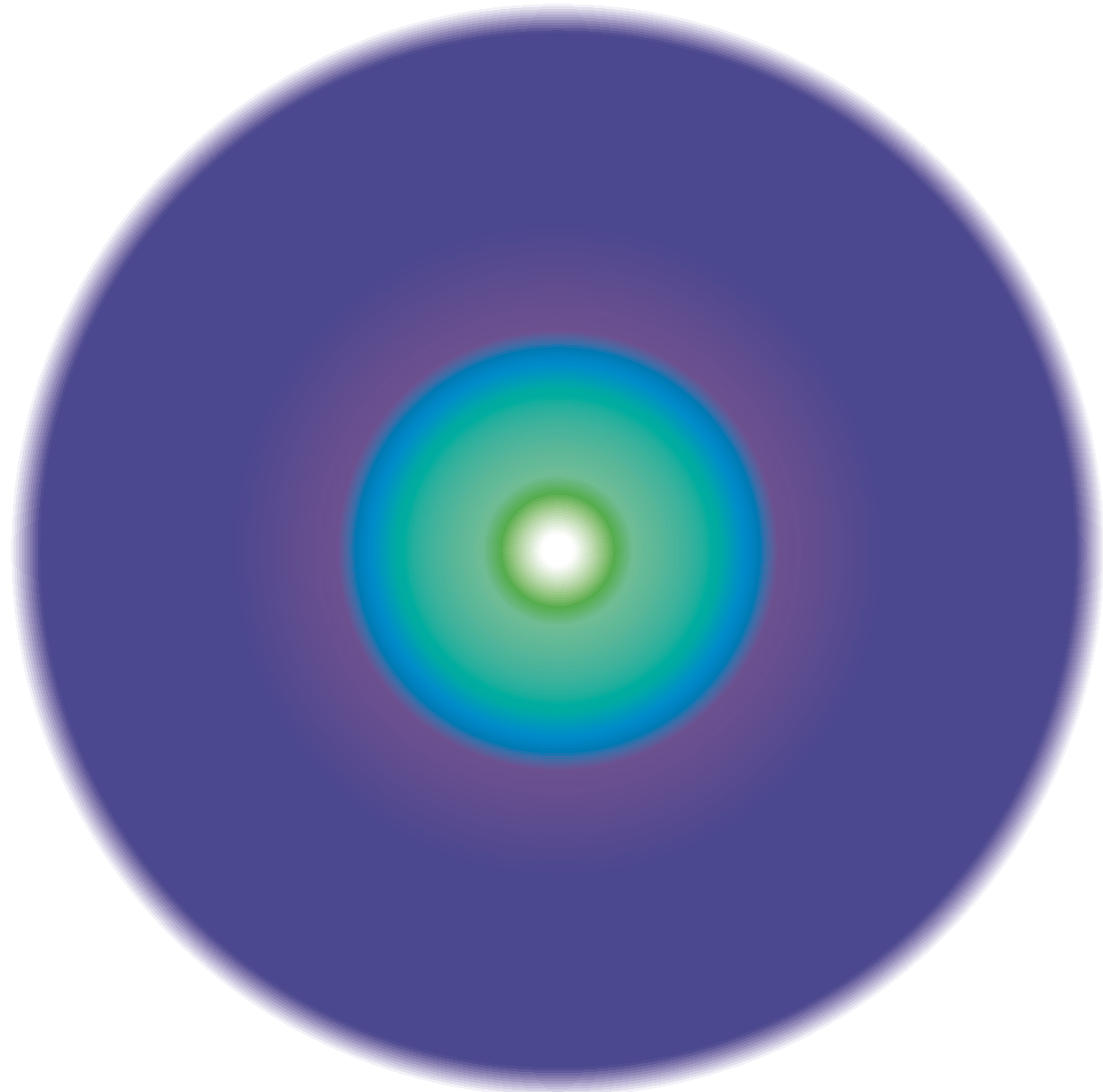


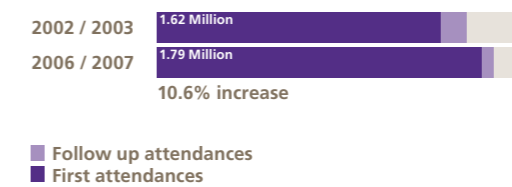


# The Acute Episode Pathway



David Dawson  
Medical Director  
Mid Yorkshire  
Hospitals NHS Trust

Figure 31. A&E attendances in Yorkshire & The Humber / Source: Department of Health dataset QMAE.



## Getting the best care for urgent conditions and in emergencies

1  
This chapter (based on the work of the Acute Episode CPG – full report available at [www.yorksandhumber.nhs.uk](http://www.yorksandhumber.nhs.uk)) sets out what we need to do to make sure everyone can get the best acute care.

2  
Across Y&H patients rely on the NHS if they need urgent or emergency healthcare. Whether they have a life-threatening illness such as a stroke, or a major or minor injury, patients have access to a wide range of clinicians including GPs, hospital doctors, nurses, pharmacists, dentists, and mental health teams. Everybody – children, adults and older people - can call on the NHS to provide the urgent or emergency healthcare they need, which is free at the point of use. On a typical day in the region 5,000 people will go to A&E, of whom 800 will be admitted to hospital.

The Case for Change

3

The need to improve acute care is clear:

- Our system is under pressure – our A&E attendances are rising and the proportion of our patients admitted from A&E is high (figure 31).
- The quality of care we provide needs to improve – there are unacceptable variations in outcomes for patients with acute illness (figure 32).
- We need to extend access to services – especially out of hours – patients are demanding better access and improved facilities (figure 33).
- There are other forces for change such as demographic and workforce change, increasing specialisation and medical and technical advance.

4

Pressure on the system: Our A&E attendances are rising – this puts pressure on the system and A&E is not always the most effective or efficient way to treat patients with minor illness.

Figure 32. Directly standardised mortality from stroke under 75 year olds, 2005 - 06 / Source: Compenium of Clinical Health Indicators, Information Centre for Health and Social Care

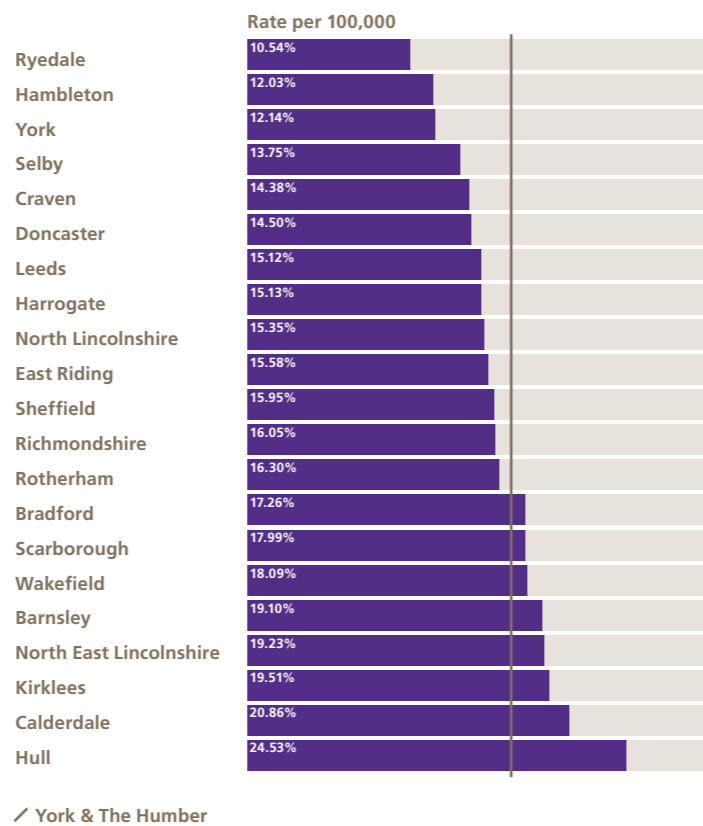
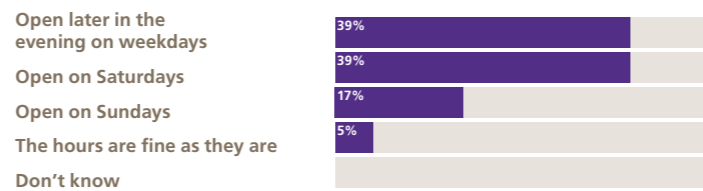


Figure 33. Polling question; If GPs' opening hours were to change, what would you change? (Pick as many as you want)



5

Quality: Acute care in Y&H is not consistently provided to the best possible standards.

6

One example where acute hospital care needs improving is in stroke care. (Others are care of patients with acute MI, major trauma and older patients with complex needs). There is evidence that there are unacceptable variations across Y&H:

- for managing stroke.
- for the processes used e.g. waits for brain imaging.
- in clinical outcomes.

7

Access: There is dissatisfaction with access to GPs and with out-of-hours services. This has been demonstrated by polling of both the public and clinical staff at a deliberative event held in Y&H on 18 September 2007. More convenient GP opening hours were wanted by all those who took part in our focus groups.

Other factors are also driving change:

8

Demographic and chronic conditions: The population is ageing and prevalence of chronic diseases is rising. Effective management of long-term conditions is essential if there is to be no acceleration of current trends in acute admission due to avoidable crises or deterioration.

9

Specialisation and Patient Safety: There are requirements for doctors to undertake a certain volume of given procedures to ensure that they build and maintain the right level of skill. This is leading to increasing specialisation of the workforce and the centralisation of some specialist services which may not be able to be provided to adequate standards in every hospital in the future.

10

Technological and medical advances: One example is telemedicine which means that experts can provide advice (and some direct treatment) via a digital link enabling more services to be provided in community settings, closer to people's homes – where this is safe and provides better value for money.

11

Workforce changes: Changes such as the Working Time Directive and to the training of doctors affect the workforce supply. The skills of NHS staff are also changing, making the care of patients outside hospitals more effective – for example emergency care practitioners are a new type of clinician able to treat many acute conditions effectively without hospital admission.

### Key Recommendations

12

The CPG has developed a new model for the development of acute care in Y&H over the next ten years and this is shown in figure 36. Within this model the key recommendations are:

#### Self Care

13

PCTs should commission a wider range of services in pharmacies and primary care.

14

The SHA or DH should develop a Self Care Manual.

15

PCTs should commission primary and secondary care providers to work together to target care for particular groups e.g. people with LTCs; care home population to promote self directed care and avoid hospital admissions.

#### Primary and Community Care

16

PCTs should develop, and ensure the delivery of consistent standards for acute care in the community, which apply both in and out of hours.

17

Extended access to these services should be available, especially in the evenings and at weekends.

18

Additional services in pharmacies and other community settings should be developed.

19

Access to mental health and social care teams should be integrated with urgent care.

20

A single point of contact with a single telephone number should be introduced for urgent (as opposed to emergency) care e.g. 888 as part of an integrated triage and signposting system.

#### Ambulance Services

21

A single point of contact for urgent care should be introduced.

22

More options for treatment at scene by skilled staff should become available.

23

After initial assessment or on face to face contact, a wider range of referrals across the health care system should be available to make best use of all services.

24

Ambulance bypass protocols should be developed for patients with stroke, acute MI, major trauma and paediatric emergencies where or when appropriate to ensure patients have access to the best treatment.

### Urgent Care Centres

25

The CPG recommend that urgent care centres should be introduced alongside major A&E departments.

26

A specification for services, staffing, facilities and management arrangements should be agreed based on the recommendations made by the Acute CPG.

27

Clear protocols for the movement of patients between UCC and A&E should be agreed.

#### A&E

28

Senior clinical decision makers should always be available at the front door.

29

There should be extended use of clinical decision units and short stay units.

#### Admitted Care

30

In hospitals, systems should be improved with the introduction of care-pathway coordinators and an emphasis (targets) on discharge.

31

Consultant decisions should be made as early as possible in patient care and no later than 12 hours.



32

New models of care should be developed as detailed in the Acute CPG pathway report for:

- Stroke
- Heart attack
- Trauma
- Older people

33

Acute providers should be commissioned to work together to develop integrated networks to support these models.

#### Generic Themes

34

Current '999' and other urgent call systems (e.g. to NHS Direct or Out of Hours providers) should be reviewed to produce consistent signposting of care tailored to local need and provision.

35

The Y&H IT strategy should address the need for the rapid transfer of patient information in the urgent care setting. NPfIT solutions that allow the transfer of patient information (electronic record, electronic prescribing etc) should be accelerated such that it becomes the norm to share records across different parts of the NHS (with appropriate confidentiality safeguards).

**36**  
New and changed roles for staff will be needed. Commissioners, Y&H SHA and educational providers should take account of this in workforce planning and in commissioning educational programmes for healthcare staff.

**37**  
The need to develop a world class service for acute care leads inevitably to a consideration for further integration of primary and secondary care. The NHS should consider how that can be achieved functionally or consider developing new models of provision.

**The Acute Episode Pathway**

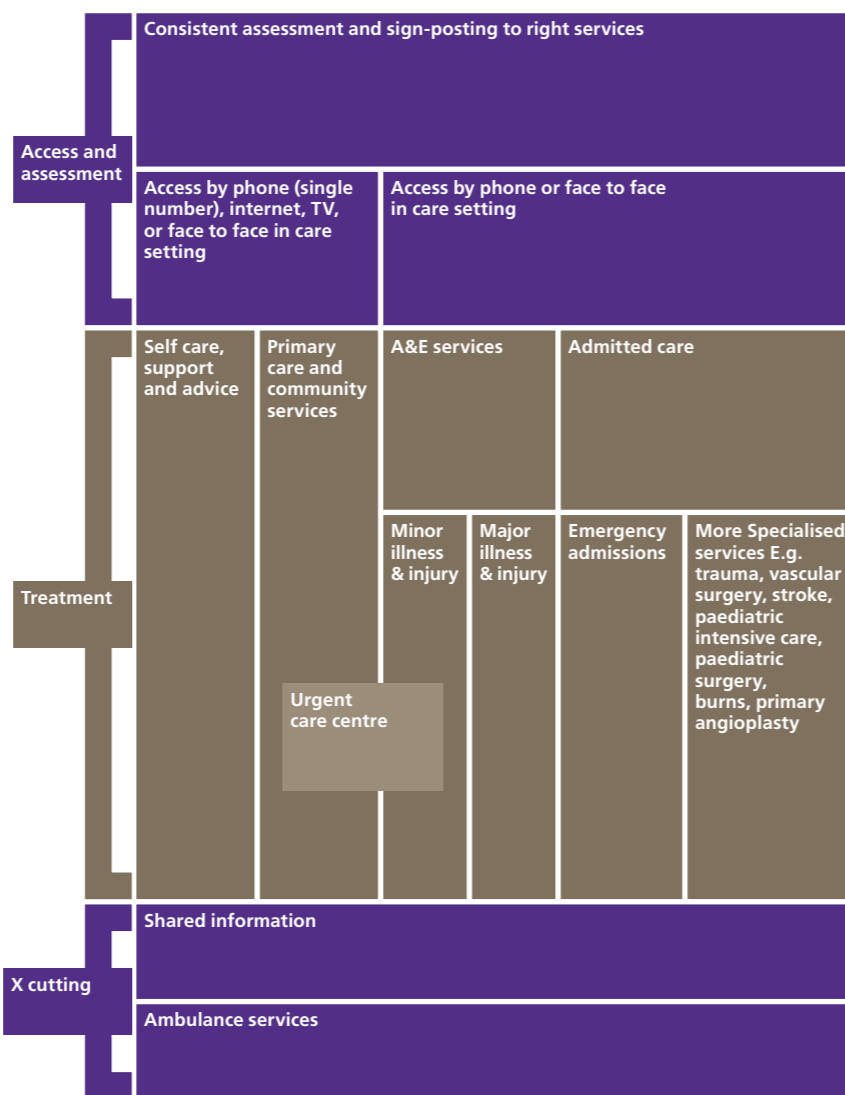
**38**  
The CPG identified the key elements which together make an effective urgent and emergency care system. This is set out in figure 34.

**The Pathway in Practice**

**Self Care and Support**

**39**  
A consistent signpost service to all urgent care services should be available 24/7 which is readily understandable for public and professionals and has single number access – with advice (GP calls could default here out of hours). Our focus groups demonstrated that this was important to patients. “something easy like 123”.

**Figure 34. The Acute Pathway / Source: Y&H Acute CPG**



**40**  
High quality, customer focussed, patient information should be available, this should include a Self-Care Handbook (which could be developed nationally or in Y&H learning from the existing Kaiser self care handbook). This should be available in multiple formats but be predominantly electronic, be regularly updated and include chapters for all the pathway areas considered as part of the Next Stage Review.

**41**  
More effective prevention and self-care supported by links to 24hr pharmacy services. This could include:

- Customer oriented advice (consider system of patient advocates aligned to expert patient programme).
- 24hr dispensing and 24hr prescribing of OTC and PGD drugs. Access can be supported by IT (cash-machine type facilities e.g. for prescriptions could be available in every urgent care centre, community settings etc).
- Improved medicine management in community.

**42**  
Incentives for healthy lifestyles and self care might be developed: e.g. NHS Club Card with:

- Lifestyle rating (smoker, weight etc).
- Medical history.
- Concessionary car park entry.
- Points for health food purchases.

**43**  
More research could be done on both the distribution of health literacy (or illiteracy) in England as well as effective interventions that raise health literacy levels. Health literacy is the process by which individuals have the capacity to obtain, process and understand basic health information.

**Primary and Community Services**

**44**  
Primary and community services must be part of an integrated urgent care system which can be flexed to meet demand at different times of the day, but which sustains consistent quality standards.

**45**  
The urgent care system must be accessible 24hrs a day (i.e. there should NOT be separate systems for 9-5 Mon-Fri and for OOH) with consistent standards and quality throughout. Fewer access points will be required at periods of lower demand, but all services (with a full part played by GPs, pharmacists, A&E) should be available in every community.

**46**  
Additionally, extended hours and the availability of more urgent primary care appointments during the day may reduce the demand on A&E services.



## Ambulance Services

47

Ambulance services are a key element in any urgent care system; they play key roles in call handling and in initial response/treatment. These roles should be developed further in future.

48

The CPG recommend that there should be a single point of contact underpinned by:

- A consistent assessment system.
- Timely access to care (e.g. cat A patients to receive a response within 8 minutes 75% of the time).
- Improved call categorisation with greater variety of response and target response times, flexible enough to reflect this variety.
- Referrals across the healthcare system and best use of all service resources.

49

A more flexible work force:

- In call handling (e.g. nurse / GP triage).
- Treatment at scene.
- Paramedic or ECP responding to every emergency.

50

Clear pathways for treat at scene and transfer to most appropriate place of care, with referrals across the healthcare system as appropriate – right place, right time.

51

Ambulance and PTS stationing should be sufficiently flexible to be able to transfer patients as soon as required between different parts of the integrated system. This may require ambulance stationing at A&E or urgent care centres and may also require the separation of urgent and patient transport services. This will need careful consideration, and take account of the need for emergency resilience.

## Urgent Care Centres

52

Urgent care centres are an effective way of extending access to primary care across a variety of settings, improving services to patients and relieving pressures on A&E. They allow the development of new models of primary care delivery, but this has been outside the remit of the Acute Care CPG.

53

Urgent care centres can be provided in a variety of settings and in ways to suit the different needs of particular communities. What might work in Leeds and Sheffield might not work in rural areas. However, as a minimum they should be available alongside (and integrated with) major A&E departments.

## A&E Services

54

Many people who attend A&E departments could be cared for outside hospital if appropriate facilities existed; some estimate this to be 50-70% of present workload. As yet there is little evidence that the transfer of this work to other settings has been achieved cost-effectively and to appropriate quality standards. However, if even a small proportion of patients could be seen in other settings, it would significantly reduce the pressure on A&E departments and offer a more local and accessible service. In our new model, many patients could be seen in the integrated urgent care centre. For the rest who attend A&E and need acute hospital care or who have major trauma, the CPG recommend:

Timely access to appropriate care (e.g. delivery of 4 hour operational standard, separate but flexible minor injury streams).

Present streaming in A&E should be modified so that the majority of minors are directed to an urgent care centre and greater attention can be given to:

- Majors (high chance of admission).
- Resuscitation.

55

Major illness and injury should receive assessment for admission and immediate treatment (with a whole hospital approach):

- Full range of specialist assessment.
- Senior clinical decision makers from A&E or emergency medicine should be at the front door with a 'Specialist' (consultant) assessment within 12hrs at the latest.

56

Serious illness and trauma:

- Full range of specialist assessment.
- Senior decision makers at the front door.
- 'Specialist' (consultant) assessment immediately.
- Critical care and full diagnostic backup.

57

Where a decision is made that highly specialised care is needed, direct ambulance transfer with A&E bypass is the ideal. This would be likely to be for primary angioplasty, stroke, aortic aneurysms and major trauma.

## Stroke

58

Stroke should be treated as a medical emergency.

59

The occurrence of stroke causes irreversible damage to the brain which needs to be prevented or minimised as far as possible. After a stroke, many people die because of the severity of the stroke itself or more commonly because of complications (such as pneumonia which may occur because of difficulties in swallowing and problems which arise as a result of immobility). 20-30% of patients die within a month of having a stroke and 13% of survivors are discharged into institutional care.

- Every year 150,000 people in the UK have a stroke.
- As many as 30% of patients who have a stroke have previously had TIAs (mini strokes) which cause no permanent damage.
- To reduce deaths from stroke the biggest impact would be made by treating TIAs before a full stroke develops – up to 80% of strokes could be prevented in this way.
- Many lives would also be saved if sufficient attention was given to the complications that can arise as a result of a stroke.
- For some patients – (up to 20%) thrombolysis will be of benefit. Patients need an urgent scan to assess whether or not they would benefit from thrombolytic therapy, which needs to be given as soon as possible.

- All patients require urgent assessment and detailed diagnosis of the cause of their stroke to determine optimal treatment.

60

The CPG made a number of recommendations to address this.

61

Investigation of TIA should be within a maximum of 7 days – for some types of TIA carotid imaging should ideally be performed at initial assessment and should not be delayed for more than 24 hours. There should be progressive improvement towards investigation for all TIAs within 24 hours.

62

Paramedics should use the FAST (face, arm, speech test) protocol for transfer of patients with suspected stroke direct to a hospital with an acute stroke unit meeting best practice standards.

63

To meet best practice all units dealing with acute stroke should have:

- Senior clinical decision makers at the “front door” able to fully assess patients and ensure speedy access to thrombolysis and a full stroke pathway within 2 hours of onset.
- Access to neuro radiology opinion – this could be via a telemedicine link.
- Organised acute stroke care and dedicated stroke units.
- Common clinical standards/protocol to underpin commissioning of stroke services.

64

Where a local hospital cannot provide or access these services (either in or out of hours) patients may require redirection to hyper acute stroke units in hospitals which are equipped in this way. Such patients should be repatriated to post-acute/rehabilitation stroke unit which should be available in every DGH operating to best practice standards. High quality rehabilitation should start on the patient’s first day supported by a specialist multidisciplinary team in the stroke unit and with early supported discharge to the community.

65

This would lead to a network of hospitals including a small number of hyper acute units (perhaps five or six) operating 24 hours a day, a larger number of hospitals offering these services for a limited period each day (in hours brain scans) and some hospitals acting only as post acute rehabilitation units.

67

Many DGHs will be able to improve services to meet these standards on a stand alone basis but this is likely to require investment. Commissioners will need to consider whether this is the best option for their populations or whether DGHs should provide these services as part of a network.

## Cardiac

68

Y&H is already developing a network of primary angioplasty providers in specialist centres. The CPG recommend that this should continue so that:

69

ST elevation acute myocardial infarction patients should be treated with reperfusion (thrombolysis or primary angioplasty) within 3hrs of symptom onset.

70

For appropriate patients primary angioplasty within 3hrs is preferred requiring direct ambulance transfer to designated centres.

71

All coronary syndrome patients should be seen by cardiologists.

72

There are agreed protocols for managing arrhythmias.

## Emergency Surgery

73

Because of increasing surgical sub specialisation, there are difficulties in providing emergency surgical services on every hospital site. There is also a need to ensure emergency surgery supports the needs of medical emergencies and critical care. It is unlikely that any hospital accepting unselected medical emergencies would be able to operate without on site emergency surgical cover.

74

There is a need to concentrate specialist major trauma facilities in Trusts which as a minimum admit more than 250 critically injured patients per year. The Royal College of Surgeons policy briefing on the provision of trauma care recommends that major trauma centres should serve populations of between 3 and 4 million depending on location and geography. For a population the size of Yorkshire and Humber the NHS would expect to see between 500 to 800 major trauma patients a year.

75

There should be a Y&H trauma system with a network model between hospitals – ideally as part of a national network. Each network would integrate pre-hospital care, initial transfer, inter-hospital transfer, definitive hospital care and rehabilitation.

76

Consideration should be given to the advantages and disadvantages of co-locating hyper specialist centres for stroke, heart attack, major trauma and specialist paediatrics. Factors to consider would be the advantages of clinical interrelationships between specialities set against the potential disadvantages of size, capacity and access and impact on other services.

77

We look at the implications of these recommendations in more detail in the chapter on delivery models.

## Older People

78

65% of all hospital beds are occupied by older patients. Their particular needs especially multiple co-morbidities cannot be ignored. The CPG therefore recommend that older people presenting as emergencies should expect the following services as standard.

79

Comprehensive geriatric assessment – not necessarily in hospital – should be carried out where necessary.

80

Alternatives to admission should be actively explored, e.g. through:

- Case finding (i.e. to identify and manage patients with LTCs).
- Falls clinics.
- Direct referral to intermediate care.
- Ambulance staff assessment and referral.

81

If admitted to hospital older people require special attention with rapid movement through A&E to dedicated elderly care units.

82

There should be enhanced roles for care homes and community facilities to support these services.

83

There should be early supported discharge to:

- Intermediate care.
- Rehabilitation in primary care.
- Fracture liaison services – treatment according to NICE guidelines reduces fracture amongst those at high risk by half.

84

There should be education and awareness to improve dignity of care and avoid inappropriate interventions.

## Barriers to Change

### Public acceptance

85

It may be difficult to win support for some proposed changes despite clinical backing and the fact that they lead to better outcomes for patients (e.g. centralisation of specialist trauma services) because public perception can be that such changes threaten local services, even when it affects only a small number. It is vital that doctors, nurses and other clinicians are supported in explaining clinical benefits to the public.



## NHS complexity and culture

86

The need to secure agreement across different organisations and specialties e.g. agreeing on the most effective distribution of care across specialist hospital and local hospitals, can be a barrier to change.

## Clinical resistance

87

Some of the changes proposed e.g. the need to have senior clinical decision makers available at the “front door” out of hours may challenge existing working practices and thus be resisted by some clinicians. Highly specialised work concentrated in specialist centres can result in secondary care clinicians in DGHs feeling that they are providing a second class service, even where this is not the case.

## Shared understanding of issues and solutions

88

Without a significant critical mass of support for, and understanding of, the case for change and the model proposed, it is unlikely that potential solutions can be applied locally.

## Workforce constraints

89

There are likely to be a range of workforce constraints, such as the availability of people with the right skills and experience in sufficient numbers and willing to work out of hours, particularly given the tight labour market, and the ageing profile of the NHS workforce in Y&H.

## Financial considerations

90

Proposed changes will need to be assessed for costs and affordability. The latter will clearly vary depending on the local circumstances. The PbR tariff needs to be flexible enough to support integrated care and not polarise in-hospital/out-of-hospital care.

## Political will and time horizons

91

Making changes to health services, especially in areas as critical as acute care, relies on the ability of the NHS to gain continuity in support from both local and national politicians. This issue is clearly linked with that of public acceptability and understanding.

## Unintended consequences

92

Further work on the impact on these proposals for each local hospital is required. The SHA is committed to supporting local services provided this does not disadvantage outcomes and experience for local people.

## Good Practice

In the East Riding of Yorkshire the Out of Hours service receives around 4,500 contacts a year between 11pm and 8am. The PCT has introduced First Contact Practitioners (FCPs) to ensure the provision of a safe, high quality and accessible Out of Hours service across what is a large area. Better services for patients include a 20% reduction in out of hours non-elective hospital admissions. More patient satisfaction is indicated by a 50% reduction in complaints, serious untoward incidents and health and safety incidents in the three months following the introduction of the FCP service.

In York pairing a paramedic with a police officer on late night weekend shifts means emergency care is now available on the city's streets – helping to reduce unnecessary 999 calls and visits to A&E.

## Conclusion

93

The Acute Episode CPG have clearly specified the action needed to improve acute care at all stages of the patient's journey through the health service. PCTs across Y&H will need to assess their own services against the models described in the full CPG report and prioritise the action to be taken locally.

94

Our pledge in taking forward this pathway will be to ensure we have senior decision-makers at the front door and beyond for acute care.

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