COMMENTS ON

CONSULTATION – HIGH QUALITY CARE FOR ALL, NOW AND FOR FUTURE GENERATIONS: TRANSFORMING URGENT AND EMERGENCY CARE SERVICES IN ENGLAND.

The Royal College of Physicians of Edinburgh (the College) is pleased to respond to the NHS England consultation on High quality care for all, now and for future generations: transforming urgent and emergency care services in England.

The College has 50% of its UK fellows and members working in the NHS in England and welcomes the opportunity to comment on this important consultation.

Answers to the questions as posed within the consultation:

7 Yes: too expensive, not sustainable, not responsive enough to need.

8 Yes

9 Partly: Self-care / management may be appropriate for only some patients. It will depend upon who leads on this issue; leaders who are enthusiastic are more likely to achieve positive results.

There is however no mention of how the courses suggested will be funded. Elderly patients may be less inclined to take up these options compared with younger patients.

10 Partly: Telephone care offers a cheap and quick option to deal with the increasing demands in primary care. It will depend upon the clinician knowing his / her patient and their listening skills when getting the patient to talk about the present problem.

The 111 service which has recently just been set up has received so much bad press that the general public may be hesitant to use it. There needs to be a consistent approach across England as to who mans the phones at the 111 call centres.

11 Yes: There is a need for more integration of primary and secondary care services. The co-location of walk in centres and Emergency departments with protocols allowing patients to move across to the more appropriate stream if needs be should be developed.

12 Yes: 999 services are being asked to do non-emergency work therefore a culture change has to occur. It is important to address the use of 999 services and the culture of heavy drinking.

ED services have dramatically changed over the years. Gone is the day when an ED consultant could manage everything. Therefore teams of appropriate specialists are required. This includes the importance of Acute Medicine to manage the acute medical patient and relieve some pressure on the ED. This is evidence based as being effective both in terms of decreasing mortality and average length of stay for medical patients.

Furthermore, it is regrettable that within the evidence document, there was mention of the increasing numbers of elderly patients and those patients with dementia presenting to the ED yet no mention of the consultant in Geriatric Medicine being available at the front door.

Perhaps an acute elderly response team with consultant geriatrician, therapists (OT +PT) and social worker is the way forward and this team may be more successful at preventing inappropriate admissions.

13 Yes: While figures presented in the evidence base suggest increasing numbers presenting to the ED, 4 hour targets and a lack of senior input at the front door are the main reasons for this trend. We suspect however that the reasons are more complex and also relate to the advances of medical science.

There is evidence of increasing complexity of referrals to the ED as well as numbers; this may also explain some of the delays within the ED that we are seeing.

The management of disease has also changed. For example the patient with a mild stroke is no longer sent home and investigated as an out-patient. This patient is admitted, has imaging done quickly and discharged home with an early supported discharge team. The patient with potential acute ischaemic heart disease has to stay for a number of hours before troponin levels are done and then, if negative the patient may be discharged.

14 Yes: The numbers of GPs is going up as expected and consultant numbers showing a larger (disproportionate) increase. Twenty years ago, the consultant physician had a large number of generic skills but there were major gaps in the care of patients with specialised conditions. Even 10 years ago stroke physicians very few in number. Other medical specialties have seen a similar demand to deal with complex patients. Instead of Type A (teaching hospital) and Type B (DGH) cardiologists we now have cardiologists concentrating on electrophysiology while other cardiologists more concerned with fixing vasculature. The increase in consultant numbers has reflected the growing demand for specialists in a particular field and Specialist Societies have been great advocates of this advance in the care of patients. The need for a more generalist model of care is now being promoted and for physicians could be built on the combined efforts of geriatricians and acute physicians

15 Yes: The stroke model in the document requires comment: The London model is used as the gold standard but it is believed that the cost of implementing this standard was huge. Other areas of England with considerably less investment are achieving outcomes similar to the London model. Therefore what works best in one area may not be the solution for all areas.

16 Other comments

The variation in availability of services that patients may access is completely unacceptable and puts undue pressure on hospital services. It is still commonplace to find patients who have not accessed their GP because they believe that no primary care services are available out of hours. The inadequate implementation of the new 111 service has resulted in a lack of confidence locally and indeed this is reinforced by the popular press.

There needs to be a strong focus on alcohol as a social disease and its impact on admission to urgent services. This is not mentioned at all except in the section on mental illness. This

work needs to link into national work on alcohol. There should be more evidence on multi-disciplinary working, nurse practitioners etc. in the ED. It is unlikely in the short time we shall be able to fill medical trainee and consultant gaps so we will have to look for other models of assessment and care.

There has been a huge investment in community support for long term conditions – community matrons, heart failure nurses, COPD services, palliative care. It is important to review the evidence for admissions avoidance to inform whether this resource should be extended or pulled back.

It would also be useful to look at evidence of outcomes relating to the 4 hour target and the other clinical quality indicators. We need to understand whether they have introduced perverse incentives and possible poorer outcome or have indeed where implemented as a quality strategy improved outcomes.

17 Yes

18 Yes

19 Mostly

20 Partly

21 All in equal measure. All are required to solve the crisis. GP practices should again provide out of hours care for their patients. IT and record sharing is crucial for quality care and avoidance of duplication. Urgent care centres should be co-located with ED with integrated governance- thus within a common commissioning framework.

There is also a need to focus on public education and perception so that they have a very good idea where to access care urgently 24/7. We must adjust the financial incentives to prioritise non-elective work and we need to promote safe hospital discharge seven days a week.

22 All but the focus on process may also be beneficial in some circumstances as the determination of clinical outcome may be difficult to show in a timeous fashion.
We must abolish incompatible IT systems between agencies and the culture of silo working. It is vital that the skill mix of staff providing care should be appropriate for the patient mix being encountered.

There are many demoralised senior hospital clinicians and 7 day working will only be achievable through expansion of consultant numbers or by very creative ideas about shift and team work. In this situation how quality continuity of care must be considered before any changes are instituted otherwise patient safety may be compromised. .

The issue of competition in healthcare remains a concern. It is possible that this will be a barrier to seamless care unless commissioning insisted on IT compatibility and shared governance between various providers. This is already seen where care for patients is compromised simply because they are treated for the same condition in different hospitals with inadequate sharing of information. Funding rules need either to change to incorporate a whole of pathway tariff, or there should be shared risk between community services and

acute Trusts to encourage admission avoidance in the community.

23 We need to redefine how we provide chronic disease or long-term disease care in the current and future environment. We need to look at models of care which are integrated between primary, secondary and social care.

24 Yes

All College responses are published on the College website www.rcpe.ac.uk.

Further copies of this response are available from Lesley Lockhart (tel: 0131 225 7324 ext 608 or email: l.lockhart@rcpe.ac.uk)

11 August 2013