to work with partners across the health and social care system to deliver change. This collaboration needs to be backed up by strong transactional commissioning if aspirations are to be turned into reality (Smith et. al, 2013). Commissioners require a high level of technical competence to undertake the 'transactional' elements of commissioning but also need strong information management and technology capabilities to help them understand variation in outcomes, resource utilisation and performance, and to use this data to hold providers to account. There is no perfect substitute for good management and leadership that understands the system and can make it work. These can be weak points for some organisations and may partly explain why recommended practice is not acted upon or fails to become embedded (King's Fund 2013).

3.5.2. Enablers

Enabling factors are those aspects that are influential in solving the current workforce crisis in EDs creatively to promote sustainable transformational change (Manley et al 2009).

A culture of transparency and openness, where assumptions about the future are shared and challenged to ensure that the decisions made result in better care for patients (NHS England Strategic Intent Update 2013). In Sheffield for example, rigorous data collection coupled with a willingness to share data between speciality teams enabled staff to understand why change was necessary and to learn from each other's failures and successes. A constant focus on patients' needs, by gathering patient stories and using them as a driver for change, also helped to ensure that the programme remained patient centred (Health Foundation Inspiring Improvement 2013).

The NHS Alliance (2012) anticipate that the NHS 111 offers an opportunity to foster increased dialogue between all players in the urgent care system, including between providers and commissioners, and to develop a culture that is supportive of true collaboration and an integrated 24/7 emergency and urgent care system.

In the first report of the urgent and emergency care review, Sir Keogh (NHS England 2013) maintained that improved communication between the hospital and community would allow GPs and patients to obtain specialist advice in a more timely way, or directly access a clinic or similar service when required. Sir Keogh argues that by removing the barriers between the hospital and community, it is possible to build a network of care in which information and expertise flows to where it is needed when it is needed and therefore allowing urgent care to be provided closer to home.

Following the Robert Francis report (2010) Health Education England (HEE) committed to providing leadership for the education and training system. This would ensure that the workforce has the right skills, behaviours and training and is available in the right numbers, to support the delivery of excellent healthcare and drive improvement. HEE pledged to support healthcare providers and clinicians to take greater responsibility for planning and commissioning education and training through development of the Local Education and Training boards (LETBs), a model that facilitates fair access to training especially for people from disadvantaged backgrounds.

Imison et al., 2013 envisage that most of the professionals who will be working in the NHS in ten years' time are working in the NHS today. They suggest any workforce redesign needs to focus more on re-training or re-assigning/re-purposing the current workforce, so that they have the skills needed to deliver new models of care, than on the training of new junior medical staff. Building on the same assessment, Duffield et al., 2010 point out that redesigning the functions and tasks within current roles may enhance efficiency by eliminating overlap between related roles and ensure that staff members are able to better utilise their professional skills and knowledge and gain more job satisfaction.

Sir Keogh (NHS England 2013) upholds the notion of developing the existing workforce by citing opportunities for extending paramedic training to better assess, prescribe for and manage patients with exacerbations of chronic illnesses and work more closely with GPs and community teams. The expertise that paramedics and pharmacists retain can be utilised more effectively to bridge the gaps in urgent care key staff shortages. The NHS Confederation (2014a) suggests development of a range of sophisticated, whole-system outcomes-based indicators, akin to a balanced scorecard to make sure that the assessment of ambulance providers' performance does not rest on response targets alone.

Health Education England (2013) identified that demarcating funding for CPD for all healthcare professionals, and instituting process to facilitate protected learning and study time motivates healthcare professionals to aspire to higher standards of practice.

Medical revalidation is a recent procedure in the UK (*introduced in 2012*), which brings all licenced practitioners into a governed system that prioritises professional development and strengthens individual accountability. Achieved through regular participation in medical appraisal, the process ensures that the healthcare workforce is up to date and fit practice. The review of the early benefits and impact of medical revalidation (NHS Revalidation Support Team 2014) revealed that medical revalidation has the ability to improve safety, quality and effective delivery of care for patients. However the results presented mixed feelings where by some doctors felt that the system was not relevant to their needs. The NHS Revalidation Support Team concluded that while appraisal, continuing professional development (CPD) and personal development plans (PDPs) are still valued, the anxiety that revalidation may make these activities more procedural and less developmental cannot be ignored.

Given that one fifth of emergency admissions can be classed as preventable at EDs presents the NHS with an opportunity to curb the ever-increasing pressures on emergency departments (EDs), taking advantage of every prospect to care for patients at home or in their communities (Triggle 2013, Trueland 2013). Trueland nevertheless raises the concerns about the unpreparedness of the community infrastructure and hence the limited capacity in the system to care for frail old people who may still need to be admitted to hospitals.

3.5.3. Inhibitors

The King's Fund (2013) identified a number factors that challenge the ability to sustain good practice in urgent care including: a lack of attention to continuous monitoring and adjustment of the system; staffing pressures; and difficulties in changing job plans for doctors to ensure 24/7 cover. Moreover systems are fragile and vulnerable to fluctuations in demand, changes in staffing or any hold up in the discharge process.

HEE asserts that the urgent and emergency care workforce is challenged by demographic changes (e.g. age-retirement, gender – maternity); disease prevalence and innovations coupled with financial anxieties; and the unpopularity of unsociable hours all of which defy planning. For example, in the devised acute care toolkit⁴, the Royal College of Physicians (2012) expressed anxiety about the difficulty of maintaining the rate of increase in acute physician posts seen in the last ten years within the current financial climate.

According to the review of training in EDs carried out by the General Medical Council (GMC) (2013), understaffing and rigid rotas are making it challenging for doctors in training to attend regular teaching sessions and to take time out for study leave (GMC 2013). The high intensity of workload largely shifts the focus of doctors in training and their consultants to service provision, leading to opportunistic rather than managed learning. As a result unsatisfactory outcomes in the annual review of competence progression (ARCP) are increasing. The GMC review also established that approximately 25 per cent of doctors who could move into higher specialty training do not pass their Emergency

Medicine Membership Exam and end up repeating the training year, taking time out or leaving the specialty or the UK to practice abroad.

HCL (2013) perceive that the swift implementation of Regional Trauma Centres and associated operating standards created an impossible workforce situation as available qualified emergency care medics were absorbed into the trauma centres leaving the rest of the country unable to source staff. The need to have a consultant presence 24/7 in adult centres and 16/7 in children's centres is a significant upshift for the existing staffing but the consultant staff base is simply not ready or available. HCL argue that patients will get better trauma care but it will be many years before overall emergency medicine gets its national workforce planning back on track.

Unfilled posts impact on the rotas and the educational opportunities for doctors in training. EDs rely on irregular locum doctors without the speciality in emergency medicine to cover out of hours shifts henceforth compromising the quality of supervision that doctors in training get. Inexperienced locum doctors may need more support from the doctor in training than they are able to return (GMC 2013). Feedback gathered from medical leaders, trainees and other key stakeholders that attended the conference on 'Better Training Better Care (BTBC)' (2013) cited service demands, the culture of not valuing training, lack of local leadership and empowerment, heavy workloads and the bias against change as major barriers to continuing professional development.

Fernandes (2011) referred to inconsistencies in the training of medical and non-medical staff involved in providing urgent and emergency care, especially in the provision of supervised placements for undergraduate and postgraduate training. The Academy of Medical Royal Colleges (2007) warned that the opportunity for GPs to opt out of the GMS contract may adversely affect the training of future GPs. Some GP registrars may lose the opportunity to develop critical skills in risk management and clinical decision making. In order to make sure that there is uniformity in training and a secure supply of the workforce to the service and the higher education (HE) sector in England, the PEEP study established that the Local Education and Training Board (LETB) commissioned model is the most appropriate funding model with access to bursary support in line with other NHS non-medical trainees. In addition, the PEEEP study strongly recommended that the curriculum for training paramedics needs to include more leadership skills development and improved learning outcomes about dementia and mental health challenges. However Lovegrove and Davis (2013) raised a matter of concern relating to how the education sector and the profession would enhance the multi-professional learning opportunities for the students in view of the academic time period (2 years) allotted to the course.

In a similar vein Dixon and Ham (2010) argue that without the capacity to undertake local systems leadership, there is a risk that the potential gains of GP-led commissioning will be outweighed by the inability to take an overview of complex issues that cut across the responsibilities of individual GP consortia, such as organising specialised care and the reconfiguring acute hospitals. Feedback from the BTBC also pinpointed an opportunity for the larger workforce and portfolio of careers and trainees to focus and learn more about leadership and management issues using the present service as a mechanism for improved quality, safety and continuity of trainee care.

There is also a lack of knowledge among both medical and non-medical staff about the role of different professionals and the impact of different services involved in providing urgent and emergency care (Fernandes 2011). Role descriptions may need to be broader to encompass acute and community care. Feedback from the BTBC conference (2013) held in Manchester called for Royal Colleges to be engaged in defining 'a community service', including the different specialty descriptions. Teams remain the arrangement of choice for people when working in primary health care. However, community nurses – such as district nurses and health visitors are being distanced from existing practice based teams. Kyle et al. (2012) believe a shared understanding of the contribution of CCNTs and trusting relationships between practitioners would streamline working together. Lakhani et al. (2007) emphasised that the breakup of primary health care teams will work against efficient urgent care provision during the daytime. The NHS Confederation (2014a) asserts that solutions hinge on change happening across the system, and on leadership and shared responsibility that unite all parts of the service.

The fragmented approach to commissioning and the lack of strategic responsibility could make the NHS system-wide change more difficult to implement (NHS England 2013, Alberti 2004). The sheer scale of the challenge means that it cannot be tackled by NHS organisations working in isolation. The split and sometimes overlapping responsibilities between NHS England and Clinical Commissioning Groups over contracting urgent care create challenges for Commissioners to achieve the system wide objective (Monitor 2014). For example While CCGs are responsible for commissioning urgent care NHS England is responsible for commissioning urgent care from GP practices, to the extent that such care falls within the GP contract (NHS Commissioning Board 2012).

Capacity, demand and performance management is hampered by problems with the quality of data and how it is reported, resulting in a significant gap in understanding the primary care system. The King's Fund review (2013) highlighted inefficiencies in the current performance metrics in reflecting the whole system's responsibility for ensuring good patient flow and available capacity. The existing systems of medical records make it impossible to track the patient journey through urgent care at an individual level (NHS Alliance 2012). The situation is exacerbated by the lack of uniformity in clinical data coding as urgent care providers code patient information differently (Fernandes 2011). Similar issues were iterated in the review of the cost effectiveness of ambulances undertaken by NAO (2011), which found that the ambulance service collects a wide range of performance data. However, the different interpretations of data requested by the NHS Information Centre and the way services define some of the metrics make it hard for commissioners to benchmark the services they receive.

3.6. Service user perspectives

In the last few years, UK health policy has strengthened the input of patients in shaping health services for the future. The NHS has shown improvements in the level of user involvement in the planning, development and delivery of healthcare services nevertheless, there is limited evidence to show that such involvement has become routine (DOH 2008). Successful, effective delivery of urgent care depends upon patient empowerment so the College of Emergency Medicine must champion the patient perspective and involvement with service redesign (Lakhani 2007). The Next Stage Review (Darzi 2008) clearly and consistently highlighted that that people want a greater degree of control and

influence over their health and healthcare, especially those who for a variety of reasons find it harder to seek out services or make themselves heard. This section presents patients' experience in seeking and using urgent and emergency care services.

Measuring the patients' experience within the healthcare system provides the route for improving the quality of care that is being given (Darzi 2008). There are standard questionnaires to measure patients' experiences and views of individual services including in-hours general practice, (National Primary Care Research & Development Centre) out of hours primary care, (Salisbury et al., 2005) 999 ambulance emergency services (Dunckley et al., 2004) and emergency departments (Picker Institute Europe 2002). The urgent and emergency care system questionnaire captures the pathway experience of a patient between services (O'Cathain et al 2010). During the design and validation of the urgent and emergency care system questionnaire, it was established that longer pathways resulted in lower levels of patient satisfaction (Knowles 2011).

Users of urgent and emergency care tend to be system users with two-thirds of users contacting two or more services in the process of obtaining definitive care (Knowles et al 2011). Expectations of NHS users are rising and the lack of satisfaction is an indicator of lower quality care that may affect future care-seeking behaviour (DeLia et al., 2012); Lord Darzi 2008). Patients and service users judge services on speed of access rather than quality of care. Patients perceive rapid care as good care (Stern 2013). The level of patient satisfaction declines with perceived long waiting times and the care and information received from nurses. Satisfaction is lower among patients triaged no-urgent than the immediate and urgent triaged patients (Muntlin et al., 2006). For example Knowles et al., 2011; Nelson 2011) found that patients overall rate ambulance and EDs services entry points as satisfactory simply because access to these services does not require an appointment, the services are available 24 h a day 7 days a week, and they are long established services familiar to the population. Patients mainly seek basic treatment, such as technical competence, a positive attitude, information, a comfortable waiting room, privacy and confidentiality (Muntlin et al 2006).

The behaviours of patients, seeking care they do not need at the wrong place in the system is shaped by the systems they face. Stern (2013) points out that the more barriers to getting care when they feel they need it the more patients will do what it takes to get seen. When faced with complicated systems at a time of individual crises, going straight to the easiest point of access, often perceived to be the ED is common sense. The quality of patient care and experience is influenced by the clinical staff available and their seniority (Commission for Health Care Audit 2008). Identifying individuals who need rapid intervention, supported by screening all requests for home visits within minutes rather than hours can have a significant impact on the wider system, reducing avoidable admissions to hospital (Stern). Tsai (2010) suggested it may be more practical to change the way in which EDs provide care rather than attempting to change how patients seek care.

In the Sir Keogh review (NHS England 2013) interviewees described how NHS urgent care has become disjointed between GPs and specialists, between the community services and hospitals - resulting in many patients feeling confused and that they had no control and as to what they should do and where they should go. Urgent care has become out of step with how people live their lives. The King's Fund

report 2013 underlined that patients lost faith in the GP out of hours services and hence continue defaulting to EDs.

It is crucial that urgent care is configured around the needs of patients. Patients want coordinated services to work as a system because they often use two or more services in the process of obtaining definitive care for an urgent problem (O’Cathain 2008). Joint Nursing and medical documentation systems have been introduced in many EDs but they are not always effective. Patients get wary of being asked the same questions a number of times, which compromises the quality of care (Way et al. 2008). What most appeals to the patients is the possibility to rapidly carry out the tests and specialist consultations which they need all in just one place (Lega et al., 2008).

Research suggests that few patients make use of publicly available information on the quality of providers, and many people find it difficult to understand and interpret data (Dixon et al 2010; Boyce et al 2010). In practice most patients rely on personal experience and recommendations of GPs, friends and families when choosing where to go for hospital treatment (King’s Fund 2013). Some authors argue that educating the public does not produce effective change in the self-referral rate to EDs (Stern 2013; Martin et al 2002) as it addresses behaviour in a rational context rather than circumstances that are affected by pain and anxiety. However public education is essential for patients to learn about various aspects of out-of-hours primary health care providers so they know better what can be expected from these services (Charante et al., 2008; Yoffe et al 2011). Yoffe et al established that educating parents on how to navigate the health system allows parents to more effectively utilise the level of care appropriate for their child’s medical needs.

The WMQRS (2010) stipulate that patients and, with the patient’s agreement, relatives and carers should have the information, encouragement and support to enable them fully to participate in decisions about their care. In the Francis report (2010) patients’ attitude were characterised by a reluctance to insist on receiving basic care or medication for fear of upsetting staff (Nystrom et al 2003). Some members of staff were singled out for praise by patients, but concerns were expressed about the lack of compassion and uncaring attitude exhibited by others towards vulnerable patients and the marked indifference they showed to visitors. Patient experiences reported reflected that many times the staff fell below the required numbers and even where present, staff lacked a sufficiently caring attitude.

The study about patients’ perceptions of the quality of care at an emergency department indicated that the majority of identified areas for quality improvement were related to nursing care (Muntlin et al 2006). This is unmistakably not just a case of getting the workforce numbers right. When patient care suffers, it is often because the staff who are treating them have not been recruited or supported to have the right skills, values or behaviours (HEE 2013). Education and training aimed at developing emergency care workforce competence must deal with the importance of being present for and attentive to the patient, irrespective of the urgency of their health care needs (Nystrom et al 2003). Assid et al., (2011) evidenced that conflict management strategies as part of the education programmes are empowering tools and resources necessary to resolve patient concerns at the lowest level.

Families that participated in the NHS 'enhanced primary services for children's and young people's urgent care to prevent unnecessary attendance at hospital emergency departments' (NHS Institute for Innovation & Improvement 2010) consistently rated the advanced paediatric nurse practitioners (APNP) consultations as 'excellent' with regard to their overall satisfaction, and, more specifically, to indicators such as: the degree to which the APNP involved the parent/carer in the child's care; how well the APNP explained their child's health problem; the APNP's patience with questions or worries; the parent/carer's understanding of and ability to cope with their child's health concern (post-consultation) and parent/carer's perceived ability to keep their child healthy (post consultation). Once patients have accessed emergency care services, healthcare professionals need to use the opportunity to assist in future decision making by explaining how the patients' problems will be treated and the circumstances in which patients should seek help from primary or emergency care services again (Way et al. 2008)

The attitudes of the staff toward the patients are determined to a large extent by how well they consider the patient to fit in with the kind of care offered by the ED. Thus, there is a risk that the frequent visitors' basic problems will be ignored, as no one will take the time to listen to their stories and discover the personal meaning of the symptoms. This results in a detrimental effect on patient satisfaction (Olsson et al 2001). Patients prefer proactive behaviour from health professionals as it can allay patients' anxiety by making them feel that their concerns are being taken seriously and that staff could sort out problems such as feeling 'stuck in' or 'bounced around' the system (O'Cathain et al 2008).

Patients' perceived reality of care relates to their subjective importance estimations. The belief that a radiograph is necessary is an important aspect in the decision to present to an ED (Coleman et al., 2001; Nelson 2011). It is particularly important that an individual's meaning attached to symptoms is attended to and respected by emergency staff (Olsson 2001, Muntlin et al., 2006). Non urgent EDs users' conditions are regularly referred to as 'clinically inappropriate', a definition that is inaccurate since it is based on strictly clinical criteria and does not take into the psychological and social factors that can influence the choice of non-urgent patients for using the EDs (Lega 2008). Some patients may be unsure about the urgency of their condition and go to the ED to find out (Guttman et al., 2003). This is an important aspect of demand for care, since it is the patient's assessment of urgency that influences the initiation of an ED visit (DeLia 2012).

For mental health care, how people are treated whilst in distressful circumstances makes a huge impact on their recovery and willingness to seek help should they need it again. People overwhelmingly want is to be treated in a warm, caring, respectful way irrespective of the circumstances in which they come into contact with the service (Mind 2011; Way et al. 2008). In their evaluation of Urgent Care Teams, Curry (2006) reported that frequent movements between wards, possibly related to meeting government targets and waiting times was perceived by patients to mean they were a low priority group, being moved to make way for 'more important cases' or for those 'in more urgent need of care'. Patients in this study expressed feelings of disempowerment and disenfranchisement with little control over what happened to them in hospital.

A study that set out to learn from older people who use urgent care services unearthed the importance of clear communication with patients and their carer's as an aspect of emergency care. These interactions are governed by local and national standards for good practice, but their success in practice is determined by the ability of healthcare staff to think clearly about the special needs of older people in busy clinical environments (Way et al. 2008). This is resonated in the Pennie Case study (2013) whereby effective communication, competence and reassurance of staff offset the waiting times in the much liked open and spacious environment of the ambulatory care unit.

Patients tend to prefer not to be admitted to hospital. When they are admitted to a ward there are long periods of perceived inactivity, when they are awaiting diagnostics or test- results (Pennie case study 2013). Patients would rather have easier and flexible access to primary care (Cabinet Office 2000). The availability of extended or 24-hour community nursing services is cited as making a significant contribution to the more appropriate management of patients. These are limited and their ability to rapidly respond is variable (Knowles 2011, King's Fund 2013).

In England barriers to primary care access persist and are sufficient to influence ED utilisation (Keog and Jones-Berry 2013). Evidence shows that GP practices whose patients report to have more timely access to appointments have lower rates of EDs visits in which they refer themselves and are discharged (Argawal et al 2011, Cowling 2013). Patients value continuity of care and prefer to visit their GPs in search of a figure with whom to create a strong and long-lasting relationship, a professional who knows their clinical history and psycho-social situation and can offer an accurate and reliable interpretation of their health needs (Lega 2008, Cowlings 2013). This is said to be the type of "competence" and empathy valued by the GP surgery group. On the other hand, patients are willing to trade continuity of care, even when highly valued, for more rapid attention to an acute medical problem (DeLia 2012, Turner et al., 2007, Gerald et al 2008; Coulter & Magee 2003). While the GP surgery users interviewed in the Study by Lega et al (2008) were not fully aware of the diagnostic and therapeutic potential of the emergency service, they expressed that EDs staff lack empathy and competence. This is demonstrated by the experience of a patient with Parkinson's disease.

Patient Story 1 (Patient's own words)

"People with Parkinson's (PwP) being taken to A&E, or minor injuries, on their own may have all their meds with them but may not have a 'carer', and this can result in them being completely ignored for 5 hours or more during which time they should have had medication, food, water and the chance to use a toilet (bottle or equivalent). Even once the patient is seen the staff start 'ordering' medication rather than using what has come with the patient, so the patient becomes much worse (it is according to the books dangerous to stop PD meds suddenly) and stays in hospital for ages even if there was no good reason for their presence there in the first place. A&E doesn't (for good reason) serve food or drink or do 'care'(meds and 'bottles') and this makes it a very dangerous place for PwP to be! They could save the hospital a fortune by a) not taking people with Parkinson's unless there is a VERY good and obvious reason that will get treated immediately; b) highlighting Parkinson's at the Triage stage and dealing with it in a timely fashion and c) using medication that comes with a patient (with a little common sense that is sadly lacking in any situation where people might get sued!) I guess you all get the message; will they?" (Patient)

In the study by DeLia (2012) it was discovered that healthier patients tend to go to EDs more rapidly than sicker patients, which may be explained by the differences in preference for continuity. If sicker patients place relatively higher value on continuity, then they would be more inclined to seek care from a regular provider first and then use the ED only if that provider was inaccessible or recommended ED use (DeLia 2012). Findings in Curry's (2006) reflected that lack of continuity of care reduces the patients' ability to form relationships with staff in EDs and are often discharged with limited or fragmented information about their illness management. This in turn reinforces the patients' passive approach to self-care and instead patients rely on professionals to cope during crises.

From a patients' perspective, poor access to general practice, anxiety about the presenting problem, awareness and perceptions of the efficacy of the services available in the ED (Lega et al., 2008) and lack of alternative pathways are important predictors of EDs attendance rates (Argawal 2011; McClelland 2007). Most patients want the security of knowing that health services will be there when they need them, their views and preferences will be acknowledged by health professionals, they will be given the help they need to help themselves and that they can access reliable information about their condition and the treatment options (Coulter 2005).

4. Methodology and methods

A systematic practice development approach combined with a stakeholder evaluation has underpinned the project's approach to achieving the Phase 1 objectives. This approach was selected so as to mirror the ways of working required to enable whole systems approaches to urgent and emergency care.

Practice development is a complex intervention that involves using what is termed the 'CIP principles' to guide the project's process – collaboration, Inclusion and participation; combined with a systematic approach to evaluation and development based on establishing a shared purpose around person-centred, safe and effective workplace cultures that enable everyone to flourish (Manley et al 2011). This approach involves active participation to develop a shared purpose and to identify ways of achieving this purpose at a number of levels. Processes also focus on developing ownership for what needs to be done to achieve the shared purpose. In addition, practice development has been combined with a stakeholder evaluation of Fourth Generation Evaluation (Guba & Lincoln 1989) to draw on and work with the *claims, concerns and issues* of all stakeholders. Collaborative, inclusive and active participation with as many stakeholders as possible

has been directed to gaining new insights into current and future urgent and emergency care pathways and service gaps and the options for addressing them.

4.1. Methods

Phase one of this three phased project has taken place between April-October 2014. The scope of phase one was to develop and pilot a gap analysis tool to identify current workforce gaps and “pinch points” in urgent care pathways across one large trust (East Kent Hospitals), local ambulance services and community health care trust.

The methods employed in Phase 1 have involved:

- A comprehensive literature review to answer six questions
- Stakeholder events and engagement
- Short surveys targeted at hard to reach stakeholder groups
- Process mapping across ten areas identified from analysis of stakeholder data

4.1.1. A comprehensive literature review

The literature review has set the scene for this project report in relation to providing the national, regional and local context around the urgent and emergency care agenda where there are implications for workforce development by answering six questions;

1. What is urgent care?
2. What are the redesign, innovation and policy issues around urgent care
3. What are the standards for urgent care
4. What are the competences for urgent care
5. What are the enablers and Inhibitors
6. What are the service user perspectives on urgent care

The literature review also reviewed schemes, local and national, and identified urgent care needs and patterns across the country and the current and potential urgent care pathways across the health economy to inform the gap analysis.

4.1.2. Stakeholder Events

Four external stakeholder events were held across the region for a wide range of stakeholders, predominantly working at a strategic level – two at Gatwick (to facilitate wider engagement of regional colleagues across Surrey and Sussex) and two in Kent (Canterbury and Medway). The events aimed to gather information by using tools such as *Claims, concerns, issues* (Guba & Lincoln 1989) and *Values clarification exercise* (Warfield & Manley 1990) to begin to develop shared purpose and shared understanding around issues surrounding current and future urgent care.

The stakeholder events focused on:

- Understanding of 'urgent' care
- Ultimate purpose of urgent care
- How purpose is achieved
- Current urgent care pathways
- Potential/future urgent care pathways
- Enablers and inhibitors
- What would be happening in effective urgent care and how this would be recognised
- Key competences required for current and future integrated urgent and emergency care
- Perceived gaps in pathway competence
- Key roles in urgent care
- Other considerations

Table 1: Number of staff and service users attended these sessions with representation

Date	Number of attendees	Represented groups
25/6/14 Canterbury Christchurch	22	A&E, Community Services, Long Term Conditions, Acute Wards, Nursing, Medical, Service user, Health Visiting
9/6/14 (a.m.) Gatwick	16	Community Services, Long Term Conditions, Acute Wards, Nursing, Medical, Service user, Health Visiting, Lecturer's, Clinician
9/6/14 (p.m.) Gatwick	8	A&E, SECAMB, Commissioning Services, Therapies, AHP, Nursing, Out of Hours
25/6/14 Medway	15	Operations, Kent County Council, Workforce, Residential Homes, lecturer's, General manager UEC

Following these initial events further engagement events were facilitated across the three hospital sites within EKHUFT aiming to gain expert knowledge and experience from further stakeholder groups. The key groups in attendance at these sessions were

- Service users
- Voluntary sector
- Learning disabilities

Three other stakeholder events were conducted for inclusion of specific staff groups as yet not represented, these included;

- EKHUFT matron's forum
- IC24 staff
- Local Surgical care practitioners/Physicians assistants
- Local higher education institute providers of learning and development in relation to urgent and emergency care

These events were facilitated using 5 key questions aiming to distil further insight. A number of patient stories were also collected from service users in relation to their experience of urgent care.

A first level analysis was completed at each event around the information gathered to identify emerging themes under each of the areas explored. This was undertaken collaboratively with participants as an engagement strategy. Second level analysis across all stakeholder events was completed by the project team and the themes resulting are presented in Appendix 1. These themes were then used to identify specific overarching areas for deeper exploration through process mapping.

4.1.3. Survey

In order to gain representation from the whole health economy and also perspectives on current and future innovations and competences, i.e. community, residential/nursing homes, acute, and the broader community and social care perspectives, specific groups that appeared to be more difficult to engage, (reflected in minimal attendance at the stakeholder events), were sent a short electronic survey. These surveys were customised to the following stakeholder groups: GP surgeries, ambulance service, residential and nursing homes, IC24, community staff and acute hospital staff. A further survey was designed for the Kent Integration Champions – citizen representatives and also the general public. Table 2 provides the number of responses across East Kent. Appendix 2 provides details of the themes arising from the analysis.

Table 2: Survey responses

Group	Number of respondents	Number of responses
Ambulance Staff & Paramedics	1	6
Community & Hospital Pharmacists	1	6
General Practitioners	8	48
Integration Champion Citizens	0	0
Public/Patient	2	12
Residential and Nursing Homes	6	36
Team Leads, Specialist Nurses & Allied Health Professionals	30	175
Total	48	283

4.1.4. Process mapping

A high level process mapping activity, informed by the themes emerging from the stakeholder events was undertaken with 14 different stakeholder contexts, across the health economy. The method used involved discussing processes and competences with teams and individuals from these groups to compile high level process and/or swim lane maps to show the levels of staff involved in the process. This provided in-depth perspectives of current issues and challenges; good practice and what worked well; asking the miracle question in terms of what perfect integrated urgent and emergency care would look like, and also, future skills and competences. The 14 contexts are identified in Box 1-. Appendix 3 details the information arising from the process mapping

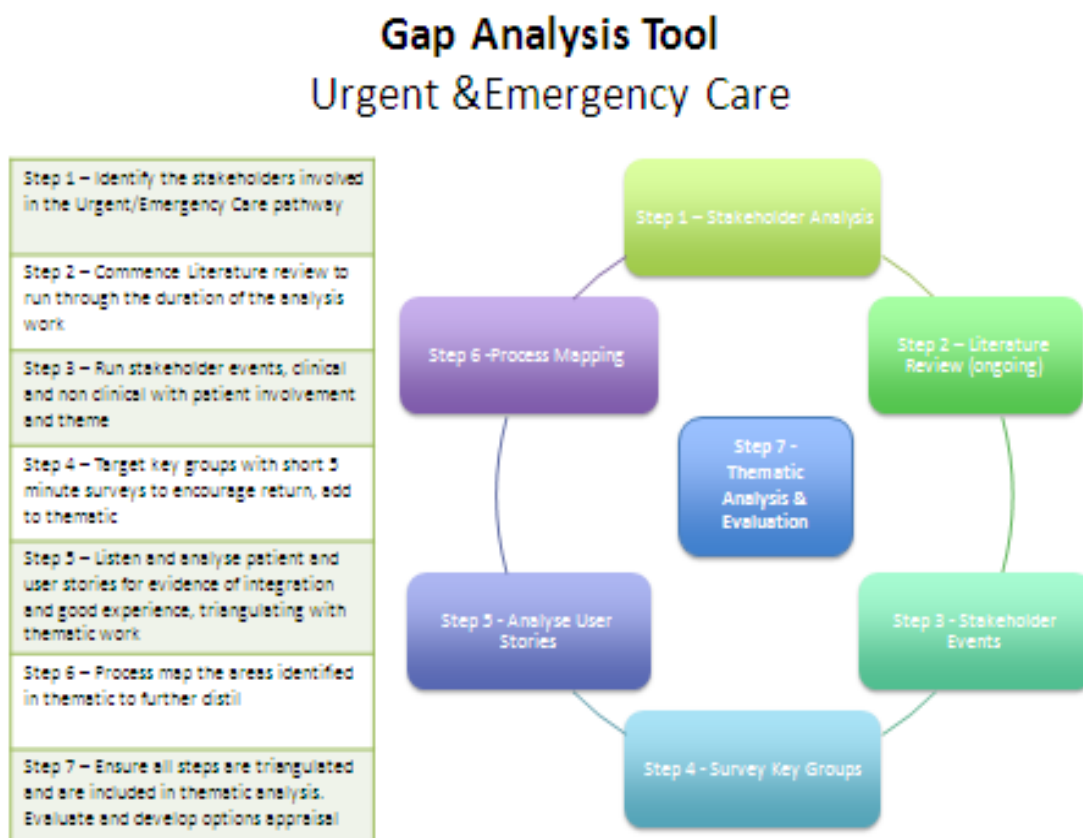
Box 1: Areas identified for in-depth process mapping:

1. Integrated Discharge Teams	8. SECAMB
2. 111	9. Care Homes
3. Hospice	10. Community Matrons and teams
4. Social Services and Enablement services	11. Rapid Response, ICT & Community Beds
5. Minor Injuries Units	12. Mental Health Services
6. Accident & Emergency	13. Ambulatory Care
7. IC24	14. Hospital at Home

4.2. Gap Analysis Tool

One of the objectives of the project was to develop a gap analysis tool in relation to urgent and emergency care that may be able to be used as a model to guide other areas of health and social care provision. The gap analysis tool is illustrated in Figure 2 and also identifies how data from using the different methods have been triangulated. Data was triangulated at each stage to enable the identification of gaps and pinch points in the competences required for an integrated urgent and emergency whole systems approach. The Gap Analysis tool describes this process.

A synthesis of all the themes emerging for the triangulation has led to a framework that describes the key inputs needed for achieving integrated whole system urgent and emergency care and subsequent workforce development. The components of this system are the focus of the next section which also draws on a number of patient stories to illustrate these components that demonstrate aspects of integration and also the interdependence between partners contributing to the system

Figure 2. Gap Analysis Tool applied to urgent and emergency care

5. Findings: Synthesizing the project data - Whole systems integrated urgent and emergency care

Project data has been triangulated from Appendices 1-3 and synthesised to develop a visual representation of the enabling factors, characteristics, inputs, outputs and workforce development needs required to enable a whole systems approach to urgent and emergency care to become a reality (Figure 3). Current inhibitors identified in each dataset analysis have been converted to enablers, so as to accentuate what needs to be in place to achieve an integrated whole systems approach to urgent and emergency care.

All stakeholders engaged in the project were and are strongly committed to the development of an integrated whole system approach for providing urgent and emergency care across the health economy where all interdependent partners work together towards the same aim.

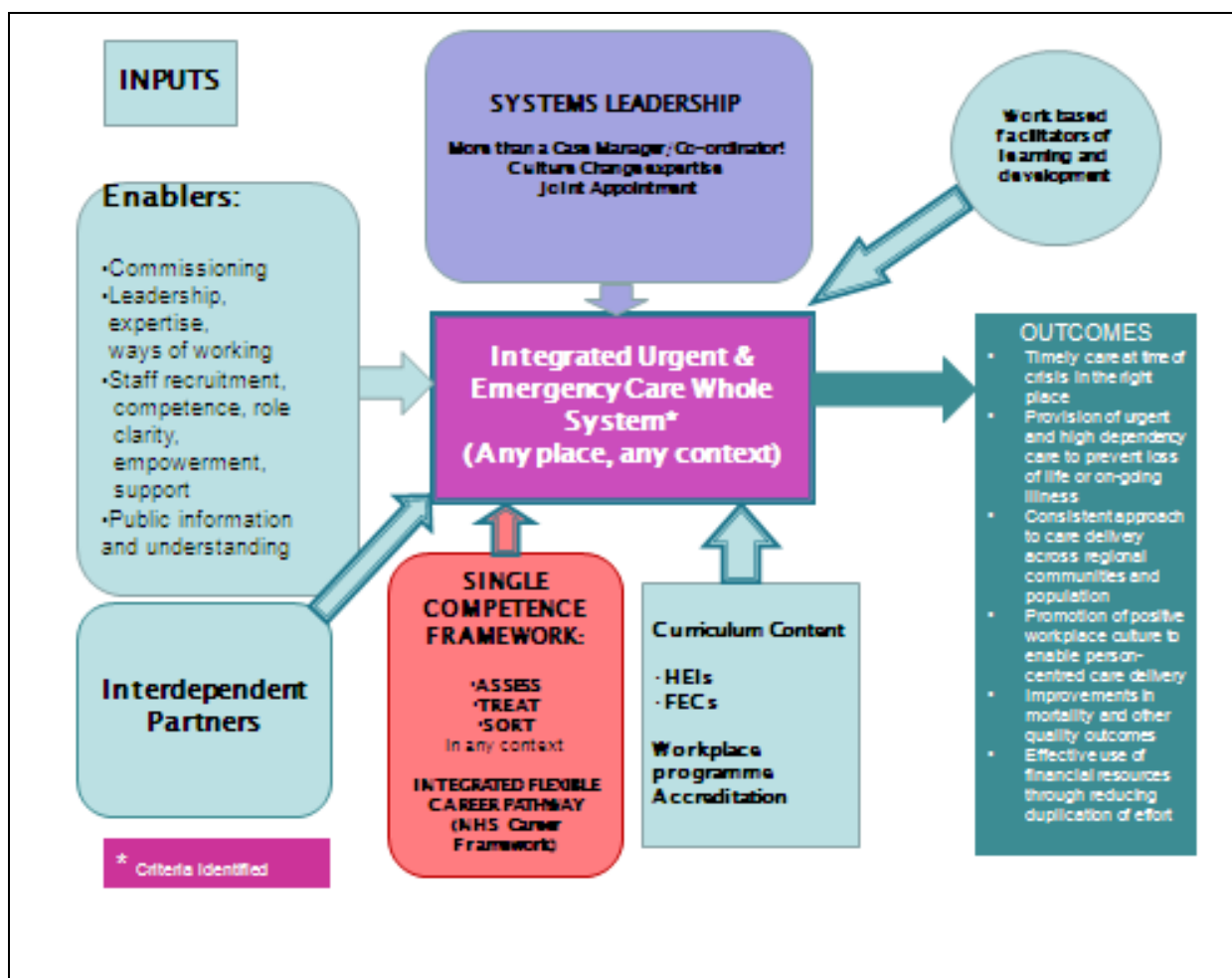
Currently shared purposes are agreed following a number of commissioned projects involving large populations of the health care economy in East Kent; specifically; EKHUFT; Kent & Medway

Community nursing services; KMPT; and the Joint Commissioners Quality Board for EKHUFT. These shared purposes encompass:

- person-centred care;
- safe care;
- effective care;
- effective workplace cultures
- care in own homes/as close to home as possible.

Competence frameworks across all levels of the NHS Career framework currently exist for these shared purposes and will provide a strong foundation for a whole systems approach when combined with specific outcome competences for urgent and emergency care to complement them.

Figure 3. The framework for achieving whole systems integrated urgent and emergency care



At the heart of future provision is required a shared vision and understanding of what a whole systems approach to integrated urgent and emergency care (IUEC) looks like and what it means for both staff and the public. Central to a whole systems approach is the concept of integration, where the contributions of partners are interdependent and the effect of their sum is greater than that

which can be achieved from their individual parts. This requires, a commitment to work in a way that recognises, values and uses the contribution that each partner brings to achieving a shared purpose, thus avoiding duplication of effort and enabling the more cost effective use of valuable NHS resources.

The workforce competences required for effective whole systems approach can never be vested in either one person or one profession/staff group, but comes from an appreciation about what each partner brings in different contexts, underpinned and supported by an infrastructure that enables integration of information, finances and resources.

The criteria emerging from the analysis that characterise a whole systems integrated approach included:

- Safe, sustainable, whole systems for all ages, person-centred (holistic), based on best evidence and practice standards (competence/standards)
- Integrates health and social care (& residential homes)
- Quality and safety focus rather than targets (See patient story 2 to illustrate the issues around providing consistency quality)
- Based on local population need
- Interdependent partners working together with no duplication towards the same purpose

Patient story 2 shows how difficult it is to currently apply a consistent measure of quality across the whole system because there is a lack of continuity of standards experienced by the patient and their relative. A whole systems approach to providing person centred safe and effective care along for example; a stoke pathway would ensure that the team providing the care follows the patient, that her electronic care records go with her to summarise her care experiences and that the community and inpatient teams work together to promote a holistic rehabilitation programme which aims to get her home as soon as possible.

Patient Story 2: Excellent person centred care for a patient experiencing stroke which deteriorated through the inpatient process

The gentleman told us about the care his wife received when she had a stroke. When he realised what was happening he dialled 999, the ambulance was dispatched and responded very quickly. His wife was taken to the Emergency Care Centre at the local hospital where again she was treated promptly and received the correct treatment.

Following the initial assessment and treatment, his wife was admitted to a ward for seven weeks in which there was a lack of continuity of quality of care with poor communication and rehabilitation. This resulted in them both feeling desperate to get her home.

Fortunately his wife recovered from the stroke but he wished that the initial care that himself and his wife experienced was consistent though out the whole of her journey

The outcomes expected of a whole systems approach therefore include:

- Timely care at time of crisis in the right place, with positive user experience
- Consistent approach to care delivery across regional communities and population
- Provision of urgent and high dependency care prevents loss of life or on-going illness
- Improvements in mortality and quality outcomes
- Promotion of positive work based culture to enable person-centred care delivery
- Effective use of financial resources through reducing duplication of effort

Patient Story 3 demonstrates what an integrated whole systems approach would look like from the perspective of an older person living in a residential home , her daughter , the story teller (who is a hospital pharmacist). It demonstrates integrated working between the residential home staff and the General Practitioner in partnership with the older person and her daughter to enable the resident to have a much better quality of life, remain symptom free, and not require admission to hospital. It also shows the positive benefits for staff through creating role clarity and enabling them to feel they are using their skills and are doing a good job in providing a quality experience because they know the person they are caring for.

Patient story 3. Integrated whole systems approach to person centred urgent and emergency care

My mother suffers from severe Dementia and lives in a residential home without nursing care. In May this year, my mother presented with seizures requiring admission to hospital twice within the same month. During the second admission my mother had to be restrained in a chair on the ward to prevent wandering and on discharge spent 7 hours in the discharge lounge waiting for an ambulance, this caused significant distress to my mother. My mother was discharged on a low dose of an anti-epileptic drug.

I was concerned that the dose would not be titrated to a therapeutic dose, resulting in my mother requiring another admission to hospital. Following a discussion with the carers at the home to determine what level of care they could provide, I phoned the GP to agree a management plan. The GP agreed to titrate the dose of the anti-epileptic drug to the recommended maintenance dose depending on her tolerability to the side-effects e.g. behavioural disturbances and drowsiness which could precipitate falls. The GP also confirmed he was happy to treat my mother at the home to avoid an unnecessary hospital admission provided that the fits had resulted in no harm or not developed a more sinister pattern.

The staff in the home were positive about this arrangement as they had concerns about the standard of care for dementia patients in an acute setting and felt they could provide better care as they were more familiar with my mother's needs.

It has been 7 months since my mother's last admission to hospital and she has not suffered from any subsequent fits and hence had no further hospital admissions. The GP treatment plan was key in addressing the management of the fits and keeping the person with dementia at the care home where their needs could be better met and they would be well cared for.

An integrated whole systems approach to urgent and emergency care is recognised by the specific criteria, identified above and also outcomes. Key enablers to such a system, together with systems leadership, a single competence framework across the NHS Career Framework and workplace facilitators of learning and development will assist with achieving this and are the focus of following sections.

Incentives such as the development of a regional urgent and emergency care fellowship scheme to support specialist, advanced and consultant level practitioners and awards that celebrate innovations in workforce design would provide further opportunities to embed a whole systems approach.

5.1. Enabling factors to an integrated whole systems approach

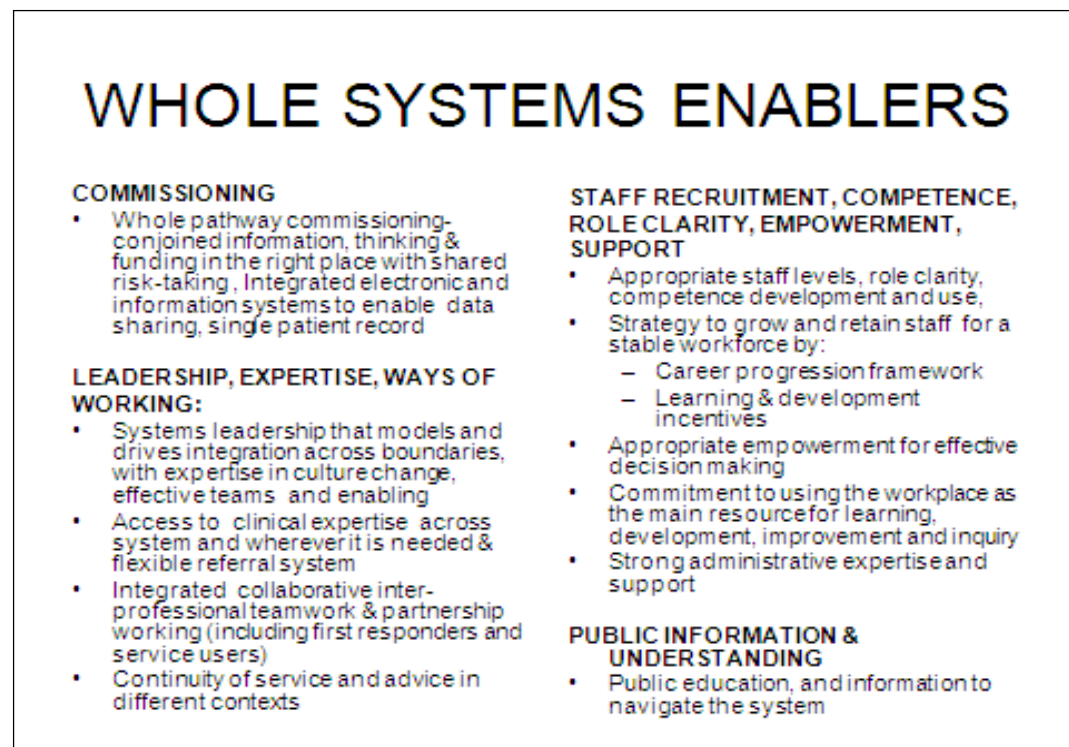
A number of key enabling factors were identified from triangulating the data about what the current challenges were in the provision of an integrated approach to urgent and emergency care, what is working or not working and what is required to be in place for a whole systems approach to become a reality. The overarching areas are outlined in Figure 3, with detail presented on Box 2. The enablers have implications for workforce development at every level of staff from; frontline care provision at provider-user interfaces; career development across urgent and emergency care; systems leadership; human resource management through to infrastructure development; public information systems, and commissioning

Commissioners are perceived as being able to provide essential leadership around 'modelling the way' by working together towards a common strategy and shared system, that models integrated working at the commissioning level and works to dismantle the barriers that prevent integrated working/ drives silo working across the system particularly around the use of budgets.

Core challenges across the whole health economy are both the recruitment and the retention of staff. The factors that impact on staff recruitment are identified in the literature review but key factors that can be addressed through workforce development to improve recruitment and retain valuable staff include:

- Leadership, both clinical and systems leadership because of the impact effective leadership can have on workplace culture, ways of working, team work, staff wellbeing and satisfaction as well as the patients experience and outcomes.
- An integrated career and competence framework to enable career development and support career progression around integrated urgent and emergency care, not just for clinicians at every level of the NHS Career framework, but also for support staff and administrators and volunteers
- Human Resource Departments. These departments are expected to lead the way in terms of living organisational and systems values and have a major role to play in developing influential and positive recruitment and retention strategies that are effective, i.e. responsive, accessible, rapid and flexible and minimises the volume of administration that negatively impacts on the time frontline staff are at the frontline and available to patients.

Box 2. Whole system enablers



5.2. Systems leadership – what does it need to look like?

Systems leadership repeatedly was recognised as a major enabler to achieving whole systems approaches to the provision of urgent and emergency care, but also key to better retention of staff too. Systems leadership needs to draw on expertise across a number of different areas, but also enable different contributing partners to work together towards a shared purpose. The expertise required of systems leaders includes the following:

- Clinical expertise, credibility for a specific client group (with case management)
- Leadership to achieve culture change through working with shared purposes achieving integrated ways of working and effective teamwork across primary and secondary care and partner organisations
- Developing, improving and evaluating person-centred, safe and effective care and services
- Consultancy functions from client-centred through to organisational and systems level (Caplan & Caplan, 1993) and process consultancy approaches (Schein, 1999) to enable expertise to be available and accessible to as many people across the system as possible
- Creating a learning culture that uses the workplace as the main resource for learning, to maximise opportunities for learning and development, competence development and innovation

To address the considerable cultural barriers existing in many areas, it is proposed that practitioners at the consultant practitioner level of the NHS Career Framework (from different disciplines; e.g. nurses, paramedics, general practitioners, allied health professionals, pharmacists etc.) are established as joint appointments across primary and secondary areas to address key priority areas

in relation to a number of key client groups (See Box 3) because they would be expected to have expertise in all the areas identified above.

In addition, because of consultancy expertise at all levels, these posts would enable expertise to be accessible across the system and with other systems leaders they would: work together; model integration and interdisciplinary team working; and enable cross system collaboration and ways of working to become embedded in the culture.

Box 3. Priority areas for joint appointments in systems leadership across primary and secondary care

Priority areas required for joint appointment consultant practitioner posts to provide systems leadership across local health economy to enable whole systems approaches to be delivered:

- People with chronic health conditions such as:
 - Diabetes
 - Asthma
 - Chronic Kidney Disease
 - Coronary Heart Disease
 - Chronic Obstructive Pulmonary Disease

- Acute, urgent care
- The frail elderly
- People with Dementia
- End of Life Care
- Children
- Management of people's pain
- Mental health & Substance Abuse
- People with learning disabilities
- Pregnancy

Workforce strategies will need to prioritise the need to grow people with this expertise, as there is a dearth of people with this range of expertise and skills. However such posts provide a tangible clinical career progression ladder that integrates practice expertise with clinical and systems leadership and would subsequently contribute to the retention of staff at the advanced level of practice and urgent and emergency practitioner levels.

Through the 40:60-50:50 split (direct expert practice: other functions) such posts would be expected to provide both clinical and systems leadership based on clinical credibility, transformational leadership and expertise in developing the culture required across the system to enable them to work together and keep focused on person centred, safe and effective care. A strong theme emerging from the analysis emphasised the need for more leaders of this nature.

A programme running at EKHUFT for aspiring consultant from a range of different disciplines currently provides support to staff as well as opportunities for career progression by focussing on all the skills required across the functions identified above to complement clinical credibility and expertise. This has paved the way for the next cohort which will be open to the wider health and social care community.

Story 4 describes how an aspiring consultant nurse works collaboratively across boundaries to ensure that a person with learning disabilities and complex needs receives appropriate care and avoids admission to A&E. It also illustrates some of innovations and resources in place, and the attributes of systems leadership, person centred, safe and effective care.

Areas of expertise that could benefit interdependent partners that have arisen in project data may include for example; tissue viability expertise and other support for residential homes; communicating with people with dementia for ambulance services; prescribing innovations for new roles and advanced practice level practitioners; holistic assessment in ambulatory care; frailty assessment in community settings, to name a few.

Story 4: Illustrates aspects of systems leadership in action

'During the last two weeks the Community Learning Disability Nurse and I have been in correspondence regarding a person with a severe learning disability and autistic spectrum condition who had recently been discharged from hospital having had a fall and fracture to a Residential Care Home. The Community Nurse contacted me regarding the individuals loss of skills and mobility over the last four months along with disturbances in behaviour which did not appear to be mental health related. On closer review of the records it was noted that the individual had experienced 2 admissions and 3 visits to A&E not quite triggering the Learning Disability Repeated Admission Pathway (www.ekhufnhs.uk/ldra), there was also reference to diagnostics suggesting a malignancy.

We were able to link up the Community Nurse with the Orthopaedic consultant and the GP via email, encouraging coordinated discussion regarding the individual, swiftly discounting the queried diagnosis of cancer, but there remained concerns regarding the behavioural changes and loss of skills.

The individual did not require emergency admission over the weekend, due in part to the collaborative practice across several organisational boundaries and the individual's care being co-ordinated effectively.'

Systems leadership posts that encompass the skill set identified above and models integrated working across different client groups that impact on urgent and emergency care will be vital for a whole systems approach to be successful. This is because expertise in culture change and transformational leadership approaches will embed change in everyday work and behaviour, so that there is a real impact on achieving purposes and collaborative ways of working. An added bonus will be derived from having a number of these posts as joint appointments across primary and secondary care as well as the enhanced effect of them working together.

5.3. Interdependent Systems Partners

Systems partners are key inputs to a whole system approach (Figure 3). The contributing partners currently are located either in primary Care or secondary Care (Figure 4). As the model shows, both of these categories are interdependent on each other. Midwifery in East Kent currently although located in secondary care provides a service to both primary and secondary care.

Figure 4. Interdependent systems partners



An integrated career and competence framework will enable integrated partners to identify their specific contribution in relation to different contexts with regard to either all aspects of the “Assess, Treat and Sort” competence framework (see Table 4) or components of it resulting in a variety of pathways both simple and complex that can work in tandem with each other.

Two stories and a case study illustrate the impact when interdependent partners work together within a whole systems approach.

Storey 5 illustrates how interdependent system partners are reliant on one another to ensure seamless, patient centred care.

Patient story 5.

A patient with end stage bronchiectasis and had home O2 and nebulisers set up and a good care package. Through the end stage of his life he developed a chest infection that required close monitoring and complex long term IV antibiotic therapy. The Hospital at Home service worked with the patient, his family, physiotherapy and the community Matrons to provide a unique package of care that enabled him to stay at home for the last 6 months of his life whilst still receiving close monitoring, the complex IV therapy and good communication links direct to his consultant.

Patient Story 6 illustrates an example of swift, seamless care delivered through Hot Ambulatory care and Case Study 3 demonstrates a collaborative approach to midwifery triage

Patient Story 6:

52-year-old gentleman referred same day directly to Hot Ambulatory from his GP, removing the need for him to be seen either in A&E or waiting for an Outpatient Appointment.

The GP discussed the clinical presentation and his suitability for Emergency Ambulatory Care with Acute Physician – patient had developed lumps in his neck. The patient was able to drive to the Hospital and did not require an Ambulance.

On arrival at the Ambulatory Unit, the patient was booked in by the receptionist, and shown to a trolley space where he was examined and assessed by the Acute Physician. Bloods were taken and on the basis of these results, the patient was booked in the following day for Ultrasound and CT Contrast. The patient was discharged from the Ambulatory Unit at 17.00 and asked to return for review the following afternoon immediately after he had had the Ultrasound and CT.

The patient attended as planned for the results of the scans, which showed abnormalities that unfortunately had spread to his lungs. Whilst in the unit, the patient was then booked for a CT guided biopsy on the following day through the Ambulatory Unit. On discharge he was given an appointment for the following week on 24/10 for follow-up bloods and to be discussed at the Lung MDM.

The system allowed for a seamless patient journey from attendance at the GP surgery directly through to the Ambulatory enabling the patient to receive the right care, at the right time and in the right place – putting him at the centre of his care.

Case study 3: Collaborative approach to maternity telephone triage

An excellent example of partnership working comes from Hampshire, where the maternity services and ambulance service run a telephone triage service for pregnant women. Midwives offer this service based within the ambulance control centre. Partnership benefits include immediate access to ambulance when required, sharing of expertise and better understanding of partner organisation. In

addition to calls coming through for the maternity triage service, midwives are able to offer advice and support when pregnant women dial 999 or 111. Women benefit from the midwives being able to focus fully on their needs and savings have been made by ensuring appropriate use of the ambulance service.

Through an integrated career and competence framework the competences of a whole system approach can be made explicit- with different interdependent partners providing complementary competences in different contexts ,but in addition it provides opportunities for career progression therefore providing recruitment and retention incentives.

5.4. An Integrated Career Competence Pathway for Urgent and Emergency Care

5.4.1. Generating the Competence Framework- Overview

The concepts of *competence* and *competency* are used interchangeably in the literature. Here we use Roach's (1992) definition of competence as "*acquiring and using evidence-based scientific and humanistic knowledge and skill in the application of therapeutic interventions in the practice setting. Competence is reflected in the cognitive, affective and psychomotor domains of learning. It is the knowledge of the role of the professional in the health care delivery systems of the hospital and the community.*"

Competence includes a *cognitive function*- acquiring and using knowledge to solve real life problems; an *integrative function*- using biomedical and psychosocial data in clinical reasoning; a *relational function* – communicating effectively with patients, service users, carers and colleagues; and an *affective moral function* – the willingness, patience and emotional awareness to use these skills judiciously and humanely. Competence depends on habits of mind including attentiveness, self-awareness and critical curiosity. Professional competence is developmental, impermanent and context dependent and outcome driven as its intention is to improve patient outcomes (Epstein and Hundert 2002).

Practitioners must first acquire the knowledge to know how to do their work and why, then must learn the skills that are required to succeed in their given role, and also demonstrate the behaviour that is required to effectively manage every situation they are likely to encounter. Finally, it is important to develop and use their own judgment to appropriately address situations where an easy or straightforward response is not apparent. Whilst practitioners may possess knowledge and skills this may not always translate to a change in behaviour and ability to provide sound clinical judgement in different situations and contexts.

Table 4: Overview of Draft Generic competences

Draft Generic Competences

ASSESS	TREAT/INVESTIGATE	SORT (Discharge, referral, admit)
<ul style="list-style-type: none"> •Assessment of First Aid needs •Holistic assessment skills at appropriate level •Protocol driven assessment •Using Assessment Tools •Prioritisation and decision-making (triage) •Communication •Risk management •IT skills •Self awareness 	<ul style="list-style-type: none"> •Diagnosing in different settings •Interpreting diagnostics •Prescribing/PDGs •Documenting •Providing Advice •Delivering interventions in different settings •Access to resources •Decision-making •Interdisciplinary collaboration 	<ul style="list-style-type: none"> • Understanding whole system • Referral system/appropriate follow-up • Timely follow up/discharge • Reflecting and Evaluating

Level of skill linked to NHS Career Framework levels 2-8 and the Shared purposes around person-centred care, safe care, effective care and effective workplace culture

The integrated **Assess, Treat, Sort** (ATS) Competence Framework presented in overview in Table 4 and in more depth in Appendix 4 has been generated from the literature review (Section 7), themes arising from secondary analysis across all stakeholder events, surveys and process mapping (Appendix 1), data derived from the survey analysis (Appendix 2) and priorities identified from the processing mapping (Appendix 3). These themes have been grouped into the tool as follows:

Assess – Assessment of First Aid Needs, Holistic Assessment at appropriate level, Protocol Driven Assessment (111), Using Assessment Tools in a Residential Home, Prioritisation Decision Making (Triage Assessment), Communication, IT Skills, and Self-Assessment,

Treat- Diagnosing in different settings, Interpreting Diagnostics, Documenting, Providing Advice, Prescribing PDGs, Delivering Interventions in Different Settings, Access to Resources, Decision Making, Interdisciplinary Collaboration.

Sort- Understand the Whole System, Referral System/Appropriate Follow-up, Timely Follow-up/Discharge, Reflecting and Evaluating,

In order to validate the themes generated within the tool an analysis of existing national competence tools and frameworks for different professions have been analysed and mapped against these core competences to ensure that we have captured the competence consistent to all health and social care professions working in the field of urgent and emergency care. Appendix 5 summarises this analysis and mapping activity.

An integrated urgent and emergency care competence framework demonstrates a joined up whole systems approach to managing the patient pathway and experience to manage optimum care in any context or setting, promoting an interdisciplinary team approach underpinned by shared risk, and integrated information and finance systems. A single competence framework that is not role dependent provides the potential for a more integrated and flexible career pathway mapped to the NHS Career Framework and a whole systems approach to leadership that offers more than the current care manager or coordinator approach from bands 1-8 (non-medical workforce).

The essential enablers identified for an Integrated Urgent and Emergency Care Whole System include an integrated approach to commissioning services, a commitment to whole systems leadership and ways of working which may include joint appointments as well as culture change expertise to deliver transformed services, and a focus on staff recruitment based on competence and knowledge and know how to provide high quality person centred safe and effective care in any context and setting with pathways and system partners in primary and secondary care.

The framework can be used in a number of additional ways:

- To facilitate continuing professional development on an individual, team and service level;
- To provide a career progression framework for integrated urgent and emergency care
- To help identify skills gaps in practice;
- To identify organisation level specific training needs;
- To inform the commissioning development and delivery of education and training for an integrated workforce;
- To aid supervision, mentorship, personal development and career planning and performance appraisal and,
- To aid recruitment and retention in different contexts.

5.4.2. Illustrative Stories of how the framework could be used

The following stories illustrate how the ATS Competence Framework could be used in everyday practice for diverse contexts and roles to facilitate work based learning, and career development.

Case study: Community 111 Call Handler

A community based 111 Call Handler could use the framework to undertake a self-assessment of their development needs for their appraisal with their line manager to reflect on their strengths and limitations in relation to their knowledge, skills and priorities for development.

Using the ATS competence framework the specific competences that would guide the self-assessment might be:

Assess-

Follows a **Protocol Driven Assessment** to undertake a holistic telephone interview of the individuals needs

Communication- consistently behaves with sensitivity and integrity, manages expectations by listening to service users, identifies and addresses ethical issues, models the principles of effective interdisciplinary cooperation

IT Skills – uses core IT competencies relevant to the environment

Self-Assessment- Acts in a way that is person Centred

Treat–

Documenting- demonstrates effective note writing and case presentation techniques, **Providing Telephone Advice-** provides evidence based telephone consultation and assessment of the person, evaluates advice provided. **Recognises potential clinical risk situations** and takes appropriate action

Sort-

Understanding Whole System-uses clinical judgement to refer to other members of the interdisciplinary team. **Maintains awareness of any new developments** in the structure and function of the NHS.

Referral System- Assesses and delegates work, Uses opportunities for health education

Reflecting and Evaluating- critically evaluates own practice to identify learning/development needs

Case Study: Developing the potential of Volunteers in Urgent and Emergency Care

A Crossroads volunteer worker whose role is to support people with Dementia by assessing them in CDU or A & E and then taking them home, provides a vital service in admission avoidance. The ATS framework could be used to help plan their continuing professional development with their local FE College or county council who offer volunteer training in the field.

If FE Colleges were encouraged to run an integrated model of learning and development for volunteers in Kent, Surrey and Sussex, the ATS framework could be used as the overarching framework to guide workplace learning and training initiatives or blended learning programmes at NVQ level.

Example 3: Advanced Practitioner working as a member of a Community Rapid Response Team

An Advanced Community Nursing Practitioner working as part of an integrated discharge team in a community setting has a vital role to play in preventing unnecessary admissions to A & E through liaison work with A & E, GPs, Ambulance Services or Care Homes to ensure that older frail people receive the care and treatment they require in the home setting to mitigate hospital admission e.g. pain management, treatment for UTI, end of life care planning with a right to choose where to die etc.

Formerly an Emergency Nurse Practitioner this practitioner uses the ATS to undertake a self-assessment and submit a portfolio of evidence to her local University to gain academic accreditation for prior learning and development in the workplace in order to tailor a blended MSc Advanced Practice programme to her development needs. By demonstrating that she already possesses Advanced Clinical Assessment and History Taking Skills, a prescribing qualification and Advanced Decision Making Skills, she is able to APEL 60 Credits at level 7.

5.4.3. Implications for Further Education Colleges and HEIs

University and Further Education Colleges in Kent, Surrey and Sussex have a vital partnership role to play in facilitating the training and advanced knowledge and skills development required to prepare the future urgent and emergency care workforce that will:

- Promote greater integration between urgent care services delivered in hospitals and services

delivered in the community – facilitated by stronger links that primary care practitioners have with community services– enabling patients to be referred more rapidly and seamlessly to relevant pathways, and improving access to community-wide responses to people’s care needs.

- Integrate provision of urgent and emergency care, based on clinical need, which makes best use of staff skills across the unscheduled care pathway (e.g. increasing access to GPs for patients with primary care needs and enabling emergency department practitioners to focus on patients with emergency care needs that require specialist care).
- Increase the interdependency and mutual support of primary and secondary care specialist and advanced practitioners, with a gradual transfer of skills, knowledge and shared competencies creating a more integrated and flexible workforce over time.

An integrated partnership model across the region will enable a stronger curriculum offering to be made to maximise the opportunity to share expertise rather than every college and University offering the same menu of learning and development. Such an integrated approach will maximise placement opportunities for students as well as opportunities for collaborative research and development to measure the impact of learning on the workforce and the service user experience. This recommendation has already been made to a meeting of the Deans of the four regional HEIs held with the HEKSS Urgent and Emergency Care programme support in October 2014. Such an approach would undoubtedly have a positive impact on the workforce strategy for Urgent and Emergency Care across the 4 Clinical Commissioning Groups.

FE Colleges have a vital role to play in developing the band 1-4 workforce in relation to providing health and social care support to children, the vulnerable, and the elderly in their own homes or in care home settings, offering NVQ Level 2-5 learning and development. Currently FE Colleges in Kent, Surrey and Sussex offer similar courses in First Aid, Business Administration, Counselling and Health and Social Care. A key recommendation is to bring the FE Colleges together to work collaboratively with the Integrated Urgent and Emergency Care Competence Framework, providing a cross-region approach would ensure that levels of care are to the national standards, with increased staff performance, motivation and improved quality of service for individuals who often work without direct supervision or on their own in a service user’s own home providing support and assistance with physical or emotional care, daily living needs or maintaining independence. Such workers might include first aid workers, health care assistants working in care homes, call centre workers, and care home staff, volunteers working as part of GP practice teams supporting the frail elderly, health promotion workers.

FE Colleges also have a vital role to play in developing the knowledge and skill set of fire, rescue and police services in identifying, safeguarding and managing the vulnerable elderly, adult and child with cognitive impairment, mental health and learning difficulties to reduce the number of inappropriate admissions to urgent and emergency care and aid referral to appropriate support services in the community.

A major issue identified in the literature relates to the communication within the system and FE colleges play a vital role in preparing future health and social care practitioners to development their health information literacy and IT Skills as well as their administration skills. An integrated approach could include the opportunity to provide administration placements for business students working in health and social care settings providing urgent and emergency care services around the region. Such

an approach could potentially enhance recruitment and retention of business administration students who frequently take up career opportunities in other sectors.

HEIs have a vital role to support the development of advanced practice skills for the future workforce redefining the role of consultant and non-medical consultants in the delivery of urgent and emergency care as well as preparing a critical mass of senior clinical leaders capable of transforming the culture and integrated models of service delivery at the front line.

Phase 1 of this project has identified a number of key recommendations for the development of the specialist and advanced practitioner curriculum in Kent, Surrey and Sussex which provides an opportunity for the four HEIs to work collaboratively to pool their expertise in offering an integrated portfolio of learning and development. Whilst there are currently initiatives in place to develop the Associate Practitioner career pathway in ambulatory care, there may be a need to explore further integrated urgent and emergency care career options underpinned by workplace learning programmes accredited through FE Colleges and HEIs.

For Advanced Practitioners working in any setting or context the core knowledge and skills that need to be delivered at level 6 and 7 are:

Competence, Knowledge, Know-How and Understanding to Assess-Treat-Sort (applied to patient pathways/context e.g. child, adult, mental health, frail elderly, palliative/end of life, long term conditions, fragility pathways, supporting residential home sector)

Advanced Clinical Skills

- Advanced Holistic Health Assessment, Examination and History Taking Skills
- Advanced Clinical Decision Making and Autonomy (included advanced Care Planning)
- Diagnostics/investigations/interpretation
- Advanced Physiological Systems Management (A & P)
- Pharmaco-therapeutics and Pharmacodynamics
- Prescribing
- Medicines Management
- Communicating with and assessing older people in their homes and managing frailty
- Interventions to reduce admission avoidance and enable discharge

Interdisciplinary Leadership and Management

- Whole Systems Leadership
- Commissioning Urgent and Emergency Care services
- Person Centred Practice
- Creating Effective Workplace Cultures
- Collaborative Practice Development
- Facilitating Learning, Creativity and Innovation in the Workplace

Clinical Governance and Risk Management

- Public Health in the Management of Long Term

- Health Informatics and Telehealth
- Risk Management and quality improvement (including legal requirements())
- Safeguarding
- Health Systems Evaluation
- Financial Management

We have recommended to the board that a Physicians Associate programme be developed collaboratively across the 4 HEIs providing opportunity for rotational placements across Kent, Surrey and Sussex. This would provide a recruitment pool from existing emergency nurse practitioner roles, medical and other clinical and technical scientists currently regulated by the HSPC. The national curriculum model would be used to underpin this programme with the placement rotation starting in the community as opposed to the A & E department. The PA programme is not being mooted as the only solution to developing the workforce, it is merely part of a more multidimensional approach.

Working closely with the Medical Schools and Deanery is vital to helping to support the on-going development of GPs in the region. Given the release of the NHS Five Year Forward report this week, it is really important to use the opportunity to explore the recommendation of GPs being co-located in ambulatory care and Minor Injury Units to improve patient flow and reduce unnecessary admissions to hospital. A rotational placement model for GPs in the region would support their career and role development whilst simultaneously developing knowledge and skills to run GP services and practices differently in the community setting.

HEIs have a vital role to play in developing attractive career pathway options for the future urgent and emergency care workforce delivering care in a variety of contexts. In particular their contribution to the development of whole systems leadership expertise has the potential to create a workforce capable of delivering credible clinical expertise to support the care of specific client groups to create an integrated approach to case management, as well as strong leadership to achieve a shared purpose and integrated ways of working across primary and secondary care contexts. Development experience in innovating, improving and evaluating person centred safe and effective services will undoubtedly impact positively on patient mortality rates and outcomes. Creating whole systems leaders with the skills to transform culture at the front line will also help to create a learning culture that uses the workplace as the main resource for learning. HEIs have a vital role to play here in supporting a culture of sustainable transformation through accreditation of workplace learning and research and development initiatives, as well as creating the opportunities to develop skilled workplace learning facilitators. Development of blended learning programmes to support workplace learning and accreditation is an important part of developing an effective workplace culture underpinned by the selection of appropriate self-assessment tools and frameworks practitioners can use to support production of professional portfolios for revalidation.

The development of joint appointments for integrated urgent and emergency care with HEIs would serve to underpin a culture of learning, development and inquiry within the workplace, facilitating individual, team and service effectiveness and the ability to measure sustainable impact of innovation over time. These appointments might be targeted to End of Life Care, Dementia, Long Term Conditions, Children and Mental Health Services.

Whilst there is no clear vision currently for developing the Consultant Practitioner workforce outside of East Kent, our experience of running the Aspiring Consultant Practitioner programme has identified the development of a critical mass of leaders with the research, inquiry, workplace learning and development skills required to transform care at the front line which will benefit the development of

integrated urgent and emergency care services in the future. There is already a Consultant Nurse for Learning Disabilities.

Creating joint appointments focused in these areas would facilitate an integrated approach to systems leadership built on a foundation of interdisciplinary team working with the potential to develop leaders at specialist, advanced, and consultant practice level. The net effect of such an investment would be to create whole integrated teams with the clinical experience and autonomy to develop a truly person centred service for different groups of service users in Kent, Surrey and Sussex. This could provide an opportunity for a regional fellowship scheme to be developed for specialist, advanced and consultant practitioners linked to Joint Appointments.

Essentially this section of the report highlights the potential for the framework to provide opportunity for FE Colleges, Universities (HEIs), and primary and secondary health and social care organisations to work together more closely to support the career development of the future urgent and emergency care workforce. Such a joined up approach would offer a more coherent offering to Clinical Commissioning Groups and encourage in turn a more integrated and sustainable model of future workforce commissioning for continuing professional training and development.

5.4.4. Further Work Required to Inform Recommendations

Specific recommendations related to development of integrated curricula include:

- a) Work across the region with key stakeholders in addition to national working groups in Urgent and emergency care to undertake further development and testing of the competence framework to answer the questions:
 - What does it mean for service?
 - What does it mean for HEI provision?
 - How would it work in practice? Developing career framework stories to illustrate how it might be embedded within recruitment and retention strategies
- b) Undertake scoping and mapping of existing curricula offerings across the region to identify areas of best practice and gaps in FE and HEI provision, Set up a cross region working group to innovate the curriculum and implement new common programme
- c) Pilot a cross region PA programme and evaluate impact on service?

6. The gaps and pinch points in current urgent and emergency care workforce provision

The gaps and pinch points were derived from analysing the datasets arising and were particularly informed by the process mapping detailed in Appendix 3. The following areas were identified

6.1. Commissioning

- Different commissioners e.g. for 111 and Out of Hours (OOH) services; and different commissioning priorities inhibit an integrated whole system approach through lack of whole systems commissioning

6.2. Systems infrastructure

- IT systems don't talk to each other, there are no shared patient records across the system
- Partners provision may be inconsistent with different opening hours and differing diagnostic provision in community settings , e.g. walk-in clinics have different opening times and provision of radiological services varies

6.3. Staff resource and expertise

- Shortage of staff generally, particularly those with higher levels of expertise and experience in urgent and emergency care
- Acute and all frontline staff don't have the skills for end of life care, working with people with Dementia and do not have the information they need
- Lacking team leadership and systems leadership results in staff not working together, working in silos, duplicating resources with inconsistencies in service resulting
- Lack of opportunities for joint education, shared learning and case review
- Lack of understanding between different disciplines/services about each other's roles and level of skills/expertise
- Limited expertise available out of hours to support seven day working specifically in relation to community transfers and social service involvement
- Interpretation of diagnostics 24/7
- Access to specialist expertise different contexts e.g. residential homes, ambulatory care, ambulance service, A&E in relation to older people with Dementia, children, long term conditions, Tissue viability, End of Life care
- Staff working in acute secondary care settings do not have full range of competences and preparation required e.g. prescribing, cannulation, intubation, ultrasound
- Staff working in GP practices, MIUs, Ambulatory Care require the skills needed to undertake ultrasounds and diagnostic procedures
- General medical contract means many GPs are working part-time, and then choosing when and where they work elsewhere attracted by high daily pay rate
- No processes for joint investigation of untoward incidents and sharing of lessons learnt
- Fragmented and unimaginative use of pharmacy services to address repeat prescribing

6.4. Human Resource Management - Recruitment & Retention of Staff

- Everyone is fishing in the same pond and there are not enough staff available so essential to recruit, retain and develop the staff that are available
- Recruitment process is too long – takes over 6mths for recruits to commence work

- Gaps between closing the loop following competence development in staff, practice and monitoring for continued competence

6.5. Children and Young People services

- Delays in implementing best practice pathways and admission areas in emergency care
- Mental health assessment for young people aged between 16-18 is lacking

6.6. Mental Health Services

- Lack of provision for and access to expertise, and Mental health beds, with CPNs overwhelmed with workload

6.7. Dental services

- Lack of dental service provision is impacting on significantly on A&E use

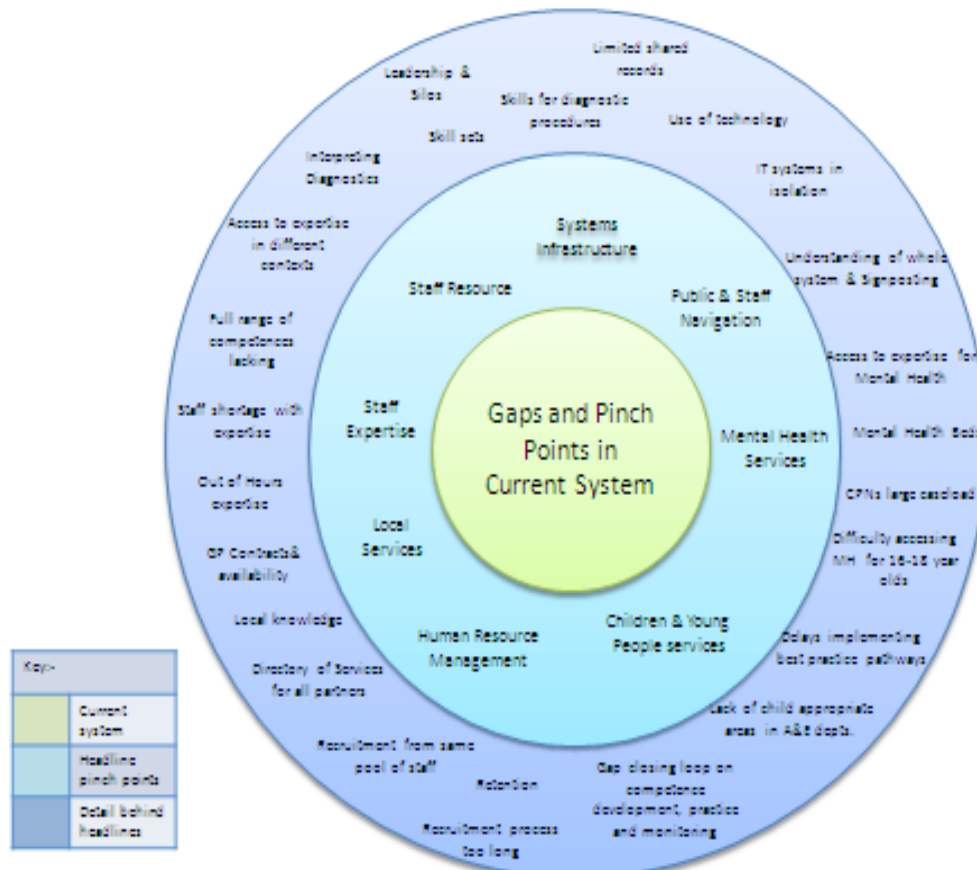
6.8. Public and staff navigation

- Understanding of whole system and signposting

6.9. Local services

- There is no directory of services accessible to all partners to assist with appropriate referral
- 111 does not have local knowledge necessary for appropriate referrals, whereas Local Referral Units would be expected to have this local knowledge

Figure 4 provides a visual illustration of the gaps and pinch points in the current urgent and emergency care service



Patient story 7 is an uncomfortable story, it illustrates the gaps and pinch points in the service, thus emphasising the importance of key aspects of competence in all contexts to ensure care is experienced as person-centred and effective. The story flags up the special needs of children often forgotten when in adult departments, inconsistent messages and the importance of effective pain relief – a frequent theme raised by service users.

Patient story 7

My daughter suffered a head injury after a fall while she was playing. I called 111 for help when my little girl started vomiting and was very drowsy. After 20 minutes on the phone speaking to a non-clinical call handler, paramedics were sent out to see and possibly treat. The paramedics were fantastic!

They carried out tests they could do at the time but were worried and decided to take her to local A&E department for further assessment. The handover took about 15 minutes. My child and I sat in the waiting room with older people, drunken young men, a few other children with their parents, people who suffered open wound injuries, young vulgar couples and people from all walks of life.

The waiting time indicated on the board was 30 minutes but after 1½ hours of waiting it was changed to 1 hour. The times kept changing and no-one spoke to me, we just kept waiting. When I enquired we were told we needed to be in majors not minors!

We had to wait a further 40 minutes whilst 3 more people were treated. I was told by the doctor my daughter needed Calpol and when I asked the Lead Emergency Department nurse they snapped back that they didn't have any Calpol to give people. A colleague of hers asked me, "do you know where Tesco is? I bit my tongue but at the reception there is a note that reads 'if in pain ask for relief' and another that instructs you not to take any medication before your treatment. Patients are already confused by the degree of inconsistency and incompetency sometimes present in many A & E departments. Lucky enough we were discharged to go home

7. Options Appraisal the solutions to addressing gaps now and in the future

There is no single workforce solution to address all the gaps and pinch points that will enable the achievement of a whole systems, integrated approach to urgent and emergency care. The options therefore identified below tackle this aspiration at different levels and from different perspectives, all will have some impact in the short, medium or long term on workforce issues. Therefore eight options have been presented in terms of breath of scope, and their positive and negative consequences and implications identified.

Option 1: Testing and refinement of the integrated career and competence framework for urgent and emergency care encompassing the contributions of all interdependent partners and staff groups as well as volunteers

The core competences have been identified around an outcome competence model using the simple **Assess, Treat, Sort** concept to apply to every setting and context to recognise the contribution of all interdependent partners within the system. This framework could be simultaneously tested, refined and implemented across the region during phase 2 of the project by working with the new roles as well as established roles that currently exist across different contexts.

Impact: This option will address all key priorities for an integrated urgent and emergency care whole system across the short, medium and long term in relation to ensuring role clarity, specific expectations and also opportunities for career progression with its impact on recruitment and retention of staff.

Positive consequence	Negative Consequence	Implications
<ul style="list-style-type: none"> The contribution of all is made explicit within a single inter-professional, team working and learning framework that also mirrors the values of integrated whole systems approaches to urgent and emergency care. This is more likely to embed an integrated whole system approach The focus of the framework is on the actions in every context to 'assess, treat, sort' - key priorities for urgent and emergency care A career framework will enable developmental opportunities for all and this is both a recruitment and retention incentive Expectations about the contribution of different disciplines will be linked to competences at each level of the NHS Career framework 	<ul style="list-style-type: none"> The knowledge and know-how required to underpin the competences is still required to be identified and linked to the NHS Career framework level. This could be delivered through a range of flexible learning opportunities Rotation across different contexts to embed full range of competences would be essential but also exposes practitioners to the whole system 	<ul style="list-style-type: none"> Phase 2 will need to include testing and refining the framework at different levels of the NHS Career Framework HEIs/FECs will need to be able to integrate competences into flexible curricula at different levels Different HEIs/FECs may wish to specialise in different areas The main resource for learning is the workplace and so skilled facilitators of learning will be required in the workplace Tools to assist with self-assessment will be required On-going maintenance of competence will need to be demonstrated Core values and competences required for providing person-centred, safe and effective care would

<ul style="list-style-type: none"> Potential for enabling consistent approaches to pay banding. 		need to complement the 'Assess, Treat, Sort' focus
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Option 2: Establish Joint Appointments across integrated partners for systems leaders in a number of key areas at level 8 of the NHS career framework – consultant practitioner, for example; in areas such as: Key long term conditions; children’s services, mental health, older people with dementia; end of life care; supporting people with pain; people with learning disabilities; prevention and tissue viability; urgent integrated care, Integrated intravenous care. These posts require expertise, clinical credibility and clinical leadership (rather than management) in caring for people within client groups as well as expertise in all the functions needed for culture change to enable people to work together towards achieving a shared vision, purpose and values; improve, learn and develop together; and also use consultancy approaches that enables expertise to be accessed by as many people as possible

Impact: These posts will have a short, medium and long-term impact. They would enable the early prioritisation of whole systems approaches and would through joint appointments more likely achieve engagement and embedded change across all interdependent partners. The benefits around culture change would begin to be evident over the medium to short term. They also offer important career progression opportunities for all disciplines which would provide incentives and also impact on recruitment and retention positively.

Positive consequence	Negative Consequence	Implications
<ul style="list-style-type: none"> Breaks down silos removing protectionism associated with roles in single contexts Drive whole systems approach to patient safety and quality as well as culture change Have the skills and expertise to facilitate an integrated approach to development, learning, improvement and inquiry Better communication across all staff levels and partners Look at needs realistically and collaboratively rather than competitively Can achieve system evaluation of impact More holistic data usage for patient outcomes, morbidity etc. Greater freedom to act Will develop systems for supervision and support, peer review, competency development & maintenance as well as drawing on expertise in using the workplace as the main 	<ul style="list-style-type: none"> Who accountable to and how would they be managed? Who funds? Operating on own in single posts do not achieve the potential that several posts provide working together. 	<ul style="list-style-type: none"> Already implemented a best practice precedent for approval of these posts with commissioners in EKHUFT CCG development – needs to be significant up front planning to create the vision for these roles to ensure funding streams identified. Need CCGs to be aligned On-going mentorship and support of these consultant practitioners will be required as they take forward novel joint appointment posts across primary and secondary care

resource for learning. This will enable practitioners at a other levels to be grown		
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Option 3: Develop a consistent and streamlined approach to co-locating GPs in the proximity of MIUs, ambulatory care to provide in-reach, so that their impact is maximised (Medway model provides a good model for this) and opportunities for rotation and growing expertise across a wide range of areas that will enable opportunities for recruitment and retention of medical consultant posts in the future

Impact: This provides a short term solution to current challenges around urgent and emergency care. Once the system is working effectively these would not be required, other than for reasons of rotating opportunities for learning and development. However broader rotation opportunities may enable better recruitment and retention of senior medical staff in the longer term

Positive consequence	Negative Consequence	Implications
<ul style="list-style-type: none"> • Appropriate referral achieved • Turn around patients quickly if need GP • Reduce numbers in A&E • Rotational scheme provides wider insight into system • Helps service users understand to attend GP practice on subsequent occasions • Provides a broad experience to GPs 	<ul style="list-style-type: none"> • Confusing situation with potential overlap between ENPs and GPs • Reducing continuity and family centred approach by GPs • Need to share record otherwise continuity for GPs patients not maintained • Deficit of GPs to run 24/7 services in general practice and this depletes numbers further 	<ul style="list-style-type: none"> • Interim short-term solution • Longer term need to be on increasing number of GPs to provide a 24/7 service. • GP clusters will enable increase sustainability in general practice and also increased range of services in general practice • Need to Up skill or recruit practice nurses , dental services/ pharmacists , physiotherapists, counsellors, support workers and diagnostics in general practice

Option 4: Develop advanced level practitioners and emergency practitioners across all key professions,(nursing, AHPs, ambulance service paramedics) to strengthen different contexts 24/7 and client groups (e.g. children, mental health, people with dementia) with experienced and expert practitioners (advanced practice level), also developing some joint appointments across primary and secondary care and establishing emergency practitioners (at bands 5-6) that will continue to feed into the advanced practitioner level, particularly in areas such as ambulatory care, MIUs, community, residential homes and GP practices.

Impact: Advanced level practitioners are recognised as providing the services required to fill the gaps. Practitioners currently working have the potential to work at the emergency and advance practitioner levels with flexible career, learning and development support. This support will enable this option to be a short, medium and long term solution if the main barriers to flexible work based learning approaches are removed (Bart's model).

Positive consequence	Negative Consequence	Implications
<ul style="list-style-type: none"> • More expertise at the front line with advanced level skills 	<ul style="list-style-type: none"> • Retention as highly desirable and so having options for 	<ul style="list-style-type: none"> • Need opportunities to get skills up to speed and department and system wide

<ul style="list-style-type: none"> • Continuity and consistent standards • Faster throughput of patients • Better outcomes • Quicker decision-making • Mores sharing of best practice innovations • Potential for more innovation in establishing services • Potential for more social enterprises • Growing facilitation and cultural change skills and leadership skills • Growing people for the future • More opportunities for career development and progression • More likely to retain staff 	<p>consultant practitioner pathways will be important</p> <ul style="list-style-type: none"> • Potential conflict between disciplines • Supervision – high demand 	<p>approach with rotational opportunities (e.g. Bart’s model)</p> <ul style="list-style-type: none"> • Assessment , monitoring and supervision • Importance for all disciplines to be recognised for same competence level between HEIs offering advanced practice programmes • Number of prescribing courses need to be increased
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Option 5: Take forward programmes around Physicians Associates to develop the recruitment pool available from graduate scientists to address shortage of Drs, nurses and paramedics and provide additional support to residential homes, community and ambulatory care teams.

Impact: These roles may provide some support in the medium term as the recruitment pool of graduate scientists is bigger than that currently available for doctors and nurses.

Positive consequence	Negative Consequence	Implications
<ul style="list-style-type: none"> • Potential for a different career development and different entry points • Potential for recruitment from a different recruitment pool • Standardisation of role exists nationally for both community and acute settings • Could provide support to GPs in d supporting residential homes, community teams and ambulatory care 	<ul style="list-style-type: none"> • Takes 2 years to complete training • Potential for inconsistent lines of accountability so may not be using all the competences prepared for • Managers may not know what they should be doing • Seen as holy grail rather than part of the solution • Another role? • Reduces opportunities for learning and development for junior Drs • Some challenges with prescribing, but often in a team with a prescriber • Needs consultant champions for their success locally 	<ul style="list-style-type: none"> • Potential to pilot the competence framework with existing PAs, Advanced practitioners, emergency practitioners across the region to ensure parity on competences across different levels of the career framework and role clarity • Potential to develop a consultant pharmacists role to overcome prescribing challenges • Supervision arrangements and rotation opportunities

Option 6: Develop both support workers in health and social care focusing on Hospital at Home and social care in residential homes.

Impact: Strengthening the skills of support workers against the career and competence framework could be achieved in the short term and will impact on raising standards in areas that currently are not well supported. In the longer term these levels could feed into the career framework.

Positive consequence	Negative Consequence	Implications
<ul style="list-style-type: none"> Developing the potential that has been identified, particularly in social care support workers. Helps patient stay in own home/close to home, maintaining independence and reducing costs Provides a career pathway for development 	<ul style="list-style-type: none"> Who's going to pay – social services or CCGs? Maintaining the talent pool if they all leave 	<ul style="list-style-type: none"> Monitoring standards – how Further Education Colleges partnership and collaboration in working with health and social care providers Higher Education Institutes and FECs working together to share opportunities for placements

Option 7: Increase number of associate practitioners in areas such as ambulatory care.

Impact: Positive short to medium impact in areas supporting these practitioners. Prepares practitioners both practically and academically providing opportunities to become registered professionals.

Positive consequence	Negative Consequence	Implications
<ul style="list-style-type: none"> Role proliferation Positive for area that employs them Career development opportunities 	<ul style="list-style-type: none"> A lot of investment over a long period of time and then may leave 	<ul style="list-style-type: none"> Need roles to be rotated across settings

Option 8: Develop administrative expertise around urgent and emergency care.

Impact: This would have short, medium and long term impact.

Positive consequence	Negative Consequence	Implications
<ul style="list-style-type: none"> Frees up frontline to clinicians for person-centred focus rather than being taken up by administrative tasks Improves patients experience and quality Improves perceived accessibility to quality data Improves the morale of current workforce as doing what they have been trained to do 	<ul style="list-style-type: none"> Risk of losing to commercial organisation 	<ul style="list-style-type: none"> Further education colleges opportunities to develop band 1-4 workforce Further education colleges could develop joint placements with health and social care providers

8. Conclusions

Phase 1 of this project has focused on identifying the priorities for workforce development in relation to delivering a whole systems approach to integrated urgent and emergency care. The priorities need to be on :

- Developing an integrated career and competence framework that values the contribution of all, contributes to and fosters interdisciplinary working and teamwork towards a shared purpose, that includes taking advantage of every prospect to care for patients at home or in their communities
- Re-purposing the current workforce, so that they have the skills needed to deliver new models of care, that focus on whole systems working, role clarity and consistent expectation and standards across the NHS Career framework level, within an integrated career and competence framework that grows all staff and provides incentives to recruitment and retention
- Developing strong systems leadership through joint appointments for consultant practitioners (and at other levels too) who across primary and secondary interfaces that have the expertise: in practice for specific client groups; leadership to enable culture change; consultancy at all levels to enable access to expertise in different contexts; developing , improving and evaluating services; and creating learning environments that focus on using the workplace as the main resource for learning

9. Recommendations

The following stakeholder recommendations are proposed:

9.1. Health Education England, Kent Surrey Sussex (HEKSS)

9.1.1. Refining and Testing the Framework

- ❖ Endorse the need for an integrated career and competence framework across urgent and emergency care to:
 - enable the contribution of all interdependent partners to be recognised;
 - support inter-professional learning and development; and
 - provide a developmental pathway that makes clear expectations the skills required for all roles or new roles linked to the NHS Career framework (and pay). (See sections: 5.1, 5.3, 5.4, 6.3; 7.0)
- ❖ Further test and refine the integrated career and competence framework with different stakeholder groups² in phase 2 of the project to spell out expectations at each level of the NHS Career Framework including HEIs running, and students undertaking advanced and specialist practice programmes, as well as staff in new roles. (See sections; 5.4.3; 5.4.4; 6.2; 7.0: option 1)

² FE Colleges, HEIs, HEKSS, Acute Trusts, Community Services, Ambulance Services, GPs, AHPs,, volunteers, care homes, fire, police

9.1.2. Supporting an Integrated Workforce Planning and Development Strategy

- ❖ Work with the 4 CCGs to develop a joint whole systems integrated workforce commissioning strategy to support development of an integrated seamless urgent and emergency care service (See sections: 5.0; 5.1;5.2; 5.3; 5.4; 6.1; 6.2;6.3;6.4;6.5;6.6;6.7;6.8;6.9)
- ❖ Invest in development of Joint Appointments between Urgent and Emergency Care Key Services across primary and secondary care (with links to HEIs) in Acute Care; End of Life Care (EoLC), Long Term Conditions, Dementia, Frail Elderly, Children, Mental Health, People with Learning Disabilities, People with Chronic health conditions: i.e. Diabetes, Chronic Kidney Disease, Coronary Heart Disease; Chronic Respiratory Disease; Pregnancy (Sections: 5.2; 6.3; 7.0: option 2, option 4)
- ❖ Support the creation of joint appointments across primary and secondary care with development of associated consultancy approaches that enable expertise to be accessed by as many people as possible. (Sections: 5.2; 5.4.3; 6.3; 7.0: option 2, option 4)
- ❖ Develop a regional Urgent and Emergency Care Fellowship Scheme to support development of Specialist, Advanced and Consultant Practitioner level roles.(Section 5.1; 5.2; 5.4; 6.3; 7.0: option 2, option 4)
- ❖ Support development, implementation and impact evaluation of an in service accredited A & E programme for band 5 and 6 practitioners to up skill the workforce with the knowledge, skills and competences to deliver safe and effective care in A & E. (Sections: 5.4.3; 6.3; 7.0:option 4)
- ❖ Develop strategies to retain the existing urgent and emergency care workforce through workplace learning, development and support for formal and informal career development opportunities. (Sections: 5.1; 5.2; 5.3; 5.4.2; 5.4.3; 6.3; 7.0: all options)
- ❖ Invest in programmes of learning and innovation that support the development of whole systems leadership skills across the health economy. (Sections: 5.1; 5.2; 5.3; 5.4; 5.4.3; 5.4.4; 6.3; 7.0: all options)

9.2. Commissioners

- ❖ Develop an integrated workforce commissioning strategy across the four CCGs to remove barriers to whole systems seamless working e.g. financial barriers, information technology, and implement enabling strategies (Sections: 5; 5.1; 5.2; 5.3; 6.1)
- ❖ Implement a regional award scheme to support the celebration of innovations in workforce design (Section: 5)
- ❖ Commission joint systems leaders posts across primary and secondary care with the full range of skills to be effective leaders to create the cultures that are required in the workplace to sustain safer and person centred services as well as places where everyone can flourish (Sections: 5.2; 6.2; 7.0: option 2, option 4)
- ❖ Prioritise recruitment and retention actions that will enable the current workforce to be retained and developed to their full potential as well as making attractive career progression models that will recruit new staff and motivate those in post to further development (Sections 5.1; 5.2; 5.4; 6.2; 6.3;7: Options:1-8)
- ❖ Prioritise Integrated information systems to enable ease of access to information by interdependent systems partners and continuity in care across the system through patient record systems that support continuity across the system (Section 5, 5.1; 5.3; 6.2; 6.8; 6.9)
- ❖ Develop a comprehensive directory of local services for partners and users 24/7 (Section 6.8; 6.9)

- ❖ Consider integrating 111 with Local Referral Units so that local knowledge benefits local population (Section 6.9)
- ❖ Support a rotational placement scheme for GPs to work in Ambulatory Care and MIU Settings to promote whole system working, continuity of patient flow and support admission avoidance initiatives as well as providing recruitment and retention incentives (Sections: 5.4.3; 6.3; 7: Option 3, option 4)
- ❖ Identify the exact deficits across the health community and move staff to enable 7/7 working by mapping numbers of staff against demand and activity sharing workforce strand underpinning commitment to sharing (Section 3.4.4.p37)

9.3. Integrated partners

- ❖ Create a rotational scheme around interdependent partners to increase understanding of the whole systems framework (Sections 5.4.3; 7: options 1, 3, 4, 5.)
- ❖ Develop a model of integrated clinical supervision to maintain standards and consistency (Sections: 5.4.1; 5.4.3; 7: Options 2,4,5)
- ❖ Develop in-service workplace learning programmes and initiatives to build the competences of the workforce rapidly by focusing on growing the number of practitioners who are able to work at the advanced level in all disciplines, and also those working at NHS levels 5-6 to grow emergency practitioners (Section 5.2.; Option 4)
- ❖ Reduce barriers to autonomous decision-making including prescribing (Section: 5; 5.4.1; 5.4.3.)
- ❖ Develop strategies to simplify the management of risk across the system and avoid system duplication and over investigation through work on role clarity and role definition (Sections : 5.0; 5.4.1; 5.4.2; 5.4.3)

9.4. Higher Education & Further Education

- ❖ Explore opportunities to develop an integrated portfolio of curricula for development of the Advanced Practice and Physicians Associate roles across KSS supported by a rotational placement scheme (Section 5.4.4.; 7: option 1-5,7)
- ❖ Maximise opportunities to support blended and workplace learning initiatives with a seamless model of accreditation linked to NHS Career Framework and role development (Section 5.4.2; 5.4.3)
- ❖ Support a regional fellowship scheme and joint appointment roles .(Section 5.1; 5.2; 5.4; 6.3; 7.0: option 2, option 4)
- ❖ Develop an accredited model for facilitating learning, development and inquiry in the workplace with FE Colleges (Sections: 5.0; 5.1; 5.3)
- ❖ Enabling rotation of learning and development opportunities to enable wider understanding of the whole systems and partnership working with other HEIs (Sections: 5.3; Options 1,2,3,4,5)
- ❖ Develop collaborative initiatives with FECs to develop the role of support workers, and career development opportunities for volunteers and business administrators (Section 5.4.3; 5.4.4; 7:options; 6,8))
- ❖ Offer a pool of expert mentors, supervisors and coaches to support development of learning in the workplace (Section 5.4.1)

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11. Appendices

Appendix 1: Themes arising from secondary analysis across all stakeholder events, surveys and process mapping

PROJECT HOPES, FEARS, EXPECTATIONS

Hopes:

- T1: Co-ordinated integrated whole systems pathway for all ages, safe and sustainable
- T2: Clarity and stability of future skills, competences, roles and workforce
- T3: Collaboration/ working together for patients
- T4: New ideas and thinking to provide new ways of thinking planning and sharing for solutions
- T5: Engaging service users and networking
- T6: Clarity of strategic direction and priorities for transformation
- T7: Project clarity

Fears:

- T1: Nothing changes and it's too late to change
- T2: Challenges too big and unachievable
- T3: Nobody working together, become more fragmented – silo working – commissioning groups do own thing (including adults and children)
- T4: Deficits in skills and committed people – now and growing
- T5: Lack of finance
- T6: Patient expectations – lack of public understanding about project and systems
- T7: Will Drs give up their historical roles

Expectations:

- T1: Recommendations based on expertise of service providers and service users and critical discussion between stakeholders or future purpose of urgent care
- T2: Understand project, how to move forward, dismantle barriers and meet standards
- T3: Clarity and sharing in achieving goals and solutions, innovations, subsequent roles and education
- T4: Network takes forward and communicates best practice
- T5: In the loop for future reports
- T6: Resources and support skills and competence development

CLAIMS, CONCERNS & ISSUES IN RELATION TO URGENT & EMERGENCY CARE PROVISION

Claims:

- T1: Specific initiatives focusing on early discharge and admission avoidance, reducing Health associated infections and improvements*
- T2: Specific tools, skills and data for collaboration

T3: 7/7 access

T4: Staff want the best for patients and can contribute in different ways

T5; Increased confidence and skills in safeguarding

T6: Expertise to break cycles and career development

T7: Experience of patients – accessible, free , quality, choice

Concerns & issues:

T1: Inconsistent service provision across all groups (including care homes)

T2: Engaging the public, managing expectations, navigating a complex system with clear definitions

T3: Lack of Skills in residential homes and social care

T4: Lack of cross-organisational and clinical leadership

T5: Tension between resource availability, focus on targets and delivering quality and safety

T6: Recruitment and retention within urgent care

T7: Lack of infrastructure & barriers to integration including CCG relationships/ communication between partners

T8: Management of Frailty

T9: Time and commitment for learning in the workplace

T10: Barriers to autonomous Decision-making

T11: National Vs Local agendas

PURPOSE OF EMERGENC& URGENT CARE, PURPOSE, HOW THE PURPOSE IS ACHIEVED AND MEANING – DEVELOPING A SHARED UNDERSTANDING AND VISION

PURPOSE of Urgent Care

T1: Provides timely care at time of crisis in the right place

T2: Manage and support high dependency urgent care to prevent loss of life, disability or ongoing illness

T3: Provide consistent standard of urgent and emergency care across regional communities and population

How purpose is achieved

T1: Rapid assessment and response

T2: Integrated uniform services 24/7 clearly defined

T3; Public engagement about the process of navigation

T4: Working together, flexibility to overcome barriers and manage risks

T5: Identifying opportunities for health and wellbeing to prevent urgent episodes

T6: Knowledgeable, skilled multi-disciplinary workforce and leadership

T7: Adequate resources to care for people holistically

T8: Managing expectations by listening to users and greater openness with local community

What urgent care means

- T1: Means different things to different people
- T2: 'Need it now, need it quickly.' time critical – requires local signposting
- T3: Unforeseen health/social care need using a co-ordinated & consistent approach
- T4: Contact system – choice about what happens taken out of persons' hands

CURRENT PROVISION, ENABLERS & CHALLENGES

Current Urgent Care Pathways and Initiatives

- T1: Condition specific pathways
- T2; Ambulatory Care
- T3: GP linked
- T4: 999 and 111 – national paramedic
- T5: Minor injuries/illness and walk-in clinics
- T6: 3rd Sector – share my care/ advanced care plans/ Care navigation service
- T7: Mental Health/ CAMS/ learning disabilities
- T8: Primary care services – adult, child, older people, primary PCT including rapid response and rehabilitation
- T9: Community Pharmacists
- T10: Hospital at Home
- T11: Co-morbidity is challenging

Enablers and inhibitors to seamless urgent- CHECK

Enablers:

- T1: GP support to residential homes
- T2: Staff sickness and morale
- T3: Support to residential homes from district nurses and CPNS

Inhibitors

- T1: 111 system not fit for purpose as diverting people into secondary care and ambulance service inappropriately and preventing people accessing OOH services
- T2: Crisis team are not experienced as being supportive to residential homes when they request help

What's working well (clinical stakeholder sessions)

- T1: Multiprofessional groups working together when crisis happens in A&E
- T2: Staff pull out all stops for seriously ill in A&E
- T3: Staff are caring even though environment is not the best in A&E
- T4: 24/7 – no-one turned away
- T5: Children triaged and treated quickly
- T6: Community **first responders** know the community well (where defib, O2, basic meds) and there within 5.5 mins, whereas Ambulance there in 20 mins
- T7: Meridian system in community

Current challenges

- T1: Need a plan to recruit and retain staff with right clinical skills to match demand (including increasing population and older people) for urgent care (not more managers!! or transient workforce)
- T2: Lack of co-ordinated and integrated collaborative working with shared purpose and simple consistent infrastructure creates delays, fragmentation, poor bed usage
- T3: Managing competing priorities: care Vs targets/penalties Vs finances
- T4: Different agendas, different perceptions, different expectations – need for realistic expectations from users
- T5: Complex contracts not fit for purpose, slows things down
- T6: Access to major trauma within 45 mins in Thanet
- T7: Lack of knowledge about available support from community by urgent care staff
- T8: Working and communicating with patients and each other
- T9: Shortage of staff, lack of responsive and comprehensive learning and development to develop key competences
- T10: People with learning disabilities/vulnerable people more likely to access A&E

WHAT WOULD THE PERFECT SYSTEM LOOK LIKE?

Miracle happened overnight and seamless integrated system appeared – what would it look like?

- T1: Full complement of staff, better use of different health professionals' expertise
- T2: Basic first aid in schools and workplaces with focus on prevention
- T3: Improvements in mortality and length of stay
- T4: Telemedicine and IT systems that talk to each other
- T5: Patients know where to access urgent and emergency care – better signposting, T6: Safe and effective patient journey based on holistic assessment and need with no 'overkill' of investigations
- T7: Reduced delays, overcrowding, crisis management
- T8: One simple whole system, uniform responsive approach, integrated working, seamless and clear, shared risk and resources
- T9: Urgent and emergency care an attractive career option
- T10: Smaller acute hospitals
- T11: Patient wouldn't have to keep repeating history
- T12: Clear communication and written info/appointment to take home
- T13: Patient feels important from beginning to end
- T14: More accessible GPS
- T15: More volunteers to talk to patients
- T16: Calm, pleasant, probate environment with facilities
- T17: Service delivered when and where it is needed
- T18: Good administrative systems and staff

CURRENT & FUTURE COMPETENCES REQUIRED**Current key competences/skills required**

- T1: Leadership across whole clinical system for innovation and development
- T2: Organisational skills to enable integration, reduce fragmentation, reduce duplication and manage risk appropriately. i.e. Risk aware not risk adverse
- T3: Advanced and specialist skills in assessment and triage across all professions and sectors at the frontline that grows experience and expertise and have local knowledge
- T4: Recognising and escalating the deteriorating patient
- T5: Telemedicine

- T6: Inter-professional communication and team work
- T7: Effective management of poor performance
- T8: Good commissioning and appropriate data management including clinical coding
- T9: Clear competences for urgent and emergency care integrating health and social aspects within a career pathway
- T10: Public education, signposting, information

Future Key competences/skills required

- T1: Holistic, rapid and shared assessment physical, psycho-social skills to enable see, investigate/treat, discharge in different settings without duplication
- T2: Leadership, creativity, whole system approaches
- T3: Assessment of risk, knowledge of legal requirements
- T4: Communication with patients and each other face-to face and phone, collaborative and interdisciplinary working across all career levels
- T5: Data analysis and interpretation
- T6: Growing expertise at different levels across an integrated career framework
- T7: Integrated health and social care skills in the community
- T8: Facilitation of learning in the workplace
- T9: Frailty, medicines management, end of Life
- T10: Educating patients on expectations from service
- T11: Providing a caring, compassionate, confidential patients experience across the whole journey and evaluating this
- T12: Induction and rotation opportunities
- T13: 24/7 service for interpreting and reporting results
- T14: admin and volunteer training
- T15: Use of Link workers
- T16: Paramedic prescribing

ADDITIONAL THEMES FROM SURVEYS

Innovations being implemented by GPs (from survey)

- T1: Piloting weekend opening through working with neighbouring practice
- T2: Hospital at Home under development
- T3: Sign up to urgent care standard producing care plans for at risk patients
- T4: Review frequent users and introduce plans to avoid emergency admission

Innovations in residential homes (from surveys)

- T1: Computerised care planning
- T2; Plans for deteriorating patient and symptom management

Innovations desired/suggestions for improving integration (from survey)

- T1: Disincentives to patients abusing service e.g. fines, 3 strikes and you're out, charge for services
- T2: Specially designed vehicles for paramedics
- T3; Information systems that enable patient outcome data to reach individual providers
- T4: Data sharing between NHS and residential homes

T5: Better dental referrals

T6: Direct referral to geriatrician and other experts e.g. tissue viability, advice line for residential homes

T7: Enable and educate residential homes around end of life care

Appendix 2: Survey analysis

1. Theme	Frequency	Theme description
FACTORS HINDERING SERVICE PROVISION		
Recruitment and retention	22	Limited front line workers, a transient workforce, lack of highly trained workforce. A lot of management and less front line workers. Non recognisable skills in some urgent care settings which could easily be applied but are not. Nurse educators need paediatric input
Poor service design and management	21	Too many overlapping services that are not joined up. Need to deliver services when and where they are needed. More coordination to avoid duplication. Needs to be more integrated as it is currently ridiculously fragmented with too many CCGs to work with. Promote GP led triage and stop competing for areas. Too much bureaucracy and encouragement to be risk averse
Limited inter professional support	6	There is limited GP support for other urgent care providers. There are boundaries between health and social care
Sign posting and increasing public awareness	4	Patients' knowledge of where to go and striking a balance between competent care delivery and continuity (<i>seeing the same GP for everything</i>)
Time for GP-patient appointment	3	Time (10 minutes) allocated to GP is not appropriate. Time is spent dealing with on the day appointments. There is insufficient time for managing LTCs and preventing admissions
Understanding roles of the different urgent care system partners	7	Urgent care providers do not understand how primary care works and thus sorting of patients is done without appropriate liaison. An understanding of what each other can or cannot do across disciplines.
Limited access to patient records	7	Patient records are not available out of hours. Data need to be active and current. All urgent care providers should have access to one database
Community beds	2	More community beds for rapid response admissions for patients in crisis rather than a lengthy and complicated hospital admission
Lack of equipment	2	Pillows and airwave mattresses which prevent consistent pressure area/ ulcer. Existing equipment is in worsening condition.

1. Theme	Frequency	Theme description
Limited financial resources	2	Stretched financial resources
SKILLS LACKING AND THEREFORE HINDERING SERVICE PROVISION		
Communication skills	13	Elderly are confused and hard of hearing, which makes them very stressed and anxious. Need to effectively manage expectations and empower patients/ carers to take care of conditions. Poor communication from secondary to primary care in form of inadequate discharge summaries.
Specialist teams for early problem identification and management of acute phase	4	Problems are not identified early as a result patients are subject to admission.
A gap in skills needed to cover some conditions	4	There is no knowledge of inflammatory joint conditions or how to manage a flare, only flagged up by patients when they become aware that the help they require is not available. Staff need education on advanced care planning. Basic knowledge of common LTC
CURRENT AND FUTURE COMPETENCES		
IT skills	12	Among administrative staff for updating and sharing records. Everyone needs IT skills to access and update electronic records
Communication skills	10	Effective information sharing in a timely fashion especially for people with long term conditions. Clear speech without raised voices and a demonstration of patience. Ability to capture patient information that would reflect their health care choices
Updated skill in clinical urgent care assessments and management of various conditions	5	Basic knowledge of managing a flare presentation of an acute joint. Skills to aspirate, perform intra articular injections/IM depo dedrone. in-depth knowledge of LTC's, the management of LTC's, current medication research (NICE etc.), clinical examination skills, diagnostic skills and knowledge of results, holistic assessment, sign posting
Tissue viability nurse	3	Tissue viability nurse lacking in a residential home to advise. Wound management and general skin protection and management

1. Theme	Frequency	Theme description
Involving stakeholders in decision making	5	Listen to the patients better especially regard normal routines - medication etc. and maintain close to their normal plans at home. Need to start at the beginning, speak to staff and service users, involve them in service development
Good leadership	3	A good leader needs to be a good source of knowledge and experience. Managers listening and supporting clinical expertise and patient management rather than constantly focussing on the financial agenda
Rotation to a larger teaching hospital to better understand roles	6	Supported training in disease specific management More time spent hands on; spending time on the wards to understand the issues affecting patients and staff day to day, to discover what we can do to improve care. more staff being able to capillary gases
Clinical nurse role in the community	4	There needs to be a high level clinical nurse role in the community to be able to assess LTC patients and help with anticipatory care planning. Staff need to have acute experience and know how the systems and processes work in both the community and hospital setting.
AHP	1	To help in facilitating care at home
Management, clerical support and general office administration	2	Managing referrals, general office admin - documentation, supplies, annual equipment checks. managerial skills: team structure, team building, support, coordination, safe working practices, strategic planning, complaint/compliments management, capturing data
EXISTING INNOVATIONS		
Pilot weekend opening	3	Running a weekend service for patients with urgent problems to attend on Saturday and Sunday
Review frequent users of OOH services	2	Review frequent users of OOH services with a view of putting plans in place to avoid them needing to access emergency care. Identification and tracking of vulnerable groups.
Increased continuity of patient care/ follow up	3	Continuity responsibilities should be the focus for providing care. Following through patients from admission to discharge by the same team of therapists, rather than handing patients over to another team and making their care disjointed

1. Theme	Frequency	Theme description
Working together with neighbouring practices/ community services	18	GP service access to community and district nurses. Working with CCG's to implement services.
Paramedics supporting prescribing	1	Paramedics have had an expended set of clinical practice guidelines
Specially designed vehicles for Paramedic Practitioners	1	Specially designed vehicles for Paramedic Practitioners in control of intelligence based information systems
A set threshold for patients seen	2	Not taking on patients where there is less or no support. Cancer patients are encouraged to use emergency department if on treatment
Plans for deterioration of conditions and symptom management	9	Forward planning with regards to transition to adult services. Have a flagging system for patients with a known diagnosis of cancer which is helpful for alerting the Acute Oncology Service / Cancer CNSs. Assessments of care for patients with long term conditions at the end of life. More integrated care plans in collaboration with specialist teams
Tele health	3	Increase use of tele- care for patients with chronic illness to contact specialist services may help prevent hospital utilisation and help patients feel supported
Better access to paediatric wards	1	Identifying vulnerable children e.g. children with learning disability and flagging on PAS so that they could be offered longer clinic appointments and better appointment times
Currently evaluating advice line	1	evaluating our advice line to establish how and who uses it and how we can improve it further
Communication skills workshop	1	communication skills workshop for generalist hospital nurses in dealing with difficult questions around end of life care/advance care planning
Shared special patient records systems	5	a standalone special patient records system linking general practice with other services that care for patients both in and out of hours. use a system called IBIS which allows communication with the Ambulance trust in relation to patients with LTC and there emergency management plans
Hot ambulatory care		introduced to avoid hospital admission for ambulant, clinical stable patients who can be managed as an outpatient
A review of documentation	1	an action group of specialist nurses and ward staff are reviewing the documentation to ensure it is not repetitive and is user friendly

1. Theme	Frequency	Theme description
FUTURE INNOVATIONS		
Punitive measures for abusing services	4	Levy fines on patients abusing the services. There is no disincentive and this breeds dependence and helplessness in the patient.
A centralised electronic patient information system	20	Integrated up to date and accurate records including medical issues and medication created collaboratively.
Multi-disciplinary teams	3	Multi-disciplinary competent teams involved in providing urgent care. Less defensive/obstructive culture seen by staff regarding patient care
Increase the availability of community services	6	Direct access to geriatrician, ICT to facilitate access to GP. There needs to be a community enhanced rapid response service for patients with LTC. Community staff should also be able to directly admit patients that need hospitalisation. GP services and responses by GP's are inconsistent and diverse leading to patients presenting in the acute hospitals for avoidable reasons
Regular clinics in residential homes	1	Professionals have weekly clinics in residential homes
Investment in new posts	2	Additional nursing, medical and therapy staff in acute admissions areas
Understand what outcomes patients are looking for	2	There has been too much focus on what professionals think patients want from a services. Some form of checklist for each patient on admission, in order that all aspects of their assessment and treatment are covered
Integrated working	14	Together it is possible to do more within the stretched resources and emphasis on good quality care. Care teams need to be well structured to offer more support in residential homes. A recent integrated care model in South Kent Coast demonstrated that services can work across boundaries when brought together and achieve results
Improve end of life care	1	Improve the comfort of patients who die in A&E to ensure they are in a comfortable bed and not on an A&E trolley
Rapid access condition specific clinics	9	Specific clinics with medical and nurse consultants following the case load and preventing avoidable hospital admissions. Care passports for people with LTC.

1. Theme	Frequency	Theme description
Improve patient/ carer comfort in the waiting area	1	If patients are to wait for long periods of time for x-rays and blood test results, it would be a good idea to provide a chair/more chairs for the patients carer to sit on in the patient cubicle, so that the patient has someone with them during their stay
OTHER COMMENTS		
Adequate funding for GP practices	4	More could be done in primary care if properly resourced and upskilled
Improve directory of services	1	Improve directory of services to enhance out of hours or hand role to more effective provider
111	2	Enhance call handler role to improve performance
A communication tool used in A & E to initiate emergency action	1	Designed a communication tool to indicate symptoms and needs, now being used in EDs and nursing homes when having to initiate an emergency action
A separate line like 111 for long term conditions	4	Patients with LTC at the end of life stage should not go through A& E but be admitted directly to wards. Consider if hospitals should have dedicated palliative care.
Volunteers to support A & E	1	volunteers to support elderly or vulnerable patients in the department access water / food etc., particularly when the dept. is very busy
GP intervention for 999 calls	1	GP intervention pre admission for 999 calls which are clearly non-emergency to provide short term step down care
Committed workforce	2	There also needs to be a far greater commitment from the Consultants, some of them dictate what they are willing to do or not do, which stalls service improvement. The NHS has a large no. of staff but very few actually deliver hands on care.
Redefine roles	4	There are many senior managers and I think their role and expectations should be reviewed. There always seems to be many meetings/discussions but there are few actions generated and these are not adhered to in a timely manner

Appendix 3: Process & Gap Analysis

1. Stakeholder	2. Current Issues/Challenges	3. Good practice/working well	4. Miracle Questions	5. Future Skills/Competences
A&E	<ul style="list-style-type: none"> • A lot of the current staff do not have the required competences to cope with the demands • Huge variance in skills within a staffing band • Difficult to keep track of competences of staff that they have undertaken or they are used • E-rostering dictates what competences you have on shift as not all banded staff have the same. ie ENP/ Paed nursing and during annual leave • Recruitment issues to fill vacancies • If nursing moves up a grade leaves a gap below which cannot be filled with required skill sets • Backfilling an issue • Reliance on locums • Poor performance not management through 	<ul style="list-style-type: none"> • Transferrable skills with some good skill sets for trained staff at band 5 & 6 • Some parts of roles are good, ie band 7 skills good leadership in clinical resus. event but not in management • Attractive roles for nurse managers/leaders but can leave gaps with lesser skilled band 6's left below. • Embedded pathways give a good patient experience with staff understanding their involvement/role • GP at Front Door – but could see more (Commissioning is a blocker) • Mental Health Liaison located within A&E 24/7 • SEAU – streamlines patients to correct surgical specialty • Pulling patients straight to HOT ambulatory • MINT nurses • Dedicated portering services 	<ul style="list-style-type: none"> • Sharing of information between providers and referrers • Clear system of how to discharge/refer to appropriate services for patient – clear signposting • Electronic cascade system which links to the PAS system • Electronic SECAMB system accessible to A&E • Staff should be able to work across the Emergency Floor • OOH work with OOH GP service/IC24 to stream patients away from A&E • Working hand in hand with other providers such as primary care /Community/ mental health/Social Services • Ability to appropriate workforce plan rather than to fire fight against demand • Ability to effectively refer suitable patients for tele-health for management of LTCs 	<ul style="list-style-type: none"> • Method of showing staff competences and booking shifts appropriately • ICPs – standardised with prescribed care plans • Attributes of management training for higher banded staff to lead • Reflective practice to look at how things went and how to learn/improve • Named nurse to pull patients through the system • TV skills or specialised nurses at front end • Project management skills • Clear role for Physicians Assistant • Incorporating ENP/ANP role more into A&E/Minors • Leadership from managers to give vision • Specialised skills to enhance A&E skills such as Paeds, TV. • Skills and competences aligned to other specialised

	<ul style="list-style-type: none"> • Spilt between Dr v nursing – lack of team working & accountability • ENPs working in isolation to rest of A&E Dept • Inappropriate patients being sent in or self-referring • Not enough access to shared records • Lots of investigations mean a wait for the patient – are they the correct ones being requested? Does the patient need all of these? • Repeat attenders and readmissions not dealt with proactively - case conference • Access to beds • Patient transport • Triage – streaming by admin staff • Not enough Paeds nurses • Difficulties in achieving 4 hour standard resulting in patients sometimes being admitted if investigations not done/completed in A&E setting 			<p>areas such as Resus & ITU re intubation</p> <ul style="list-style-type: none"> • All nursing staff able to cannulate • Recognising deteriorating patient • Dementia toolkit
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<p>Secamb</p>	<ul style="list-style-type: none"> • A lot of unnecessary calls • Unable to prescribe • Not enough Paramedic Practitioners • Too many pathways for paramedics to look at in order to signpost effectively at the scene • IT not shared effectively • Competencies and pay bandings do match Acute setting • Paperwork – is it read? Is it enough? • Very process driven and prevents free thinking • Activity increasing • Differing systems across the different areas, ie LRU for Canterbury & Ashford and not for other areas 	<ul style="list-style-type: none"> • Able to signpost a lot of calls when received • Other stakeholders open to sharing pathways and SECAMB taking direct, ie RR, Ambulatory pilot • Paramedic Practitioners able to be first responders in cars and able to assess situation • Use of the support workers • Good leadership • Dedicated GP numbers to arrange GP appts by Paramedics at the scene, • Access to GPs at A&E/MIU to make appts/gain advice avoiding admission • Good see and treat skills diverts attendance at MIU • Able to bypass A&Es and take direct to MIUs etc • Building up the IBIS database – useful for LTC management • Less patients transferred to acute setting despite rise in total number of calls 	<ul style="list-style-type: none"> • Organisations being able to work together • Shared ownership • One IT system able for all to access and share records and care plans • Similar processes with one DOS booklet to show pathways • Secamb practitioners paid at the level of competence to other staff – such as Trust ENPs, ANPs etc 	<ul style="list-style-type: none"> • Prescribing • Paramedic Practitioners trained to ANP level, with more band 7 senior decision makers • Shared competency levels between organisations/consistency • Role of Emergency Practitioner in Nursing/Care Homes to be developed • Skills in identifying Sepsis and early giving of AB's
<p>111</p>	<ul style="list-style-type: none"> • Staff turnover gives variance in quality and interpretation of process tool. • Signposting set for 15 miles – this can direct patients to 	<ul style="list-style-type: none"> • Training programme – varied and offering wide range of training media • Service more widely recognised and usage has gone up 	<ul style="list-style-type: none"> • Links to electronic shared records • Promoting 111 more – untapped potential and building confidence 	<ul style="list-style-type: none"> • Ability to signpost more effectively • To give a service which is more person centred and not evident it is delivered from a flow chart

	<p>the wrong areas is the zone goes over the sea, ie Sheppey</p> <ul style="list-style-type: none"> • Some of the outputs are inconsistent, ie for urgent apt but the patients are not urgent when seen • Nowhere to record it patient has LTC • Wrong addresses are picked up • No links to any records, ie GP, share my care etc 	<ul style="list-style-type: none"> • Clinical support by floor walking GPs to assist in managing complex calls • Facility for clinical call back to the patient 	<ul style="list-style-type: none"> • Improvement in how the DOS is updated and what is contained to enable operators to signpost correctly • Ability to hold onto good staff – turnover huge • 	<ul style="list-style-type: none"> •
Ambulatory	<ul style="list-style-type: none"> • CCGs providing some services such as DVT without correct training/competences giving poor consistency • Difficulties in recruiting right level of staff, ie Acute Physicians, highly trained nursing staff • Silo working with Acute v community • 	<ul style="list-style-type: none"> • Enabler to prevent admission • New Hot Process models to treat all patients as ambulatory as proven otherwise • Amb Score • Nurse Prescribing • Quick and responsive decision making • Use of Band 4 nurses is increasing • Review clinics • Whole system pathways – linking to H@H and Community 	<ul style="list-style-type: none"> • Ring fenced areas to enable flow of patients without impact of bed capacity issues • Resourced service to enable 7 day working for consistent service • Seamless links to Community Nursing teams • Whole systems working • Signposting via 111, LRUs • Use of Hot clinics to enable patients to return without admission • Shadow working with other providers 	<ul style="list-style-type: none"> • Sharing of nurse led discharge in Acute setting • More IV trained Community Nurses to deliver IVs/cannulate • More band 6/7 nurses to enable nurse led pathways and decision making • Physicians Assistants to fill gap between Acute Physicians and Nursing staff • Emergency Floor Doctors rotating roles into Ambulatory, CDUs and A&E including medical rotas to share knowledge and ownership
Care Homes	<ul style="list-style-type: none"> • Input by CNS staff is predominated by Quality 	<ul style="list-style-type: none"> • Sharing of information such as Dashboards by the Acute Trusts on admission 	<ul style="list-style-type: none"> • Communication and focused MDT Board Rounds 	<ul style="list-style-type: none"> • Increased role of CNS to give leadership, quality and

	<p>RCA's and admission avoidance and not training</p> <ul style="list-style-type: none"> • Differing levels of support given to Homes by GPs – due to locality, personality and priorities of CCG • Care Homes “labelled” by Acute setting for sending patients in • Lack of consistency around geriatrician roles in Community • Varying support with dementia residents, particularly around escorts • Varying links and accessibility to specialist areas such as Tissue Viability, RR, Enablement etc • Complex patients • Task orientated care plans which prevent staff from being person centred • How to identify the deteriorating patient and escalate appropriately • Readmissions • Levels of training, skills & motivation of staff 	<ul style="list-style-type: none"> • Ability to focus on homes with high admission rates • Advanced Care Planning for some patients • CCG Operational groups – MDT focus • Medical input by Acute Geriatrician in Community • Board Rounds with MDT in Acute setting 	<ul style="list-style-type: none"> • Consistency of service • Training packages for homes for all staff groups • Leadership and Visionary skills evident in all homes to enable quality serviced for residents • Acute Trusts to recognise importance of involving care homes in discharge planning • Reduce and breakdown barriers to enable specialties to in-reach to NH to prevent issues such as Pressure Ulcers and to RH to provide short term enablement – quality benefit to the residents. • Learn from other countries around models of looking after older generation 	<p>training advice to Care Homes</p> <ul style="list-style-type: none"> • Give level of support to both Residential and Care Homes regardless of trained member of staff • Dementia training to all staff • Person centred skills • Agreement of skill sets for all levels of staff in care homes • Peer Review of homes by GPs and other homes • Use of ANPs and PA s to support delivery of care • To link with educational establishments to embed learning ethos and clinical supervision and retain staff • Nurse Prescribing – Community • Student nurses to play vital role as fresh pair of eyes and sharing up to date knowledge
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<p>Hospice</p>	<ul style="list-style-type: none"> • Accuracy and reliability of referrals • Need to “eyeball” patients first • Bed availability if a patient requires and wants an urgent admission • Difficulty in recruiting senior staff, particularly in geographical areas 	<ul style="list-style-type: none"> • Good range of options for the patient • Hospice at Home service to support patients and carers enabling patients to remain at home – run by Band 3 nurses and gives quick response • MDT approach – reduces boundaries of roles and work as a team • Patients can be seen in their own home, OPD etc gives flexibility • Highly skilled band 6/7’s to work alongside Drs • Share my care – prevents admissions and enables patient to be treated at home • 365 days a year help line for known patients to access service – patients and carers • Person centred care at all times delivered by strong MDT team ethos • Low turnover of staff 	<ul style="list-style-type: none"> • Band 5 nurses to be part of the Hospice at Homes service to widen the number of patients that can be seen • Dovetail to Community Services • All service providers have access to Share My Care or similar • Extend helpline for all patients/carers requiring service 	<ul style="list-style-type: none"> • Community services to work with teams to share learning around pain relief and IVs • Mini referrals to be developed to enable assessment and access to the SPA • Sharing of learning and strengthen relationships with other providers at all levels of the teams to enable appropriate referrals • 24/7 advice line with appropriate clinical knowledge to reassure & signpost – user/provider • Rotation of staff and increasing roles, ie AP will enable gaps in recruitment of current establishment
<p>IDT</p>	<ul style="list-style-type: none"> • Difficulties in leading and managing a multiagency team • Pull system sometimes fails due to personalities rather than roles 	<ul style="list-style-type: none"> • MDT team involving all stakeholders required for discharge and admission avoidance at front end of acute and with strong links and understanding of community processes/systems 	<ul style="list-style-type: none"> • Breaking down of barriers between health and social care • Communication and awareness by service users of who to contact 	<ul style="list-style-type: none"> • Leadership skills for all membership • Team working and shared purpose – values clarification

	<ul style="list-style-type: none"> • Split between Health and Social Care • Barriers of timescales, ie choice, time to assess cause delays in the pathway and can be used as obstacles • Person centred is not obviously priority • 7 days working gives variance of service in some of the disciplines • Capturing of what is not working • Referral process to DNs despite in-reaching • Continuing Health Care and Fast track services not covered by IDT – poor responses affecting patient wishes 	<ul style="list-style-type: none"> • Cluster working with band 5-7 nursing staff • “Pull” system in order for process to work proactively, focus on front door • Prevents admission through the different stages of the acute setting • Split of Front and back team gives clarity around focus areas • 7 day service • Access to Share My Care • Links to Community Neighbourhood teams to support transition of care • Good use of admin staff to expand boundaries • Use of voluntary sector to provide additional services such as Red Cross, Carers first – to give info to carers etc • Access to Mental health Liaison services 24/7. • All health staff able to do basic physio assessments with some able to order equipment 	<ul style="list-style-type: none"> • Shared records used by all on same system for Kent and Medway • Shared and responsive pathways across whole systems, ie DNs, Fast Track, CC • Identify and adapt discharge processes to make • Services to in-reach and be part of IDT - Continuing Care, Fast Track • Involvement in ward based MDT meetings • To be central information point for all discharge related processes and procedures for both staff and patients and relatives • Dementia specialist to be included in Front end team • Respite wards 	<ul style="list-style-type: none"> • Team must be MDT with access to services/advice not part of the team • Use of PA’s to assist with EDN, drug issues and clinical input to enable discharge • Decision making ability • Development of tools for MDT • Appropriate capacity planning to enable planning of DN workload • Dementia training • Nurse prescribing • Nurse led discharge
IC24	<ul style="list-style-type: none"> • Confidence around 111 and call handler skills • Commissioning and integration • Negativity between staff and practitioners 	<ul style="list-style-type: none"> • Good ANP and paramedic are vital to success • Paramedics drive themselves as opposed to Dr staff who won’t • Collaborative working with SECAMB 	<ul style="list-style-type: none"> • Removal of barriers • Rotational posts for staff through ED, MIU etc – evaluate to see competences 	<ul style="list-style-type: none"> • ACP and paramedic practitioners • Nurse prescribing – also linked to clinical examination

	<ul style="list-style-type: none"> • Other providers – continuity and recruitment/retention issues • Folkestone GP pilot 7 day working led to increase in IC24 contact • GPs expensive • Agencies competing – rates of pay plus difficult to assess competencies and quality – lack of control 	<ul style="list-style-type: none"> • Lots of data available to share 	<ul style="list-style-type: none"> • Primary care facility placed in secondary care facility, ie Isle of Sheppey • Standardised rates of pay for ANPs 	<ul style="list-style-type: none"> • PGD’s linked to clinical assessments • National standard for advance practitioner training • Paramedic and practice nurses have different skill set but can all be called practitioners • Needs to be on NMC register • Understand what skills/competency deficits are – looking at in hours v OOH • Needs to be MDT
<p>Community Matrons/Teams</p>	<ul style="list-style-type: none"> • Referral process is inconsistent • Difficulties in understanding which competencies staff are supposed to have • Boundaries of which teams take which patients – linked to GPs • Capacity issues – tend to get send referrals which are not appropriate and expected to pick up • Inappropriate referrals • Block contracts can cause issues of ownership both for community and acute trusts 	<ul style="list-style-type: none"> • Range of banded staff from lower bands to 8A • In-reach to Acute setting • Community Matrons to form part of IDT • Use of Care Plans – creating and updating • Point of contact for many patients • Patients rely on DN visit – could attend practice? 	<ul style="list-style-type: none"> • Seamless whole systems working with clear roles and responsibilities • Pulling patients by community matrons in-reaching diverting to other schemes such as telehealth • Sharing care plans with other stakeholders • To work with other initiatives – such as Hospital at Home, Ambulatory to form part of pathway • To include more at the front-door with their knowledge of the patient and links to GP 	<ul style="list-style-type: none"> • Consistent competencies • Demand & Capacity and availability • Expand use of Telehealth and technology • IV access • Ability for staff to accept greater range of patients. • Shadowing and sharing learning

	<ul style="list-style-type: none"> Trust of knowledge between professionals from other providers Discharge information from Acute not clear or correct on occasion 			
SS/Enablement at Home	<ul style="list-style-type: none"> Care Managers in acute and community have limited understanding of processes which impacts when covering 7/7 Working to timelines Communication with ward teams and patients/carers Not documenting in Medical notes – working in isolation Out of area patients – difficulties in resolving due to boundaries 	<ul style="list-style-type: none"> Social Care Discharge Coordinators integral to steam-lining acute to community Cluster working in acute setting as part of IDT Access to step down/social services beds Bed Manager giving central availability feeding into IDT More autonomy around authoring care packages and enablement Use of KEAH for short term care packages 	<ul style="list-style-type: none"> Linking of whole systems removing barriers such as timescales of 72 hours to assess – moving away from task and process to person centered To really work as an integrated team (health and social) 	<ul style="list-style-type: none"> Shadowing all areas of SS responsibility to give knowledge and understanding of processes & systems Shared purpose Leadership Ability to move away from process and timelines to person centred approach
Rapid Response & ICT	<ul style="list-style-type: none"> District Nurse referrals are not consistent Referrals for DNs not always appropriate – could be seen by practice nurse Delays with Continuing care – poor process and response. And Fast Track. Lack of beds for CC, F/T and for general community patients 	<ul style="list-style-type: none"> Band 5 and 6 nursing teams – nurse led service for RR Good integrated working with Physio and OT rehab service Assessments carried out by all levels of staff from band 4 – 6 Range of services can be offered, referral to POTS, SS, Care Package, Re-enablement, Community Bed 	<ul style="list-style-type: none"> Shared records system which all disciplines have access to Streamlined process for CC, fast-track and Rehab beds to enable patients to be transferred to appropriate environment. Focus on patient pathway in community Joined up 7 day process by all agencies 	<ul style="list-style-type: none"> Leadership – encouraging flow and patient pathway/experience focus Wide range of clinical competences

	<ul style="list-style-type: none"> • Difficult to find rehab placements • Delays in Community Hospitals discharging due to Social Services delays in setting care packages • Focus in Community Hospitals is not EDD • Bed managers in Community finish as 4 • Overlap on occasion with Acute POTS and RR. 	<ul style="list-style-type: none"> • Referral process open to include most patients categories • Support IDT • Provide care packages for immediate start providing have capacity • Support SS care packages providing a date is set to start • Support workers can set goals with the patient • Use CIS which SS also use to enable shared records • Have competencies around equipment, POT basic assessments 	<ul style="list-style-type: none"> • Links to navigation centre/LRU to ensure correct signposting and quality service to patient • Specialised clinics to be run in community by POTS – ie Hips & Knees – led by Band 4 enhanced recovery and quicker discharge for patient • Early supported discharge for Stroke – link Acute and Community POTS 	
Hospital at Home	<ul style="list-style-type: none"> • Referral process to be robust/consistent • Overlap between community and H@H caseload v commissioning from CCG • Not able to hand patients over to Community staff as do not have capacity or training to take on patient • Lack of IV skills in community • Limited amount of patients able to be suitable • Both Push and Pull system to H@H which is dependent on the individuals in charge 	<ul style="list-style-type: none"> • Patient experience excellent • Outcomes good • LOS not increased • HAI rate is less if H@H take patients • Good decision making and clinical skills in band 5/6 staff • Virtual MDT ward rounds ensure whole clinical team approach • Committed Team approach • Embedded with Surgical areas 	<ul style="list-style-type: none"> • Joined up working with Community Services to enable seamless quality service • Service to be expanded to take band 3 nursing staff and above with POTS to enhance the numbers of patients that can be taken and the care that can be delivered • Closer working with front end, ie A&E, Ambulatory to enable care to be given closer to home • Working with all specialties to enable the benefits of the service to be available • Work as part of the IDT 	<ul style="list-style-type: none"> • IV skills in community • Understanding of services by ward teams to enable appropriate referrals to take place. • Signposting from A&E & Ambulatory to deliver specialised nursing advice • Leadership skills to evidence benefits and further develop service • Links/provision of tele-health and specialised nursing teams • Awareness of other services etc which could help

	<p>or visiting the ward as opposed to automatic process</p> <ul style="list-style-type: none"> • Not all specialties are included • Some Consultant resistance to referring to a virtual ward • Geography of where patients are located could make the service inefficient • Pressure to take unsuitable patients due to bed pressures 		<ul style="list-style-type: none"> • Engagement with Community Pharmacy teams • Links/working with Hospice @ Home team 	<p>patients be further managed at home,</p>
<p>MIUs</p>	<ul style="list-style-type: none"> • Not all diagnostics available • Different opening times may cause patients to go to Acute sites • Signposting sometimes means patients are seen and then sent to Acute A&E – delays in patient treatment • Sometimes feeling of isolation due to working in small teams 	<ul style="list-style-type: none"> • SECAMB now take patients directly to some MIU • Led by ENPs – good all round skills and knowledge • Matron overseeing • Use of telemedicine • Nurse led discharge • Nurse led prescribing – some PGDs • Team working approach • Leadership skills • Can re-attend for some dressings but should go to practice nurse • Good signposting skills and links to GP practices 	<ul style="list-style-type: none"> • Links to GPs/GPs working out of MIUs would increase the number of patients being seen and support nursing staff • Deliver Ambulatory pathways • Access share my care or electronic records, particularly around LTC and repeat attenders. • Links to community teams and CCGs to address repeat attenders for ACPs • Could take more if enough staffing and Radiography/Sonographers available to support • Extend SECAMB to take more patients to MIUs 	<ul style="list-style-type: none"> • ANPs and PA’s would increase the types and numbers of patients which could be seen • Diagnostic training to nursing staff, ie ultrasound • Basic Physio assessment skills • Rotation amongst MIUs and Acute A&E Minors to enhance practice and build relationships & confidence

<p>Mental Health</p>	<ul style="list-style-type: none"> • Hard to access service if between 16-18 • Can take time for patients to get access to the right service • Difficulties if patient is still deemed as not discharged clinically before MH team will get involved if patient in A&E. • MH beds • Waiting times for Psych appointments may cause deterioration in patient's condition resulting in urgent attendance at A&E • Large caseload for MH Nurses in Community – fluctuating depending on location 	<ul style="list-style-type: none"> • A&E Liaison located within A&E depts. • Signposting improved 	<ul style="list-style-type: none"> • Single point of access for urgent mental health response • Access through 1 number and will be in operation in 3 centres covering Kent • Link to 111 • Routing and signposting • Tele-triage and assessment • Access to electronic patient record • Availability of SPA for relatives and carers as well as patients. 	<ul style="list-style-type: none"> • Listening and empathy skills for SPA operators • More trained MH nurses in Community
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Appendix 4: Competence framework

ASSESS	TREAT/INVESTIGATE	SORT ³
<p>1. Assessment of First Aid Needs (first attenders)</p> <p>4. Holistic assessment at appropriate level</p> <ul style="list-style-type: none"> • Structures interview so that the individual is encouraged to express their concerns, expectations and understandings, so that these can be appropriately addressed Undertakes a tailored and holistic assessment in order to development an appropriate management plan • Conducts a systematic assessment and examination for individuals relevant to the context to include the recognition of people who are acutely ill/deteriorating and or have long term conditions • Take a patient history appropriate to context to include history of presenting complaint past medical history, social history, family history, psychological assessment, allergies, review of body systems and assessment of risk • Identifies differing needs of vulnerable adults and children applying appropriate assessment strategies • Undertakes a comprehensive mental state examination tailored to the needs of the patient and context including assessment of appearance, behaviour, level of conscious, 	<p>Diagnosing in different settings</p> <ul style="list-style-type: none"> • Conducts and initiates appropriate diagnostic procedures in different contexts e.g. residential care homes, GP surgeries, hospices, MIUs, ambulances, homes • Accesses a local system of case management for people with long term conditions which is not solely disease-specific Formulates a differential diagnosis based on objective and subjective data • Uses clinical judgement to select most likely diagnosis in relation to all information obtained • Recognises potential clinical risk situations and take appropriate action to minimise/eliminate risk 	<p>Understanding whole system</p> <ul style="list-style-type: none"> • Demonstrates effective assessment of people in relation to the application of local discharge policies • Uses clinical judgement regarding referral to other members of the inter-disciplinary team to enable integrated working • Promotes a culture of inter-disciplinary working to ensure effective discharge planning • Maintains an awareness of any new developments in the structure and function of the NHS and particularly in relation to their area of practice • Engages with and evaluates new developments in integrated urgent and emergency care that improve the person s experience and outcomes

³ Encompasses Referral, Discharge, Admission

memory and higher cognitive functioning		
2.Protocol driven assessment (111) <ul style="list-style-type: none"> Applies principles of clinical governance to minimise risk to patient and ensure safe standards of working practice Systematically applies and complies with assessment driven protocols for telephone triage 	Interpreting diagnostics <ul style="list-style-type: none"> Interprets and responds appropriately to results from consultation (assessment, history, physical and mental examination and diagnostic investigations) Determines the relevance of screening tests Recognises when information/data is incomplete and works safely within these limitations Recognises key diagnostic errors and issues relation to diagnosis in the face of incomplete data Recognises when a clinical situation is beyond their competence and seek appropriate support 	Referral system/appropriate follow-up <ul style="list-style-type: none"> Assesses and delegates workload and monitors delegated work load effectively Effectively manages people at the interface of different specialities and agencies, including primary/secondary care, imaging and laboratory specialities Utilises advance communication skills when implementing advance care planning and end of life care
3.Using assessment tools (residential home) <ul style="list-style-type: none"> Assess all older people accessing urgent care for the presence of frailty syndromes – falls, immobility, incontinence, confusion Assesses older people for cognitive impairment using a validated tool 	Documenting <ul style="list-style-type: none"> Initiates and maintains accurate, timely and relevant treatment records Demonstrates effective note writing and case presentation techniques Documents treatment, plans and results succinctly, accurately and promptly to enable access by all members of the health care team Uses existing advanced plans to guide appropriate actions 	Timely follow-up/discharge <ul style="list-style-type: none"> Effectively and efficiently hand over responsibility to other health and social care professionals Actively involves and empowers people and/or carers in discharge planning process Appropriately and sensitively identifies and uses opportunities for health education
Prioritisation, decision –making (triage) <ul style="list-style-type: none"> Recognises the importance of people’s rights in accordance with legislation, policies and 	Providing Advice <ul style="list-style-type: none"> Provides evidence-based advice in telephone consultations and/or 	Reflecting and evaluating <ul style="list-style-type: none"> Reviews individual progress and adjusts the plan in response to

<p>procedures Prioritizes people’s wishes encompassing their beliefs, concerns, expectations and needs</p> <ul style="list-style-type: none"> • Recognises when to take appropriate action in safeguarding and promoting the welfare of the child • Ensures triage systems are in place for effective decision making. • Use technology such as tele-health to assist in decision making to ensure that hospital admissions are prevented by liaising with appropriate long term condition specialities • Utilises advance clinical judgement to prioritise care for patients with long term conditions, or requiring end of life and oncology services • Recognises the needs of vulnerable children and ensures that systems are in place to offer person centred use of resources • Identifies when to share information in a timely and accurate manner whilst respecting legislation on the control and confidentiality of information 	<p>different media based on assessment of the person</p> <ul style="list-style-type: none"> • Provides evidence-based advice in face-to face settings based on assessment of the person • Evaluates advice provided, its quality and effectiveness • Identifies and takes action when own or others behaviours undermines equality and diversity 	<p>assessment and test results</p> <ul style="list-style-type: none"> • Develops and reviews clinical management plans based on a full inter-disciplinary assessment Promotes review of discharge-planning and policy to ensure effectiveness • Critically evaluates own practice to identify learning/development needs and utilise learning opportunities
	<p>Prescribing/PDGs</p> <ul style="list-style-type: none"> • Interprets written prescriptions accurately, seeking confirmation when the drug, dose or route of administration is unclear • Determines and proposes appropriate therapeutic interventions from full range of available prescription medications used in the clinical setting. • Writes accurate and eligible prescriptions in outpatient, inpatient and 	<ul style="list-style-type: none"> • Communicates the implications and the consequences of the diagnosis and drug management of an urgent condition in the longer term clearly and appropriately to the person experiencing it

	<p>primary care setting for review and signature by supervising clinician</p> <ul style="list-style-type: none"> • Uses the BNF and local formularies appropriately and be familiar with systems for reporting side effects/drug interactions in context • Recognises responsibility for facilitating patient concordance for the drug regime being proposed by them and prescribed by supervising clinician • Recognises the support needed by a dying patient and makes provision for the use of medicines, special equipment, formal palliative instruments 	
<p>Communication</p> <ul style="list-style-type: none"> • Consistently behaves with integrity and sensitivity • Prioritises patient’s wishes encompassing their beliefs, concerns, expectations and needs • Managing expectations by listening to users • Identify and address ethical and legal issues which may impact on patient care, casers and society e.g. human rights, confidentiality, informed consent, responding to complaints • Values the roles fulfilled by other members of the health and social care team and communicates with them effectively • Models the principles of effective interdisciplinary cooperation in order to maximise optimum treatment opportunities for the patient 	<p>Delivering interventions in different settings</p> <ul style="list-style-type: none"> • Establishes and maintains a safe practice environment • Effectively manage patients at the interface of different specialities and agencies, including primary/secondary care • Demonstrates effective multi-agency working through awareness of roles and responsibilities within other services • Applies appropriate procedural skills relevant to patient assessment findings • Uses appropriate manual handling techniques for the situation/context using appropriate aids available • Delivers interventions in homes/residential care settings 	<ul style="list-style-type: none"> • Monitors and follows up changes in person’s condition and response to treatment recognising indicators of person’s response • Effectively and efficiently hands over responsibility to other health and social care professionals • Delivers bad news on patient and family, understands impact of this for the person and offers appropriate referral to counselling/bereavement services • Communicates effectively and appropriately verbal and non-verbal information, advice, instruction and professional opinion to service users, colleagues and others • Uses structured education programmes and information sources for

<ul style="list-style-type: none"> • Demonstrates effective communication with children, young people and their families • Communicate effectively and appropriately with patients and carers even when communication is difficult • Facilitates patient and/or carer involvement in management, planning and control of their own health and illness • Demonstrates the ability to communicate effectively in complex and demanding situations • Delivers bad news skilfully according to needs of individual peoples and their relatives/carers • Responds skilfully and appropriately when responding to questions regarding end of life and advance care planning 	<ul style="list-style-type: none"> • Delivers interventions in emergency vehicles • Delivers care interventions in general practice/clinic/department settings 	<p>urgent care conditions and can refer appropriately</p>
<p>IT skills</p> <ul style="list-style-type: none"> • Uses core IT competencies relevant to clinical environment, to ensure effective use of electronic health care systems • Choose effective information systems, tools and techniques to facilitate discussion and enhance team function (IPC Core Competence Domain 3 CC1) 	<p>Access to resources</p> <ul style="list-style-type: none"> • Accesses resources to support treatment e.g. for wound management and skin protection • Maintains safe use of technology and equipment to treat person troubleshooting where appropriate (Adapted ACCP) 	
<p>Self-Assessment</p> <p>Acts in a way that is person centered :</p> <ul style="list-style-type: none"> • Values people as individuals, acknowledging and respecting diversity, and recognising people's expressed beliefs, preferences and choices 	<p>Decision-making</p> <ul style="list-style-type: none"> • Listens to others and takes other viewpoints into consideration • Uses full scope of knowledge , skills and abilities of available health professionals to make decisions 	<ul style="list-style-type: none"> • Takes action to ensure that patient safety is not compromised • Recognises when other staff members are under stress and not performing as expected and provides appropriate support • Participates in team meetings including

<ul style="list-style-type: none"> • Communicates roles and responsibilities clearly to other team members, patients and families Incorporates an understanding of one’s own behaviour and its effect on others • Consistently demonstrates commitment to interprofessional shared values , honesty and integrity in relationships with patients, families and other team members • Works/Practises safely and effectively within their scope of practice • Practises within the legal and ethical boundaries of own/role profession • Practises as an autonomous professional, exercising their own professional judgement on appropriate knowledge and skills to inform practice • Works/practises in a non-discriminatory manner maintaining confidentiality • Acts fairly in all situations • Reflects on and reviews practice • Keeps up to date through learning and development opportunities • Uses principles of and techniques for effective time management • Engages in evidence-based practice, evaluate practice systematically and participate in audit procedures • Displays team leadership so that teams are effective and deliver safer care • Monitors own performance , and maintains a portfolio of learning and development to demonstrate fitness to practice 	<p>about care that is safe, timely, efficient, effective and equitable</p> <ul style="list-style-type: none"> • Formulates a diagnostic and therapeutic plan for the person with the information available and communicate treatment appropriately • Makes appropriate clinical and clerical decisions in order to optimise the effectiveness of the clinical team resource • Implements national and local guidelines/legal requirements as relevant to area of practice • Implements knowledge of local healthcare systems in order to be able to fully participate in managing health and social care provision • Addresses issues and demonstrate techniques involved in studying the effect of diseases on communities and individuals- public health • Demonstrates ability to plan and deliver programmes of education and training 	<p>discussions around service development and improvement</p> <ul style="list-style-type: none"> • Uses assessment and treatment to maximise team learning and to evaluate effectiveness of teaching for range of stakeholders • Gathers information, including qualitative and quantitative data, that helps to evaluate the responses of service users to their care • Contributes to audit and review in quality management, including quality control, quality assurance and the use of appropriate outcome measures • Engages in continuous professional and interprofessional learning and development to enhance team performance
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<ul style="list-style-type: none"> • Understand the key concepts of the knowledge base relevant to their profession • Demonstrates ability to facilitate learning through varied means across a range of contexts and within scope of practice 		
	<p>Interdisciplinary Collaboration</p> <ul style="list-style-type: none"> • Applies relationship building values and principles of team dynamics to perform effectively in different team roles to plan and deliver person centred care • Contributes as a member of the interdisciplinary team • Works with and values the contribution of each member of the urgent and emergency care team • Works together with other partners contributing to an integrated approach to urgent and emergency care across the health economy 	

Appendix 5: Competences mapped

Guidance and competences for the provision of services using practitioners with Special interests (PwSis)

Common core principles and competences for social care and health workers working with adults at the end of life care

Competence and curriculum framework for the Physician Assistant

Common core skills and knowledge for the children's workforce

Safeguarding children and young people: roles and competences for health care staff INTERCOLLEGIATE DOCUMENT Third edition: March 2014

Core Competencies for Interprofessional Collaborative Practice

Health information management and informatics core competencies for individuals working with electronic health records

The competence and curriculum framework for the emergency care practitioner

Foundation Degree or Diploma of Higher Education in Paramedic Sciences- Stage One Competences

Developing ambulatory care registered nurse competencies for care coordination and transition management

Silver book