RLH 24.6.08. Doc. 3

Emergency and Out of Hours Care in Bristol

Draft Report to the Bristol PCT—based on the proceedings of a MedChi/BMA conference held in Bristol on April 1st. 2008.

(a full account of the proceedings can be found on the MedChi website www.bristolmedchi.co.uk).

Introduction

This document has been produced following the above meeting which was attended by about 55 people. It is addressed to the Bristol PCT The subject is complex and not all issues are dealt with here.

Functions of the PCT.

- The main function of the PCT is to purchase health-care for the local population in line with governmental directives.
- It follows from the above that the planning options available to the PCT are constrained.
- It is not clear to us whether the PCT has any freedom to innovate or to pursue its own policies. For instance, is the PCT compelled to implement the creation of Independent Treatment Centres even if, after careful consideration, it does not consider such developments to be desirable or, for that matter, whether they should receive priority funding?
- There are certain important matters that are not, as far as we understand, within the direct remit of the PCT Examples would be issues concerned with Foundation Status, whether there should be a single acute trust in Bristol and whether there should be one or more acute stroke units in Bristol. Indeed, it is not clear to us which body/ organization is responsible for these and a number of other matters.

General comments.

- We have not seen any documents produced by the PCT, the Bristol Health Services Plan or the SHA on emergency and out of hours care.
- It was very clear at the meeting on April 1st. that some of the current policies lack a sound evidence base. Indeed ,in some instances (eg Walk-in- Centres) the available evidence is that they are not cost-effective. This leads to the conclusion that logically they should be abandoned and the money spent more effectively elsewhere. How does the PCT regard this matter?
- There is considerable confusion regarding terminology in some areas. Examples include urgent care centre, major trauma centre and polyclinic. It would be helpful if everyone including the PCT would define any terms that are used in its documents.

Summary of recommendations.

General

- The various elements, Primary Care, hospital care (both acute Trusts), pharmacists, the ambulance service, social services, and Public Health should collaborate to produce a blueprint for emergency care which can be updated from time to time, in the light of experience. This could involve the establishment of a standing emergency care committee. This would need to take note of the geographical characteristics of the locality and must cover both urban and rural locations.
- Those services that have been shown not to be cost-effective should be abandoned.
- Every effort should be made to ensure that the service is used efficiently. Patients should be discouraged from oscillating around the system—eg going to the GP out-of hours service and then going to a Walk-in Centre and then going to A and E. This is unnecessarily costly.
- Because of the lack of evidence in many areas, a cautious approach, inevitably involving an element of experimentation, should be adopted. This matter is discussed further below in the section on research. We repeat our view that the whole topic will require critical review from time to time. This will involve the careful collection and analysis of data.

Commissioning

- An attempt should be made to improve the commissioning process.
- There was support for the idea of commissioning services on the basis of pathways of care rather than separate sections of the process. (this would probably need to be a research project as no evidence for the proposition could be cited).

Access to emergency care

- There was general support for keeping access simple. The old and well tried approaches should not be abandoned—people understand them and they usually work. There are three.
- The General Practitioner would normally be the first step.. Telephone advice should always be available as to where the patient should go.
- Dial 999
- Go to A and E.
- There is little support for the idea of a single telephone number for emergency help. This has not worked well in, for instance, NHS Direct.

Patient Records

- There is strong support for making clinical records readily available. (turning up at A and E without any records being available is both unsafe and costly in terms of wasted time and resources). This matter is of particular importance bearing in mind the increasing choice that patients have when they seek help.

Hospital Care

- Hospital care is expensive and must be used appropriately. This will involve both admission and discharge procedures.
- Patients should be seen by experienced staff at all times(24/7).
- There needs to be a substantial increase in the number of emergency physicians (possibly a total of 8-10 per emergency department).
- There should be a continual assessment of the use of hospital beds. This may involve daily or twice daily ward-rounds by the consultant and possibly being prepared to discharge patients at the weekend (research needed).
- There should continue to be two A and E Departments for the Bristol clinical area. The availability of specialist services, including particularly neurosurgery, at each site will require further discussion.
- Discussion regarding the number and siting of acute stroke units is needed.

Community Care

- There was support for providing as much care as possible “in the community” rather than in major hospitals.
- There is support for the notion of establishing a series of Urgent Care Centres (properly defined!) which would be staffed 24/7 and would include investigative facilities such as X-Rays.
- There was discussion as to whether there should be an Urgent Care Centre at the entrance to A and E Departments. This could act as a form of triage intended to prevent “inappropriate” attendances at A and E. There was no general agreement on this matter and no evidence base was quoted (another research project!).
- Staffing. There is agreement that nurses should not be given major diagnostic responsibilities (for which they are not trained). At the same time there is support for an expanded role for paramedics and pharmacists (more research !!).
- Evaluation of the GP led out of hours service is needed (curiously, this subject received little attention at the meeting).
- There is a need for evaluating the out of hours service for vulnerable groups such as “the frail elderly”, very young children and those living in deprived areas.

Priority Areas

- Heart disease, stroke and cancer are three governmental priorities. The first two frequently present as emergencies.
- Considerable progress has been made with heart disease.
- Progress with stroke has been limited and the condition should receive particular attention from planners and the PCT.

Research

- There appears to be a remarkable lack of high quality publications available to those planning service configurations. Virtually no evidence from abroad was quoted (we appear to be an island in more than one sense!).
- The quality of the locally-based research presentations was excellent.
- There needs to be a major expansion of research in this important area. Bristol is an excellent place in which to undertake this—combining the work currently being undertaken in our Primary Care Research Unit with other elements that would include hospital, public health and social service dimensions. We look to the PCT to support this proposal.

Finally

So far there is no very clear idea of what an Emergency and Out of Hours Service will eventually look like. No one was able to identify any examples in the UK, or elsewhere, of a locality that has a high quality emergency service that could serve as a national model. This presents an exciting opportunity for Bristol. What does the PCT say?

(comments on this draft document to RLH please at rlangtonhewer@doctors.org.uk by the end of July 2008).