

## **EMERGENCY SERVICES IN BRISTOL**

**(RLH interviewed Jonathan Benger on 30 October 2006)**

*Jonathan graduated in medicine from Bristol University in 1990. He was appointed as Consultant in Emergency Medicine at the BRI in December 2003. He has a specific remit for research and development at the UBHT. He is also a senior research fellow at the University of the West of England (seconded for two days each week). The academic component of research and teaching is complimented by an active clinical commitment in both adult and paediatric emergency departments. He already has an impressive list of publications to his credit and is currently establishing a Pre-Hospital Care Service for the Avon region. He is closely involved with the development and delivery of a new training course for emergency care practitioners.*

### **BACKGROUND**

Urgent care is causing much anxiety nationally and locally. It is seen as an uncontrolled area of healthcare. In most Emergency Departments the flow of patients is difficult to predict or control. About three-quarters of beds in acute hospitals are occupied by emergency admissions. The number of patients referred to Emergency Departments is rising inexorably. Many factors underlie the current crisis. Some of these are discussed in the paragraphs below.

#### **Recent initiatives/changes**

##### **Consistency /reorganisations**

During the last few years there have been significant inconsistencies in Government policy-making. For instance, community care is being encouraged – thus hopefully taking the strain off major hospitals. At the same time, many community hospitals are being closed. The choice agenda (see below) is sometimes in conflict with the principle of using resources efficiently. This lack of consistency, together with a plethora of re-organisations and initiatives, has led to a degree of demoralisation amongst NHS planners and staff. It often seems that there is a lack of co-ordination and overall central direction.

##### **Evidence**

Doctors are constantly exhorted to base their clinical practice on evidence. Indeed, they may find themselves in legal difficulties if they fail to do so. NICE bases its advice on evidence. Many doctors find it difficult to adjust to frequent governmental initiatives for which there is no sound evidence base. In some cases changes are introduced after a single pilot study. It seems that different standards are being applied to clinical medicine and the organisation of health care. We shall return to this matter later in the interview.

##### **Choice**

The Government is committed to giving patients choice, and has expanded the options as far as emergency care is concerned. However this in itself creates difficulties. Take someone who becomes unwell on a Saturday afternoon. Options include consulting a community pharmacist, going to a walk-in centre, ringing NHS Direct, going to a minor injuries unit, ringing the GP out-of-hours service, or going to the nearest Emergency Department. The

problem is that patients are confused and the services are not appropriately signposted or utilised. It is also wasteful of time and resources. This has led to the proposition that there should be a series of unified **urgent care centres**. This is discussed further below.

### **Emergency versus elective work**

I have already indicated that emergency work is largely unpredictable. You simply don't know what/who will come through the door next. In comparison, elective work is relatively easy to schedule and arrange. Surgeons doing elective work experience much frustration when their lists are cancelled at the last moment because of emergencies. Waiting lists inevitably lengthen. Many surgeons have long advocated some separation of emergency and elective work. One solution would be to move more of the elective work to the independent sector, or even a separate dedicated hospital, and this is now happening in some areas. However, the effect of shifting this work on the financial viability of core NHS hospitals is uncertain, and could certainly be a problem.

### **Costs/Funding/PFI**

The present Government policy is that where possible services should be moved out of acute hospitals into the community – where they would be more accessible to patients (e.g. holding more consultant clinics in primary care premises). However, it is more efficient to concentrate resources on a limited number of sites. The distribution of facilities widely across the community may be superficially attractive, but is likely to be expensive and possibly unaffordable. The same comment applies to some other initiatives.

A further major problem concerns the funding of new projects. All the big projects are planned to be paid for via the Private Finance Initiative (PFI). This will prove extremely expensive in the long term. The relevant trusts will in effect have to take out a huge 30 year mortgage which will put a major strain on the remainder of the health-care budget because current healthcare revenue will be diverted to support capital expenditure and service the long-term debt. Under PFI NHS Trusts also find themselves locked into maintenance and support service contracts that cannot be renegotiated and where recourse is limited.

### **Withdrawal of GP Urgent Care Services**

A significant change occurred when the GP contract was re-negotiated. Individual GP's were released from their contractual obligation to look after patients 24 hours a day, seven days a week. They were given the option to withdraw from out-of-hours work. The result has been that only about 20% of GP's have subsequently contracted to do out-of-hours work. In addition, there has been a withdrawal of Saturday morning and evening surgeries. All of this has totally altered the pattern of out-of-hours provision. The PCTs now have responsibility for out of hours primary care services. These are being provided in a number of ways. For instance, local co-operatives or private companies, sometimes at great expense, are providing a range of out-of-hours cover for general practices.

**RLH** - How satisfactory is this?

**JB** – Much depends on the individual provider. Some are good, others are dreadful.

Many GP's no longer perceive themselves as being involved with urgent care, and many patients do not believe that there is a GP emergency service any more. As a result many patients are not using the GP as a route to urgent care—even during “office” hours. There has even been some discussion in the medical press as to whether GPs should train in urgent care

at all! In some areas patients no longer trust the GP service – particularly when children become ill. It must be emphasised, however, that some GP's do continue to provide a high quality, reasonably comprehensive, service. Bristol has some really excellent GP's.

**RLH** – So what is the role of the GP now?

**JB** – GP targets are largely related to the management of chronic disease. There are financial incentives for GPs to manage blood pressure, cholesterol levels and diabetes. There are no such incentives in relation to urgent care, and contrary to government aspirations most GPs are not willing to undertake minor surgery in their practices.

**RLH** – What is the result of all this on attendances at Emergency Departments?

**JB** – There is a steady upswing in the number of attendances at Emergency Departments. These include patients who do not require admission to hospital – many of whom would in earlier times have attended their GP's surgery. Sometimes the practice receptionist will tell the patient that there is no available appointment to see the GP on that day and the patient is advised to go to the hospital. The Emergency Department is the only place which is manned 24 hours a day by on-site doctors, and where a full range of diagnostic and therapeutic facilities are available. Furthermore, because of the 4 hour maximum waiting time target patients know that they will not have to wait for ever: long waiting times previously acted as a deterrent to patient attendance, but this is no longer the case.

We live in a 24-hour society. Supermarkets are open 18-24 hours a day, so why not the NHS? For this, and other, reasons there has been a major increase in attendances at emergency departments overnight. There is a surge at about 10.00pm – a time that seems to be particularly convenient for many people. The numbers attending throughout the night has increased greatly – with alcohol also being an important factor. Ironically, it was not long ago that the Emergency Departments were quite quiet at night because people did not think that it was reasonable to go to see the doctor at that time! The problem for Emergency Departments has been further exacerbated by the fact that many alternatives, eg. Walk-In Centres and the Southmead Minor Injuries Unit, shut at night.

The elderly population pose particular difficulties. Ten years ago chronic diseases were less treatable, but with the benefits of modern healthcare many people with complex co-morbidities are frequently admitted and re-admitted and re-admitted again in a short space of time. . .

**RLH** – what can be done about this?

**JB** - It's all about demand management and keeping people at home where possible. This is the sort of work that would have been previously undertaken by a good GP service, and still is in some cases. However the government and many primary care trusts have been pursuing various initiatives and alternative schemes. For instance – developing acute response teams, intermediate care, appointing community matrons etc. However, the cost of many of these schemes is high, and their value uncertain. A recent research paper, published in the BMJ, suggested that community matrons are not clinically effective. A more promising concept is the Emergency Care Practitioner (ECP): a paramedic or nurse with extended skills who works with the ambulance service or primary care to provide care on the spot rather than automatically transporting the patient to hospital. There are, in fact, a whole raft of community initiatives, but at the moment they are not well co-ordinated and most have not been evaluated or costed.

**RLH** – Clearly, very large sums of money are being spent on these problems. Could you say something more about evaluation?

**JB** – Evaluation is difficult – partly because the research/evaluation cycle is out of kilter with the 4/5 year period that usually separates general elections. Political constraints over-ride the requirement for scientific evaluation, and at the same time high quality trials (e.g. RCTs) are notoriously difficult in this area. Multiple changes are occurring at any one time, and this makes evaluation of any one component nigh on impossible. We need new and faster techniques for assessing the value, or otherwise, of a wide range of healthcare initiatives. This could be a fruitful area for future research.

## **THE FUTURE**

**JB** - what is required is a unified urgent care service so that patients can go to one place and get help 24 hours a day. We need to combine primary care skills, and some of the existing services, into one place which offers a full range of services and skills.

In summary, there would be a single point of access to a range of services which provide unscheduled care and which would include a GP out of hours service, Walk-In Centre, a minor injuries unit, and an Emergency Department. On entry to such a unit the patient would be met by a senior nurse who would say – 'Right, your problem is sore throat – there is someone here who will help you.' For another patient – 'Oh you have sprained your ankle – you need a minor injuries practitioner – go over there'. There would need to be several such centres in Bristol, situated in/near areas of high population density to facilitate patient access. Whether they can be afforded is another matter!

### **Major trauma**

**RLH** – What about the management of multiple trauma?

**JB** – Major trauma is rare, and reducing in incidence. This is partly because we no longer have a large industrial base, so that industrial accidents rarely occur. Furthermore, motor cars are becoming safer. The BRI, BCH, and Bristol Eye Hospital see more than 100,000 patients annually as emergencies. Only 0.08% suffer multiple trauma. You can't allow this small number of cases to dominate Emergency Services – important as such patients are.

**RLH** – We have already discussed the problems of older people with chronic problems. Tell me more about other aspects of the workload at the BRI Emergency Department.

**JB** – Acute medicine now dominates our workload. Chest pain is a common presenting problem, and a major problem. It is our job to receive, resuscitate, diagnose and refer every patient with illness and injury, but it is medical illness, not injury, that predominates.

### **The concept of a single major Emergency Centre for Bristol**

**RLH** – Should there be a single trauma and emergency service in Bristol?

**JB** – No. The biggest Emergency Department in the UK is in Nottingham where they see about 130,000 patients annually. This is right at the brink of what is manageable. One reason for saying this is that a large Emergency Department must have a similarly large hospital behind it. We are currently admitting to hospital about 20% of those who attend the ED. A

single ED for Bristol might see as many as 200,000 patients per year, which is 550 a day. This means that, allowing for some direct GP admissions you would have to find around 150 emergency beds in the supporting hospital every day. I think that we need two acute hospitals in Bristol, each with its own Emergency Department. The idea of a single mega-hospital in Bristol is simply not realistic.

**RLH** – Do you think that both hospitals should do exactly the same thing? Derek Alderson (see interview in archive section of MedChi website).suggested that one hospital should be for emergencies and the other for elective care.

**JB** – From a hospital perspective the acute/elective split makes sense because surgeons, in particular, are constantly frustrated by finding that their beds are occupied by medical emergencies. The problem with this proposition is that a lot of services would still be split over both sites. Most branches of surgery have both an emergency and an elective workload.

Overall, Bristol needs two acute hospitals each with an Emergency Department and each of these able to admit the basic bread and butter work in medicine and surgery.

**RLH** – Would the two hospitals do exactly the same thing?

**JB** – Probably not. There is an argument for some clustering of specialist services. One hospital would provide for most of the district general hospital work. The other would provide mainly specialist services. Both could have a full Emergency Department.

We need collaboration between hospitals. I entirely agree with Derek that there should be one Acute Trust in Bristol so that sensible discussions can be conducted regarding the rationalisation of services. This should eliminate much of the unwelcome rivalry between the two acute trusts. Even then, some degree of experimentation will be inevitable.

## **The BRI**

**RLH** – Would you like to say a little more about the role of the BRI?

**JB** – It won't surprise you to learn that my view is that UBHT is best placed to take on the specialist services role. Children's services and cardio-thoracics are already on the UBHT campus. Neuro-science is the main service that is currently missing from the BRI, but given the current plans to re-develop the Southmead site neurosciences are destined to leave the Frenchay site in any case. This provides an ideal opportunity to re-evaluate the provision of services in a rational way.

**RLH** – Is there space on the BRI campus for neuro-sciences?

**JB** – Yes, probably. Clearly re-development will be required, and UBHT has to be prepared to lose some services if it is to gain others. However, working to accommodate neurosciences within the existing UBHT campus would be cheaper than providing a re-built neurosciences block on the Southmead site, particularly if this is done under the provisions of the Private Finance Initiative (see above).

**RLH**- That is an interesting suggestion. I personally doubt, however, whether the Frenchay folks would take kindly to the idea. Swapping a semi-rural environment for the overcrowded city-centre BRI campus might not be too attractive! The Southmead site might be acceptable.

## **The South Bristol Hospital**

ELH—Could you say something about the plan to close the Bristol General Hospital and to put the beds into the new South Bristol Hospital.

JB – People in the south of the city have been promised a new hospital for at least the last 60 years, however I have some concerns about this. We have learned from experience that when you create intermediate care beds which can be accessed directly by GPs those beds tend to be used to prevent people going into the main hospital (“step up”), and whilst this is entirely legitimate it makes it difficult to implement the original objective of emptying the BGH and using the new community hospital as a “step down” facility from full hospital care. A further problem is that part of the new facility is earmarked as a Diagnostic and Treatment Centre (DTC) to be run by a commercial organisation. This has financial implications- our healthcare community will be saddled with a substantial debt that will be indirectly supporting private organisations in creating a shareholder profit. Moving even a small percentage of elective services from a large acute Trust such as UBHT to the independent sector can be extremely destabilising. I fear that the new hospital may prove financially untenable unless the current plans are reconsidered.

### **FINALLY**

I thanked Jonathan Benger for giving up his time so that I could interview him. It was encouraging to meet someone who is thinking through so many of the difficult issues that face Bristol in its planning of healthcare services.

### **BULLET POINTS**

- Emergency Departments are finding it difficult to cope with the ever-increasing number of patients
- The recent change in the GP contract has led to most GPs giving up out of hours work. This is one of several factors that has led to today's problems with emergency provision.
- Bristol needs a unified, city-wide and coordinated urgent-care service. This development would be greatly facilitated by the establishment of a single acute trust for Bristol.
- We need 2 or 3 comprehensive urgent care centres manned 24 hours a day, 365 days a year, combining expertise in primary care, minor injuries and emergency medicine. These would act as a single point of access for patients with a wide range of illness and injury, and would be best sited in combination with the current Bristol Emergency Departments.

RLH. Editor.