Item 9: North Kent: Emergency and Urgent Care Review and Redesign (Long Term)

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 10 October 2014

Subject: North Kent: Emergency and Urgent Care Review and Redesign (Long Term)

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by NHS Swale CCG.

It provides additional background information which may prove useful to Members for Agenda Items 8 and 9.

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1. Introduction

(a) On 18 January 2013 NHS Medical Director Professor Sir Bruce Keogh announced a comprehensive review of the NHS urgent and emergency care system in England. *The End of Phase One Report*, published on 13 November 2013, outlined the case for change and proposals for improving urgent and emergency care services in England.

(b) The report made proposals in five key areas for the future of urgent and emergency care services in England:

- Provide better support for people to self-care;
- Help people with urgent care needs to get the right advice in the right place, first time;
- Provide highly responsive urgent care services outside of hospital so people no longer choose to queue in A&E;
- Ensure that those people with more serious or life threatening emergency care needs receive treatment in centres with the right facilities and expertise in order to maximise chances of survival and a good recovery;
- Connect all urgent and emergency care services together so the overall system becomes more than just the sum of its parts.

(c) Phase two of the review is now under way, overseen by a delivery group comprised of more than 20 different clinical, managerial and patients' associations. A report on progress was published in August 2014. Actions taken by the Review Team included the development of commissioning guidance and specifications for new ways of delivering urgent and emergency care; identifying sites to trial new models of delivery for urgent and emergency care and 7 day services; and developing new payment mechanisms for urgent and emergency care services, in partnership with Monitor (NHS England Urgent and Emergency Care Review Team 2014).

2. National pressures

(a) Keogh reported that the current system of urgent and emergency care is under 'intense, growing and unsustainable pressure' (Keogh 2013: 5). Each year the NHS deals with 438 million visits to a pharmacy in England for health related reasons; 340 million GP consultations; 24 million calls to NHS urgent and emergency care telephone services; 7 million emergency ambulance journeys and 21.7 million attendances at A&E departments, minor injury units and urgent care centres. Demand for these services has been rising year on year with almost a 50% increase in emergency hospital admissions over the last 15 years.

(b) Further, Keogh stated that 'A&E departments have become victims of their own success' (Keogh 2013: 5). Keogh cites three reasons for the growing pressures on urgent and emergency care:

- A rising demand from an aging population with increasingly complex needs and often multiple, long-term conditions;
- A 'confusing and inconsistent array of services' outside hospital such as walk-in centres and minor injury units;
- A high public trust in the A&E brand.

3. Winter Pressures

(a) In August 2013, the Prime Minister announced that 53 NHS Trusts, identified as being under the most pressure, would benefit from an additional £500 million over the next two years to ensure their Accident and Emergency departments are fully prepared for winter (Department of Health 2013).

(b) £221 million non-recurrent funding was allocated to Trusts for winter 2013/14 including Dartford and Gravesham NHS Trust (£4 million) and Medway NHS Foundation Trust (£6.1 million). This allocation was followed up in November 2013 by a further £150 million distributed across all 157 Clinical Commissioning Groups in England (NHS England 2013).

(c) Further initiatives to relieve winter pressure on A&E in 2013/14 included the development of the Better Care Fund, a £3.8 billion integration fund to join up health and social care services and a £15 million cash injection to NHS 111 to prepare the service for potential winter pressures (Department of Health 2013).

(d) In June 2014 it was announced that Urgent Care Working Groups, which were established to reduce winter pressures in 2013/14, would become System Resilience Groups to provide year round capacity planning (NHS England 2014a). In August 2014, an additional £2.6 million of funding was announced to grow and support the work of volunteers in hospitals to reduce winter pressures (NHS England 2014b).

4. Types of Emergency Care

(a) Emergency care departments are divided into a number of types, corresponding to different levels of care provision (House of Commons Library 2014).

(b) Type 1 departments are defined as those with a consultant led 24-hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients. They are sometimes known as 'major' A&E departments, and are the kinds of large facilities that are traditionally associated with A&E. Type 1 departments make up around two-thirds of all A&E attendances in England (House of Commons Library 2014).

(c) Type 2 departments are consultant led facilities with a single specialty, such as ophthalmology or dentistry. An example of this is Moorfields Eye Hospital in London whose A&E department accounts for around one-seventh of all type 2 attendances in England. Around 15% of NHS providers recorded in the NHS England statistics operate a type 2 emergency department (House of Commons Library 2014).

(d) Type 3 departments are other types of A&E/minor injury unit with designated accommodation. They may be doctor-led or nurse-led and treats at least minor injuries/illnesses. They can be routinely accessed without appointment. They exclude NHS walk-in centres and services which are mainly or entirely appointment-based such as GP practices or outpatient clinics. Type 3 departments make up just under a third of all A&E attendances (House of Commons Library 2014).

5. Key Trends – Attendance

(a) In 2013/14 there were 21.8 million attendances at England's A&E departments. 65% of attendances were at Type 1 departments. A&E attendances in England represented almost 87% of all emergency attendances in the UK. Despite the perception that A&E attendance has risen substantially, Type 1 departments have experienced only a modest rise in attendance since 2004, with 7% higher attendance recorded at Type 1 departments in 2013/14 than in 2004/05. While attendances at Type 1 departments have risen in line with changes in the level and age structure of the population, attendances at Type 3 departments have risen at a faster rate (House of Commons Library 2014).

(f) The elderly are most likely to attend A&E, and are most likely to arrive by ambulance. Of working age adults, those aged 20-24 have the highest rate of attendance at A&E. Attendances for those aged 85+ have risen 20% more than would be predicted by population growth alone (House of Commons Library 2014).

(c) A&E departments tend to register more attendances in the summer and fewer in the winter. January is the quietest month, while the period from late spring to mid-summer is the busiest. 59% of A&E attendances occur between 09.00 and 18.00; only 9% of A&E attendances are between the hours of midnight and 07.00. Monday is the busiest day in A&E, with levels of attendance almost 10% above the daily average and 8% above the second-busiest day, Sunday (House of Commons Library 2014).

(d) In 2012/13 dislocation/joint injury/fracture/amputation (4.4%) was the most common category of first diagnosis for A&E patients, followed by sprain/ligament injury (3.7%) and gastrointestinal conditions (3.7%). Over half the recorded patients in 2012/13 received either no treatment or only guidance: 37% of A&E attendance resulted in only guidance or advice and a further 14% resulted in no treatment (House of Commons Library 2014).

(e) Attendance rates at A&E are higher in England and Northern Ireland than in Scotland or Wales. In England, attendances are highest relative to population size in major cities and lowest in rural areas. In 2013/14 the highest A&E attendance rate was in Birmingham & the Black County and lowest in Lancashire (House of Commons Library 2014).

Table 1 - A&E attendance rates per 1,000 resident populations

NHS Area	**Type 1** (per 1000 population)	**Type 2 & 3** (per 1000 population)
Birmingham & the Black County	343	237
Lancashire	210	66
Kent and Medway	262	113

6. Key Trends – Performances

(a) There are a variety of measures of waiting times at A&E, including average time to treatment, average time spent in A&E, and percentage of patients spending less than four hours in A&E. NHS England has a target that 95% of patients at A&E departments should be discharged, admitted or transferred within four hours of their arrival. This is measured on a quarterly basis against all A&E departments (House of Commons Library 2014).

(b) Medway NHS Foundation Trust was one of the providers with the highest % of patients (14.4%) waiting over four hours in Type 1, 2 & 3 A&E departments in April - June 2014. The worst performing provider was South Devon Healthcare NHS Foundation Trust with 16.4% of patients waiting over four hours. Table 2 shows the % of patients

spending over 4 hours in a Type 1 A&E department and rank[1] for the four acute providers in Kent (House of Commons Library 2014).

Table 2 - Provider-level waiting times data for Type 1 A&E departments in Kent

Provider	**2012**		**2013**	
	%	**Rank**	**%**	**Rank**
Dartford and Gravesham NHS Trust	4.7%	47	5.0%	49
East Kent Hospitals University NHS Foundation Trust	6.4%	89	6.7%	93
Maidstone and Tunbridge Wells NHS Trust	7.2%	108	4.4%	33
Medway NHS Foundation Trust	6.0%	82	11.1%	134

(c) The number and percentage of patients spending over four hours in A&E has risen in recent years. 2014 has so far seen higher rates of patients spending over four hours in A&E than previous years in England. In 2013/14 the number of patients spending over four hours in A&E departments was 38% than in 2004/05 and almost three times higher than in 2005/06 (House of Commons Library 2014).

(d) The average time to treatment is just under one hour which has remained stable since 2008. Patients who are eventually admitted to hospital typically spend twice as long in A&E as those who are not. 70% of patients who are admitted to hospital spend longer than 3 hours in A&E, while 19% of those who are discharged with no follow-up and 27% of those who are discharged with a GP follow-up spend longer than three hours. Almost a quarter of all admitted patients leave A&E in the ten-minute period between 3 hours 50 minutes and 4 hours after their arrival (House of Commons Library 2014).

(d) The number and percentage of patients admitted to hospital via Type 1 departments has risen in recent years. Around three-quarters of all emergency admissions are via A&E departments. 99% of admissions are Type 1 A&E departments, with only 42,000 coming via Type 2 & 3 departments in 2013/14. 3.8 million patients were admitted to hospital via a Type 1 department – just over a quarter of all attendees at Type 1 departments in 2013/14. There was a 6.6% increase in admissions at Type 1 departments in the quarter ending June 2014 than the equivalent quarter in 2013. The percentage of long waiting times for admissions is closely related to overall A&E performance (House of Commons Library 2014).

[1] 140 Trusts, who provide Type 1 A&E departments, were ranked using NHS England Weekly A&E SitReps Data; rank 1 had the lowest and rank 140 had the highest % of patients spending over 4 hours in a Type 1 A&E department and

7. Potential Substantial Variation of Service

(a) It is for the Committee to determine if this service change constitutes a substantial variation of service.

(b) Medway Health and Adult Social Care Overview and Scrutiny Committee considered the proposals on 30 September 2014. They determined that this service change constituted a substantial variation of service. If the HOSC determines the proposed service change to be substantial, a Joint HOSC will need to be established.

(c) If the HOSC deems this service change as not being substantial, this does not prevent the HOSC from reviewing the proposed change at its discretion and making reports and recommendations to NHS Dartford, Gravesham and Swanley CCG, NHS Medway CCG and NHS Swale CCG.

(d) If the HOSC determines this proposed change of service to be substantial, a timetable for consideration of the change will need to be agreed between the Joint HOSC and NHS Dartford, Gravesham and Swanley CCG, NHS Medway CCG and NHS Swale CCG after the meeting. The timetable will include the proposed date that NHS Dartford, Gravesham and Swanley CCG, NHS Medway CCG and NHS Swale CCG intends to make a decision as to whether to proceed with the proposal and the date by which the HOSC will provide any comments on the proposal.

(e) If a Joint HOSC is established, the power to refer to the Secretary of State will not be delegated to the joint committee, the power to refer will remain with the individual committees (Kent HOSC and Medway HASC) which appointed the joint committee.

8. Recommendation

If the proposed service change is *not substantial:*

RECOMMENDED that guests be thanked for their attendance at the meeting, that they be requested to take note of the comments made by Members during the meeting and that they be invited to attend a meeting of the Committee in three months.

If the proposed service change is *substantial*:

RECOMMENDED that:

(a) The proposed service change constitutes a substantial variation of service and that a Joint HOSC be established with Medway Council, with the Kent HOSC receiving updates on the work of the Joint Committee.

(b) Guests be thanked for their attendance at the meeting and that they be requested to take note of the comments made by Members during the meeting.

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Background Documents

Cabinet Office (2014) '*£2.6 million funding for volunteers that support hospitals (08/08/2014)*', https://www.gov.uk/government/news/26million-funding-for-volunteers-that-support-hospitals

Department of Health (2013) '*Prime Minister announces £500 million to relieve pressures on A&E (09/08/2013)*', https://www.gov.uk/government/news/prime-minister-announces-500-million-to-relieve-pressures-on-ae

House of Commons Library (2014) *'Accident and Emergency in the UK: Statistics (22/09/2014)*', http://www.parliament.uk/briefing-papers/sn06964/accident-and-emergency-care-in-the-uk-statistics

Keogh KBE, Sir Bruce (2014) *'Transforming urgent and emergency care services in England - Urgent and Emergency Care Review: End of Phase 1 Report (13/11/2013)*', http://www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.FV.pdf

NHS England (2013) *'Winter Pressures – Media Briefing Note (01/11/2013)*', http://www.england.nhs.uk/wp-content/uploads/2013/11/150mill-ease-wntr-pres.pdf

NHS England (2014a) *'Operational resilience and capacity planning for 2014/15 (13/06/2014)',* http://www.england.nhs.uk/wp-content/uploads/2014/06/op-res-cap-plan-1415.pdf

NHS England (2014b) *'Volunteer groups to get £2m to support vulnerable patients this winter (08/08/2014)*', http://www.england.nhs.uk/2014/08/08/winter-volunteer/

NHS England Urgent and Emergency Care Review Team (2014) *'Transforming urgent and emergency care services in England - Update on the Urgent and Emergency Care Review (19/08/2014)*', http://www.nhs.uk/NHSEngland/keogh-review/Documents/uecreviewupdate.FV.pdf

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