“Not the Default Option.”

Health Overview and Scrutiny Committee,
Kent County Council
March 2012

A Review into Levels of Attendance at Accident and Emergency Departments.

Kent County Council

Accident and Emergency: Not the Default Option

1. Key Issues

(a) As many as 1 in 5 people who attend accident and emergency departments in Kent and Medway could be treated more effectively elsewhere.[1] This runs counter to the health service's aim of making sure everyone is seen in the right place at the right time by the right person.

(b) The impact goes beyond that of the individual turning up at A&E. The forecast spend for 2011/12 on accident and emergency attendances by Kent and Medway residents is just under £45 million. An additional £342 million is likely to be spent on emergency hospital admissions.[2] In the current financial climate, with the NHS as a whole asked to find £20 billion in efficiency savings by the end of 2014/15 as part of QIPP (Quality, Innovation, Productivity and Prevention), it was not surprising to find that all the NHS organisations we spoke to agreed that reducing accident and emergency attendances and admissions was a local priority. Nationally, the QIPP workstream looks to achieve a 10% reduction in A&E attendances.[3]

(c) With limited resources, each A&E attendance costs £52 to £183 and where this is spent on people who could be treated elsewhere, it is unable to be spent on other services.[4] There is also a negative impact on the organisations providing the services. Those available outside acute hospitals may be under utilised, and there is a knock on effect to the whole range of services provided by the Hospital Trusts and the Ambulance Service as staff and resources are diverted to deal with emergency attendances and subsequent admissions.[5]

(d) Yet for all the discussion about the cost of A&E, the alternatives are not without cost. The Committee was provided with information on the overall costs of different elements of urgent and emergency care[6] and we will be following this issue up to see what the costs are of individual episodes of care at Minor Injuries Units and elsewhere.

(e) However, if we concentrate too much on the details of the costs of care we risk being diverted from the bigger picture. Most important is the impact on the patient concerned. The care provided by the skilled professionals in accident and emergency departments is generally very

[1] HOSC Minutes, 25 November 2011.
[2] Evidence from NHS Kent and Medway, HOSC Agenda 14 October 2011, p.14.
[3] Department of health, October 2011, http://www.dh.gov.uk/en/Healthcare/Qualityandproductivity/QIPPworkstreams/DH_115468
[4] Evidence from NHS Kent and Medway, HOSC Agenda 14 October 2011, p.30.
[5] Evidence from South East Coast Ambulance Service NHS Foundation Trust, HOSC Agenda 14 October 2011, p.45. Evidence from Maidstone and Tunbridge Wells NHS Trust, HOSC Agenda 25 November 2011, p.4.
[6] Evidence from NHS Kent and Medway, HOSC Agenda 14 October 2011, p.35.

good, and a necessary service for thousands of people each week across Kent and Medway. For many people though, they may be missing the convenience of care closer to home as well as avoiding an unnecessary visit to hospital.

(f) The majority of people attending A&E go there directly, without having being referred or conveyed by an ambulance.[7] The Committee was made aware of research which had been conducted around the reasons why people choose to go to accident and emergency departments over the alternatives. The reasons are no doubt very complex and depend on the individuals concerned and the situation, but, tellingly, research in Maidstone in 2008 showed **that 42% chose A&E because they did not know where else to go.**[8]

(g) More generally, the Committee senses that both where there is a lack of knowledge or confusion about the alternatives, and where accessing the alternatives has been a negative experience, attending A&E has in effect become the default option for too many people. A 24/7 accident and emergency department is a great asset to a community and there will always be a need for the life saving skills delivered by the health professionals working in them, particularly where there is a good chance of being seen within 4 hours. However, there is an urgent need to address this idea of default.

(h) The Committee has identified four interconnected factors it believes have contributed to this idea of default which will set the context for the recommendations it is making.

(i) These factors are:

- the changing nature of urgent and emergency care;
- lack of consistency;
- lack of joined up services; and
- lack of effective communication.

2. The Changing Nature of Urgent and Emergency Care

(a) The Department of Health defines urgent and emergency care as "the range of healthcare services available to people who need medical advice, diagnosis and/or treatment quickly and unexpectedly."[9] This is a helpful definition, but it is very broad and covers everything from advice received online or on the phone from NHS Direct to being transferred to a Major Trauma Centre in a London Hospital.

[7] Evidence from Acute Trusts, HOSC Agenda 25 November 2011.
[8] Evidence from NHS Kent and Medway, HOSC Agenda 14 October 2011, p.25.
[9] Department of Health, October 2011, http://www.dh.gov.uk/en/healthcare/urgentandemergencycare/index.htm

(b) The Committee heard about a wide range of services available across the whole care pathway, with more in development. Accident and emergency departments themselves are also changing and this is mirrored by changes in each part of the pathway. Many of these changes are positive and contribute to delivering improved healthcare and saving lives. However, where they are not communicated successfully to the public or coordinated well with each other, there is a danger that they are having the **unintended consequence of increasing public confusion.** This could exacerbate the tendency to regard the nearest A&E department as an element of certainty and continuity and hence the default option.

(c) Primary care, and GPs in particular, are key to ensuring people receive the right care at the right time. They provide continuity of care and are in a better position to treat the whole person than staff in an A&E. While concerns were raised during our evidence gathering around the difficulties sometimes experienced by people wishing to make an appointment with a GP, this was balanced by the acknowledged need to ensure that GPs could access the appropriate services provided by others efficiently and directly for their patients.

(d) There are six Type 1 accident and emergency departments within Kent and Medway providing a full range of services for minor and major emergencies. Work is already underway to address accident and emergency attendances. All the Acute Trusts we spoke to were looking at ways to allow patients to bypass A&E, such as being directly admitted to an assessment unit by a GP, or signposting people who turned up but could be seen elsewhere to a more appropriate place. Many sites had pharmacies, GP services and other non-emergency care co-located with the A&E department. We heard that such work had enabled East Kent Hospitals NHS University Foundation Trust to reduce A&E attendances by 2%. Good work in other areas had been impacted by changes outside of Kent, such as the closure of A&E at Queen Mary's in Sidcup.

(e) A&E itself is also changing, with the establishment of certain specialist centres. Patients requiring primary angioplasty, for example, will often be taken direct to William Harvey hospital at Ashford. Three hospitals are aiming to be Level 2 Trauma Units, and this will also impact where people are taken in certain clinical circumstances. The intention is for these units to be at the William Harvey in Ashford, Medway and Pembury.

(f) Parallel to these changes, the ambulance service itself is also changing, with the training and introduction of Paramedic Practitioners able to treat people at home or closer to home, and Critical Care Paramedics able to care for patients over longer distances to enable them to access specialist treatment.

(g) There are mental health services provided along the entire urgent and emergency care pathway. This includes the Crisis Resolution and Home Treatment Teams who take referrals from a range of sources, and provide treatment at home as well as facilitating admissions to acute inpatient beds. It was admitted that finite resources may mean the Teams are unable to prioritise someone in A&E.[10] However, the good work in developing liaison psychiatry services embedded in A&E departments across the County was recognised.[11] The well regarded RAID (Rapid Assessment Interface and Discharge) 24/7 service in Birmingham had looked to the service in East Kent for inspiration.[12] The liaison psychiatry services in Medway and West Kent are also great successes, but are not currently provided 24/7.[13]

(h) On 1 April 2011, Kent Community Health NHS Trust was formed as a new organisation, bringing together the two community service provider arms of the Primary Care Trusts in West Kent and Eastern and Coastal Kent. One of the major health policy drivers in recent years has been towards a broader shift of activity out of the acute sector and into the community and there is a lot of interesting activity in this sector, including telehealth and the use of community hospitals to provide step up beds from the community to avoid acute hospital admission. The Trust made the point that the levels of people attending A&E do not directly impact community health services; however, there was the potential for more effective use of the sector to avoid admission to hospital.[14]

(i) One area of community services activity which is directly geared to providing an alternative to A&E attendance are the **10 minor injuries units and 3 walk in centres across Kent and Medway.**[15] The levels of use vary across the sites, with the Folkestone walk in centre seeing 1000 patients each month, and the minor injuries unit in Faversham seeing 100.[16] The evidence tends to suggest that while people living near one of these sites will often turn to them before A&E, increasing their use is restricted by at least two things. Firstly, the geographical spread means that access to them is unequal; **Maidstone, for example, does not have a minor injuries unit**, meaning the A&E at the acute hospital is the more accessible option. Secondly, there is variation across minor injuries units and walk in centres with regards the services offered and the opening hours. At the six minor injury units and one walk in centre run by Kent Community Health NHS Trust, for example, the opening hours vary. Where people are unclear about

[10] Evidence from Kent and Medway NHS and Social Care Partnership Trust and NHS Kent and Medway, HOSC Agenda 3 February 2012, p.20.
[11] Ibid, p.21
[12] Minutes, HOSC, 3 February 2012.
[13] Evidence from Kent and Medway NHS and Social Care Partnership Trust and NHS Kent and Medway, HOSC Agenda 3 February 2012, p.21.
[14] Information from Kent Community Health NHS Trust, HOSC Agenda 14 October 2011, p.52.
[15] Evidence from NHS Kent and Medway, HOSC Agenda 14 October 2011, p.23.
[16] Ibid.

what services are available and when, the easier choice is to go straight to A&E. **The very phrase 'minor injury' means different things to medical professionals and the public.**

(j) All of these developments taken together mean an increase in the complexity of the problems presented by those patients who do attend A&E departments.

(k) It would be highly misleading to suggest that the different healthcare providers never acted in an integrated way or worked together to improve the quality of services. For example, Dartford and Gravesham NHS Trust had worked with local nursing homes and GPs on the assessment of elderly patients before being sent to hospital. This had resulted in a 30% reduction in admissions from nursing homes.

(l) The Committee feel strongly that any patient requiring urgent care shouldn't notice any difference when moving from one organisation to another, such as from a minor injuries unit to an A&E department, and different providers need to share information efficiently and effectively. Anecdotal evidence suggests that this is not always the case.[17] If the patient experience is disjointed, such as being referred to A&E from a minor injuries unit with tests being carried out twice in the same day, then this will impact future decisions negatively. However, we also acknowledge that there is sharing of information across Trusts and as not all minor injuries units are able to carry out all tests, the tests may be different, but the perception of the patient remain. We feel this is an area where further work needs to be undertaken to fully assess the extent of this problem.

(m) The situation is analogous with regards GP out-of-hours services, where the first experience (or the reported experience of others) is likely to determine future choices, even where the provider may have changed, or the service improved. This is one area where we hope the development of Clinical Commissioning Groups and thus the increased involvement of GPs in commissioning decisions will be able to make a positive impact.

(n) One message that came out from all the meetings the Committee held on this topic was the belief within the NHS that the coming together of three changes across Kent and Medway would address a lot of these issues. These are:

- NHS 111.
- NHS Pathways.
- Directory of Services.

(o) NHS 111 is to be a single point of access for patients unable to contact their GP, but who do not need to call 999 or attend A&E. It has been

[17] Minutes, HOSC, 6 January 2012.

trialled in the North East of England and results suggest it has led to a decrease in A&E attendances.[18] The intention is that it becomes an England-wide non-emergency healthcare service on a three-digit telephone number.[19] When rolled out nationally by April 2013, it will replace the NHS Direct number, though NHS Direct is expected to continue, alongside other providers.[20] It will be commissioned locally.[21] The procurement for the whole south east coast region is currently underway with a view to it becoming operational by 1 April 2013. NHS Pathways is triage software currently used for 999 calls and some GP out of hours calls. The Directory of Services refers to the development of a live database of what services are available when and where. The intention is that the three of them in conjunction will ensure that anyone using the service will be directed to the right service in the right place to suit each individual person.

(p) If successful, this could be the biggest means to changing the default to A&E which we currently have. **The importance of getting the communication of the change right cannot be underestimated. A person's first experience of 111 may determine whether there is a second.**

3. Conclusion

(a) This short report has focused on the challenges faced by the local health economy in finding another way of responding to the needs of people who attend A&E in a more effective and efficient manner. However, there is the much bigger issue of why people need to access urgent and emergency care services in the first place. While accidents will always happen, there are large numbers of A&E attendances which could be prevented in the first place, and not simply be dealt with elsewhere.

(b) Overall, it has been estimated that around 35% of A&E attendances are alcohol related (including violent assaults, road traffic accidents, mental health emergencies and deliberate self-harm).[22] Locally, self-

[18] Evidence from South East Coast Ambulance Service NHS Foundation Trust, HOSC Agenda 14 October 2011, p.47.
[19] Ofcom, *New 111 non-emergency healthcare phone number confirmed*, December 2009, http://media.ofcom.org.uk/2009/12/18/new-111-non-emergency-healthcare-phone-number-confirmed/
[20] Department of Health, *NHS 111*, November 2010, http://www.dh.gov.uk/en/Healthcare/Urgentandemergencycare/DH_115054
[21] Department of Health, *Dear Colleague Letter. Rolling out the NHS 111 Service,* August 2011, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_129104.pdf
[22] Department of Health, *Checklist Improving the management of patients with mental ill health in emergency care* settings, September 2004, p.3 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4089197.pdf

harm is the third highest reason for attending A&E in West Kent and Medway, and sixth highest reason in East Kent.[23]

(c) The evidence for saying that a higher priority needs to be given to public health and preventive work speaks for itself. The establishment of the Health and Wellbeing Board in Kent and the transfer of public health responsibilities to local government give grounds for optimism. While we can admit that problems exist and that all sectors of the health service agree that reducing A&E attendances is a priority, we believe that not only can those one in five people referred to at the beginning of this report be treated more appropriately and at a lower cost to the whole health economy, but that more can and will be done to reduce the need for any kind of urgent and emergency care.

4. Recommendations

1. **The patient journey should be seamless, with no duplication of diagnostic tests, or better communication with patients of why tests are being carried out. We ask the commissioners and providers to report back to the Committee with details of what work is being undertaken to assess the scale of the problem and achieve this.**

2. **Lack of awareness or confusion around the alternatives to accident and emergency mean turning to A&E is often the simplest and most rational choice, even where it is not the most appropriate one. Commissioners and providers should produce a joint communication plan to simplify the choice of GP out-of-hours services, minor injuries units, walk-in-centres and other alternatives and improve public understanding.**

3. Following from the above recommendation, the Committee asks that commissioners and providers explore the appropriateness and viability of introducing **standardised opening hours** around a clearly understood set of services across all the minor injury units in Kent.

4. We ask the commissioners to provide further information on the costs per case for those patients seen at a walk in centre or minor injuries unit compared to those seen at A&E departments.

5. The Committee congratulates the work done so far in developing Liaison Psychiatry services and asks that commissioners and providers work together to ensure the successes are consolidated and the service fully rolled out across the county.

[23] Evidence from Kent and Medway NHS and Social Care Partnership Trust and NHS kent and Medway, HOSC Agenda 3 February 2012, p.20-21

6. The role of GPs in ensuring the goal of each person receiving the most appropriate treatment at the right time is achieved cannot be underestimated. We ask NHS Kent and Medway to provide assurances that all of the emerging Clinical Commissioning Groups are leading on the work to develop the urgent and emergency care pathway.

7. The rollout of 111 is a great opportunity accompanied by great risks. There is only one chance to introduce it properly. The Committee requests that the commissioners of the service and relevant providers involve the HOSC and other key stakeholders early on in the development of the communication and implementation strategies.

8. The creation of the Health and Wellbeing Board and transfer of substantial public health responsibilities to local government provides a golden opportunity to develop integrated preventive health plans and we ask the Health and Wellbeing to prioritise work which will reduce the number of people entering the urgent and emergency care pathway in the first place.

9. The HOSC requests that NHS Kent and Medway produce a written report for the Committee by the end of the year detailing what success has been achieved in reducing attendance at A&E and what plans have been agreed with the NHS provider Trusts in order to further meet the challenge.

Appendix – Committee Meeting Information

(a) In the first part of 2011, the Health Overview and Scrutiny Committee of Kent County Council held a series of meetings into *NHS Financial Sustainability.* In the resulting report, the Committee undertook to carry out a series of further whole systems reviews focussing on some of the key areas impacting financial sustainability across the Kent health economy.

(b) To provide a focus to the discussions, the Committee looked to answering the following two strategic questions:

- What is the impact of the current levels of attendance at accident and emergency departments on the sustainability of health services across Kent and Medway?
- How can levels of attendance best be reduced?

(c) The HOSC held three meeting on the first of these reviews, *Reducing Accident and Emergency Admissions.* The dates of these meetings, along with names of organisations attending are below along with links to the Agendas. The evidence provided to the Committee from NHS organisations in Kent and Medway can be found in the respective Agendas.

- 14 October 2011
    - NHS Kent and Medway
    - South East Coast Ambulance Service NHS Foundation Trust
    - Kent Community Health NHS Trust
    - Kent Local Medical Committee
        - Link: http://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=3502&Ver=4
- 25 November 2011
    - East Kent Hospitals NHS University Foundation Trust
    - Medway NHS Foundation Trust
    - Dartford and Gravesham NHS Trust
    - Maidstone and Tunbridge Wells NHS Trust
        - Link: http://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=3503&Ver=4
- 3 February 2012
    - NHS Kent and Medway

- Kent and Medway NHS and Social Care Partnership Trust
- Kent Local Medical Committee

  - Link: http://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=3977&Ver=4

(d) Preliminary findings were published and discussed at the meeting of 6 January 2012.

  - Link: http://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=3976&Ver=4

(e) The Committee would like to thank everyone involved in the inquiry for their openness and informative engagement with the process. The HOSC has always aimed at a constructive engagement with the local NHS and believes that scrutiny should lead to positive outcomes. The following findings and recommendations are offered in this spirit.