

Report of the Acute Care Clinical Working Group

Introduction

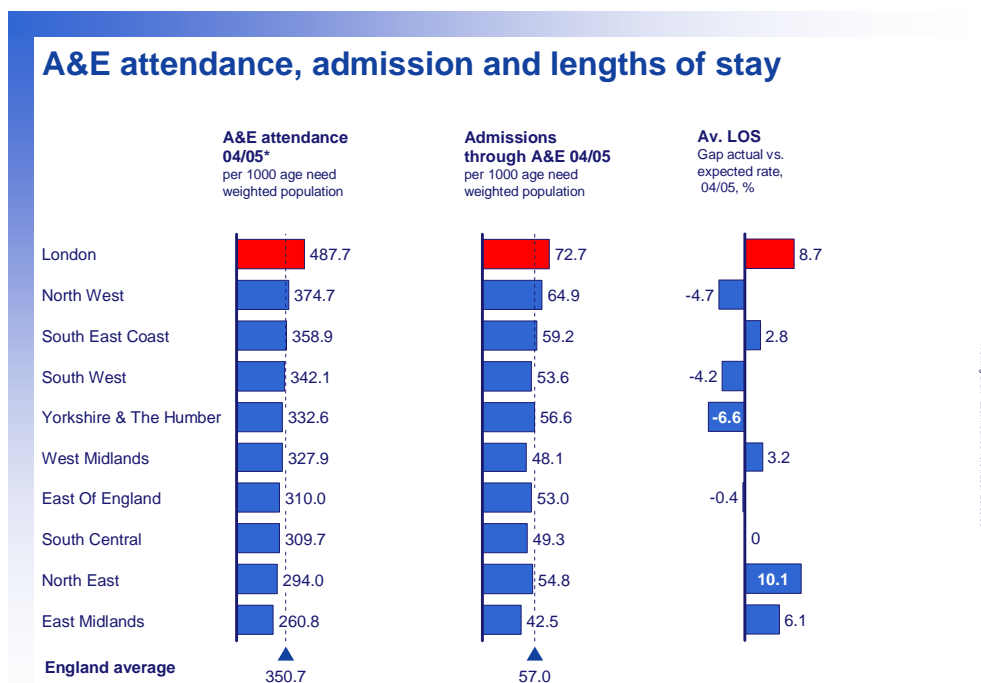
This report is the output of the Acute Care Clinical Working Group (for membership please see Appendix B). It summarises the discussion of two meetings of the group on 11 January and 5 March, along with the output from the Healthcare for London clinical conference on 19 February and extensive work outside these meetings, including the sharing of papers and best practice examples within the group. It draws on the latest national policy documents and thinking.¹

The report makes recommendations for improving both the quality and access to acute care across London, from treatment of life-threatening injuries through to less serious issues.

1. Current problems

Acute care overview

London has proportionately more A&E attendances and A&E admissions than other SHAs and the second highest length of stay:

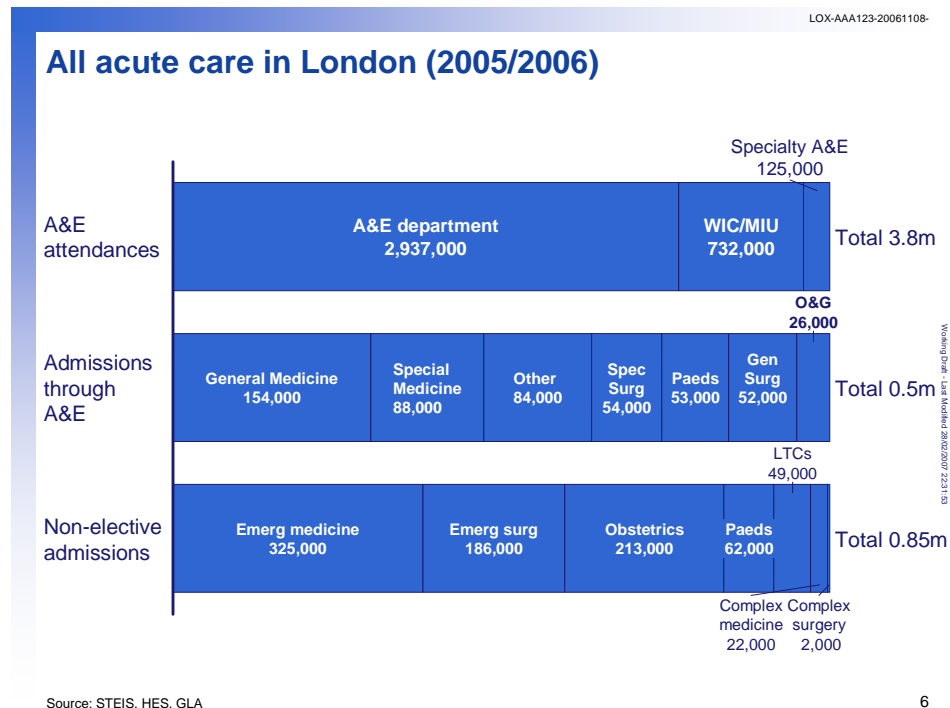


*A&E dept., minor injury unit, walk-in centres. Expected day case rate = national average/upper quartile day case rate for case-mix of activity as performed by SHA.
Source: DH Hospital Activity Statistics 04/05, HES 04/05, team analysis

¹ See for instance Sir George Alberti, *Emergency Access: The clinical case for change*, Department of Health, December 2006

A&E attendances

In London, there were 2.94 million attendances at an A&E Department (77 per cent of total A&E attendances) in 2005/06 but only 0.5 million admissions (17 per cent of attendees admitted):



The categories used in the above graphs are from Hospital Episode Statistics.

Admissions through A&E – Special medicine includes all the medical specialties eg. cardiology, rheumatology. Special surgery includes all the surgical specialties eg ENT, orthopaedics.

Non-elective admissions – Emergency medicine includes all the non-elective general medicine. Obstetrics includes delivery and antenatal non-elective activity. Paeds is all non-elective paediatrics. Complex medicine includes all the non-elective medical specialties, while complex surgery includes all non-elective surgical specialties.

Many of the 83 per cent who were not admitted could be treated elsewhere. The report of the London Reform programme estimated that approximately 40 per cent of people attending A&E have a problem which could be resolved through contact with primary care professionals.² A year long study of a major London hospital found that over 40 per cent of those attending the A&E had health problems that could be dealt with in primary care.³

The provision of care for people with minor illness and injury in A&E departments is not ideal – patients are seen by junior doctors rather than

² *Simple and Direct Access to Emergency and Urgent Care Services Across London*, Final Report of the London Reform Programme, July 2005

³ McKinsey analysis based on flow mapping and interviews

GPs, although the latter are better skilled and experienced in dealing with minor illness and minor injury; there are often waits to be seen, and A&E departments are often a significant distance from people's homes and work places.

Why are people going to A&E? It seems to partly be a problem of accessing other services. Access to GP services outside normal working hours is poor. In a survey of 7000 Londoners by MORI it was the only aspect of GP care where there was net dissatisfaction.⁴ The NAO report into out of hours (OOH) care found that most OOH provision was not yet meeting the national quality requirements and it was also expensive.⁵ There needs to be more local urgent care provision.

The MORI poll found that 45 per cent of respondents had used A&E in the last year.⁶ A&E users were more likely to be fulltime (47 per cent) than part-time (44 per cent) workers, bearing out the idea that A&E usage outside normal office hours may in part be due to a lack of known alternatives. 56 per cent of parents and 54 per cent of 16-24 year olds had used A&E in the last year.

Other likely reasons why people attend A&E are that they know they will be seen in 4 hours, they know it will be open and perhaps a desire to ensure that there is the ability to escalate care if the problem is more serious than is feared (this might be especially true of parents).

There are clear alternatives to A&E such as Walk in Centres (WiCs) but in London in 2005/06 there were only 0.73 million attendances at WiCs and Minor Injury Units (just 19 per cent of total A&E attendances). It seems that whilst there has been a proliferation of access points, unless they are co-located and patients are diverted to them from A&E, they are not stemming the rise in A&E attendances.⁷

High usage of ambulance services

At present there is a high volume of 999 calls and this is rising by 7 per cent a year. Currently 75 per cent of 999 callers are transported to A&E and the evidence suggests that 40 per cent of these patients have needs that could be dealt with in primary care.⁸ This graph demonstrates how most patients do not need an ambulance response:

⁴ Ipsos MORI, *London Residents' Attitudes to Local Health Services and Patient Choice*, December 2006

⁵ NAO, *The Provision of Out of Hours care in England*, May 2006

⁶ Ipsos MORI, *London Residents' Attitudes to Local Health Services and Patient Choice*, December 2006

⁷ Clinical view from SW London

⁸ Pippa Bagnall, *Hear and Treat Strategic Business Case*, 2005

The UK is almost alone amongst its international comparators in not having a system of regional trauma centres. As a result current UK mortality for severely injured trauma patients who are alive when they reach a hospital is 40 per cent higher than the US.¹³ The 2000 Royal College of Surgeons Report advocated the development of trauma centres but this has never been put into practice.¹⁴

Another good example is stroke care. In the past, the only good care for stroke was rehabilitative treatment. However technological advances have made interventional treatment for some stroke patients possible, if done soon after a stroke's onset. Such interventions are dependent on skilled staff and dedicated technologies that cannot operate at every district general hospital.

What is needed are specialist stroke units with CT scans to determine if a patient is having an ischaemic or a haemorrhagic stroke (thrombolysis can be used on ischaemic stroke patients but harms people with a haemorrhagic stroke) available as soon as possible and prompt physiotherapy. Treating stroke victims in specialist treatment centres saves lives and reduces disability.

Professor Alistair Buchan has found in his work in Canada and Oxford that patients who receive rapid access to a CT scan followed by thrombolytic treatment (using a drug called tPA) within 90 minutes of onset are more than twice as likely to have favourable outcomes after three months compared to a control group.¹⁵

Other studies confirm this impact - one UK investigation showed that the odds of death in hospital were reduced by 11 per cent for patients treated in specialist stroke units with prompt CT scans.¹⁶ This approach is supported by both the Stroke Association and in the National Service Framework for Older People. Patient satisfaction with specialist stroke care is also higher.¹⁷

Yet at the moment too many trusts are trying to provide what should be quite specialised treatment and the latest data shows that as a result the quality of stroke care is poor:

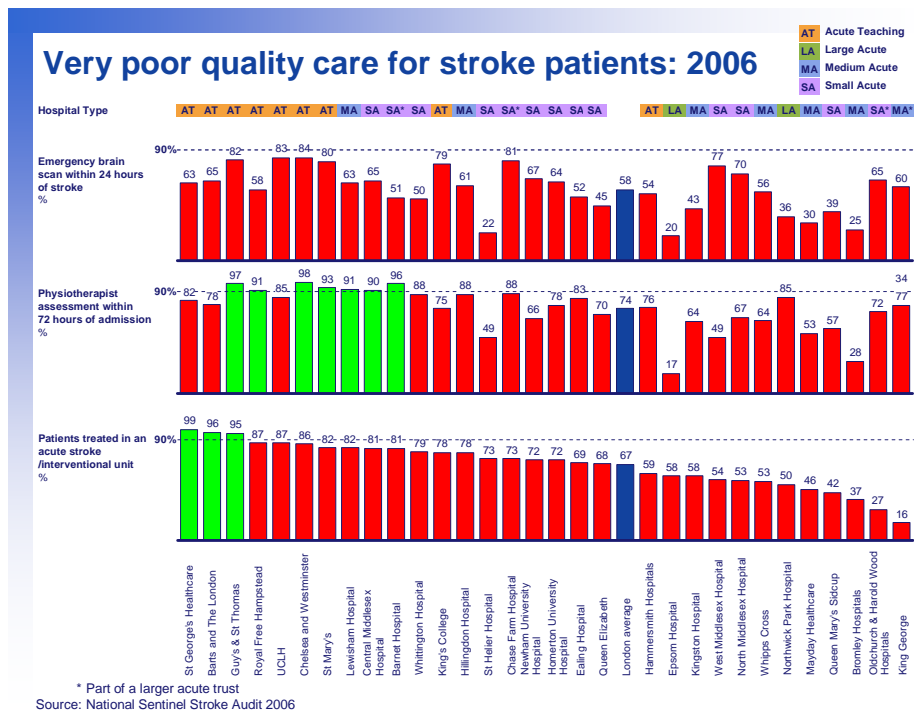
¹³ UK Trauma Audit & Research Network 2001-2004 dataset, US National Trauma Databank 2004

¹⁴ Royal College of Surgeons, *Better Care for the Severely Injured*, 2000

¹⁵ A. Buchan, *Best practice in Stroke Care 2007*, presentation at the Healthcare for London conference, 19 February 2007

¹⁶ Brian Jarman, Paul Aylin and Alex Bottle, "Acute stroke units and early CT scans are linked to lower in-hospital mortality rates," *BMJ* 2004;328;369+

¹⁷ Mayor S, "Stroke patients prefer care in specialist units." *BMJ* 2005 Jul 16;331(7509):130



1

Even more worryingly, stroke care seems to have worsened in recent years. In 2004, seven London Trusts were giving 90 per cent or more of their patients an emergency brain scan within 24 hours (best practice would be within an hour of the onset of stroke). Now no trusts are achieving even that less than ideal benchmark.

The current lack of centralisation of stroke and trauma care is in contrast to the work done by the London Ambulance Service and acute trusts to concentrate primary angioplasty interventions on a nine sites with the necessary skills.

Improving specialist care

Other services also require some centralisation to deliver the best treatment. The group focussed on two in particular – emergency surgery and paediatrics. In both cases it is a question of achieving sufficient volumes to allow for the development of specialist clinical skills and to achieve safe cover in light of the European Working Time Directive (EWTB).

The recent conference of the Association of Surgeons of Great Britain and Ireland concluded that emergency surgery was now a specialty in its own right.¹⁸ Emergency surgery also requires rapid access to diagnostics (especially radiology) and intensive care units which cannot be provided at every local hospital.

The Royal College of Paediatrics and Child Health said in their submission to the Healthcare for London Review that “the current children’s healthcare

¹⁸ See conference report at http://www.asgbi.org.uk/pdfs/EGS_Consensus_Bullet_Points-FINAL.pdf

workforce cannot safely sustain the number of existing inpatient and acute children's services."¹⁹

This is borne out by recent studies. The Healthcare Commission report on children's services in hospital found that during the day five per cent of hospitals with A&E departments lacked sufficient cover by staff with advanced paediatric life support training and this rose to sixteen per cent at night.²⁰

In addition only seventeen per cent of trusts treat all their emergency child patients in a child-only section of their A&E. Sixteen per cent of inpatient paediatric units carried out less work with children than the minimally recommended level. Care is more accurate in hospitals that treat large numbers of children. For instance a US study found that the rate of misdiagnosis for appendicitis in the hospitals with the most paediatric patients was half that in the hospitals with the least.²¹

A particular weakness at present is paediatric orthopaedic (especially trauma) care. Nationally, 25 per cent of acute trusts have no provision for a children's fracture service and 40 per cent have difficulties providing a safe anesthetic service. This, coupled with the lack of recruitment into paediatric orthopaedics, means that children with injury are already getting a sub-standard service.²²

2. International models of care

Other countries have developed high quality models of acute care. These include developments to reduce A&E attendances through the provision of excellent urgent care in local facilities and centralisation of specialist services for acute illness.

The Kaiser Permanente healthcare system provides urgent care in a network of local clinics resulting in lower levels of A&E attendances. They have an average of 120 attendances per 100 age/need weighted population compared with London which has nearly 500.

Part of the reason for this much lower attendance level is Kaiser's requirement that A&E attenders make a co-payment, but setting aside this aspect, the NHS can learn from Kaiser's integrated approach to urgent care.

In Ontario they have implemented a comprehensive stroke strategy. This slide shows what that means for stroke organisation (in a much more rural environment than in London):

¹⁹ *Healthcare for London – RCPCH response*

²⁰ Healthcare Commission, *Improving services for children in hospital*, February 2007

²¹ Douglas S. Smink, Jonathan A. Finkelstein, Ken Kleinman and Steven J. Fishman. "The Effect of Hospital Volume of Pediatric Appendectomies on the Misdiagnosis of Appendicitis in Children". *Pediatrics* 2004;113;18-23

²² British Orthopaedic Association, *Blue Book on Paediatric Orthopaedic Services*, 2006

Case study: Ontario's coordinated stroke strategy


Ontario's Coordinated Stroke Strategy

Programme background:

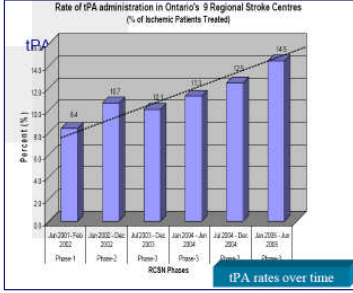
- \$30m annual ring-fenced allocation to develop co-ordinated stroke strategy
- Catchment population of 12million

Configuration with volume thresholds:

- **Comprehensive stroke centres** (2-3 million):
 - 24/7 telephone consultation
 - Internet access to CT/MRI with online interpretation
 - Neurologist on site within 30 minutes
 - Neurosurgery and interventional neuroradiology available
- **Regional 24/7 acute stroke centre** (300-700,000):
 - ED triage protocol receive bypass out of hours
 - <30 minute access to CT/MRI with interpretation
 - Neurologist available within 30 minutes
- **District stroke centre** (100,000-200,000):
 - ED triage protocol
 - Access to CT with interpretation
 - Stroke clinical pathway
 - Stroke unit with multidisciplinary team



Impact on tPA administration rates:



Phase	Period	tPA Rate (%)
Phase 1	Jan 2002 - Feb 2002	6.4
Phase 2	Jan 2003 - Dec 2003	10.7
Phase 3	Jan 2004 - Dec 2004	11.4
Phase 4	Jan 2005 - Dec 2005	13.1
Phase 5	Jan 2006 - Jun 2006	14.5

What would it mean for London?

Configuration:

- X regional stroke centres
- X comprehensive stroke centres

Services:

- Rapid transport system
- PACS CT and remote imaging systems

Potential impact:

- Reduction in LOS of ~60%*
- Reduction in stroke beds of ~30-50 per million population**

* Oxford Stroke Programme achieved reduced ALOS from >30 days to 18 days (from 2004 to 2005).

** Calgary (1 million population) reduced stroke beds by 50 after the introduction of Alberta's Provincial Stroke Strategy; Oxford Acute Stroke Programme reduced JR2 beds by 60 (2 million population of Thames Valley SHA).

Source: Best practice in stroke care for 2007, Alistair Buchan, Nuffield Dept of Medicine, University of Oxford, UKStrokeRN.

Working Draft - Last Modified 03/04/2007 10:27 AM

9

3. Best practice

Preventing the need for acute care

Prevention is obviously better than cure, and some emergency admissions are avoidable by taking action locally. For instance, fractured neck of femur is a common reason for admission for older people – in 2005/06 68,416 patients with a fractured neck of femur were operated on in England with a cost to the NHS of at least £384 million.²³ Yet quite modest alterations to an older person's environment can reduce their risk of falling and hence of fracturing their femur.

London good practice

A randomised clinical trial has shown that a specialist falls service at King's College Hospital in London has reduced the incidence of falls by over 50 per cent. It registers older people who attend A&E as a result of a fall; supported by a falls nurse specialist, A&E staff use a single risk assessment and screening tool. There are clear lines of access to the multi-disciplinary rapid response team and discharge to intermediate care. Referral to a comprehensive specialist falls clinic (including full carotid sinus syndrome and syncope assessment, environmental assessment and multi-disciplinary rehabilitation services) follows agreed criteria and is processed through the nurse specialist.

²³ NHS Institute, *Focus On: Fractured Neck of Femur*, October 2006

Other areas where more could be done to prevent emergency admissions are:

- Improving access to healthcare in residential homes. Various studies and reports have found that healthcare provision in some homes is of a poor quality.²⁴
- Providing alternatives to hospital admission through more step-up intermediate care, either at home or in a community inpatient facility.
- Improved management of long-term conditions, such as the use of specialist nurses to care for people with acute exacerbations of chronic obstructive pulmonary disease (this area is being considered by the long-term conditions clinical working group).
- Greater use of telecare/telehealth to support people in their own homes.

Consistent access

For Londoners needing urgent care there should be a “Right Response, First Time, In Time, Every time.” This would entail consistent triage and/or treatment, either face-to-face or over the phone.

Most people’s first access point for urgent care is by phone. In London annually, NHS Direct has 0.9 million calls, London Ambulance Service (LAS) has 1.1 million calls and GP OOH has 1.5 million calls. Calls to these services should be treated consistently. To do this the group proposes a “Hear and Treat” integrated model of urgent care telephone access in London.

Such a model should meet the following requirements or design principles:

1. Be done consistently wherever it’s done, and by whomever, as recommended in the recent Department of Health urgent care consultation.²⁵
2. Answer the phone. This is simple, but is not always happening as 150,000 calls go unanswered. And LAS have over 300,000 abandoned calls each year.
3. Have no call backs as people get frustrated when told a service will ring back and often go elsewhere (eg to A&E).
4. Achieve case closure as much as possible. 70 per cent of NHS Direct calls are referred on to other services.
5. When case closure not achieved, onward referral occurs with the fewest possible steps and without the need for the patient to repeat their story.
6. Be auditable for safety and consistency.
7. Have access to real-time information about availability of fullest possible range of services, including social care and mental health as well as mainstream health needs. This means not just the list of chemists in your area, but which one is open now.

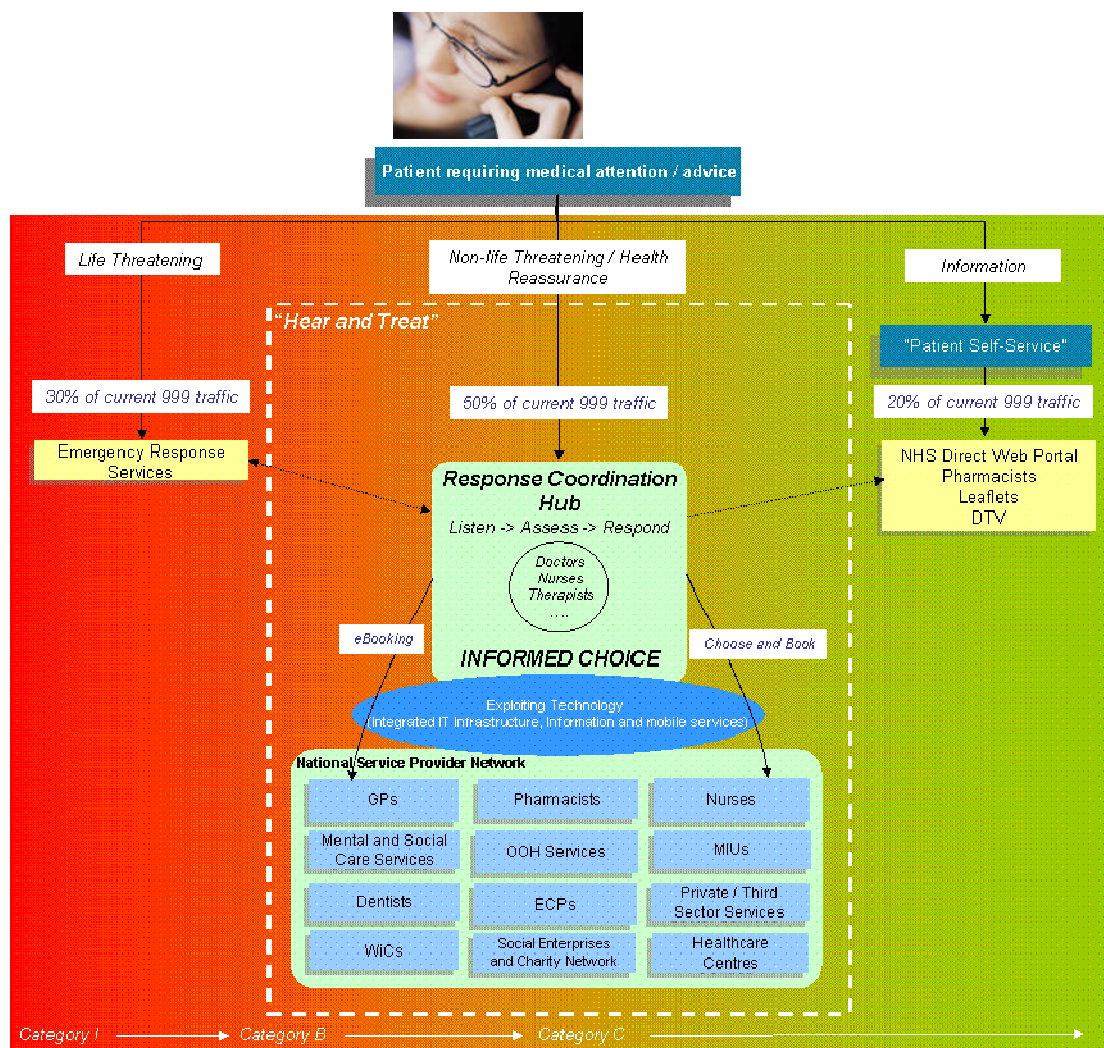
²⁴ See for instance the recent poll by the Patients Association which found that pain relief in residential homes was poor (<http://www.patients-association.org.uk/>).

²⁵ *Direction of travel for urgent care: a discussion document*, Department of Health, October 2006

8. Be capable of making appointments for patients (eg with their GP) and following them through routinely to check whether patients are complying and are safe.

If the patient has to access face-to-face care, then ideally the hear and treat system could also advise on journeys, routes and means of travel to the advised destination. This could be done orally or by sending directions and details to patients' mobile phones to help them get where they are going eg the local pharmacy.

This illustrative diagram shows how it could work:



To complement urgent care telephone access there should be improved telephone access for making in-hours GP appointments. This was highlighted in the two Healthcare for London public deliberative events as an issue needing significant improvement.

Urgent care

To provide face-to-face urgent care there should be urgent care centres, both in hospitals with A&E departments and in polyclinics.

Urgent care centres would be commissioned by primary care trusts (PCTs) to provide a full range of urgent care services. Current GP OOH arrangements would be subsumed into the urgent care centres. Local decisions would be needed as to whether Walk in Centres would become urgent care centres.

In an urgent care centre, care should be provided by multidisciplinary teams including GPs (some of whom could have a special interest in urgent care/emergency medicine), nurses, emergency care practitioners, mental health crisis response teams and urgent social care workers (depending on the availability of staff and local needs). Given the number of attendances for urgent care related to drug and alcohol abuse, urgent care centres should also have professionals skilled in helping patients with these problems.

Studies have shown that a number of attendances could be safely cared for by nurses and emergency care practitioners.²⁶ The multidisciplinary team would both respond to urgent care requests with home visits to treat patients and also work to provide care to patients who have walked into the urgent care centre.

Patients will be made aware of their nearest urgent care centre through local publicity and should know that, after telephoning, this is their first point of call for urgent care needs. There is good evidence that if patients attend these centres they will not be referred on to full-scale A&E. For instance, a study in Croydon PCT found that referrals from the GP OOH service, NHS Direct, a Walk in Centre and a minor injuries unit together only accounted for three per cent of A&E attendances at the nearby hospital.²⁷

Urgent care centres should be open seven days a week for at least 18 hours a day, with many open 24 hours a day. There will be local flexibility in hours depending on local need. A doctor will be on site the whole time. Urgent care centres will have diagnostic equipment on site including x-ray, ultrasound, ECG, echocardiogram, spirometry and blood testing.

Ambulance stations/staff could also be co-located at these urgent care centres wherever feasible. The LAS should have more freedom, knowledge and skills to decide whether a patient should be taken to an urgent care centre, local hospital or major acute hospital.

In hospitals, A&E departments should care for blue light patients and those patients who cannot be managed in urgent care centres (either the one co-located on-site or others in the local network). All walk-in patients to the hospital site would go into the urgent care centre and be managed there or transferred as appropriate.

We expect that polyclinics would, over time, come to be the site of most GP in-hours care as GP practices migrate to take advantage of the improved

²⁶ M. Sakr et al, "Emergency nurse practitioners: a three part study in clinical and cost effectiveness" *Emergency Medicine Journal* 2003; 20:158–163.

²⁷ M. Lakhani, A. Fernandes and G. Archard, *RCGP Position statement on urgent care*, March 2007

facilities at the polyclinic site. Urgent care centres at polyclinics can then integrate and work with GP in-hours provision.

Serious illness and trauma

Serious illness and trauma will be provided at hospitals with A&Es supported by a full range of specialists. Angioplasty (which is offered on nine sites in London for heart attack patients) provides a model for how to organise specialised acute care and a similar approach is needed in stroke and trauma.

Major trauma care

For trauma, there would be the introduction of a trauma system within London, integrating hospital and pre-hospital care to identify and deliver patients to a specialised place of care quickly and safely.

At the centre of this system would be the trauma centres. New trauma centres would complement the existing provision at the Royal London Hospital, which has a multi-specialty trauma service and currently manages over 950 trauma patients per year. The Royal London is the only large academic unit in the UK that demonstrates a significant improvement in trauma patient outcomes.²⁸ Their 2006 figures demonstrate 28 per cent reduction in mortality in the most severely injured patients when compared to the national average.

Stroke care

For stroke a network arrangement should be put in place with several sites providing CT scans 24 hours a day, seven days a week, specialists on standby to deliver thrombolysis to suitable patients and physiotherapists available to start the rehabilitation process at an early stage. These centres should be complemented by other hospitals sites to provide CT scans during the daytime and promote excellence in stroke rehabilitation. Such an approach should seek to ensure that whatever time of day a patient had a stroke they would receive a CT scan within one hour, allowing rapid thrombolysis if required.

Ambulance bypass

Patients suffering from a stroke or severe trauma injuries would be taken direct to specialist centres, bypassing nearer hospitals. This is not dangerous - evidence from Scotland showed longer pre-hospital times in the rural environment are not associated with differences in mortality or length of stay for moderately and severely injured patients.²⁹

It is better to take longer to get to the right hospital. Direct transfer to a trauma centre as opposed to transfer into one from another hospital reduces

²⁸ UK Trauma Audit & Research Network 2006 statistics

²⁹ McGuffie AC, Graham CA, Beard D, Henry JM, Fitzpatrick MO, Wilkie SC, Kerr GW, Parke TR "Scottish urban versus rural trauma outcome study," *J Trauma*. 2005 Sep;59(3):632-8.

mortality and lengths of stay.³⁰ At present over two-thirds of trauma patients in London are transferred to a specialist unit rather than being taken straight there. There is an average delay of six hours in transferring patients from a local hospital to a specialist centre. Delays of twelve hours or more are not uncommon. Within London almost all bypasses can be achieved in less than 30 minutes.³¹

The London Ambulance Service already bypasses hospitals for patients needing primary angioplasty – all staff can interpret twelve-lead ECGs and take the patient to the hospital most appropriate for their care.

Emergency surgery

To ensure the best care for patients needing emergency surgery, services should be centralised on fewer sites. Centralisation of emergency surgery could be done on a 24/7 basis, or could be done just at night. In either case, this will require consideration of how to provide a surgical opinion in hospitals with an A&E and emergency medical admissions but no emergency surgery department.

There are three potential models for doing this:

1. Emergency surgery is provided during the day time at local hospitals but not at night. At night, cover is provided by non resident surgeons.
2. Emergency surgery is provided during the day time at local hospitals. At night, cover is provided by surgeons from the nearest major hospital providing 24/7 emergency surgery.
3. Groups of local hospitals work together to provide emergency surgery, perhaps on a rotation basis between sites.

With all these models, telemedicine could be used to support networks, and/or the provision of cover and advice from remote sites.

A&Es at local hospitals without emergency surgery should have emergency doctors able to resuscitate, intubate and ventilate patients who may then need to be transferred for emergency surgery. Clear protocols will need to be put in place to support the care for, and transfer of, patients between sites as necessary. There is good evidence that transfer to specialist care is effective. For instance two studies have found that transfer for angioplasty is safe and improves outcomes.³²

³⁰ Sampalis et al. "Direct transport to tertiary trauma centers versus transfer from lower level facilities: impact on mortality and morbidity among patients with major trauma." *J Trauma*. 1997 Aug;43(2):288-95

³¹ *Modernising Major Trauma Services in London*, London Severe Injuries Working Group, 2001

³² "A randomized trial of transfer for primary angioplasty versus on-site thrombolysis in patients with high-risk myocardial infarction. The air primary angioplasty in myocardial infarction study," Grines, CL; Westerhausen, Jr, DR, Grines, LL, et al., *J Am Coll Cardiol*, 2002; 39:1713-1719 and "Hospital transfer for primary coronary angioplasty in high risk patients with acute myocardial infarction," E Straumann, S Yoon, B Naegeli, J Frielingsdorf, A Gerber, E Schuiki, O Bertel, *Heart* 1999; 82:415-419 (October)

Paediatrics

For children, we would expect urgent care centres to be able to deal with most urgent care.

However, where clinical opinion (eg triage by a paramedic, GP at an urgent care centre or clinical assessment by phone) deems that specialist paediatric care is needed, children and their parents will be transferred or directed straight to a major acute site with specialist paediatric care eg for paediatric orthopaedic surgery. This will be facilitated by paediatric retrieval teams.

All hospitals with acute paediatric inpatient facilities should conform to the child-friendly standards set out in the Children and Young People's National Service Framework.³³

Local hospitals

The centralisation of services such as emergency surgery will mean there are more local hospitals in London following a blueprint similar to that of the Central Middlesex hospital.

These hospitals will be centres of excellence in providing acute care to their local population. With A&E departments open 24 hours and appropriately staffed with senior doctors they will have the support of High Dependency Units and be able to carry out short-term ventilation of the small numbers of seriously ill patients needing transfer to a more specialist centre.

Discharge and rehabilitation

It is important that good quality care is provided at the end of an acute episode, to help a patient return to normality. Best practice will mean that rehabilitation should take place as close to a patient's home as possible. In some cases this will be in a local hospital, when a patient needs more intensive rehabilitative care.

In many instances, however, it will be in a patient's own home. A Cochrane review found that early supported discharge plus home-based rehabilitation for stroke patients delivered good quality care whilst reducing average length of stay by eight days.³⁴ As we know (see graph on page one) the current average length of stay in London is long and this is very expensive for the London NHS, with no benefits for patients.

4. Barriers

³³ *NSF for Children, Young People and Maternity Services Part 1: Standard for Hospital Services*, Department of Health, 2004

³⁴ "Early supported Discharge Trialists. Services for reducing duration of hospital care for acute stroke patients," *Cochrane Database Systematic Review*, 2005 (2)

Public perception and behaviour. The public see A&E departments as the solution to their health care needs. They now know that the A&E wait is four hours, but it can take 48 hours to see a GP. The public desire for immediate access is shown by the MORI poll findings that 61 per cent of people wanted an improvement in waiting times at A&E compared with 46 per cent who felt quicker appointments with a GP were necessary.³⁵ There is a significant challenge to encourage public to go elsewhere (eg polyclinic, wait for their GP appointment etc).

Infrastructure. The NHS in London does not generally have the right infrastructure in place for urgent care alternatives to A&E – both in terms of IT and estates.

Clinical resistance. The changes proposed in this report are evidence-based, but there may still be clinical opposition, especially from doctors working in district general hospitals that are classified as local hospitals and lose specialties such as emergency surgery. Amongst clinicians there will be concern about the domino effect – ie, once you remove emergency surgery other services will go/suffer. There is a need to be clear to doctors etc that not every hospital can do everything for reasons of clinical quality and safety.

Political will. Will there be sufficient political backing to centralise patient services to improve the quality of care? There has not been in the past. The Institute of Public Policy Research has explored this issue in their work on *The Future Hospital*.³⁶

Workforce. There needs to be the development of an appropriately skilled workforce to effectively deliver urgent care. The London Ambulance Service have had difficulty recruiting clinical telephone advisors in central London. The Royal College of Surgeons have endorsed the concept of a consultant community surgeon who would work in local hospitals on planned procedures but could give surgical opinion out of hours.

Financial flows. Financial flows through Payment by Results (PbR) and other mechanisms need to be examined to ensure they incentivise the right treatment. An example of this is that in 07/08 the LAS are being paid £38 for each person who is treated at the scene and not conveyed to A&E. Unbundling of the acute and rehabilitative elements of stroke and trauma care needs to happen to support a model of care that centralises the acute intervention, but then localises rehabilitation.

There are currently some perverse incentives eg St Georges Healthcare NHS Trust are now running a 24 hour primary angioplasty service for patients across south west London, but current PbR rules mean they only receive 50 per cent of the tariff for any new admissions that take them above their activity threshold. We recognise that *Options for the Future of Payment by Results*:

³⁵ Ipsos MORI, *London Residents' Attitudes to Local Health Services and Patient Choice*, December 2006

³⁶ J. Farrington-Douglas, *The Future Hospital: the progressive case for change*, IPPR, January 2007

2008/09 to 2010/11 suggests there should be flexibility to allow full reimbursement from 2008/09, but interim arrangements will be needed.³⁷

5. Solutions

Recommendation one. Everything is done to avoid the need for acute care. GPs should be pro-actively caring for their registered populations. Multidisciplinary community teams based at polyclinics will be doing preventative work in the community. Two good examples would be ensuring the homes of older people are as “fall-proof” as possible and that residential homes have access to good quality healthcare to reduce the usage of urgent care. Where local services have demonstrated an approach that reduces patients need for acute care this should be developed across London.

Recommendation two. Patients have good information about available services and can make an informed choice in accessing care. Patient education to encourage people to act promptly on symptoms is needed as well eg current campaign on taking chest pains seriously.

Recommendation three. “Hear and Treat” put into operation across London. This would mean that people accessing urgent care in London will have a well-known number they can ring at any time (the possibility of a single number for London needs to be considered) and would access a virtual call centre hub, bringing together the call-handling operations of existing organisations.

Call handlers would have access to high-quality real-time information and advice, tailored to the location of the caller. Staff answering calls would assess and determine the most appropriate course of action, from self-care advice on the one hand through to transfer to emergency services and ambulance response. Calls could be passed on to the local urgent care centre so that the caller can speak directly to clinicians, mental health teams, social care etc as required. Where clinical advice is given it should be provided by experienced staff and quality must be auditable.

Callers who need face-to-face care should be directed to walk in to their local urgent care centre, access a nearby pharmacy or have an appointment booked with their GP or other healthcare professional (eg nurse or mental health worker) for the next day. There should be a high completion rate of advice with callers clear as to what they should do next. If possible, 999 call handlers should have access to the “hear and treat” system to handle calls by providing appropriate advice.

Recommendation four. GP in-hours phone systems need to be improved so they can cope with high volumes of calls. Care could also be improved through the greater use of GP telephone triage. GP in-hours services will

³⁷ *Options for the Future of Payment by Results: 2008/09 to 2010/11, DH, March 2007*
http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_073103

increasingly be concentrated on polyclinic sites (although we recognise that not all GP practices will do this). This concentration will allow the provision of additional services in a safe environment.

Recommendation five. Urgent care should predominantly be provided at urgent care centres in polyclinics. These centres would provide a focus for existing GP Out of Hours provision and integrate it with walk-in care. These urgent care centres will be open seven days a week for at least 18 hours a day, with most open 24 hours.

Recommendation six. Twenty four hour urgent care centres will be the front-end of A&Es at local hospitals and major acute hospitals. Patients will be able to self-present at the urgent care centre where they will be triaged by an experienced emergency department nurse, who can determine if they can be safely treated in the urgent care centre, or if they need to be treated in the A&E. All patients brought by ambulance as part of an emergency response will go directly into A&E.

Recommendation seven. Local hospitals should be developed as excellent providers of normal acute inpatient care. They should be the standard setters for the majority of medical emergencies and provide good rehabilitative care through their medical, nursing and therapist workforce. The workforce should be engaged in this development.

Recommendation eight. Patients with serious illness (stroke or cardiac) or trauma requiring specialist care should be taken directly to the most appropriate hospital. To support this approach London Ambulance Service will have by-pass protocols in place (as already happens for primary angioplasty) and will improve training so their staff are better able to detect stroke symptoms and know when injuries are so severe that a trauma centre is required. This could be achieved by supporting paramedic staff with doctors skilled in pre-hospital assessment.

The resource implications for the London Ambulance Service of identifying and transporting patients to the most appropriate centre (as well as offering more “see and treat” on site and of providing rapid transfers between hospitals) need to be considered.

Recommendation nine. To concentrate expertise for the most specialised care, services should be centralised to improve quality and patient safety. The exact configuration and location of specialist services needs to be determined as the Healthcare for London work is taken forward.

We provisionally suggest there should be three trauma centres for London, replicating the trauma centre model designed at the Royal London Hospital. This figure is derived from the Royal College of Surgeons recommendation that trauma centres should serve between one and three million people depending on population density. London’s trauma centres would operate at the upper end of that range, given its high population density.

We provisionally suggest there should be seven fully comprehensive stroke centres, providing rapid CT scans 24/7 and supported by neurology departments. At night, stroke victims would be taken straight to one of these sites. The comprehensive sites would be supported by other hospitals providing interventional stroke care during the daytime, including the administration of tPA. We should aim to ensure that all stroke patients are given a CT scan within one hour of the onset of stroke and a patient should not be admitted to a stroke unit before having a scan. The exact configuration of services needs to be implemented as part of a stroke strategy for London.

Recommendation ten. Emergency surgery should not be provided by every hospital A&E department. However, surgical opinion will be available at all A&Es within a reasonable time-frame following admission. Emergency department doctors will be able to resuscitate, intubate and ventilate patients who require immediate surgical care to allow rapid transfer to hospitals with emergency surgery on site. To support this, all A&Es should have senior medical decision-makers (middle-grade or higher doctors) on duty 24 hours a day.

Paediatric acute care should similarly not be provided at every site. Consideration should be given as to whether local hospitals handle paediatric A&E cases (supported by access to paediatric opinion) or whether parents and children are always directed/transported to hospitals with on-site acute paediatrics and dedicated children's facilities.

Recommendation eleven. To take account of these changes, care should be commissioned on a network basis to ensure that a sector understands each provider's role in responding to acute care needs. The strategic health authority (SHA) could facilitate this by taking an overview role.

Recommendation twelve. Where patients have been taken to specialised centres, when stable they will be repatriated to their local hospital for inpatient rehabilitation and then, when safe to do so, back home.

Recommendation thirteen. There should be the flexibility to make local adjustments to tariff to facilitate the best patient care, such as appropriately rewarding hospitals taking more complex cases. The SHA could act as the arbiter in this.

Conclusion

The group believes implementing these changes will improve the quality of treatment for people with acute care needs. Appendix A gives a couple of examples of patients accessing care.

Appendix A

60 year-old man has a stroke at home. Wife dials 999 and an ambulance dispatched to deal with this category A call. The ambulance collects man and takes him to a major acute hospital in 30 minutes, bypassing his local hospital which was 15 minutes away. He is given a CT scan within 20 minutes of arriving at hospital to determine the cause of his stroke. CT scan reveals it is an ischemic attack and he is given tPA. He recuperates on a dedicated stroke ward and starts receiving physiotherapy within two days of the stroke.

Twenty five year-old working man has cut himself on a rusty nail. Travels to his local hospital because he knows he will be treated within four hours in A&E. Walks into the urgent care centre where he is seen by a nurse skilled in emergency medicine. He is treated here (cut cleaned and stitched and he is given a tetanus jab), without any need to cross over into the major A&E side. He is told about his local polyclinic with its urgent care centre open 24 hours a day.

Appendix B

MEMBERSHIP OF ACUTE CARE CLINICAL WORKING GROUP

Ara Darzi (Chair)	Imperial College and St Mary's NHS Trust
Steve Amiel	Camden Primary Care Trust
Stuart Bell	South London and the Maudsley Mental Health Trust
Peter Bradley	London Ambulance Service
Tom Coffey	Wandsworth Primary Care Trust
Elaine Cole	Barts and the London NHS Trust
Nigel Edwards	NHS Confederation
Nancy Fontaine	Whipps Cross University Hospital
Charles Gutteridge	Barts and the London NHS Trust
David Hunt	British Orthopaedic Association
Keith Ison	Guy's and St Thomas' NHS Foundation Trust
Fionna Moore	London Ambulance Service
Graham Morgan	NW London Hospitals NHS Trust
Claire Perry	Lewisham Hospital NHS Trust
Julian Redhead	London Emergency Medicine Consultants Group
John Riordan	Retired Consultant (NW London Hospitals NHS Trust)
Carl Shakespeare	QE2, Woolwich/SE London
Steve Shaw	Royal Free Hampstead NHS Trust
Chris Streater	St Georges Healthcare NHS Trust
Simon Williams	London Borough of Merton
Jean Drouin (Facilitator)	McKinsey & Co.